# Prison Rape Elimination Act (PREA) Audit Report
## Juvenile Facilities

☐ **Interim** ☒ **Final**

**Date of Report** April 26, 2021

## Auditor Information

| | |
|---|---|
| **Name:** Robert Burns Latham | **Email:** RobertBLatham@icloud.com |
| **Company Name:** Latham Corrections Consulting LLC | |
| **Mailing Address:** 677 Idlewild Circle | **City, State, Zip:** Birmingham, Alabama 35205 |
| **Telephone:** 205-746-1905 | **Date of Facility Visit:** September 10-11, 2020 |

## Agency Information

| | | | |
|---|---|---|---|
| **Name of Agency**<br>Wayne Halfway House, Inc | | **Governing Authority or Parent Agency** *(If Applicable)*<br>Click or tap here to enter text. | |
| **Physical Address:** 942 Andrew Jackson Drive | | **City, State, Zip:** Waynesboro, Tennessee 38485 | |
| **Mailing Address:** same as physical address | | **City, State, Zip:** Click or tap here to enter text. | |
| **The Agency Is:** | ☐ Military | ☒ Private for Profit | ☐ Private not for Profit |
| ☐ Municipal | ☐ County | ☐ State | ☐ Federal |
| **Agency Website with PREA Information:** https://www.standingtalltn.com/ | | | |

### Agency Chief Executive Officer

| | |
|---|---|
| **Name:** Jason Crews | |
| **Email:** waynehwh@tds.net | **Telephone:** 931-722-4166 |

### Agency-Wide PREA Coordinator

| | |
|---|---|
| **Name:** Larry Morrisett | |
| **Email:** larrywhwh@tds.net | **Telephone:** 865-210-9493 |
| **PREA Coordinator Reports to:**<br>Jason Crews | **Number of Compliance Managers who report to the PREA Coordinator:**<br>4 |

## Facility Information

| | | | |
|---|---|---|---|
| **Name of Facility:** Standing Tall Music City | | | |
| **Physical Address:** 3981 Stewarts Lane | | **City, State, Zip:** Nashville, Tennessee 37218 | |
| **Mailing Address (if different from above):** same as physical address | | **City, State, Zip:** Click or tap here to enter text. | |
| **The Facility Is:** | ☐ Military | ☒ Private for Profit | ☐ Private not for Profit |
| ☐ Municipal | ☐ County | ☐ State | ☐ Federal |

**Facility Website with PREA Information:** https://www.standingtalltn.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: Council on Accreditation (COA)
☐ N/A

**If the facility has completed any internal or external audits other than those that resulted in accreditation, please describe:**
Click or tap here to enter text.

### Facility Administrator/Superintendent/Director

| | | | |
|---|---|---|---|
| **Name:** Stacy Williams | | | |
| **Email:** stacywhwh@tds.net | | **Telephone:** 615-686-2022 | |

### Facility PREA Compliance Manager

| | | | |
|---|---|---|---|
| **Name:** Stacy Williams | | | |
| **Email:** stacywhwh@tds.net | | **Telephone:** 615-686-2022 | |

### Facility Health Service Administrator ☒ N/A

| | | | |
|---|---|---|---|
| **Name:** Click or tap here to enter text. | | | |
| **Email:** Click or tap here to enter text. | | **Telephone:** Click or tap here to enter text. | |

| Facility Characteristics | |
|---|---|
| **Designated Facility Capacity:** | 50 |
| **Current Population of Facility:** | 43 |
| **Average daily population for the past 12 months:** | 42 |
| **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 |
| **Average length of stay or time under supervision** | 4 to 6 months |
| **Facility security levels/resident custody levels** | Level III: Juvenile Justice Enhanced Security Measures |
| **Number of residents admitted to facility during the past 12 months** | 94 |
| **Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for *72 hours or more*:** | 91 |
| **Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for *10 days or more:*** | 87 |
| **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<br>☐ U.S. Marshals Service<br>☐ U.S. Immigration and Customs Enforcement<br>☐ Bureau of Indian Affairs<br>☐ U.S. Military branch<br>☐ State or Territorial correctional agency<br>☐ County correctional or detention agency<br>☐ Judicial district correctional or detention facility<br>☐ City or municipal correctional or detention facility (e.g. police lockup or city jail)<br>☐ Private corrections or detention provider<br>☐ Other - please name or describe: Click or tap here to enter text.<br>☒ N/A |
| **Number of staff currently employed by the facility who may have contact with residents:** | 83 |
| **Number of staff hired by the facility during the past 12 months who may have contact with residents:** | 187 |

| | |
|---|---|
| **Number of contracts in the past 12 months for services with contractors who may have contact with residents:** | 1 |
| **Number of individual contractors who have contact with residents, currently authorized to enter the facility:** | 6 |
| **Number of volunteers who have contact with residents, currently authorized to enter the facility:** | 0 |
| **Physical Plant** | |
| **Number of buildings:**<br><br>**Auditors should count all buildings that are part of the facility, whether residents are formally allowed to enter them or not. In situations where temporary structures have been erected (e.g., tents) the auditor should use their discretion to determine whether to include the structure in the overall count of buildings. As a general rule, if a temporary structure is regularly or routinely used to hold or house residents, or if the temporary structure is used to house or support operational functions for more than a short period of time (e.g., an emergency situation), it should be included in the overall count of buildings.** | 2 |
| **Number of resident housing units:**<br><br>**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.** | 4 |
| **Number of single resident cells, rooms, or other enclosures:** | 50 |
| **Number of multiple occupancy cells, rooms, or other enclosures:** | 0 |
| **Number of open bay/dorm housing units:** | 0 |
| **Number of segregation or isolation cells or rooms (for example, administrative, disciplinary, protective custody, etc.):** | 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<br>☒ Local hospital/clinic<br>☐ Rape Crisis Center<br>☐ Other (please name or describe: (Vanderbilt University Medical Center) |

| 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<br>☐ Agency investigators<br>☒ 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<br>☐ Local sheriff's department<br>☐ State police<br>☐ A U.S. Department of Justice component<br>☐ Other (please name or describe: Click or tap here to enter text.)<br>☐ N/A |
| **Administrative Investigations** | |
| **Number of investigators employed by the agency and/or facility who are responsible for conducting ADMINISTRATIVE investigations into allegations of sexual abuse or sexual harassment?** | 0 |
| **When the facility receives allegations of sexual abuse or sexual harassment (whether staff-on-resident or resident-on-resident), ADMINISTRATIVE INVESTIGATIONS are conducted by: Select all that apply** | ☐ Facility investigators<br>☐ Agency investigators<br>☒ 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<br>☐ Local sheriff's department<br>☐ State police<br>☐ A U.S. Department of Justice component<br>☒ Other (please name or describe: Tennessee Department of Children's Services (DCS) |

| | |
|---|---|
| | ☐ N/A |

# Audit Findings

## Audit Narrative

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

### Introduction

The Prison Rape Elimination Act (PREA) onsite audit of Standing Tall Music City (STMC) was conducted September 10-11, 2020. The parent agency for Standing Tall Music City is Wayne Halfway House, Inc. located at 942 Andrew Jackson Drive, Waynesboro, Tennessee 38485. The audit was conducted by Robert B. Latham from Birmingham, Alabama, who is a U. S. Department of Justice Certified PREA auditor for juvenile facilities. The auditor conducted the audit as a single auditor with no additional support staff. The facility contacted the auditor regarding the audit and a contract was agreed upon and signed July 2, 2020. There are no known existing conflicts of interest or barriers to completing the audit. This is the first PREA audit for the new facility.

**Wayne Halfway House, Inc. Mission Statement**
The mission of Wayne Halfway House, Inc. is to provide quality residency and in-home services that increase the number of juvenile males who permanently exit the state custody system and go on to lead successful, independent adult lives.

**Standing Tall Music City Mission Statement**
Our motivation is driven by our compassion to help these children in their journey towards becoming a healthier, happier, and more independent individual. An individual who will make good decisions and can handle all of life's future obstacles.

### Audit Methodology
### Pre-Onsite Audit Phase

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

**Notice of Audit Posting and Timeline**
The audit notice was posted July 27, 2020. The notices were in English and Spanish. The audit notice was posted using a large font and easy-to-read language on colorful green paper. The audit notices were placed throughout the facility, in places visible to all residents and staff. Pictures of the posted audit notices were emailed to the auditor on July 27, 2020 for verification. Further verification of their placement was made through observations during the onsite review. The audit notices included a statement regarding confidentiality of resident and staff correspondence with the auditor. No correspondence was received during any phase of the audit.

**Pre-Audit Questionnaire (PAQ) and Supporting Documentation**
The PAQ and supporting documentation was received August 19, 2020. The PAQ was completed on August 14, 2020 and revised October 17, 2020. The documentation was received on a flash drive. The documentation was well organized by standard. The auditor reviewed the PAQ, policy, procedures, and supporting documentation. Using the Auditor Compliance Tool and Checklist of Documentation, the auditor formed an issues log and further discussed the documentation with the PREA Coordinator while onsite.

## Requests of Facility Lists

Standing Tall Music City provided the following information for interview selections and document sampling:

| | |
|---|---|
| Complete Resident Roster | An up-to-date roster was provided upon arrival to the facility. |
| Youthful inmates/detainees | N/A (Standing Tall Music City does not accept youthful inmates/detainees.) |
| Residents with physical disabilities | None were identified. |
| Residents with cognitive disabilities | None were identified. |
| Residents who are Limited English Proficient | None were identified. |
| Lesbian, Gay, and Bisexual Residents | None were identified. |
| Transgender or Intersex Residents | None were identified. |
| Residents in segregated housing | N/A (Standing Tall Music City does not have segregated housing.) |
| Residents in isolation | None were identified or observed. |
| Residents who reported sexual abuse | None were identified. |
| Residents who reported sexual victimization during risk screening | One (1) resident reported sexual victimization during risk screening. |
| Complete Staff Roster | The staff roster and schedule were provided upon arrival to the facility. |
| Specialized Staff | Specialized staff were identified on the roster. |
| All contractors who have contact with the residents | The facility identified no contractors who have contact with the residents. |
| All volunteers who have contact with the residents | The facility has no volunteers. |
| All grievances/allegations made in the 12 months preceding the audit | 58; Zero (0) grievances concerning allegations of sexual abuse and sexual harassment |
| All allegations of sexual abuse and sexual harassment reported for investigation in the 12 months preceding the audit | 6 |
| Detailed list of number of sexual abuse and sexual harassment allegations in the 12 months preceding the audit | 6 |
| Incident Reports | 533; 6 (six) incident reports regarding sexual abuse or sexual harassment |
| All hotline calls made in the 12 months preceding the audit | Six (6); All allegations of sexual abuse or sexual harassment are reported through the DCS hotline. |

External Contacts

The following external contacts were made:

| | |
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| Just Detention International | Just Detention International reviewed their database for records and information and reported no information for the preceding 12 months. |
| Community Based Organizations (CBOs) | Nashville Children's Alliance (NCA) |
| The Tennessee Department of Children Services Hotline | The auditor contacted the Tennessee Department of Children Services Hotline at 877-237-0004. |
| SAFE/SANE Programs | SAFEs are available through Vanderbilt University Medical Center's partnership with Our Kids in Nashville. |

**Research**

Tennessee Mandated Reporter Law - Statutory citation(s): T.C.A. §§ 37-1-401, 37-1-403, 37-1-410, 37-1-412, 37-1-413, 37-1-602, 37-1-605, 40-35-111.

- Who is required to report sexual abuse?
  Any person, including, but not limited to, any: Physician, osteopathic physician, medical examiner, chiropractor, nurse or hospital personnel engaged in the admission, examination, care or treatment of persons; Any other health or mental health professional; Practitioner who relies solely on spiritual means for healing; School teacher or other school official or personnel; Judge of any court of the state; Social worker, day care center worker, or other professional child care, foster care, residential or institutional worker; Law enforcement officer; Authority figure at a community facility, including any facility used for recreation or social assemblies for educational, religious, social, health or welfare purposes, including, but not limited to, facilities operated at schools, the boy or girl scouts, the YMCA or YWCA, the boys and girls club or church or religious organizations; or

- When is a report required?
  Knowledge or reasonable cause to suspect that a child has been sexually abused, regardless of whether such person knows or believes that the child has sustained any apparent injury as a result of such abuse.

- Where does it go? The local office of the Department of Children's Services (DCS) or to the judge having juvenile jurisdiction or to the office of the sheriff or the chief law enforcement official of the municipality where the child resides. Each report of known or suspected child sexual abuse occurring in a facility licensed by the department of mental health and substance abuse services, or any hospital, shall also be made to the local law enforcement agency in the jurisdiction where such offense occurred.

- What timing and procedural requirements apply to reports?

  Reports must be made immediately. Reports may be made via telephone or otherwise, on the Department of Children's Services Central Intake Division hotline at 1-877-237-0004 (1-877-54ABUSE) or online (at: https://apps.tn.gov/carat/referral/emergency.html).

## Onsite Audit Phase

**Entrance briefing**
An entrance briefing was held with the PREA Coordinator. The auditor and the PREA Coordinator conducted an in-depth review of the standards, policy, and documentation. The agenda for the two days was discussed, and the auditor began the audit by interviewing staff and residents. The site review was conducted on the second day of the audit.

**Site review**
The auditor had access to, and observed, all areas of the facility. The auditor was provided a diagram of the physical plant during the pre-onsite phase of the audit and was thus familiar with the layout of the facility. In addition to the four living units, the auditor reviewed outside recreation, indoor gymnasium, game room, staff offices, lobby, control center, kitchen, dining room, classrooms, and the library. On the first day of the onsite audit the population of the facility was 42 juveniles.

**Processes and areas observed**
The auditor observed the intake and risk screening to better understand the process. Grievance boxes are accessible to the residents. Boxes are located in the dining room and school. Grievance forms are available. Writing utensils are available upon request. The grievance boxes are checked daily.

Phones for reporting sexual abuse, sexual harassment or for contacting external crisis intervention services are available through a resident's counselor. The staff conducting the site review described the showering process, pointed out the location of the cameras and PREA posters with telephone numbers for reporting sexual abuse and sexual harassment. The PREA posters are prominently placed in the housing units. Cross-gender announcements were observed upon entering housing units and the auditor informally asked residents about reporting and basic information about sexual safety at the facility.

**Specific area observations**
Cameras were located throughout the facility. The auditor observed the toilet and shower areas are out of view of the cameras. Residents shower one at a time behind the privacy of a swinging door. Wherever residents were present, the auditor observed officers actively supervising the residents. Classrooms were all observed to be compliant with the 1:8 ratio requirements. Classrooms were observed to have ratios of 1:5. Staff supervision and the video surveillance system mitigate blind spots.

**Exit briefing**
An exit briefing was held with the Chief Operating Officer/PREA Coordinator, Facility Director, PREA Compliance Manager, HR Director, Director of Security, and Program Assistant. The auditor discussed the onsite audit. Some additional documentation for residents interviewed was requested and provided. The documentation provided by the facility, prior to the onsite phase of the audit, did omit some required documentation. The auditor requested the PREA Coordinator review the PAQ to ensure there were no omissions. Interviews with the staff and residents demonstrated training and education were effective.

Specific areas discussed:
**115.313**
Additional Unannounced rounds are required to demonstrate the practice is fully implemented. Corrective action is complete.

**115.315**

Staff training for how to conduct cross-gender pat-down searches, and searches of transgender and intersex residents is required. Corrective action is complete.

**115.321**
Memorandum of Understanding for Victim Advocacy Services is required. Corrective action is complete.

**115.322**
The agency shall publish the investigations policy for allegations of sexual abuse and sexual harassment on its website. Corrective action is complete.

**115.335**
Specialized training for medical and mental health care staff is required. Corrective action is complete.

**115.341**
Additional 90 day risk reassessments are required for verification the practice is fully implemented. Corrective action is complete.

**115.353**
Resident refresher training is needed for outside support services for victims of sexual abuse. Corrective action is complete.

**115.354**
The agency shall establish a method to receive third-party reports of sexual abuse and sexual harassment and shall distribute publicly information on how to report sexual abuse and sexual harassment on behalf of a resident. Corrective action is complete.

## Interviews Logistics

**Location and Privacy**
Interviews were held in the indoor gymnasium. The location provided privacy, was centrally located to minimize disruption of daily activities and programing and provided room for social distancing and air circulation needed for coronavirus precautions.

**Selection Process**
Specialized staff were selected based on their respective duties in the facility. Twelve (12) officers, randomly selected from every shift, were interviewed using the random staff interview protocol. Ten (10) residents, randomly selected from each housing unit, were interviewed using the random resident interview questionnaire. The resident population was forty-two (42) on the first day of the audit. Target interviews were selected by information provided by the facility and resident interviews. One (1) residents who reported sexual victimization during risk screening was identified.

| Interview Protocols | Number of Interviews |
|---|---|
| **Administration and Agency Leadership** | |
| Agency Head Designee (Operations Manager) | 1 |
| Facility Director | 1 |
| PREA Coordinator | 1 |
| PREA Compliance Manager | 1 |
| | |

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|---|---|
| Medical Staff | 1 |
| Mental Health Staff | 1 |
| Non-Medical Staff Involved in Cross-Gender Strip Searches or Visual Body Cavity Searches | N/A |
| Administrative (Human Resources) Staff | 1 |
| Agency Contract Administrator | N/A |
| Intermediate or Higher-level Facility Staff (unannounced rounds) | 1 |
| SAFE and SANE | 1 (Our Kids) |
| Investigative Staff | 1 (DCS Investigator) |
| Staff who Perform Screening for Risk of Victimization and Abusiveness | 1 |
| Staff who Supervise Residents in Isolation (no isolation) | N/A |
| Staff on the Incident Review Team | 1 |
| Designated Staff Member Charged with Monitoring Retaliation | 1 |
| Security First Responders | 1 |
| Non-Security Staff First Responders | 1 |
| Intake Staff | 1 |
| **Random Sample of Staff** | |
| First Shift | 8 |
| Second Shift | 4 |
| Total Random Sample of Staff | 12 |
| **Volunteers Contractors who have Contact with Residents** | |
| Volunteers | N/A |
| Contractors | N/A |
| **Residents** | |
| Random Sample of Residents from all Housing Units | 9 |
| **Targeted Residents** | |
| Residents who Reported a Sexual Abuse | None identified |
| Residents with Cognitive Disabilities | None identified |
| Residents with Physical Disabilities | None identified |
| Limited English Proficient Residents | None identified |
| Gay, Lesbian, and Bisexual Residents | None identified |
| Transgendered and Intersex Residents | None identified |
| Residents in Isolation | None identified |
| Residents who Disclosed Prior Sexual Victimization During Risk Screening | 1 |
| **Interview Totals** | |
| Total Number of Staff Interviews | 28 |
| Total Number of Resident Interviews | 10 |
| Total Number of Interviews | 38 |

**Interviewed Residents Length of Time at Facility**

| Days or Months | Number of Residents |
|---|---|
| 1 Day to 31 Days | 3 |
| 32 Days to 6 Months | 4 |
| 7 Months to 12 Months | 3 |
| 13 Months Plus | 0 |
| **Total** | 10 |

**Records Review**

| Name of Record | Total Records Reviewed |
|---|---|
| Personnel Records/Documentation | 60 |
| Volunteers and Contractors Files/Documentation | 6 |
| Training Files/Documentation/Records | 30 |
| Resident Records | 26 |
| Medical/Mental Health Records and Documentation for Victims | 0 |
| Grievance Forms (Sexual Abuse and Sexual Harassment) | 0 |
| All Incident Reports (Sexual Abuse and Sexual Harassment) | 6 |
| Investigation Records (Sexual Abuse and Sexual Harassment) | (CPS/DCS) |

**Investigative Files**

| **Youth-on-Youth Sexual Victimization** | Substantiated | Unsubstantiated | Unfounded |
|---|---|---|---|
| Nonconsensual Sexual Acts | 0 | 0 | 0 |
| Abusive Sexual Contact | 0 | 0 | 0 |
| Sexual Harassment | 4 | 0 | 0 |
| | | | |
| **Staff-on-Youth Sexual Abuse** | 0 | 0 | 0 |
| Staff Sexual Misconduct | 0 | 0 | 0 |
| Staff Sexual Harassment | 2 | 0 | 0 |

| **Reporting Method** | **Sexual Abuse** | | **Sexual Harassment** | |
|---|---|---|---|---|
| | Youth-on-Youth | Staff-on-Youth | Youth-on-Youth | Staff-on-Youth |
| Hotline | 0 | 0 | 0 | 0 |
| Grievance | 0 | 0 | 0 | 0 |
| Verbal Report | 0 | 0 | 4 | 2 |
| Anonymous | 0 | 0 | 0 | 0 |
| Third Party | 0 | 0 | 0 | 0 |
| Reports by Staff | 0 | 0 | 0 | 0 |

## Facility Characteristics

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

### Characteristics Related to PREA and Sexual Safety

| Introduction | |
|---|---|
| Parent Agency | Wayne Halfway House, Inc |
| Other Significant Relationship Information | Contracted with the Tennessee Department of Children's Services |
| Facility Name | Standing Tall Music City |

| | |
|---|---|
| Facility Address | 3981 Stewart's Lane. Nashville, TN 37218 |
| Age of Facility | 2019; The facility opened in October of 2019. |
| Total Facility Rated Capacity | 50 |
| **Resident Population Size and Makeup** | |
| Average daily population in the last 12 months | 40 |
| Actual population on day 1 of the onsite portion of the audit | 42 |
| Population Gender | Male |
| Population Ethnicity | Multiethnic |
| Average Length of Stay | 4 to 6 months |
| **Staff Size and Makeup** | |
| Total Staff Size | 83 |
| Number of Security Staff | 83 |
| Types of Supervision Practiced: | Direct Supervision |
| Number of Volunteers who may have contact with residents | 0 |
| Number of Contractors who may have contact with residents | 6 |
| Number of Interns who may have contact with residents | 0 |
| **Number and Type of Housing Units** | |
| Number of single-occupancy cells | 50 |
| Number of multiple-occupancy cells | 0 |
| Number of open-bay dorms | 0 |
| Number of segregation/isolation units | 0 |
| Number of medical units | 0 |
| Number of closed units | 0 |
| Type of Supervision (direct or indirect) | Direct |
| Video Monitoring | yes |

## Facility Operations

**Physical Plant Description**
Standing Tall Music City is located at 3981 Stewart's Lane, Nashville, TN 37218. Standing Tall Music City is a Residential Treatment Center that includes a 37,540 square foot building composed of 50 individual dorms for our residents, office space, classrooms, a large library, an indoor gym, indoor recreational areas, and a large cafeteria for meals. There is also a large enclosed outdoor recreational area, where our residents can remain physically active. A shaded picnic area is convenient on sunny days and is used for special events. A state of the art greenhouse (currently not in use) ensures that residents have access to other beneficial tasks, such as growing and nurturing their own plants.

**Services Available**
Standing Tall Music City provides Level 3 residential treatment services to residents admitted to their care. The youth are provided assistance through clinical services which include a psychological and educational assessment, as well as involvement in a therapeutic treatment program. The residents are under care 24 hours a day and have been determined to have significant emotional and psychological treatment needs.

Supportive Services

- Individual, group, and family case management and counseling
- Alcohol and Drug abuse prevention and education counseling
- Behavior support and management

Education and Vocational Assistance
- In-house schooling offered
- Assistance with college or vocational school admissions
- Job placement and monitoring

Recreation and Activities
- Recreation program geared toward the interests of the residents
- Independent living skills training and practice
- Community activities including but not limited to movies, sports, paid employment, volunteer work, and participation in community events when possible

## Summary of Audit Findings

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

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

### Standards Exceeded

**Number of Standards Exceeded:** 1

**List of Standards Exceeded:**

Standard 115.331 Employee Training

### Standards Met

**Number of Standards Met:** 34

**List of Standards Met:**

### Standards Not Met

**Number of Standards Not Met:** 8

**List of Standards Not Met:**

Standard 115.313 Supervision and monitoring
Standard 115.315 Limits to cross-gender viewing and searches
Standard 115.321 Evidence protocol and forensic medical examinations
Standard 115.322 Policies to ensure referrals of allegations for investigations
Standard 115.335 Specialized training: Medical and mental health care
Standard 115.341 Screening for risk of victimization and abusiveness
Standard 115.353 Resident access to outside confidential support services
Standard 115.354 Third-party reporting

# PREVENTION PLANNING

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

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

**115.311 (a)**

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

**115.311 (b)**

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

**115.311 (c)**

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

**Auditor Overall Compliance Determination**

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

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

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

**Instructions for Overall Compliance Determination Narrative**

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

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

**The following evidence was analyzed in making the compliance determination:**

**Documents:**

1. WHWH Policy 6.13 Zero-Tolerance Standards and Guidelines for Sexual Harassment, Assault or Rape Incidents and PREA
2. WHWH Policy 6.13.a Zero-Tolerance Standards and Guidelines for Sexual Harassment, Assault or Rape Incidents and PREA
3. WHWH Policy 6.4 Abuse Reporting
4. DCS Policy 18.8 Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
5. Wayne Provision Organizational Structure
6. STMC Organizational Chart
7. STMC Pre-Audit Questionnaire responses

**Interviews:**

1. Interview with the PREA Coordinator
2. Interview with the PREA Compliance Manager

**Site Review Observations:**
Observations during on-site review of physical plant

**Findings (By Provision):**

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

WHWH policy states a commitment to a zero-tolerance standard for all forms of sexual abuse, sexual harassment, assault, misconduct, and rape through private provider implementation of PREA as outlined in Public Law 108-79, Section 3. The policy outlines how the facility will implement the zero-tolerance approach to preventing, detecting, and responding to sexual abuse, assault, misconduct, sexual harassment, or rape. Definitions of prohibited behaviors are found in a glossary at the end of the policy.

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

The WHWH Chief Operations Officer serves as the PREA Coordinator. The PREA Coordinator is identified on the facility's organizational chart. The PREA Coordinator confirmed he has sufficient time and authority to develop, implement and oversee agency efforts to comply with the PREA standards.

**115.311 (c)**
PAQ: The facility has designated a PREA Compliance Manager. The PREA Compliance Manager has sufficient time and authority to coordinate the facility's efforts to comply with the PREA standards. The position of the PREA Compliance Manager is in the agency's organizational structure.

Each facility designates a PREA Compliance Manager. The PREA Compliance Manager for the facility is the Facility Director. During the onsite phase of the audit the facility's PREA Compliance Manager was the Compliance Manager. The Facility PREA Compliance Manager confirmed she has sufficient time and authority to coordinate facility efforts to comply with the PREA Juvenile Standards. The Compliance Manager is no longer employed at the facility.

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

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

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

**115.312 (a)**

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

**115.312 (b)**

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

**Auditor Overall Compliance Determination**

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

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

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

**Instructions for Overall Compliance Determination Narrative**

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

**The following evidence was analyzed in making the compliance determination:**

**Documents:**

1. WHWH Policy 6.13.a Zero-Tolerance Standards and Guidelines for Sexual Harassment, Assault or Rape Incidents and PREA
2. DCS Policy 18.8 Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
3. STMC Pre-Audit Questionnaire responses
4. Tennessee Department of Children's Services (DCS) Contract

**Findings (By Provision**):

**115.312 (a)**

The Tennessee Department of Children's Services (DCS) contracts for the confinement of its residents with Standing Tall Music City. The contract specifies STMC's obligation to adopt and comply with the PREA standards. The auditor reviewed the contract for verification.

**115.312 (b)**

The contract provides for DCS contract monitoring to ensure STMC is complying with the PREA standards. The auditor reviewed the contract for verification.

**Corrective Action**

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

## Standard 115.313: Supervision and monitoring

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

**115.313 (a)**

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

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

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

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

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

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

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

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

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

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

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

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

**115.313 (b)**

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

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

**115.313 (c)**

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

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

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

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

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

**115.313 (d)**

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

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

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

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

**115.313 (e)**

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

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

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

**Auditor Overall Compliance Determination**

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

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

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

**Instructions for Overall Compliance Determination Narrative**

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

**The following evidence was analyzed in making the compliance determination:**

**Documents:**

1. WHWH Policy 11.1 Residential Treatment Services – Residency Care Services (Staffing Plan)
2. WHWH Policy 6.13.a Zero-Tolerance Standards and Guidelines for Sexual Harassment, Assault or Rape Incidents and PREA
3. DCS Policy 18.8 Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
4. 2020 Staffing Plan Assessment
5. Unannounced Supervisory Rounds
6. STMC Daily Activity Schedules
7. STMC Pre-Audit Questionnaire responses

**Documents (Corrective Action):**

1. Unannounced Supervisory Rounds

**Interviews:**

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

**Site Review Observations:**

Observations during on-site review of physical plant

**Findings (By Provision):**

**115.313 (a)**
PAQ: Since the 2017 PREA audit:

1. The average daily number of residents: 40
2. The average daily number of residents on which the staffing plan was predicated: 45

WHWH policy states the agency has developed, documented, and makes its best efforts to comply on a regular basis with a staffing plan that provides for adequate levels of staffing, and, where applicable, video monitoring, to protect residents against abuse. The auditor reviewed the staffing plan and verified it is inclusive of all standard requirements.

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

**115.313 (b)**
PAQ: Each time the staffing plan is not complied with, the facility documents and justifies all deviations from the staffing plan.
Policy states STMC and its employees shall comply with the following staffing plan except during limited and discrete exigent circumstances and shall fully document any deviations from this plan during such circumstances.

WHWH policy states Wayne Halfway House, Inc. and its employees shall comply with the following staffing plan except during limited and discrete exigent circumstances and shall fully document any deviations \from this plan during such circumstances.

Documentation of facility staff to youth ratio compliance, accounting for every hour of every day, including during school hours, is available for Department of Children's Services staff to review upon request. This documentation includes: Staff names and units supervised. Information documenting which youth were on each unit during the same times must also be available.

The Facility Director confirmed there have been no circumstances in which the facility has been unable to meet the requirements of the staffing plan, with the exception of exigent circumstances during a period of a COVID-19 outbreak. The facility documents all instances of non-compliance with the staffing plan and includes an explanation for non-compliance.

**115.313 (c)**
PAQ:

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

2. The facility maintains staff ratios of a minimum of 1:8 during resident waking hours.
3. The facility maintains staff ratios of a minimum of 1:16 during resident sleeping hours.
4. In the past 12 months:
5. The number of times the facility deviated from the staffing ratios of 1:8 security staff during resident waking hours: Zero (0)
6. The number of times the facility deviated from the staffing ratios of 1:16 security staff during resident sleeping hours: Zero (0)

WHWH policy states staff persons counted in the staff-to-youth ratio are persons who have been hired and properly trained to provide direct program services. When necessary, other personnel who have completed appropriate training may also be assigned to perform direct care duties and, at that given time, may be counted in the staff-to-youth ratios of 1:8 day and night. Ratios are followed except during limited and discrete exigent circumstances, which shall be fully documented.

The Facility Director confirmed STMC is obligated by DCS to maintain ratios of staff-to-youth ratios of 1:8 during the day and 1:16 at night. He ensures the facility maintains appropriate staffing ratios through holdovers and call-ins. The auditor observed the staff-to-youth ratios to be in compliance with the standard requirements.

**115.313 (d)**
PAQ: At least once every year the agency or facility, in collaboration with the PREA Coordinator, reviews the staffing plan to see whether adjustments are needed to:
1. The staffing plan;
2. Prevailing staffing patterns;
3. The deployment of monitoring technology; or
4. The allocation of agency or facility resources to commit to the staffing plan to ensure compliance with the staffing plan.

WHWH policy states as part of the Annual Risk Assessment, the Executive Director meets with the PREA Coordinator, Security Supervisor, Performance and Quality Improvement Coordinator, and any other assigned administrative staff members to review the staffing plan and determine whether adjustments are needed, assessing each area below. The Wayne Halfway House, Inc. staffing plan takes into consideration each of the following:
1. Generally accepted juvenile secure residential practices;
2. Any judicial findings of inadequacy;
3. Any findings of inadequacy from Federal investigative agencies;
4. Any findings of inadequacy from internal or external oversight bodies;
5. All components of the facility's plant (including "blind spots" or areas where staff or residents may be isolated);
6. The composition of the resident population, if changes have occurred;
7. The number and placement of supervisory staff;
8. Programs/activities occurring on a particular shift;
9. Any applicable State or local laws, regulations, or standards;
10. The prevalence of substantiated and unsubstantiated incidents of sexual abuse;
11. Prevailing staffing patterns;
12. The deployment of video monitoring systems and other monitoring technologies;
13. The allocation of agency/facility resources to commit to the staffing plan to ensure compliance; and
14. Any other relevant factors.

This annual review of the Staffing Plan shall be included in each Annual Risk Assessment, which is presented for assessment by the Board of Directors. If changes are recommended, they shall be documented as a revision to this procedure.

The PREA Compliance Manager confirmed being consulted regarding any assessments of, or adjustments to, the staffing plan for STMC. She confirmed the assessment occurs annually and is documented through the Staffing Plan Assessment. The auditor reviewed the 2020 Staffing Plan Assessment for verification.

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

WHWH policy states intermediate-level and higher-level staff shall conduct unannounced rounds to identify and deter staff sexual abuse and sexual harassment or any other staff misconduct. Each unannounced round shall be documented. Over time the unannounced rounds shall cover all shifts and all areas of the facility. Staff members are prohibited from alerting other staff members of the conduct of such rounds.

The Director of Security confirmed the PAQ responses. He stated the unannounced rounds are documented in logbooks as “PREA Checks” in red ink. He prevents staff from alerting other staff that he is conducting the unannounced rounds by not announcing they are occurring and not conducting them on a set schedule.

PREA Site Review: During the onsite tour of the facility the auditor observed the living units and classrooms were compliant with the staffing ratios. Staff were actively engaging with the residents and supervising them.

**Corrective Action**
Based upon review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding supervision and monitoring. Corrective action is complete.

**115.313 (e)**
Documentation of documented unannounced rounds covering all shifts was required for verification this standard provision is fully implemented. The auditor requested documentation of the unannounced rounds be provided period of three months to demonstrate the procedure is institutionalized. The facility completed the rounds and provided them for verification.

## Standard 115.315: Limits to cross-gender viewing and searches

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

**115.315 (a)**

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

**115.315 (b)**

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

**115.315 (c)**

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

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

**115.315 (d)**

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

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

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

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

**115.315 (e)**

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

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

**115.315 (f)**

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

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

**Auditor Overall Compliance Determination**

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

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

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

**Instructions for Overall Compliance Determination Narrative**

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

**The following evidence was analyzed in making the compliance determination:**

**Documents:**
1. WHWH Policy 9.1.a Resident Rights – Privacy from Cross-Gender Viewing and During Transgender and Intersex Searches
2. WHWH Policy 11.1.s Searches
3. STMC Pre-Audit Questionnaire responses

**Documents (Corrective Action):**
1. Staff Training Records

**Interviews:**
1. Interview with the PREA Coordinator
2. Interviews with a Random Sample of Staff
3. Interviews with a Random Sample of Residents
4. Interviews with Transgendered and Intersex Residents – N/A

**Site Review Observations**:
Observations during on-site review of physical plant

**Findings (By Provision):**

**115.315 (a)**
PAQ: The facility does not conduct cross-gender strip or cross-gender visual body cavity searches of residents.
In the past 12 months:

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

STMC does not conduct cross-gender strip searches or cross-gender visual body cavity searches.

**115.315 (b)**
PAQ: The facility does not permit cross-gender pat-down searches of residents, absent exigent circumstances.
In the past 12 months:

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

STMC does not conduct cross-gender pat-down searches except in exigent circumstances. Exigent circumstances would include emergency situations involving a threat to life, limb, or property.

Policy review and interviews with staff and residents confirmed cross-gender searches are restricted.

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

WHWH policy states although Wayne Halfway House, Inc. does not perform any cross-gender strip searches, cross-gender visual body cavity searches, and cross-gender pat-down searches, should such a search ever occur, Wayne Halfway House, Inc. shall document and justify all cross-gender strip searches, cross-gender visual body cavity searches, and cross-gender pat-down searches.

**115.315 (d)**
PAQ:

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

WHWH policy states residents have the right to shower, perform bodily functions, and change clothing without staff of the opposite gender viewing their buttocks or genitalia, except in exigent circumstances or when such viewing is incidental to routine room checks (this includes viewing via video camera). In order to ensure this right, the following procedures are to be followed by all staff members:

1. Staff members of the opposite gender shall announce their presence before entering residents' rooms or bathrooms.
2. All staff members shall knock on residents' room doors and wait for response before entering, unless an emergency or dangerous situation is perceived to be occurring.

3. Two staff members shall be present when any staff member enters a resident's room, unless an emergency or dangerous situation is perceived to be occurring. In such a situation, the staff member entering without a second staff member shall call for a second staff member, who shall follow immediately into the room**.**

Resident interviews confirmed female staff announce their presence when entering the housing units and residents are never naked in full view of female staff. Male staff conduct showers.

Staff interviews confirmed female staff announce their presence before entering residents' rooms or bathrooms. Staff confirmed residents are able to dress, shower, and use the toilet without being viewed by staff of the opposite gender.

PREA Site Review: Staff conducting the tour described the shower process. Male staff monitor showers while the residents shower behind the privacy of a swinging door. Female staff are restricted from being in the area during showers.

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

WHWH policy requires staff members shall conduct searches of transgender or intersex residents in a sensitive and appropriate manner, protecting the resident's right to bodily privacy. In order to ensure this right, the following procedures are to be followed by all staff members:

1. Staff members are prohibited from searching or physically examining a transgender or intersex resident for the sole purpose of determining the resident's genital status.
2. All new staff members, as a part of pre-service training, shall participate in training on conducting searches of trans gender and intersex residents in a professional and respectful manner, consistent with security needs.

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

**115.315 (f)**
WHWH policy states all staff members shall participate in training on conducting searches of trans gender and intersex residents in a professional and respectful manner, consistent with security needs. Staff interviewed confirmed they have received such training.

**Corrective Action**
Based upon review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding limits to cross-gender viewing and searches. Corrective action is complete.

**115.315 (f)**
Staff training for how to conduct cross-gender pat-down searches, and searches of transgender and intersex residents was required. Staff training logs were provided for verification the training has been received.

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

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

**115.316 (a)**

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

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

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

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

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

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

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

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

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

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

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

**115.316 (b)**

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

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

**115.316 (c)**

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

**Auditor Overall Compliance Determination**

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

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

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

**Instructions for Overall Compliance Determination Narrative**

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

**The following evidence was analyzed in making the compliance determination:**

**Documents:**

1. WP Policy 9.1 Client Rights
2. WHWH Policy 8.8 Special Needs Residents
3. WHWH Policy 6.13.a Zero-Tolerance Standards and Guidelines for Sexual Harassment, Assault or Rape Incidents and PREA
4. DCS Policy 18.8 Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
5. STMC Pre-Audit Questionnaire responses
6. Linguistica International Interpreting Service Agreement
7. End Silence: Youth Speaking Up about Sexual Abuse in Custody
    - Billy Speaks Out is for male youth ages 14-18.
    - Carlo's Question is for LGBTQ youth
    - Charlie's Report is for male youth ages 10-13
8. Resident Handbook (English and Spanish)
9. Hotline Numbers and Outside Support Services (English and Spanish)
10. Special Education Teacher's Certification

**Interviews:**

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

**Site Review Observations:**
Observations during on-site review of physical plant

**Findings (By Provision):**

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

WHWH policy states appropriate provisions will be made as necessary for residents who are of limited English proficiency, have disabilities (including those who are deaf or hard of hearing, those who are blind or have low vision), and those with low intellectual functioning, psychiatric, or speech or reading disabilities. Residents in need will be evaluated on a case-by-case basis as to the most appropriate way to provide materials, and provisions will be made for each within the same time limits as other residents. STMC utilizes the End Silence: Youth Speaking Up about Sexual Abuse in Custody. The series is intended for youth 10-13, 14-18, and LGBTI youth. Linguistica International provides reliable, effective, and authentic document translations in over 350 languages and American Sign Language interpretation (ASL). Special education teachers are available as needed.

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

**115.316 (b)**

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

Spanish-speaking only residents will be provided with an interpreter for assessments and to provide educational materials. In addition, the resident handbook with PREA materials will be provided in Spanish. STMC has a contract with Linguistica International.

There were no residents identified as limited English proficient during the onsite audit.

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

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

WHWH policy states the agency does not rely on resident interpreters for PREA information and education except in urgent circumstances where safety may be compromised.

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

**Corrective Action**
Based upon review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding residents with disabilities and residents who are limited English proficient. No corrective action is required.

## Standard 115.317: Hiring and promotion decisions

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

**115.317 (a)**

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

- Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has been convicted of engaging or attempting to engage in sexual activity in the

community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse? ☒ Yes ☐ No

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

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

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

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

**115.317 (b)**

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

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

**115.317 (c)**

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

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

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

**115.317 (d)**

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

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

**115.317 (e)**

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

**115.317 (f)**

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

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

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

**115.317 (g)**

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

**115.317 (h)**

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

**Auditor Overall Compliance Determination**

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

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

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

**Instructions for Overall Compliance Determination Narrative**

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

**The following evidence was analyzed in making the compliance determination:**

**Documents:**

1. WP Policy 4.3 Recruitment and Selection
2. WHWH Policy 4.3 Recruitment and Selection
3. WHWH Policy 4.4 Background Checks
4. WHWH Policy 6.13.a Zero-Tolerance Standards and Guidelines for Sexual Harassment, Assault or Rape Incidents and PREA
5. DCS Policy 4.1 Employee Background Checks
6. DCS Policy 18.8 Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
7. STMC Pre-Audit Questionnaire responses
8. Background Check History
9. Tennessee Department of Children's Services Database Search Results
10. Employee Questionnaires for Hire, Promotions and Evaluations

**Interviews:**

1. Interview with Human Resources Staff

**Site Review Observations:**
Observations during on-site review of physical plant

**Findings (By Provision):**

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

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

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

engaged in 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.

These questions are asked during the hiring process, for promotions and during annual evaluations. The auditor reviewed Employee Questionnaires for hire verification. There have been no promotions or annual evaluations conducted at the facility.

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

The STMC Human Resources Director confirmed the facility considers prior incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any contractor, who may have contact with residents.

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

WHWH policy states background checks on all prospective employees and independent contractors will be performed in accordance with all standards of the State of Tennessee Department of Children's Services, as stated in DCS Administrative Policies and Procedures 4.1 Employee Background Checks, the DCS Contract Provider Manual, and PREA §115.317. These checks include Tennessee Department of Children's Services Database Search Results.

During the past 12 months:

1. The number of persons hired who may have contact with residents who have had criminal background record checks: 187
2. The percent of persons hired who may have contact with residents who have had criminal background record checks: 100%

The STMC Human Resources Director confirmed the facility performs criminal record background checks and considers pertinent civil or administrative adjudications for all newly hired employees who may have contact with residents and all employees, who may have contact with residents, who are being considered for promotions. The facility also consults the Tennessee Department of Children's Services Database

The auditor reviewed Employee Background Checks and Tennessee Department of Children's Services Database Search Results for verification.

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

WHWH policy states Wayne Halfway House, Inc. shall complete a criminal background record check and consult applicable child abuse registries (or receive a copy of the criminal background check and consultation of applicable child abuse registries performed on the employee of a subcontracting agency by that subcontracting agency) before enlisting the services of any subcontractor who may have contact with residents.

During the past 12 months:

1. The number of contracts for services where criminal background record checks were conducted on all staff covered in the contract who might have contact with residents: 7
2. The percent of contracts for services where criminal background record checks were conducted on all staff covered in the contract who might have contact with residents: 100%

The STMC Human Resources Director confirmed the facility performs criminal record background checks and considers pertinent civil or administrative adjudications before enlisting the services of any contractor who may have contact with residents. The facility also consults the Tennessee Department of Children's Services Database

The auditor reviewed Contractor Background Checks and Tennessee Department of Children's Services Database Search Results for verification.

**115.317 (e)**

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

WHWH policy requires criminal records background check of current employees and contractors are conducted annually.

The auditor reviewed criminal background record checks of current employees and contractors for verification.

**115.317 (f)**

WHWH policy states during all pre-hiring interviews, the interviewer shall ask the candidate and document the answers as to whether the candidate:

a. 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);
b. Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or
c. Has been civilly or administratively adjudicated to have engaged in the activity described in paragraph (2) of this section.

In addition, the above questions shall be asked during interviews for hiring or promotions and in any interviews or written self-evaluations conducted as part of reviews of current employees. All employees have a continuing affirmative duty to disclose any such misconduct.

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

of current employees. STMC also imposes upon employees a continuing affirmative duty to disclose any such previous misconduct.

These questions are asked during the hiring process, for promotions and during annual evaluations. The auditor reviewed Pre-Employment Questionnaires for verification.

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

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

**115.317 (h)**
The STMC Human Resources Director confirmed STMC shall provide information on substantiated allegations of sexual abuse or sexual harassment involving a former employee upon receiving a request from an institutional employer for whom such employee has applied to work.

**Corrective Action**
Based upon review and analysis of the available evidence, the auditor has determined the agency and facility exceeds this standard regarding hiring and promotion decisions. New employees and contractors receive an extensive criminal records background check upon hire and annually thereafter. No corrective action is required.

## Standard 115.318: Upgrades to facilities and technologies

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

**115.318 (a)**

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

**115.318 (b)**

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

**Auditor Overall Compliance Determination**

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

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

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

**Instructions for Overall Compliance Determination Narrative**

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

**The following evidence was analyzed in making the compliance determination:**

**Documents:**
1. STMC Pre-Audit Questionnaire responses

**Interview:**
1. Interview with the Agency Head Designee (Operations Manager)
2. Interview with the Facility Director

**Site Review Observations:**
Observations during on-site review of physical plant

**Findings (By Provision):**

**115.318 (a)**
PAQ: The agency or facility has acquired a new facility or made a substantial expansion or modification to existing facilities since August 20, 2012.

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

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

The Operations Manager and Facility Director both confirmed when installing or updating a video monitoring system, electronic surveillance system, or other monitoring technology, the agency shall consider how such technology may enhance the agency's ability to protect residents from sexual abuse.

PREA Site Review:
The auditor observed the video monitoring system.

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

# RESPONSIVE PLANNING

## Standard 115.321: Evidence protocol and forensic medical examinations

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

**115.321 (a)**

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

**115.321 (b)**

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

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

**115.321 (c)**

- Does the agency offer all residents who experience sexual abuse access to forensic medical examinations, whether on-site or at an outside facility, without financial cost, where 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 the compliance determination:**

**Documents:**

1. WP Policy 6.4 Abuse Reporting Risk Prevention and Management
2. WHWH Policy 6.4 Abuse Reporting
3. WHWH Policy 6.13.a Zero-Tolerance Standards and Guidelines for Sexual Harassment, Assault or Rape Incidents and PREA
4. DCS Policy 14.25 Special Child Protective Services Investigations
5. DCS Policy 18.8 Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
6. Investigations Statement
7. STMC Pre-Audit Questionnaire responses

**Document (Corrective Action):**
MOU with Nashville Children's Alliance: https://nashvillechildrensalliance.org/

**Interviews:**

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

**Site Review Observations:**
Observations during on-site review of physical plant

**Findings (By Provision):**
**115.321 (a)**
PAQ: STMC is not responsible for conducting administrative or criminal sexual abuse investigations (including resident-on-resident sexual abuse or staff sexual misconduct).

DCS is responsible for conducting administrative sexual abuse investigations. DCS investigators work directly with the Metro Police Department for criminal sexual abuse investigations.

Staff interviewed confirmed they know and understand the agency's protocol for obtaining usable physical evidence if a resident alleges sexual abuse. They acknowledged DCS/CPS and local law enforcement are responsible for conducting sexual abuse investigations.

**115.321 (b)**
STMC is not responsible for conducting any form of criminal or administrative sexual abuse investigations.

**115.321 (c)**

PAQ: The facility offers all residents who experience sexual abuse access to forensic medical examinations. Forensic medical examinations are offered without financial cost to the victim. Where possible, examinations are conducted by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs). When SANEs or SAFEs are not available, a qualified medical practitioner performs forensic medical examinations.
During the past 12 months:

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

DCS has a statewide network of Rape Crisis Centers to provide residents who experience sexual abuse access to forensic medical examinations. SAFEs and SANEs are available through the Vanderbilt University Medical Center and Our Kids in Nashville. Our Kids is a Nashville nonprofit that provides expert medical evaluations and crisis counseling in response to concerns of child sexual abuse. Our Kids offers free 24/7 coverage to 47 Middle Tennessee counties. The auditor contacted Our Kids to confirm availability of the services.

**115.321 (d)**
PAQ: STMC makes a victim advocate from a rape crisis center available to the victim, in person or by other means.

The facility has a Memorandum of Understanding with Nashville Children's Alliance for victim advocate services.

There were no residents who reported a sexual abuse present during the onsite audit.

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

There were no residents who reported a sexual abuse present during the onsite audit.

**115.321 (f)**
PAQ: STMC is not responsible for administrative or criminal investigating allegations of sexual abuse and relies on another agency to conduct these investigations. DCS policy outlines they are the responsible agency, and they follow the requirements of paragraphs §115.321 (a) through (e) of the standards.

The auditor reviewed DCS Policy 14.25 Special Child Protective Services Investigations for verification.

**Corrective Action**
Based upon review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding evidence protocol and forensic medical examinations. Corrective action is complete.

**115.321 (d)**
The facility has a Memorandum of Understanding with Nashville Children's Alliance for victim advocate services.

## Standard 115.322: Policies to ensure referrals of allegations for investigations

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

**115.322 (a)**

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

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

**115.322 (b)**

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

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

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

**115.322 (c)**

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

**115.322 (d)**

- Auditor is not required to audit this provision.

**115.322 (e)**

- Auditor is not required to audit this provision.

**Auditor Overall Compliance Determination**

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

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

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

**Instructions for Overall Compliance Determination Narrative**

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

**The following evidence was analyzed in making the compliance determination:**

**Documents:**

1. WHWH Policy 6.4 Abuse Reporting
2. WHWH Policy 6.13.a Zero-Tolerance Standards and Guidelines for Sexual Harassment, Assault or Rape Incidents and PREA
3. DCS Policy 14.25 Special Child Protective Services Investigations
4. DCS Policy 18.8 Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
5. Incident Reports/Referrals
6. STMC Pre-Audit Questionnaire responses

**Document (Corrective Action):**

1. Investigations policy for allegations of sexual abuse and sexual harassment - published on its website

**Interview:**
Interview with the Agency Head Designee (Operations Manager)

**Site Review Observations:**
Observations during on-site review of physical plant

**Findings (By Provision):**
**115.322 (a)**
PAQ: STMC ensures that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment.
In the past 12 months:

1. The number of allegations of sexual abuse and sexual harassment that were received: Six (6)
2. The number of allegations resulting in an administrative investigation: Two (2)
3. The number of allegations referred for criminal investigation: Two (2)
4. Referring to allegations received in the past 12 months, all administrative and/or criminal investigations were completed: Yes

DCS policy ensures that an administrative or criminal investigation is competed for all allegations of sexual abuse, sexual assault, sexual misconduct, and sexual harassment. All incidents are documented on the Tennessee Family and Child Tracking System (TFACTS). The agency head designee stated STMC ensures that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment. He stated DCS is responsible for all investigations and local law enforcement is involved for criminal investigations.

The auditor reviewed four (4) allegations of youth-on-youth sexual harassment and two (2) allegations of staff-on-youth sexual harassment. The auditor reviewed the allegations were referred to DCS/CPS for investigation.

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

WHWH Policy 6.13.a Zero-Tolerance Standards and Guidelines for Sexual Harassment, Assault or Rape Incidents and PREA is not published on the facility's website at. The policy requires that all allegations of sexual abuse or sexual harassment be referred for investigation to DCS. All incidents are documented on the Tennessee Family and Child Tracking System (TFACTS). The auditor verified the policy is published on the STMC website and reviewed documentation of referrals of allegations of sexual abuse and sexual harassment.

**115.322 (c)**
WHWH Policy 6.13.a Zero-Tolerance Standards and Guidelines for Sexual Harassment, Assault or Rape Incidents and PREA describes the responsibilities of both the STMC and DCS.

The auditor reviewed the policy and verified the policy describes investigative responsibilities of both the agency and DCS.

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

The Tennessee Department of Children's Services (DCS) has policy governing the conduct of sexual abuse and sexual harassment investigations. The auditor reviewed DCS Policy 14.25 Special Child Protective Services Investigations and DCS Policy 18.8 Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA for verification.

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

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

**Corrective Action**
Based upon review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding policies to ensure referrals of allegations for investigations. Corrective action is complete.

**115.322 (b)**
The agency published the investigations policy for allegations of sexual abuse and sexual harassment on its website. The auditor reviewed the website for verification.

# 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 the compliance determination:**

**Documents:**

1. WP Policy 10.2 Employee Training and Development
2. WHWH Policy 6.13.a Zero-Tolerance Standards and Guidelines for Sexual Harassment, Assault or Rape Incidents and PREA
3. DCS Policy 18.8 Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
4. DCS Policy 20.20 Guidelines for Managing Children/Youth in DCS Custody Related to Sexual Orientation, Gender Identity and Expression
5. STMC Pre-Audit Questionnaire responses
6. Training Materials used for Pre-Service and Annual In-Service Training
7. PREA Training Orientation Video
8. Form CS-0940 Employee/Volunteer/Contractor Acknowledgement and Notification of Prison Rape Elimination Act (PREA)
9. Training Sign-In sheets
10. Preservice Training Final Exams

**Interview:**
Interview with a Random Sample of Staff

**Site Review Observations:**
Observations during on-site review of physical plant

**Findings (By Provision):**
**115.331 (a)**
PAQ: STMC trains all employees who may have contact with residents on the eleven (11) required topics.

All STMC employees who have contact with residents complete training on:
(1) Its zero-tolerance policy for sexual abuse and sexual harassment; (2) How to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures; (3) Residents' right to be free from sexual abuse and sexual harassment; (4) The right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment; (5) The dynamics of sexual abuse and sexual harassment in juvenile facilities; (6) The common reactions of juvenile victims of sexual abuse and sexual harassment; (7) How to detect and respond to signs of threatened and actual sexual abuse and how to distinguish between consensual sexual contact and sexual abuse between residents; (8) How to avoid inappropriate relationships with residents; (9) How to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents; (10) How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities; and (11) Relevant laws regarding the applicable age of consent.

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

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

WHWH policy states training shall be tailored to the unique needs and attributes of residents of juvenile facilities and to the gender of the residents. The employee shall receive additional training if the employee is reassigned from a facility that houses only female residents.

The auditor reviewed staff training records for verification.

**115.331 (c)**
PAQ: The number of staff currently employed by the facility, who may have contact with residents, who were trained or retrained on PREA requirements: 83
The percent of staff currently employed by the facility, who may have contact with residents, who were trained or retrained on PREA requirements: 100%

WHWH policy states employees that have direct contact with residents will receive training during orientation or in-service and through annual refresher training thereafter.

The auditor reviewed the PREA training curriculum and staff training records for verification.

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

WHWH policy states all employees shall sign form CS0940, Employee Acknowledgement and Notification of Prison Rape Elimination Act (PREA) to acknowledge they have read the DCS zero-tolerance policy and understand the training they have received.

The auditor reviewed employee acknowledgement forms and staff training records for verification.

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

## Standard 115.332: Volunteer and contractor training

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

**115.332 (a)**

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

**115.332 (b)**

- Have all volunteers and contractors who have contact with residents been notified of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents (the level and type of training provided to volunteers and

contractors shall be based on the services they provide and level of contact they have with residents)? ☒ Yes ☐ No

**115.332 (c)**

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

**Auditor Overall Compliance Determination**

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

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

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

**Instructions for Overall Compliance Determination Narrative**

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

**The following evidence was analyzed in making the compliance determination:**

**Documents:**

1. WP Policy 10.2 Employee Training and Development
2. WHWH Policy 6.4 Abuse Reporting
3. WHWH Policy 6.13.a Zero-Tolerance Standards and Guidelines for Sexual Harassment, Assault or Rape Incidents and PREA
4. DCS Policy 18.8 Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
5. DCS Policy 20.20 Guidelines for Managing Children/Youth in DCS Custody Related to Sexual Orientation, Gender Identity and Expression
6. STMC Pre-Audit Questionnaire responses
7. Training Materials used for Pre-Service and Annual In-Service Training
8. PREA Training Orientation Video
9. Form CS-0940 Employee/Volunteer/Contractor Acknowledgement and Notification of Prison Rape Elimination Act (PREA)
10. Preservice Training Final Exams

**Interviews:**
Interviews with Volunteers who have Contact with Residents (no volunteers)

**Site Review Observations:**
Observations during on-site review of physical plant

**Findings (By Provision):**

**115.332 (a)**

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

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

WHWH policy states all volunteers who have contact with residents will be trained on their responsibilities under the agency's sexual abuse and sexual harassment prevention, detection, and response policies and procedures.

The auditor reviewed the training curriculum and volunteer/contractor acknowledgement form for verification.

**115.332 (b)**

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

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

**115.332 (c)**

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

WHWH policy states all Wayne Half-Way House, Inc., volunteers, and contractors shall sign form CS0940, Employee Acknowledgement and Notification of Prison Rape Elimination Act (PREA) to acknowledge they have read the DCS zero-tolerance policy and understand the training they have received. Wayne Half-Way House, Inc. will maintain documentation on all employees, volunteers and contractors who receive training on PREA.

The auditor reviewed the volunteer/contractor acknowledgement form for verification.

**Corrective Action**

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

## Standard 115.333: Resident education

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

**115.333 (a)**

- During intake, do residents receive information explaining the agency's zero-tolerance policy regarding sexual abuse and sexual harassment? ☒ Yes ☐ No

- During intake, do residents receive information explaining how to report incidents or suspicions of sexual abuse or sexual harassment? ☒ Yes ☐ No

- Is this information presented in an age-appropriate fashion? ☒ Yes ☐ No

**115.333 (b)**

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

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

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

**115.333 (c)**

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

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

**115.333 (d)**

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

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

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

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

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

**115.333 (e)**

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

**115.333 (f)**

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

**Auditor Overall Compliance Determination**

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

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

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

**Instructions for Overall Compliance Determination Narrative**

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

**The following evidence was analyzed in making the compliance determination:**

**Documents:**

1. WHWH Policy 8.8 Special Needs Residents
2. WHWH Policy 6.13.a Zero-Tolerance Standards and Guidelines for Sexual Harassment, Assault or Rape Incidents and PREA
3. DCS Policy 18.8 Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
4. STMC Pre-Audit Questionnaire responses
5. Youth Acknowledgement of PREA Standards for STMC
6. DCS form CS-0939, Youth Acknowledgment and Notification of Prison Rape Elimination Act (PREA)
7. End Silence: Youth Speaking Up about Sexual Abuse in Custody
   - Billy Speaks Out is for male youth ages 14-18.

- Carlo's Question is for LGBTQ youth
- Charlie's Report is for male youth ages 10-13

8. Resident Handbook (English and Spanish)
9. Hotline Numbers and Outside Support Services (English and Spanish)
10. Pamphlet - "Your Right to be Safe from Sexual Abuse and Assault – A Guide for Youth"
11. DCS Pamphlet - "A Teen's Guide to Reporting Abuse" (English and Spanish)
12. Special Education Teacher's Certification
13. PREA Video
14. PREA Quiz

**Interviews:**

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

**Site Review Observations:**
Observations during on-site review of physical plant

**Findings (By Provision):**
**115.333 (a)**
PAQ: Residents receive information at time of intake about the zero-tolerance policy and how to report incidents or suspicions of sexual abuse or sexual harassment. This information is provided in an age appropriate fashion. Of residents admitted during the past 12 months: The number who were given this information at intake: 71

WHWH policy states during the intake process, residents receive information explaining, in an age appropriate fashion, the 90 day risk reassessments zero-tolerance policy regarding sexual abuse, sexual assault, sexual misconduct, and sexual harassment and how to report incidents or suspicions of sexual abuse or sexual harassment, retaliation by other residents or staff for reporting sexual abuse and sexual harassment, and staff neglect or violation of responsibilities that may have contributed to such incidents.

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

The auditor reviewed intake records of residents entering the facility in the past 12 months and residents interviewed for verification. This information is documented with the Youth Acknowledgement of PREA. The auditor also reviewed relevant education materials including resident handbooks, pamphlets, and the "End Silence" Youth Training Booklets.

**115.333 (b)**
PAQ: Of residents admitted during the past 12 months the number who received such education within 10 days of intake: 60

Written and verbal information on PREA is provided and explained to all residents within forty-eight (48) hours of arrival and includes at a minimum:

1. STMC zero-tolerance policy regarding PREA;
2. prevention and intervention;
3. self-protection and how to avoid risk situations;
4. consequences for engaging in any type of sexual activity while at the facility;
5. how to obtain medical and mental health treatment and counseling;
6. how to safely report sexual abuse.

The PREA Compliance Manager confirmed STMC ensures that residents are educated regarding their rights to be free from sexual abuse and sexual harassment, and to be free from retaliation for reporting such incidents, and regarding agency policies and procedures for responding to such incidents by providing the information in various educational formats and requiring the residents to sign an acknowledgment form stating they understand then information. She confirmed residents are made aware of these rights within twenty-four (24) hours after intake and take a PREA quiz within 10 days after intake. Residents interviewed confirmed they were informed of their right not to be sexually abused and sexually harassed, how to report, and their right not to be punished for reporting, during the intake process. Residents stated they received the information on their first or second day at the facility. They also confirmed they received information about the facility's rules against sexual abuse and harassment.

The auditor reviewed intake records of residents entering the facility in the past 12 months and residents interviewed for verification. This information is documented with the Youth Acknowledgement of PREA. The auditor also reviewed relevant education materials including resident handbooks, pamphlets, and the "End Silence" Youth Training Booklets.

**115.333 (c)**
PAQ: All residents were educated within 10 days of intake.

WHWH policy requires that residents who are transferred from one facility to another be educated regarding their rights to be free from sexual abuse and sexual harassment and to be free from retaliation for reporting such incidents, and regarding agency policies and procedures for responding to such incidents to the extent that the policies and procedures of the new facility differ from those of the previous facility.

The PREA Compliance Manager confirmed all residents are educated on the facility's zero-tolerance policy on sexual abuse and sexual harassment regardless if they are transferred from other facilities.

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

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

WHWH policy states appropriate provisions are made as necessary for residents who are of limited English proficiency, have disabilities (including those who are deaf or hard of hearing, those who are blind or have low vision), and those with low intellectual functioning, psychiatric, or speech or reading disabilities. Spanish-speaking only residents will be provided with an interpreter for assessments and to provide educational materials. Residents in need of interpreters, other than Spanish, are evaluated

on a case-by-case basis as to the most appropriate way to provide materials, and provisions will be made for each within the same time limits as other residents.

STMC utilizes the End Silence: Youth Speaking Up about Sexual Abuse in Custody. The series is intended for youth 10-13, 14-18, and LGBTI youth. The facility provides PREA educational materials in Braille and has an agreement for a sign-language interpreter for deaf or hard of hearing youth. Special education teachers are available as needed.

**115.333 (e)**
PAQ: The agency maintains documentation of resident participation in PREA education sessions.

WHWH policy states all residents are required to sign DCS form CS-0939, Youth Acknowledgment and Notification of Prison Rape Elimination Act (PREA) to acknowledge they have been notified and informed of PREA and on how to report incidents of sexual abuse/assault/misconduct/harassment. Copies of the signed form will be sent to the resident's parents/guardians, family services worker, and the original signed form will be maintained in the resident's case file.

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

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

The auditor reviewed the resident handbook, pamphlets, and other educational materials available in English and Spanish.

During the site review the auditor observed PREA posters are placed prominently in areas of the facility that are easily accessible by the residents.

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

## Standard 115.334: Specialized training: Investigations

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

**115.334 (a)**

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

**115.334 (b)**

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

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

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

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

**115.334 (c)**

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

**115.334 (d)**

- Auditor is not required to audit this provision.

**Auditor Overall Compliance Determination**

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

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

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

**Instructions for Overall Compliance Determination Narrative**

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

**The following evidence was analyzed in making the compliance determination:**

**Documents:**

1. WHWH Policy 6.13.a Zero-Tolerance Standards and Guidelines for Sexual Harassment, Assault or Rape Incidents and PREA
2. DCS Policy 5.2 Professional Development and Training Requirements
3. DCS Policy 18.8 Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
4. Memorandum of Understanding with Wayne County Sheriff's Department
5. STMC Pre-Audit Questionnaire responses

STMC does not conduct any form of administrative or criminal sexual abuse investigations. Investigators are employed and trained by DCS. DCS investigators receive specialized training from the Tennessee Bureau of Investigations (TBI) and National Institute of Corrections (NIC) online training in sexual abuse investigations involving juveniles.

The DCS Special Investigators Unit Training Curriculum includes:
(1) What is PREA; (2) Confined Settings and Sexual Abuse Investigations; (3) Receiving a Referral for a Sexual Abuse Investigation in a Confined Setting; (4) Gathering Information during a Sexual Abuse Investigation in a Confined Setting; (5) Conducting a Sexual Abuse Investigation within a Confined Setting; (6) Interviewing Juvenile Sexual Abuse Victims; (7) Sexual Abuse Evidence Collection in Confinement Settings; (8) False Allegations; (9) Recanting Information; (10) Witnessing Sexual Abuse; (11) Substantiating a Case for Prosecution Referral; (12) Miranda Warning; and (13) Garrity Warning

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

## Standard 115.335: Specialized training: Medical and mental health care

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

**115.335 (a)**

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

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

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to respond effectively and professionally to juvenile victims of sexual abuse and sexual harassment? (N/A if the agency

does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.) ☒ Yes ☐ No ☐ NA

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

**115.335 (b)**

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

**115.335 (c)**

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

**115.335 (d)**

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

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

**Auditor Overall Compliance Determination**

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

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

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

**Instructions for Overall Compliance Determination Narrative**

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

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

**The following evidence was analyzed in making the compliance determination:**

**Documents:**

1. WHWH Policy 6.13.a Zero-Tolerance Standards and Guidelines for Sexual Harassment, Assault or Rape Incidents and PREA
2. DCS Policy 18.8 Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
3. Training Materials used for Pre-Service and Annual In-Service Training
4. Form CS-0940 Employee/Volunteer/Contractor Acknowledgement and Notification of Prison Rape Elimination Act (PREA)
5. Staff Acknowledgement of STMC Policy and Protocol Regarding PREA
6. Training Sign-In sheets
7. STMC Pre-Audit Questionnaire responses

**Documents (Corrective Action):**

1. Medical and Mental Health Specialized Training Logs

**Interviews:**

Interviews with Medical and Mental Health Staff

**Site Review Observations:**

Observations during on-site review of physical plant

**Findings (By Provision):**

**115.335 (a)**

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

1. The number of all medical and mental health care practitioners who work regularly at this facility who received the training: Nine (9)
2. The percent of all medical and mental health care practitioners who work regularly at this facility who received the training required by agency policy:100%

Wayne Half-Way House, Inc. will ensure that all full and part time medical and mental health care practitioners who work regularly in its facilities receive training. This training shall include:

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

Interviews with medical and mental health staff confirmed they had not previously received the specialized training topics regarding sexual abuse and sexual harassment.

**115.335 (b)**

PAQ: STMC does not employee medical staff that conduct forensic exams. Forensic medical examinations are performed offsite.

Interviews with medical and mental health staff confirmed forensic medical examinations are not conducted at STMC.

**115.335 (c)**
PAQ: The agency maintains documentation showing that medical and mental health practitioners have completed the required training.

The auditor reviewed the Specialized PREA Training for Medical and Mental Health Care Standards Acknowledgement for the clinical director for verification.

**115.335 (d)**
WHWH policy states all Wayne Half-Way House, Inc. employees and contractors that have direct contact with residents will receive training during orientation or in-service and through annual refresher training thereafter. This training includes the training topics required by standard § 115.331. The level and type of training provided to volunteers and contractors shall be based on the services they provide and level of contact they have with residents, but all volunteers and contractors who have contact with residents shall be notified of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents required by standard § 115.332.

The auditor reviewed training logs of medical and mental health care practitioners to ensure they received the training for employees and contractors/volunteers (depending on their status) in the referenced standards.

**Corrective Action**
Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding specialized training for medical and mental health care. Corrective action is complete.

**115.335 (a)**
Specialized training for medical and mental health care staff was completed. The auditor reviewed a training sign-in sheet for verification.

# SCREENING FOR RISK OF SEXUAL VICTIMIZATION AND ABUSIVENESS

## Standard 115.341: Screening for risk of victimization and abusiveness

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

**115.341 (a)**

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

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

**115.341 (b)**

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

**115.341 (c)**

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

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

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

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

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

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

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

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

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

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

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

**115.341 (d)**

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

- Is this information ascertained during classification assessments? ☒ Yes ☐ No

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

**115.341 (e)**

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

**Auditor Overall Compliance Determination**

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

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

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

**Instructions for Overall Compliance Determination Narrative**

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

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

**The following evidence was analyzed in making the compliance determination:**

**Documents:**

1. WHWH Policy 6.13.a Zero-Tolerance Standards and Guidelines for Sexual Harassment, Assault or Rape Incidents and PREA
2. DCS Policy 18.8 Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
3. DCS form CS-0946 Assessment, Checklist, and Protocol for Behavior and Risk for Victimization
4. STMC Pre-Audit Questionnaire responses

**Documents (Corrective Action):**

1. Risk Reassessments

**Interviews:**

1. Interview with the PREA Coordinator
2. Interview with the Staff Responsible for Risk Screening
3. Interviews with a Random Sample of Residents

**Site Review Observations:**
Observations during on-site review of physical plant

**Findings (By Provision):**
**115.341 (a)**
PAQ: The agency has a policy that requires screening (upon admission to a facility or transfer to another facility) for risk of sexual abuse victimization or sexual abusiveness toward other residents
The policy requires that residents be screened for risk of sexual victimization or risk of sexually abusing other residents within 72 hours of their intake.
In the past 12 months:
The number of residents entering the facility (either through intake or transfer) whose length of stay in the facility was for 72 hours or more who were screened for risk of sexual victimization or risk of sexually abusing other residents within 72 hours of their entry into the facility: 42
The policy requires that a resident's risk level be reassessed periodically throughout their confinement.

WHWH policy states during the intake process, DCS form CS-0946 Assessment, Checklist, and Protocol for Behavior and Risk for Victimization will be administered to residents within twenty-four (24) hours of admission. If additional, relevant information about a resident is received by the facility after the initial screening, the counselor or designated staff member will reassess the resident's risk of victimization or abusiveness within 30 days of the resident's date of admission, based on the previous assessment and the additional information. Residents are reassessed for risk of sexual victimization or risk of sexually abusing other residents every 90 days.

The auditor reviewed completed DCS form CS-0946 Assessment, Checklist, and Protocol for Behavior and Risk for Victimization examples for verification.

The PREA Compliance Manager confirmed she screens residents upon admission to the facility or transfer from another facility for risk of sexual abuse victimization or sexual abusiveness toward other residents. She stated she screens residents for risk of sexual victimization or risk of sexually abusing

other residents within 72 hours of their intake. The information is ascertained through conversations with residents during intake, medical and mental health screenings, and reviewing any relevant court records. Resident's risk levels are reassessed every ninety (90) days.

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

**115.341 (b)**
PAQ: Risk assessment is conducted using an objective screening instrument. Such assessments shall be conducted using an objective screening instrument.

**115.341 (c)**
At a minimum, the agency shall attempt to ascertain information about:
1. Prior sexual victimization or abusiveness;
2. Any gender nonconforming appearance or manner or identification as lesbian, gay, bisexual, transgender, or intersex, and whether the resident may therefore be vulnerable to sexual abuse;
3. Current charges and offense history;
4. Age;
5. Level of emotional and cognitive development;
6. Physical size and stature;
7. Mental illness or mental disabilities;
8. Intellectual or developmental disabilities;
9. Physical disabilities;
10. The resident's own perception of vulnerability; and
11. Any other specific information about individual residents that may indicate heightened needs for supervision, additional safety precautions, or separation from certain other residents.

The PREA Compliance Manager confirmed the initial risk screening considers all aspects required by the standard.

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

The PREA Compliance Manager confirmed the information is ascertained through conversations with residents during intake, medical and mental health screenings, and reviewing any relevant court records.

**115.341 (e)** The agency shall implement appropriate controls on the dissemination within the facility of responses to questions asked pursuant to this standard in order to ensure that sensitive information is not exploited to the resident's detriment by staff or other residents.

The PREA Compliance Manager confirmed the agency has outlined who can have access to a resident's risk assessment within the facility, in order to protect sensitive information from exploitation. The individuals include the PREA Compliance Manager and Director of Security.

**Corrective Action**
Based upon review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding obtaining information from residents. Corrective action is complete.

**115.341 (a)**
Additional 90 day risk reassessments were required for verification the practice is fully implemented. The auditor requested documentation of the 90 day risk reassessments be provided for a period of three months to demonstrate the procedure is institutionalized. The facility completed the reassessments and provided them to the auditor for verification.

## Standard 115.342: Use of screening information

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

**115.342 (a)**

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

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

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

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

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

**115.342 (b)**

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

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

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

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

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

**115.342 (c)**

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

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

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

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

**115.342 (d)**

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

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

**115.342 (e)**

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

**115.342 (f)**

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

**115.342 (g)**

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

**115.342 (h)**

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

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

**115.342 (i)**

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

**Auditor Overall Compliance Determination**

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

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

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

**Instructions for Overall Compliance Determination Narrative**

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

**The following evidence was analyzed in making the compliance determination:**

**Documents:**

1. WP Policy 8.1 Behavior Support and Management
2. WHWH Policy 6.13.a Zero-Tolerance Standards and Guidelines for Sexual Harassment, Assault or Rape Incidents and PREA
3. WHWH Policy 8.1 Behavior Support and Management
4. WHWH Policy 11.1 Room Assignments
5. DCS Policy 18.8 Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
6. DCS form CS-0946 Assessment, Checklist, and Protocol for Behavior and Risk for Victimization
7. At-Risk Protocol section of DCS form CS-0946
8. Documentation of Resident Move
9. STMC Pre-Audit Questionnaire responses

**Interviews:**

1. Interview with the PREA Coordinator
2. Interview with the PREA Compliance Manager
3. Interview with Staff Responsible for Risk Screening
4. Interview with the Facility Director
5. Interview with Staff who Supervise Residents in Isolation – N/A
6. Interviews with Medical and Mental Health Staff
7. Interviews with Transgendered/Intersex/Gay/Lesbian/Bisexual Residents – N/A
8. Residents in Isolation (for risk of sexual victimization/who allege to have suffered sexual abuse) – N/A

**Site Review Observations:**
Observations during on-site review of physical plant

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

The auditor reviewed the risk assessments for verification the facility uses information from the screening information to inform housing, bed, work, education, and program assignments with the goal of keeping all residents safe and free from sexual abuse. The resident's risk levels are listed and determine room assignment. The PREA Compliance Manager confirmed the facility uses information from the risk screening during intake to keep residents safe and free from sexual abuse and sexual harassment by determining housing and room assignments.

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

1. The number of residents at risk of sexual victimization who were placed in isolation: 0

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

The Facility Director confirmed there is no use of isolation.

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

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

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

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

WHWH policy states in making housing and programming assignments for transgender or intersex residents, the facility considers on a case-by-case basis whether a placement would ensure the resident's health and safety, and whether the placement would present management or security problems.

The PREA Compliance Manager confirmed housing and programming assignments for transgendered and intersex residents are considered on a case-by-case basis whether the placement would ensure the resident's health and safety, and whether the placement would present management or security problems.

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

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

The PREA Compliance Manager confirmed placement and programming assignments are reassessed at least twice each year to review any threats to safety experienced by the resident. She stated reassessments would happen every 30 days and Safe Housing reassessments are every 90 days.

**115.342 (f)**

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

WHWH policy states a transgender or intersex resident's own views with respect to his or her own safety is given serious consideration.

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

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

WHWH policy states transgender and intersex residents are given the opportunity to shower separately from other residents.

The PREA Compliance Manager confirmed transgender and intersex residents are given the opportunity to shower separately from other residents.

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

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

If a resident is isolated pursuant to paragraph (b) of this section, the facility shall clearly document:
(1) The basis for the facility's concern for the resident's safety; and
(2) The reason why no alternative means of separation can be arranged.

STMC does not use isolation.

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

STMC does not use isolation.

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

# REPORTING

## Standard 115.351: Resident reporting

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

### 115.351 (a)

- Does the agency provide multiple internal ways for residents to privately report: Sexual abuse and sexual harassment? ☒ Yes ☐ No

- Does the agency provide multiple internal ways for residents to privately report: Retaliation by other residents or staff for reporting sexual abuse and sexual harassment? ☒ Yes ☐ No

- Does the agency provide multiple internal ways for residents to privately report: Staff neglect or violation of responsibilities that may have contributed to such incidents? ☒ Yes ☐ No

### 115.351 (b)

- Does the agency also provide at least one way for residents to report sexual abuse or sexual harassment to a public or private entity or office that is not part of the agency? ☒ Yes ☐ No

- Is that private entity or office able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials? ☒ Yes ☐ No

- Does that private entity or office allow the resident to remain anonymous upon request? ☒ Yes ☐ No

- Are residents detained solely for civil immigration purposes provided information on how to contact relevant consular officials and relevant officials at the Department of Homeland Security to report sexual abuse or harassment? (N/A if the facility *never* houses residents detained solely for civil immigration purposes.) ☐ Yes ☐ No ☒ NA

### 115.351 (c)

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

- Do staff members promptly document any verbal reports of sexual abuse and sexual harassment? ☒ Yes ☐ No

### 115.351 (d)

- Does the facility provide residents with access to tools necessary to make a written report? ☒ Yes ☐ No

- Does the agency provide a method for staff to privately report sexual abuse and sexual harassment of residents? ☒ Yes ☐ No

**Auditor Overall Compliance Determination**

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

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

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

**Instructions for Overall Compliance Determination Narrative**

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

**The following evidence was analyzed in making the compliance determination:**

**Documents:**

1. WP Policy 9.1 Grievance Policy for Clients Families
2. WHWH Policy 6.1.a Incident Reporting
3. WHWH Policy 6.13.a Zero-Tolerance Standards and Guidelines for Sexual Harassment, Assault or Rape Incidents and PREA
4. WHWH Policy 9.3 Grievance Policy for Clients Families
5. DCS Policy 18.8 Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
6. STMC Pre-Audit Questionnaire responses
7. Duty to Report - Tennessee Code Annotated 37-1-403 and 37-1-605
8. Youth Grievance Form
9. Program Handbook for Residents and Staff
10. Hotline Numbers and Outside Support Services (English and Spanish)
11. DCS Pamphlet - "A Teen's Guide to Reporting Abuse" (English and Spanish)
12. Pamphlet - "Your Right to be Safe from Sexual Abuse and Assault – A Guide for Youth"

**Interviews:**

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

**Site Review Observations:**
Observations during on-site review of physical plant

**Findings (By Provision):**

**115.351 (a)**
PAQ: The agency has established procedures allowing for multiple internal ways for residents to report privately to agency officials about: Sexual abuse or sexual harassment; Retaliation by other residents or staff for reporting sexual abuse and sexual harassment; AND Staff neglect or violation of responsibilities that may have contributed to such incidents.

WHWH policy states residents may report allegations of sexual abuse, assault, misconduct, and/or harassment internally or externally. They may also report, internally or externally, retaliation by other residents or staff members for reporting sexual abuse and harassment and staff neglect or violations of responsibilities that may have contributed to these incidents. If they choose to report internally, they may do so by telling any staff member or by filing a grievance (such grievance would be treated as an emergency or urgent situation and would be handled immediately).

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

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

WHWH policy states residents may report allegations of sexual abuse/assault/ misconduct/harassment externally to a public or private entity or office that is not part of the agency. This includes but may not be limited to:

1. Local law enforcement agencies and may remain anonymous upon request
2. Department of Children's Services Family Services Workers
3. DCS Child Abuse Hotline at 1-877-237-0004
4. Their John L. Attorney or Guardian ad Litem

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

The auditor observed posters with information for reporting sexual abuse or sexual harassment.

STMC does not detain youth solely for civil immigration purposes.

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

WHWH policy includes a Duty to Report - As per Tennessee Code Annotated 37-1-403 and 37-1-605 Pursuant to TCA 37-1-403 and 37-1-605, any person who has knowledge of or is called upon to render aid to any child/youth who is being sexually abused, sexually assaulted or sexually harassed has the duty to report such abuse. In terms of PREA standards, this duty to report includes but is not limited to any knowledge, suspicion, or information they receive regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency. Staff members may have this knowledge by any means including personal witness or reports made verbally, in writing, anonymously, by third parties or by any other means and must in all cases be reported. Any allegation received from another institution or agency must be reported and investigated in the same manner according to PREA standards and DCS mandates.

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

**115.351 (d)**
PAQ: The facility provides residents with access to tools to make written reports of sexual abuse or sexual harassment, retaliation by other residents or staff for reporting sexual abuse and sexual harassment, and staff neglect or violation of responsibilities that may have contributed to such incidents.

The PREA Compliance Manager confirmed residents would be given a pencil to make written reports of sexual abuse or sexual harassment, retaliation by other residents or staff for reporting sexual abuse and sexual harassment, and staff neglect or violation of responsibilities that may have contributed to such incidents. Grievance forms are available and the locked grievance boxes that are checked daily.

**115.351 (e)**
PAQ: The agency has established procedures for staff to privately report sexual abuse and sexual harassment of residents.

Staff report to the DCS Child Abuse Hotline at 1-877-237-0004.

Staff interviewed identified the DCS Child Abuse Hotline as a way for them to privately report sexual abuse and sexual harassment of residents. Other answers included writing grievances and reporting to supervisors.

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

## Standard 115.352: Exhaustion of administrative remedies

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

**115.352 (a)**

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

**115.352 (b)**

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

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

**115.352 (c)**

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

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

**115.352 (d)**

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

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

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

**115.352 (e)**

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

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

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

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

- If a parent or legal guardian of a juvenile files a grievance (or an appeal) on behalf of a juvenile regarding 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 the compliance determination:**

**Documents:**

1. WP Policy 9.1 Grievance Policy for Clients Families
2. WHWH Policy 9.3 Grievance Policy for Clients Families
3. WHWH Policy 6.13.a Zero-Tolerance Standards and Guidelines for Sexual Harassment, Assault or Rape Incidents and PREA
4. DCS Policy 14.15 Reporting False Allegations of Child Sexual Abuse
5. DCS Policy 24.5 DOE Youth Grievance Procedures
6. DCS Policy 18.8 Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
7. STMC Pre-Audit Questionnaire responses
8. Duty to Report - Tennessee Code Annotated 37-1-403 and 37-1-605
9. Tennessee Code Annotated 37-1-413
10. Program Handbook for Residents and Staff
11. Youth Grievance Form

**Interviews:**
Interviews with Residents who Reported a Sexual Abuse - N/A

**Site Review Observations:**
Observations during on-site review of physical plant

**Findings:**
This standard does not apply to STMC. All resident grievances regarding sexual abuse are investigated externally by DCS.

STMC does not have an administrative procedure for dealing with resident grievances regarding sexual abuse. WHWH policy allows a resident to submit a grievance regarding an allegation of sexual abuse at any time regardless of when the incident is alleged to have occurred. Agency policy 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 allows a resident to submit a grievance alleging sexual abuse without submitting it to the staff member who is the subject of the complaint. The agency's policy requires that a resident grievance alleging sexual abuse not be referred to the staff member who is the subject of the complaint.

Residents may get assistance in filing requests for administrative remedies relating to allegations of sexual abuse from third parties, including other residents, staff members, family members, attorneys, and/or outside advocates. Those third parties may also file such requests on behalf of residents. If the resident declines to have third-party assistance in filing a grievance alleging sexual abuse, staff members of Wayne Half-Way House, Inc. must document the resident's decision to decline.

Third parties, including parents, advocates, other residents, or any other person may report allegations of resident sexual abuse or sexual harassment internally by contacting any staff member or by filing an emergency grievance. It is suggested that in order to provide for immediate action, the third party directly contact the Executive Director or the Security Supervisor at 1-931-722-3272 and notifying the person answering the telephone that the situation is an emergency. This information shall be provided in the parent letter, resident handbook, Family Services Worker information letter, and be posted in the common area of the facility.

PAQ: In the past 12 months:
The number of grievances that were filed that alleged sexual abuse: Zero (0)

The auditor reviewed the Program Handbook for Residents and Staff to determine that relevant information is provided.

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

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

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

**115.353 (a)**

- Does the facility provide residents with access to outside victim advocates for emotional support services related to sexual abuse by providing, posting, or otherwise making 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 the compliance determination:**

**Documents:**

1. WHWH Policy 6.4 Abuse Reporting
2. WHWH Policy 6.13.a Zero-Tolerance Standards and Guidelines for Sexual Harassment, Assault or Rape Incidents and PREA
3. DCS Policy 18.8 Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
4. STMC Pre-Audit Questionnaire responses
5. Duty to Report - Tennessee Code Annotated 37-1-403 and 37-1-605
6. Program Handbook for Residents and Staff
7. Resident Handbook Signature Page
8. Hotline Numbers and Outside Support Services (English and Spanish)

**Documents (Corrective Action):**

1. Memorandum of Understanding with the Nashville Children's Alliance
2. Resident Handbook – updated with contact information for access to outside victim advocates for emotional support services

**Interviews:**

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

**Site Review Observations:**
Observations during on-site review of physical plant

**Findings (By Provision):**
**115.353 (a)**
PAQ: The facility provides residents access to outside victim advocates for emotional support services related to sexual abuse by:

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

WHWH policy states Wayne Halfway House, Inc. shall provide residents with access to outside victim advocates for emotional support services related to sexual abuse, by providing, posting, or otherwise making accessible mailing addresses and telephone numbers, including toll free hotline numbers where available, of local, State, or national victim advocacy or rape crisis organizations. Wayne Halfway

House, Inc., shall enable reasonable communication between residents and these organizations and agencies, in as confidential a manner as possible.

STMC developed a Memorandum of Understanding with the Nashville Children's Alliance for victim advocates for emotional support services related to sexual abuse. Residents were not knowledgeable of services available outside of the facility for dealing with sexual abuse if they ever need it.

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

WHWH policy states Standing Tall Music City. shall inform residents, prior to giving them access, of the extent to which such communications will be monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws.

There are signs posted, wherever residents have phone access, informing the residents that that their conversations would not intentionally be monitored or recorded. The signs let residents know that if they were to communicate with outside victim advocates the calls are subject to mandatory reporting laws.

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

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

STMC developed a Memorandum of Understanding with the Nashville Children's Alliance for victim advocates for emotional support services related to sexual abuse.

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

The Facility Director and PREA Compliance Manager confirmed the facility would provide residents with reasonable and confidential access to their attorneys or other legal representation and reasonable access to parents or legal guardians.

Residents confirmed the facility allows them to see or talk with their lawyer or another lawyer and they are allowed to talk with that person privately. Residents also confirmed the facility allows them to see or talk with their parents or someone else such as a legal guardian.

**Corrective Action**

Based upon review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding resident access to outside support services and legal representation. Corrective action is complete.

**115.353 (a)**
STMC developed a Memorandum of Understanding with the Nashville Children's Alliance for victim advocates for emotional support services related to sexual abuse. Residents were not knowledgeable of services available outside of the facility for dealing with sexual abuse if they ever need it.

The PREA Coordinator stated this deficiency was corrected by the following: at admission and periodically throughout a youth's time at STMC, supervisors, therapists, case managers, medical staff, and administrative staff will provide education and re-education regarding external support services for victims of sexual abuse including our agreements with Nashville Children's Alliance and Our Kids. Information was also posted on the dorms and included in the Program Handbook.

## Standard 115.354: Third-party reporting

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

**115.354 (a)**

- Has the agency established a method to receive third-party reports of sexual abuse and sexual harassment? ☒ Yes ☐ No

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

**Auditor Overall Compliance Determination**

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

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

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

**Instructions for Overall Compliance Determination Narrative**

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

**The following evidence was analyzed in making the compliance determination:**

**Documents:**

1. WHWH Policy 6.4 Abuse Reporting
2. WHWH Policy 6.13.a Zero-Tolerance Standards and Guidelines for Sexual Harassment, Assault or Rape Incidents and PREA
3. DCS Policy 18.8 Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
4. STMC Pre-Audit Questionnaire responses
5. Program Handbook for Residents and Staff
6. Hotline Numbers and Outside Support Services (English and Spanish)

**Document (Corrective Action):**

1. A link to the Department of Children's Services Central Intake Division hotline at 1-877-237-0004 (1-877-54ABUSE) and online website at: https://apps.tn.gov/carat/referral/emergency.html was published on the facility's website.

**Site Review Observations:**
Observations during on-site review of physical plant

**Findings (By Provision):**
**115.354 (a)**
PAQ: The agency or facility provides a method to receive third-party reports of resident sexual abuse or sexual harassment. This information is not distributed publicly.

Third parties, including parents, advocates, other residents, or any other person may report allegations of resident sexual abuse or sexual harassment internally by contacting any staff member or by filing an emergency grievance. It is suggested that in order to provide for immediate action, the third party directly contact the Executive Director or the Security Supervisor at 1-931-722-3272 and notify the person answering the telephone that the situation is an emergency. This notification procedure and contact information shall be provided in the parent letter, resident handbook, Family Services Worker information letter, and be posted in the common area of the facility.

**Corrective Action**
Based upon review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding third-party reporting. Corrective action is complete.

The facility did not distribute publicly information on how to report sexual abuse and sexual harassment on behalf of a resident. The auditor suggested facility reporting information is published on the facility's website. A link to the Department of Children's Services Central Intake Division hotline at 1-877-237-0004 (1-877-54ABUSE) and online website at: https://apps.tn.gov/carat/referral/emergency.html was published on the facility's website.

# OFFICIAL RESPONSE FOLLOWING A RESIDENT REPORT

## Standard 115.361: Staff and agency reporting duties

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

**115.361 (a)**

- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency? ☒ Yes ☐ No

- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding retaliation against residents or staff who reported an incident of sexual abuse or sexual harassment? ☒ Yes ☐ No

- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding any staff neglect or violation of responsibilities that may have contributed to an incident of sexual abuse or sexual harassment or retaliation? ☒ Yes ☐ No

**115.361 (b)**

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

**115.361 (c)**

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

**115.361 (d)**

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

- Are medical and mental health practitioners required to inform residents of their duty to report, and the limitations of confidentiality, at the initiation of services? ☒ Yes ☐ No

**115.361 (e)**

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

- Upon receiving any allegation of sexual abuse, does the facility head or his or her designee promptly report the allegation to the alleged victim's parents or legal guardians unless the facility has official documentation showing the parents or legal guardians should not be notified? ☒ Yes ☐ No

- If an alleged victim is under the guardianship of the child welfare system, does the facility head or his or her designee promptly report the allegation to the alleged victim's caseworker instead of the parents or legal guardians? ☒ Yes ☐ No

- If a juvenile court retains jurisdiction over the alleged victim, does the facility head or designee also report the allegation to the juvenile's attorney or other legal representative of record within 14 days of receiving the allegation? ☒ Yes ☐ No

**115.361 (f)**

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

**Auditor Overall Compliance Determination**

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

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

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

**Instructions for Overall Compliance Determination Narrative**

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

**The following evidence was analyzed in making the compliance determination:**

**Documents:**

1. WP Policy 9.2 Confidentiality and HIPPA
2. WHWH Policy 6.13.a Zero-Tolerance Standards and Guidelines for Sexual Harassment, Assault or Rape Incidents and PREA
3. WHWH Policy 6.1.a Incident Reporting
4. WHWH Policy 6.4 Abuse Reporting
5. WHWH Policy 9.2.a Limits of Confidentiality
6. DCS Policy 18.8 Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA

7. STMC Pre-Audit Questionnaire responses
8. Duty to Report - Tennessee Code Annotated 37-1-403 and 37-1-605

**Interviews:**

1. Interview with the PREA Compliance Manager
2. Interview with the Facility Director
3. Interviews with a Random Sample of Staff
4. Interviews with Medical and Mental Health Staff

**Site Review Observations:**

Observations during on-site review of physical plant

**Findings (By Provision):**

**115.361 (a)**

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

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

WHWH policy states Duty to Report - Tennessee Code Annotated 37-1-403 and 37-1-605 Laws and STMC requires all staff to report immediately and according to policy any knowledge, suspicion, or information they receive regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency; retaliation against residents or staff who reported such an incident; and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation.

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

**115.361 (b)**

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

Duty to Report - As per Tennessee Code Annotated 37-1-403 and 37-1-605 Pursuant to TCA 37-1-403 and 37-1-605, any person who has knowledge of or is called upon to render aid to any child/youth who is being sexually abused, sexually assaulted or sexually harassed has the duty to report such abuse.

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

**115.361 (c)**

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

WHWH policy states apart from reporting to the designated supervisors and designated state and local services agencies, staff members are prohibited from revealing any information related to a sexual abuse report to anyone other than to the extent necessary to make treatment, investigation, and other security and management decisions.

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

**115.361 (d)**
Medical and mental health practitioners are required to report sexual abuse to DCS. They are mandated to follow Duty to Report laws. Medical and mental health practitioners are required to inform residents at the initiation of services of their duty to report and the limitations of confidentiality.

Interviews with medical and mental health staff confirmed they disclose the limitations of confidentiality and their duty to report at the initiation of services to a resident. They confirmed they are required by law to report any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment upon learning of it. They both reported they have not become aware of such incidents.

**115.361 (e)**
WHWH policy requires that upon receiving any allegation of sexual abuse, the Executive Director or his or her designee shall promptly report the allegation to the alleged victim's parents or legal guardians, unless Wayne Halfway House, Inc. has official documentation showing the parents or legal guardians should not be notified. If the alleged victim is under the guardianship of DCS, the report shall be made to the alleged victim's Family Services Worker instead of the parents or legal guardians. If a juvenile court retains jurisdiction over the alleged victim, the Executive Director or designee shall also report the allegation to the juvenile's attorney or other legal representative of record within 14 days of receiving the allegation.

The PREA Compliance Manager confirmed when the facility receives an allegation of sexual abuse the allegation is reported to the DCS Child Abuse Hotline and the victim’s legal guardians as appropriate. This notification would usually occur during the shift in which the allegation was received. The Facility Director confirmed when the facility receives an allegation of sexual abuse the allegation is reported to the DCS Child Abuse Hotline and the victim’s legal guardians as appropriate. This notification would occur immediately upon the allegation being received. If a juvenile court retains jurisdiction over the alleged victim, she will report the allegation to the juvenile’s attorney. All allegations of sexual abuse and sexual harassment are reported to the DCS Special Investigations Unit. STMC does not conduct administrative or criminal investigations.

**115.361 (f)**
WHWH policy requires all allegations of sexual abuse must be reported immediately to the DCS Child Abuse Hotline at 1-877-237-0004. DCS ensures that an administrative or criminal investigation is completed for all allegations of sexual abuse/assault/misconduct/harassment.

The Facility Director confirmed all allegations of sexual abuse and sexual harassment (including those from third-party and anonymous sources) are reported directly to designated facility investigators.

**Corrective Action**

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

## Standard 115.362: Agency protection duties

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

**115.362 (a)**

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

**Auditor Overall Compliance Determination**

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

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

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

**Instructions for Overall Compliance Determination Narrative**

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

**The following evidence was analyzed in making the compliance determination:**

**Documents:**

1. WHWH Policy 6.13.a Zero-Tolerance Standards and Guidelines for Sexual Harassment, Assault or Rape Incidents and PREA
2. DCS Policy 18.8 Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
3. STMC Pre-Audit Questionnaire responses

**Interviews:**

1. Interview with the Agency Head Designee (Operations Manager)
2. Interview with the Facility Director
3. Interviews with a Random Sample of Staff

**Site Review Observations:**
Observations during on-site review of physical plant

**Findings:**
PAQ: When the agency or facility learns that a resident is subject to a substantial risk of imminent sexual abuse, it takes immediate action to protect the resident (i.e., it takes some action to assess and implement appropriate protective measures without unreasonable delay).
In the past 12 months:

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

WHWH policy requires upon learning that a resident is subject to a substantial risk of imminent sexual abuse, staff members on duty shall take immediate action to protect the resident. This will include but not be limited to separating the resident from any potential perpetrator of sexual abuse, providing protection as needed, and notifying the Facility Director or his/her designee for further instruction.

The Operations Manager and Facility Director confirmed immediate action would be taken to protect a resident subject to a substantial risk of imminent sexual abuse. These actions would include separating the resident from the potential perpetrator and providing one-on-one supervision with a staff member. Staff interviewed confirmed they would immediately separate a resident subject to a substantial risk of imminent sexual abuse from a potential perpetrator, provide close observation, and provide one-on-one supervision.

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

## Standard 115.363: Reporting to other confinement facilities

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

**115.363 (a)**

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

- Does the head of the facility that received the allegation also notify the appropriate investigative agency? ☒ Yes ☐ No

**115.363 (b)**

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

**115.363 (c)**

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

**115.363 (d)**

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

**Auditor Overall Compliance Determination**

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

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

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

**Instructions for Overall Compliance Determination Narrative**

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

**The following evidence was analyzed in making the compliance determination:**

**Documents:**

1. WP Policy 6.4 Abuse Reporting Risk Prevention and Management
2. WHWH Policy 6.4 Abuse Reporting
3. WHWH Policy 6.13.a Zero-Tolerance Standards and Guidelines for Sexual Harassment, Assault or Rape Incidents and PREA
4. DCS Policy 18.8 Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
5. STMC Pre-Audit Questionnaire responses

**Interviews:**

1. Interview with the Agency Head Designee (Operations Manager)
2. Interview with the Facility Director

**Site Review Observations:**
Observations during on-site review of physical plant

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

WHWH policy requires If a resident discloses that victimization occurred while the resident was confined at another facility/agency and he has not previously disclosed this, the staff member to which the information was disclosed will report the alleged abuse incident directly and immediately to the DCS Child Abuse Hotline at 1-877-237-0004, to the Department of Children's Services Family Services Worker, and the STMC Facility Director.

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

WHWH policy states upon receiving an allegation that a resident was sexually abused while confined at another facility, the Executive Director or his or her designee shall notify the head of the facility or appropriate office of the agency where the alleged abuse occurred. Notification shall be provided as soon as possible, but no later than 72 hours after receiving the allegation. The Executive Director or designee shall document in the resident's file that such notification has been made and whether it was made within 72 hours of receiving the allegation.

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

WHWH policy states the Executive Director or designee shall document in the resident's file that such notification has been made and whether it was made within 72 hours of receiving the allegation.

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

DCS ensures that an administrative or criminal investigation is completed for all allegations of sexual abuse, sexual assault, sexual misconduct, and sexual harassment.

The Operations Manager confirmed DCS and the WHWH Executive Director would be the point of contact. The Facility Director confirmed if an allegation is received from another facility or agency that an incident of sexual abuse or harassment occurred in the facility, DCS would conduct the investigation. She stated there are no examples of this occurring.

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

## Standard 115.364: Staff first responder duties

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

**115.364 (a)**

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

- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Preserve and protect any crime scene until appropriate steps can be taken to collect any evidence? ☒ Yes ☐ No

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

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

**115.364 (b)**

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

**Auditor Overall Compliance Determination**

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

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

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

**Instructions for Overall Compliance Determination Narrative**

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

**The following evidence was analyzed in making the compliance determination:**

**Documents:**

1. WHWH Policy 6.13.a Zero-Tolerance Standards and Guidelines for Sexual Harassment, Assault or Rape Incidents and PREA
2. DCS Policy 18.8 Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
3. MDHS DYS Pre-Audit Questionnaire responses

**Interviews:**
1. Interviews with Security Staff and Non-security Staff First Responders
2. Interviews with a Random Sample of Staff

**Site Review Observations:**
Observations during on-site review of physical plant

**Findings (By Provision):**
**115.364 (a)**
PAQ: The agency has a first responder policy for allegations of sexual abuse. The agency policy requires that, upon learning of an allegation that a resident was sexually abused, the first security staff member to respond to the report shall be required to:
1. Separate the alleged victim and abuser;
2. Preserve and protect any crime scene until appropriate steps can be taken to collect any evidence;
3. If the abuse occurred within a time period that still allows for the collection of physical evidence, request that the alleged victim not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating; and
4. If the abuse occurred within a time period that still allows for the collection of physical evidence, ensure that the alleged abuser does not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating.

In the past 12 months, the number of allegations that a resident was sexually abused: Zero (0)

WHWH policy requires staff follow the DCS Protocol: First Responder Guidelines for Sexual Assault for guidelines on responding to sexual assaults.

Interviews with Security Staff and Non-Security Staff confirmed they were knowledgeable of their first responder duties.

**115.364 (b)**The agencies policy requires that if the first staff responder is not a security staff member, that responder shall be required to:
1. Request that the alleged victim not take any actions that could destroy physical evidence.
2. Notify security staff.

Of the allegations that a resident was sexually abused made in the past 12 months, the number of times a non-security staff member was the first responder: Zero (0)

WHWH policy requires if the first staff responder is not a security staff member, that responder is required to request that the alleged victim not take any actions that could destroy physical evidence and the staff responder shall immediately notify the Security Supervisor, or if not available, the Executive Director.

Interviews with Security Staff and Non-Security Staff confirmed they were knowledgeable of their first responder duties. Staff interviewed were knowledgeable of their first responder duties.

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

## Standard 115.365: Coordinated response

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

**115.365 (a)**

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

**Auditor Overall Compliance Determination**

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

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

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

**Instructions for Overall Compliance Determination Narrative**

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

**The following evidence was analyzed in making the compliance determination:**

**Documents:**
1. WHWH Policy 6.13.a Zero-Tolerance Standards and Guidelines for Sexual Harassment, Assault or Rape Incidents and PREA
2. WHWH Policy 6.1 Risk Prevention and Management, Incident Reporting
3. DCS Policy 18.8 Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
4. STMC Pre-Audit Questionnaire responses
5. DCS Protocol: First Responder Guidelines for Sexual Assaults
6. Coordinated Response Plan – PREA Allegations

**Interview:**
Interview with the Facility Director

**Site Review Observation:**
Observations during on-site review of physical plant

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

STMC has a Coordinated Response Plan for PREA Allegations 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.

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

The Facility Director confirmed that after the initial actions of facility first responders and leadership, DCS coordinates the actions among medical and mental health practitioners and investigators. The STMC Coordinated Response Plan and DCS Protocol: First Responder Guidelines for Sexual Assaults is followed.

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

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

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

**115.366 (a)**

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

**115.366 (b)**

- Auditor is not required to audit this provision.

### Auditor Overall Compliance Determination

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

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

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

**Instructions for Overall Compliance Determination Narrative**

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

**The following evidence was analyzed in making the compliance determination:**

**Documents:**

1. WHWH Policy 6.13.a Zero-Tolerance Standards and Guidelines for Sexual Harassment, Assault or Rape Incidents and PREA
2. DCS Policy 18.8 Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
3. STMC Pre-Audit Questionnaire responses

**Interview:**
Interview with the Agency Head Designee (Operations Manager)

**Site Review Observations:**
Observations during on-site review of physical plant

**Findings (By Provision):**
**115.366 (a)**
PAQ: The agency, facility, or any other governmental entity responsible for collective bargaining on the agency's behalf has not entered into or renewed any collective bargaining agreement or other agreement since the last PREA audit.

The Operations Manager confirmed STMC has not entered into or renewed any collective bargaining agreements.

**115.366 (b)**
STMC has not entered into or renewed any collective bargaining agreements.

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

## Standard 115.367: Agency protection against retaliation

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

### 115.367 (a)

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

- Has the agency designated which staff members or departments are charged with monitoring retaliation? ☒ Yes ☐ No

### 115.367 (b)

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

### 115.367 (c)

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency monitor: The conduct and treatment of residents or staff who reported the sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency monitor: The conduct and treatment of residents who were reported to have suffered sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Act promptly to remedy any such retaliation? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency monitor: Any resident disciplinary reports? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency monitor: Resident housing changes? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency monitor: Resident program changes? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency monitor: Negative performance reviews of staff? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency monitor: Reassignments of staff? ☒ Yes ☐ No

- Does the agency continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need? ☒ Yes ☐ No

**115.367 (d)**

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

**115.367 (e)**

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

**115.367 (f)**

- Auditor is not required to audit this provision.

**Auditor Overall Compliance Determination**

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

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

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

**Instructions for Overall Compliance Determination Narrative**

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

**The following evidence was analyzed in making the compliance determination:**

**Documents:**

1. WHWH Policy 1.4 Protection for Reporters of Suspected Misconduct
2. WHWH Policy 6.4 Abuse Reporting
3. WHWH Policy 6.13.a Zero-Tolerance Standards and Guidelines for Sexual Harassment, Assault or Rape Incidents and PREA
4. DCS Policy 18.8 Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
5. STMC Pre-Audit Questionnaire responses
6. PREA Retaliation Log

**Interviews:**

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

**Site Review Observations:**
Observations during on-site review of physical plant

**Findings (By Provision):**
**115.367 (a)**
PAQ: The agency has a policy to protect all residents and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other residents or staff.

The Agency designates staff member(s) or charges department(s) with monitoring for possible retaliation.
The name(s) of the staff member(s): Erika Kemble
The title(s) of the staff member(s): HR Manager

WHWH policy states retaliation or negative consequences for reporting sexual abuse/harassment or cooperating with sexual abuse/harassment investigations will not be tolerated and will result in disciplinary action up to and including termination. All staff members are required to report immediately and according to WHWH policy retaliation against residents who reported sexual abuse or sexual harassment. Staff members have a duty to and must also report staff neglect or violations of responsibilities that may have contributed to an incident or retaliation.

**115.367 (b)**
WHWH policy states for a period of ninety (90) days following a report, the Executive Director will appoint a staff member on site to monitor the treatment of the resident or staff that made a report, and the resident who was reported to be abused, to identify attempts at retaliation or negative consequences and will act immediately to remedy any such actions.

The Operations Manager stated the facility would protect residents and staff from retaliation for sexual abuse or sexual harassment allegations by monitoring write-ups, looking at grievances, and reviewing

disciplinary reports. The Facility director stated the facility would make housing changes and staff would be placed on administrative leave while under investigation. The PREA Compliance Manager stated the role she plays in preventing retaliation against residents and staff who report sexual abuse or sexual harassment, or against those who cooperate with sexual abuse or sexual harassment investigations is checking in with the residents during any investigations and implementing a safety plan. She stated the different measures she would take to protect residents and staff from retaliation would be separating youth to different units. She confirmed she would initiate contact with residents who have reported sexual abuse.

The auditor reviewed documentation demonstrating youth housing changes were made to protect residents.

**115.367 (c)**
PAQ: The agency and/or facility monitors the conduct or treatment of residents or staff who reported sexual abuse and of residents who were reported to have suffered sexual abuse to see if there are any changes that may suggest possible retaliation by residents or staff.
The length of time that the agency and/or facility monitors the conduct or treatment: 90 days
The agency/facility acts promptly to remedy any such retaliation.
The agency/facility continues such monitoring beyond 90 days if the initial monitoring indicates a continuing need.
The number of times an incident of retaliation occurred in the past 12 months: Zero (0)

WHWH policy states or a period of ninety (90) days following a report, the Executive Director will appoint a staff member on site to monitor the treatment of the resident or staff that made a report, and the resident who was reported to be abused, to identify attempts at retaliation or negative consequences and will act immediately to remedy any such actions. Monitoring will include, but not be limited to:

1. Resident disciplinary reports or room changes
2. Negative performance reviews or staff reassignments
3. Periodic status checks of residents

Standing Tall Music City will continue monitoring beyond ninety (90) days if evidence indicates a continued need.

The Facility Director stated measures she would take when she suspects retaliation is staff supervision and potential termination. The PREA Compliance Manager stated things she looks for to detect possible retaliation include injuries and changes in behavior. She monitors resident disciplinary reports and housing changes. She stated she would monitor the conduct and treatment of residents and staff who report the sexual abuse of a resident or were reported to have suffered sexual abuse for 90 days. If there is concern that potential retaliation might occur, the maximum length of time that you the facility would monitor conduct and treatment would be until a youth is discharged from the facility.

The auditor reviewed the PREA Retaliation Log for verification.

**115.367 (d)**
WHWH policy states monitoring will include periodic status checks of residents. The PREA Compliance Manager stated things she looks for to detect possible retaliation include injuries and changes in behavior. The auditor reviewed the PREA Retaliation Log for verification.

**115.367 (e)**

WHWH policy states if any individual involved in a report expresses fear of retaliation, Wayne Halfway House, Inc. will take appropriate measures to protect that individual.

The Operations Manager stated if an individual who cooperates with an investigation expresses fear of retaliation, the agency takes measures to protect that individual against retaliation including separating staff from residents and staff shift changes. The Facility Director stated the different measures she would take to protect residents and staff from retaliation are removal of alleged abusers, staff no contact status, and involving law enforcement. The Facility Director stated measures she would take when she suspects is staff supervision and potential termination.

The auditor reviewed documentation demonstrating youth housing changes were made to protect residents.

**115.367 (f)**
Standing Tall Music City's responsibility to monitor retaliation will terminate if the allegation is unfounded.

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

## Standard 115.368: Post-allegation protective custody

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

**115.368 (a)**

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

**Auditor Overall Compliance Determination**

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

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

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

**Instructions for Overall Compliance Determination Narrative**

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

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

**The following evidence was analyzed in making the compliance determination:**

**Documents:**

1. WHWH Policy 6.13.a Zero-Tolerance Standards and Guidelines for Sexual Harassment, Assault or Rape Incidents and PREA
2. DCS Policy 18.8 Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
3. STMC Pre-Audit Questionnaire responses

**Interview:**
Interview with the Facility Director

**Site Review Observations:**
Observations during on-site review of physical plant

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

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

If a resident who alleges to have suffered sexual abuse is held in isolation, the facility affords each such resident a review every 30 days to determine whether there is a continuing need for separation from the general population.

The Facility Director confirmed STMC does not use isolation.

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

# INVESTIGATIONS

## Standard 115.371: Criminal and administrative agency investigations

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

**115.371 (a)**

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

- Does the agency conduct such investigations for all allegations, including third party and anonymous reports? [N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations. See 115.321(a).] ☐ Yes ☐ No ☒ NA

**115.371 (b)**

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

**115.371 (c)**

- Do investigators gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data? ☒ Yes ☐ No

- Do investigators interview alleged victims, suspected perpetrators, and witnesses? ☒ Yes ☐ No

- Do investigators review prior reports and complaints of sexual abuse involving the suspected perpetrator? ☒ Yes ☐ No

**115.371 (d)**

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

**115.371 (e)**

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

**115.371 (f)**

- Do agency investigators assess the credibility of an alleged victim, suspect, or witness on an individual basis and not on the basis of that individual's status as resident or staff?
  ☒ Yes ☐ No

- Does the agency investigate allegations of sexual abuse without requiring a resident who alleges sexual abuse to submit to a polygraph examination or other truth-telling device as a condition for proceeding? ☒ Yes ☐ No

**115.371 (g)**

- Do administrative investigations include an effort to determine whether staff actions or failures to act contributed to the abuse? ☒ Yes ☐ No

- Are administrative investigations documented in written reports that include a description of the physical evidence and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings? ☒ Yes ☐ No

**115.371 (h)**

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

**115.371 (i)**

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

**115.371 (j)**

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

**115.371 (k)**

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

**115.371 (l)**

- Auditor is not required to audit this provision.

**115.371 (m)**

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

**Auditor Overall Compliance Determination**

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

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

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

**Instructions for Overall Compliance Determination Narrative**

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

**The following evidence was analyzed in making the compliance determination:**

**Documents:**

1. WHWH Policy 6.13.a Zero-Tolerance Standards and Guidelines for Sexual Harassment, Assault or Rape Incidents and PREA
2. DCS Policy 14.7 Special Child Protective Services Investigations
3. DCS Policy 14.3 Screening, Response Priority and Assignment of Child Protective Services Cases.
4. DCS Policy 18.8 Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
5. STMC Pre-Audit Questionnaire responses

**Interviews:**

1. Interview with PREA Coordinator
2. Interview with PREA Compliance Manager
3. Interview with Facility Director
4. Interview with Investigative Staff (DCS)

**Site Review Observations**:

1. Observations during on-site review of physical plant

**Findings (By Provision):**

**115.371 (a)**
PAQ: The agency/facility does not have a policy related to criminal and administrative agency investigations.

DCS is responsible for allegations of sexual abuse or sexual harassment. The DCS investigator stated once a case is received, it takes less than 24 hours to initiate an investigation following an allegation of sexual abuse or sexual harassment. The investigator confirmed she handles anonymous or third-party reports of sexual abuse and sexual harassment in the same manner as all investigations. She begins by interviewing the individual who reported the allegation. The auditor reviewed the reports for allegations of sexual abuse and sexual harassment and observed they were received in a timely manner.

The auditor reviewed two allegations of staff-on-youth sexual harassment.

**115.371 (b)**
DCS investigators receive specialized training in sexual abuse investigations involving juveniles. The DCS investigator confirmed she received training specific to conducting sexual abuse and sexual harassment investigations in confinement settings through classroom and computer-based training. She confirmed she received the required training,

**115.371 (c)**
The DCS Investigator gathers all evidence, reviews video surveillance footage if available, and interviews alleged victims, suspected perpetrators, and witnesses. The investigation will include reviewing any prior complaints and reports of sexual abuse involving the suspected perpetrator. The investigator will not terminate the investigation solely because the victim recants the allegation.

The DCS investigator confirmed the first steps in initiating an investigation is contacting the facility where an allegation of sexual abuse or sexual harassment has been made and requesting all available information. This occurs within 24 hours. She then travels to the facility to review any video footage that may be available, and conducts interviews with the alleged victim, alleged perpetrator, and all witnesses. Direct and circumstantial evidence she would be responsible for gathering in an investigation of an incident of sexual abuse would include video footage, interviews, statements, third-party information, etc.

**115.371 (d)**
PAQ: The agency does not terminate an investigation solely because the source of the allegation recants the allegation.

The DCS investigator confirmed an investigation does not terminate if the source of the allegation recants the allegation.

**115.371 (e)**
The DCS investigator confirmed when she discovers evidence that a prosecutable crime may have taken place, she consults with prosecutors before conducting compelled interviews.

**115.371 (f)**
The DCS investigator confirmed she judges the credibility of an alleged victim, suspect, or witness based on evidence. She stated under no circumstance, does she require a resident who alleges sexual

abuse to submit to a polygraph examination or truth telling device as a condition for proceeding with an investigation.

**115.371 (g)**
The DCS investigator confirmed the efforts she makes during an administrative investigation to determine whether staff actions or failures to act contributed to the sexual abuse include investigating the allegation and coordinating with the DCS PREA Coordinator. She confirmed she documents administrative investigations in written reports. The reports include incident reports, interviews, and all available evidence.

**115.371 (h)**
The DCS investigator confirmed criminal investigations documented. There were no criminal investigations during the audit period. The investigations are documented in the appropriate TFACTS incident reporting section.

**115.371 (i)**
PAQ: Substantiated allegations of conduct that appear to be criminal are referred for prosecution. The number of sustained allegations of conduct that appear to be criminal that were referred for prosecution since the last PREA audit: Two (2)

The DCS investigator confirmed cases are referred for prosecution only when there are substantiated allegations of conduct that appears to be criminal. The auditor reviewed two allegations of staff-on-youth sexual harassment that were referred to law enforcement.

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

WHWH policy sates documentation is maintained for a period of no less than the last day of employment of an allegedly perpetrating employee, plus five (5) years and seven (7) years after a resident’s twenty-second (22nd) birthday.

**115.371 (k)**
The DCS investigator confirmed an investigation continues when a staff member alleged to have committed sexual abuse or sexual harassment terminates employment prior to a completed investigation into his/her conduct.

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

**115.371 (m)**
WHWH policy states STMC and its employees shall cooperate with outside investigators, and the Executive Director shall endeavor to remain informed about the progress of the investigation. Documentation of each attempt to remain informed shall be kept in the resident's file with the Sexual Abuse Incident Review form and associated documents.

The Facility Director stated if an outside agency investigates allegations of sexual abuse, the facility remains informed of the progress of a sexual abuse investigation through the Child Protective Services (CPS) referral tracking system. The PREA Coordinator stated he regularly communicates with the Child Protective Services Special Investigations Unit Supervisor to follow up on any issues related to ongoing or previous investigations. The Facility Administrators maintain positive relationships with outside investigators and routinely get follow-up information regarding investigation closures and findings.

The DCS investigator confirmed when an outside agency investigates an incident of sexual abuse in this facility, she would support the investigative process and communicate with the outside agency to remain informed of the progress.

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

## Standard 115.372: Evidentiary standard for administrative investigations

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

**115.372 (a)**

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

**Auditor Overall Compliance Determination**

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

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

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

**Instructions for Overall Compliance Determination Narrative**

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

**The following evidence was analyzed in making the compliance determination:**

**Documents:**

1. WHWH Policy 6.13.a Zero-Tolerance Standards and Guidelines for Sexual Harassment, Assault or Rape Incidents and PREA
2. DCS Policy 14.7 Child Protective Services Investigation Track
3. DCS Policy 14.25 Special Investigations Unit Child Protection Services Investigations
4. DCS Policy 18.8 Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
5. STMC Pre-Audit Questionnaire responses

**Interview:**
Interview with Investigative Staff (DCS)

**Site Review Observations**:
Observations during on-site review of physical plant

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

DCS policy states a report of child abuse by the alleged perpetrator may be classified as substantiated if there is a preponderance of evidence, in light of the entire record, which substantiated the individual committed physical, severe or child sexual abuse, as defined in Tennessee Code Annotated 37-1-102 or 37-1-602.

The DCS investigator confirmed she refers to the preponderance of the evidence to substantiate allegations of sexual abuse or sexual harassment.

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

## Standard 115.373: Reporting to residents

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

**115.373 (a)**

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

**115.373 (b)**

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

**115.373 (c)**

- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The staff member is no longer posted within the resident's unit? ☒ Yes ☐ No

- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The staff member is no longer employed at the facility? ☒ Yes ☐ No

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

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

**115.373 (d)**

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

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

**115.373 (e)**

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

**115.373 (f)**

- Auditor is not required to audit this provision.

**Auditor Overall Compliance Determination**

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

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

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

**Instructions for Overall Compliance Determination Narrative**

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

**The following evidence was analyzed in making the compliance determination:**

**Documents:**

1. WHWH Policy 6.13.a Zero-Tolerance Standards and Guidelines for Sexual Harassment, Assault or Rape Incidents and PREA
2. DCS Policy 18.8 Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
3. STMC Pre-Audit Questionnaire responses

**Interviews:**

1. Interview with Facility Director
2. Interview with DCS Investigator
3. Interview with Residents who Reported a Sexual Abuse – N/A

**Site Review Observations:**
Observations during on-site review of physical plant

**Findings (by provision):**
**115.373 (a)**
PAQ: The agency has a policy requiring that any resident who makes an allegation that he or he suffered sexual abuse in an agency facility is informed, verbally or in writing, as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded following an investigation by the agency.
In the past 12 months:

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

WHWHH policy states Child Protective Services notifies the Department of Children's Services Family Services Worker and the Security Supervisor of the outcome of the investigation. If necessary, the Security Supervisor will request the relevant information from Child Protective Services in order to inform the resident. When the Security Supervisor learns the outcome of the investigation, the Security

Supervisor or his/her designee will inform the alleged victim directly as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded.

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

The DCS Investigator confirmed she is aware that when a resident makes an allegation of sexual abuse, the resident must be informed as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded following an investigation.

**115.373 (b)**
PAQ: If an outside entity conducts such investigations, the agency requests the relevant information from the investigative entity in order to inform the resident of the outcome of the investigation.
In the past 12 months:

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

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

1. The staff member is no longer posted within the resident's unit;
2. The staff member is no longer employed at the facility;
3. The agency learns that the staff member has been indicted on a charge related to sexual abuse within the facility; or
4. The agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility.

There has not been a substantiated or unsubstantiated complaint (i.e., not unfounded) of sexual abuse committed by a staff member against a resident in the past 12 months. There were two (2) substantiated allegations of staff-on-youth sexual harassment.

WHWH policy states following a resident's allegation that a staff member has committed sexual abuse against the resident, Standing Tall Music City shall subsequently inform the resident (unless Child Protective Services has determined that the allegation is unfounded) whenever:

1. The staff member is no longer posted within the resident's unit (during the investigation, the staff member shall not be in any area with the resident without being directly supervised);
2. The staff member is no longer employed at the facility;
3. The agency learns that the staff member has been indicted on a charge related to sexual abuse within the facility; or
4. The agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility.

**115.373 (d)**
PAQ: Following a resident's allegation that he or she has been sexually abused by another resident in an agency facility, the agency subsequently informs the alleged victim whenever:

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

WHWH policy states following a resident's allegation that he has been sexually abused by another resident, Standing Tall Music City shall subsequently inform the alleged victim whenever:

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

**115.373 (e)**
PAQ: The agency has a policy that all notifications to residents described under this standard are documented.
In the past 12 months:

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

WHWH policy states documentation of notifications shall be provided and maintained in the resident's file on a page or pages following the applicable Serious Incident Report.

**115.373 (f)**
An agency’s obligation to report under this standard shall terminate if the resident is released from the agency’s custody.

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

# DISCIPLINE

## Standard 115.376: Disciplinary sanctions for staff

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

**115.376 (a)**

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

**115.376 (b)**

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

**115.376 (c)**

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

**115.376 (d)**

- Are all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff 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 the compliance determination:**

**Documents:**

1. WP Policy 4.9 Performance Improvement and Disciplinary Action
2. WP Policy 6.4 Abuse Reporting
3. WHWH Policy 6.13.a Zero-Tolerance Standards and Guidelines for Sexual Harassment, Assault or Rape Incidents and PREA
4. DCS Policy 18.8 Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
5. STMC Pre-Audit Questionnaire responses

**Site Review Observations:**
Observations during on-site review of physical plant

**Findings (by provision):**
**115.376 (a)**
PAQ: Staff is subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies.

Any Wayne Halfway House, Inc. employee that violates the facility's sexual abuse and sexual harassment policies will be subject to disciplinary action up to and including termination.

**115.376 (b)**
In the past 12 months:

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

Any employee who is found to have perpetrated or participated in sexual abuse, sexual assault, sexual misconduct, rape, sexual harassment of a resident, or harassment to a witness of these acts, will be terminated.

The auditor reviewed staff termination notices.

**115.376 (c)**
PAQ: Disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) are commensurate with the nature and circumstances of the acts committed, the staff member's disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories.
In the past 12 months, the number of staff from the facility that have been disciplined, short of termination, for violation of agency sexual abuse or sexual harassment policies: Zero (0)

Sanctions for violations (other than engaging in sexual abuse or any other criminal sexual act) will be determined by the employee's supervisor in consultation with the Executive Director, or solely by the Executive director commensurate with the nature and circumstances of the acts committed or omitted, the staff member's disciplinary history, and the sanctions imposed for comparable offenses by other staff members with similar histories.

**115.376 (d)**
PAQ: All terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, are reported to law enforcement agencies, unless the activity was clearly not criminal, and to any relevant licensing bodies. In the past 12 months, the number of staff from the facility that have been reported to law enforcement or licensing boards following their termination (or resignation prior to termination) for violating agency sexual abuse or sexual harassment policies: Two (2)

Any employee who engages in sexual abuse of any type will be reported to law enforcement agencies, the Department of Children's Services, and any other licensing agencies.

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

## Standard 115.377: Corrective action for contractors and volunteers

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

**115.377 (a)**

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

**115.377 (b)**

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

**Auditor Overall Compliance Determination**

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

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

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

**Instructions for Overall Compliance Determination Narrative**

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

**The following evidence was analyzed in making the compliance determination:**

**Documents:**

1. WP Policy 4.9 Performance Improvement and Disciplinary Action
2. WP Policy 6.4 Abuse Reporting
3. WHWH Policy 6.13.a Zero-Tolerance Standards and Guidelines for Sexual Harassment, Assault or Rape Incidents and PREA
4. DCS Policy 18.8 Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
5. STMC Pre-Audit Questionnaire responses

**Interview:**
Interview with Facility Director

**Site Review Observations:**
Observations during on-site review of physical plant

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

Any contractor or volunteer who is found to have perpetrated or participated in sexual abuse, sexual assault, sexual misconduct, rape, sexual harassment of a resident, or harassment to a witness of these acts, will be terminated. Any contractor or volunteer who engages in sexual abuse of any type will be reported to law enforcement agencies, the Department of Children's Services, and any other licensing agencies.

**115.377 (b)**

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

The Facility Director stated in the case of any violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer, the facility would take remedial measures and prohibit further contact with residents. The contractor or volunteer would have no contact with the residents during the investigation.

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

## Standard 115.378: Interventions and disciplinary sanctions for residents

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

**115.378 (a)**

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

**115.378 (b)**

- Are disciplinary sanctions commensurate with the nature and circumstances of the abuse committed, the resident's disciplinary history, and the sanctions imposed for comparable offenses by other residents with similar histories? ☒ Yes ☐ No

- In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident is not denied daily large-muscle exercise? ☒ Yes ☐ No

- In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident is not denied access to any legally required educational programming or special education services? ☒ Yes ☐ No

- In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident receives daily visits from a medical or mental health care clinician? ☒ Yes ☐ No

- In the event a disciplinary sanction results in the isolation of a resident, does the resident also have access to other programs and work opportunities to the extent possible? ☒ Yes ☐ No

**115.378 (c)**

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

**115.378 (d)**

- If the facility offers therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse, does the facility consider whether to offer the offending resident participation in such interventions? ☒ Yes ☐ No

- If the agency requires participation in such interventions as a condition of access to any rewards-based behavior management system or other behavior-based incentives, does it always refrain from requiring such participation as a condition to accessing general programming or education? ☒ Yes ☐ No

**115.378 (e)**

- Does the agency discipline a resident for sexual contact with staff only upon a finding that the staff member did not consent to such contact? ☒ Yes ☐ No

**115.378 (f)**

- For the purpose of disciplinary action does a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred NOT constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation? ☒ Yes ☐ No

**115.378 (g)**

- If the agency prohibits all sexual activity between residents, does the agency always refrain from considering non-coercive sexual activity between residents to be sexual abuse? (N/A if the agency does not prohibit all sexual activity between residents.) ☒ Yes ☐ No ☐ NA

**Auditor Overall Compliance Determination**

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

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

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

**Instructions for Overall Compliance Determination Narrative**

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

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

**The following evidence was analyzed in making the compliance determination:**

**Documents:**

1. WHWH Policy 6.13.a Zero-Tolerance Standards and Guidelines for Sexual Harassment, Assault or Rape Incidents and PREA
2. STMC Policy 8.5 Disciplinary Reports
3. DCS Policy 18.8 Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
4. STMC Pre-Audit Questionnaire responses

**Interviews:**

1. Interview with Facility Director
2. Interviews with Medical and Mental Health Staff

**Site Review Observations:**
Observations during on-site review of physical plant

**Findings (by provision):**
**115.378 (a)**
PAQ: Residents are subject to disciplinary sanctions only pursuant to a formal disciplinary process following an administrative finding that the resident engaged in resident-on-resident sexual abuse. Residents are subject to disciplinary sanctions only pursuant to a formal disciplinary process following a criminal finding of guilt for resident-on-resident sexual abuse.
In the past 12 months:

1. The number of administrative findings of resident-on-resident sexual abuse that have occurred at the facility: Zero (0)
2. The number of criminal findings of guilt for resident-on-resident sexual abuse that have occurred at the facility: Zero (0)

A resident may be subject to disciplinary sanctions only pursuant to a formal disciplinary process following an administrative finding that the resident engaged in resident-on-resident sexual abuse or following a criminal finding of guilt for resident-on-resident sexual abuse. The disciplinary process for PREA-related offenses shall be initiated only after investigation by DCS and a finding that the allegation is substantiated. In such case, the following process shall occur:

1. If the resident is still at STMC, a Child and Family Team Meeting will be held with all appropriate persons including the resident present or with documentation that they were informed of the time, date, and location of the meeting and were invited to attend.
2. The Child and Family Team will discuss and decide upon the nature of any disciplinary sanctions beyond court mandated sanctions that are to be imposed. All PREA standards will be met in the assignment of sanctions. Sanctions to be enacted will be documented and kept in the resident's file.

**115.378 (b)**
In the event a disciplinary sanction for resident-on resident sexual abuse results in the isolation of a resident, the facility policy requires that residents in isolation have daily access to large muscle exercise, legally required educational programming, and special education services. In the event a

disciplinary sanction for resident-on resident sexual abuse results in the isolation of a resident, residents in isolation receive daily visits from a medical or mental health care clinician. In the event a disciplinary sanction for resident-on resident sexual abuse results in the isolation of a resident, residents in isolation have access to other programs and work opportunities to the extent possible.
In the past 12 months:

1. The number of residents placed in isolation as a disciplinary sanction for resident-on resident sexual abuse: Zero (0)
2. The number of residents placed in isolation as a disciplinary sanction for resident-on resident sexual abuse, who were denied daily access to large muscle exercise, and/or legally required educational programming, or special education services: N/A
3. The number of residents placed in isolation as a disciplinary sanction for resident-on resident sexual abuse, who were denied access to other programs and work opportunities: N/A

STMC does not use isolation as a disciplinary sanction. The Facility director stated disciplinary sanctions residents are subject to following an administrative or criminal finding the resident engaged in resident-on-resident sexual abuse would include loss of level or removal from the facility. The sanctions would be proportionate to the nature and circumstances of the abuses committed, the residents' disciplinary histories, and the sanctions imposed for similar offenses by other residents with similar histories. Isolation is not used as a disciplinary sanction.

**115.378 (c)**
The disciplinary process shall consider whether a resident's mental disabilities or mental illness contributed to his behavior when determining what type of sanction, if any, should be imposed.

The Facility Director stated mental disability or mental illness is considered when determining sanctions.

**115.378 (d)**
PAQ: The facility offers therapy, counseling, or other interventions designed to address and correct the underlying reasons or motivations for abuse. If the facility offers therapy, counseling, or other interventions designed to address and correct the underlying reasons or motivations for abuse, the facility considers whether to require the offending resident to participate in such interventions as a condition of access to any rewards-based behavior management system or other behavior based incentives. Access to general programming or education is not conditional on participation in such interventions.

The therapist stated if the facility offers therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse, the facility shall consider whether to offer the offending resident participation in such interventions. The therapists have been trained on providing services to offenders.

**115.378 (e)**
PAQ: The agency disciplines residents for sexual contact with staff only upon finding that the staff member did not consent to such contact.

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

**115.378 (f)**

PAQ: The agency prohibits disciplinary action for a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred, even if an investigation does not establish evidence sufficient to substantiate the allegation.

For the purpose of disciplinary action, a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred shall not constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation.

**115.378 (g)**
PAQ: The agency prohibits all sexual activity between residents. The agency deems such activity to constitute sexual abuse only if it determines that the activity is coerced.

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

# MEDICAL AND MENTAL CARE

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

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

**115.381 (a)**

- If the screening pursuant to § 115.341 indicates that a resident has experienced prior sexual victimization, whether it occurred in an institutional setting or in the community, do staff ensure that the resident is offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening? ☒ Yes ☐ No

**115.381 (b)**

- If the screening pursuant to § 115.341 indicates that a resident has previously perpetrated sexual abuse, whether it occurred in an institutional setting or in the community, do staff ensure that the resident is offered a follow-up meeting with a mental health practitioner within 14 days of the intake screening? ☒ Yes ☐ No

**115.381 (c)**

- Is any information related to sexual victimization or abusiveness that occurred in an institutional setting strictly limited to medical and mental health practitioners and other staff as necessary to inform treatment plans and security management decisions, including housing, bed, work, education, and program assignments, or as otherwise required by Federal, State, or local law? ☒ Yes ☐ No

**115.381 (d)**

- Do medical and mental health practitioners obtain informed consent from residents before reporting information about prior sexual victimization that did not occur in an institutional setting, unless the resident is under the age of 18? ☒ Yes ☐ No

**Auditor Overall Compliance Determination**

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

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

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

**Instructions for Overall Compliance Determination Narrative**

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

**The following evidence was analyzed in making the compliance determination:**

**Documents:**

1. WHWH Policy 6.13.a Zero-Tolerance Standards and Guidelines for Sexual Harassment, Assault or Rape Incidents and PREA
2. WHWH 9.2.a Limits of Confidentiality
3. DCS Policy 18.8 Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
4. STMC Pre-Audit Questionnaire responses
5. Assessment, Checklist and Protocol for Behavior and Risk for Victimization
6. Medical and Mental Health Care PREA Referral Acknowledgement Form

**Interviews:**

1. Interview with Staff Responsible for Risk Screening
2. Interviews with Residents who Disclosed Sexual Victimization at Risk Screening

**Site Review Observations:**
Observations during on-site review of physical plant

**Findings (by provision):**
**115.381 (a)**
PAQ: All residents at this facility who have disclosed any prior sexual victimization during a screening pursuant to §115.341 are offered a follow-up meeting with a medical or mental health practitioner. The follow-up meeting was offered within 14 days of the intake screening. Medical and mental health staff maintain secondary materials (e.g., form, log) documenting compliance with the above required services. In the past 12 months, the percent of residents who disclosed prior victimization during screening who were offered a follow up meeting with a medical or mental health practitioner: 100%

WHWH policy requires if screening or assessments indicates that a resident has experienced prior sexual victimization, whether it occurred in an institutional setting or in the community, designated staff will ensure that the resident is offered a follow-up meeting with a medical or mental health practitioner within fourteen (14) days of the intake screening.

The PREA Compliance Manager confirmed that if screening indicates that a resident has experienced prior sexual victimization, whether in an institutional setting or in the community, a follow-up meeting is offered with a psychologist. She confirmed the meeting would occur within fourteen (14) days.

The auditor reviewed examples of Medical and Mental Health Care PREA Referral Acknowledgement Forms for verification that youth are offered the opportunity to speak with clinical staff per the requirements of the standard.

**115.381 (b)**
PAQ: All residents who have previously perpetrated sexual abuse, as indicated during the screening pursuant to § 115.341, are offered a follow-up meeting with a mental health practitioner. The follow-up meeting was offered within 14 days of the intake screening. Mental health staff maintain secondary materials (e.g., form, log) documenting compliance with the above required services. In the past 12 months, the percent of residents who previously perpetrated sexual abuse, as indicated during screening, who were offered a follow up meeting with a mental health practitioner: 66%

WHWH policy states if the screening indicates that a child/youth has previously perpetrated sexual abuse/assault/misconduct/harassment, whether it occurred in an institutional setting or in the community, designated staff will ensure that the resident is offered a follow-up meeting with a mental health practitioner within fourteen (14) days of the intake screening.

The PREA Compliance Manager confirmed that if screening indicates that a resident previously perpetrated sexual abuse, whether in an institutional setting or in the community, a follow-up meeting is offered with a psychologist. She confirmed the meeting would occur within fourteen (14) days.

The auditor reviewed examples of Medical and Mental Health Care PREA Referral Acknowledgement Forms for verification that youth are offered the opportunity to speak with clinical staff per the requirements of the standard.

**115.381 (c)**
PAQ: Information related to sexual victimization or abusiveness that occurred in an institutional setting is strictly limited to medical and mental health practitioners.

During the site review the auditor observed placement of juveniles based on risk of sexual victimization or abusiveness.

**115.381 (d)**
PAQ: Medical and mental health practitioners obtain informed consent from residents before reporting information about prior sexual victimization that did not occur in an institutional setting unless the resident is under the age of 18.

Medical and mental health staff confirmed informed consent from residents is required for residents 18 and older before reporting about prior sexual victimization that did not occur in an institutional setting.

## Standard 115.382: Access to emergency medical and mental health services

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

**115.382 (a)**

- Do resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services, the nature and scope of which are determined by medical and mental health practitioners according to their professional judgment? ☒ Yes ☐ No

**115.382 (b)**

- If no qualified medical or mental health practitioners are on duty at the time a report of recent sexual abuse is made, do staff first responders take preliminary steps to protect the victim pursuant to § 115.362? ☒ Yes ☐ No

- Do staff first responders immediately notify the appropriate medical and mental health practitioners? ☒ Yes ☐ No

**115.382 (c)**

- Are resident victims of sexual abuse offered timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate? ☒ Yes ☐ No

**115.382 (d)**

- Are treatment services provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident? ☒ Yes ☐ No

**Auditor Overall Compliance Determination**

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

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

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

**Instructions for Overall Compliance Determination Narrative**

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

**The following evidence was analyzed in making the compliance determination:**

**Documents:**

1. WHWH Policy 6.13.a Zero-Tolerance Standards and Guidelines for Sexual Harassment, Assault or Rape Incidents and PREA
2. DCS Policy 18.8 Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
3. STMC Pre-Audit Questionnaire responses

**Interviews:**

1. Interviews with Medical and Mental Health Staff
2. Interviews with Residents who Reported a Sexual Abuse – N/A
3. Security Staff and Non-Security Staff First Responders

**Site Review Observations:**
Observations during on-site review of physical plant

**Findings (by provision):**
**115.382 (a)**
PAQ: Resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services. The nature and scope of such services are determined by medical and mental health practitioners according to their professional judgment. Medical and mental health staff maintain secondary materials (e.g., form, log) documenting the timeliness of emergency medical treatment and crisis intervention services that were provided; the appropriate response by non-health staff in the event health staff are not present at the time the incident is reported; and the provision of appropriate and timely information and services concerning sexually transmitted infection prophylaxis.

WHWH policy states Wayne Halfway House, Inc. shall offer medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse in any jail, lockup, or juvenile facility. 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. The victim shall be offered medical and mental health services consistent with the community level of care

Medical and mental health care staff ensure resident victims of sexual abuse receive immediate and unimpeded access to emergency medical treatment and crisis intervention services. Both staff stated the nature and scope of these services would be determined according to their professional judgment and policy and procedure.

**115.382 (b)**
Staff were knowledgeable of their first responder duties. If no qualified medical or mental health practitioners are on duty at the time a report of recent abuse is made, staff first responders shall take preliminary steps to protect the victim and shall immediately notify the appropriate medical and mental health practitioners.

**115.382 (c)**
PAQ: Resident victims of sexual abuse while incarcerated are offered timely information about and timely access to sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate. Medical and mental health staff maintain secondary materials documenting the timeliness of emergency medical treatment and crisis intervention services that were provided; the appropriate response by non-health staff in the event health staff are not present at the time the incident is reported; and the provision of appropriate and timely information and services concerning sexually transmitted infection prophylaxis.

WHWH policy states if the victim remains in the program, counseling and other services will be provided, to include but not necessarily be limited to:

a. Standing Tall Music City will develop a safety action plan that includes a review/adjustment, if necessary, of appropriate housing, bed, program, education, and work assignments to keep the resident safe and free from sexual abuse.
b. An assessment by a mental health professional.
c. Mental health counseling as needed.
d. Unimpeded access to emergency medical treatment and crisis intervention services.
e. Timely information about and timely access to tests for sexually transmitted infections, as medically appropriate.

Medical staff confirmed victims of sexual abuse offered timely information and services concerning sexually transmitted infection prophylaxis.

**115.382 (d)**
PAQ: Treatment services are provided to every victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident.

WHWH policy states treatment services shall be without financial cost to the victim. No resident will be denied access to treatment resources and/or services for failing to fully disclose details to internal investigators, outside law enforcement investigators, and/or medical/mental health staff.

**Corrective Action**
Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding access to emergency medical and mental health services. No corrective action is required

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

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

**115.383 (a)**

- Does the facility offer medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility? ☒ Yes ☐ No

**115.383 (b)**

- Does the evaluation and treatment of such victims include, as appropriate, follow-up services, treatment plans, and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody? ☒ Yes ☐ No

**115.383 (c)**

- Does the facility provide such victims with medical and mental health services consistent with the community level of care? ☒ Yes ☐ No

**115.383 (d)**

- Are resident victims of sexually abusive vaginal penetration while incarcerated offered pregnancy tests? (N/A if "all-male" facility. *Note: in "all-male" facilities, there may be residents who identify as transgender men who may have female genitalia. Auditors should be sure to know whether such individuals may be in the population and whether this provision may apply in specific circumstances.*) ☐ Yes ☐ No ☒ NA

**115.383 (e)**

- If pregnancy results from the conduct described in paragraph § 115.383(d), do such victims receive timely and comprehensive information about and timely access to all lawful pregnancy-related medical services? (N/A if "all-male" facility. *Note: in "all-male" facilities, there may be residents who identify as transgender men who may have female genitalia. Auditors should be sure to know whether such individuals may be in the population and whether this provision may apply in specific circumstances.*) ☐ Yes ☐ No ☒ NA

**115.383 (f)**

- Are resident victims of sexual abuse while incarcerated offered tests for sexually transmitted infections as medically appropriate? ☒ Yes ☐ No

**115.383 (g)**

- Are treatment services provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident? ☒ Yes ☐ No

**115.383 (h)**

- Does the facility attempt to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners? ☒ Yes ☐ No

**Auditor Overall Compliance Determination**

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

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

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

**Instructions for Overall Compliance Determination Narrative**

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

**The following evidence was analyzed in making the compliance determination:**

**Documents:**

1. WHWH Policy 6.13.a Zero-Tolerance Standards and Guidelines for Sexual Harassment, Assault or Rape Incidents and PREA
2. DCS Policy 18.8 Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
3. STMC Pre-Audit Questionnaire responses

**Interviews:**

1. Interviews with Medical and Mental Health Staff
2. Interviews with Residents who Reported a Sexual Abuse – N/A

**Site Review Observations:**
Observations during on-site review of physical plant

**Findings (by provision):**
**115.383 (a)**
PAQ: The facility offers medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility.

WHWH policy states Wayne Halfway House, Inc. shall offer medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse in any jail, lockup, or juvenile facility.

The auditor observed the facility has mental health staff at the facility. Medical treatment is provided offsite.

**115.383 (b)**
WHWH policy states 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.

The mental health staff stated residents who have been victimized would meet with a therapist, provided follow-up services, and provide trauma focused therapy. Medical staff stated the facility would follow the ER discharge notes. A nurse practitioner would be available to provide follow-up services as needed.

**115.383 (c)**
WHWH policy states the victim shall be offered medical and mental health services consistent with the community level of care.

Medical and mental health care staff confirmed medical and mental health services are consistent with the community level of care.

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

STMC is an “all-male” facility.

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

STMC is an “all-male” facility.

**115.383 (f)**
PAQ: Resident victims of sexual abuse while incarcerated are offered tests for sexually transmitted infections as medically appropriate.

WHWH policy states if the victim remains in the program, counseling and other services will be provided, to include timely information about and timely access to tests for sexually transmitted infections, as medically appropriate.

**115.383 (g)**
PAQ: Treatment services are provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident.

WHWH policy states treatment services shall be without financial cost to the victim. No resident will be denied access to treatment resources and/or services for failing to fully disclose details to internal investigators, outside law enforcement investigators, and/or medical/mental health staff.

**115.383 (h)**
PAQ: The facility attempts to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history and offers treatment when deemed appropriate by mental health practitioners.

WHWH policy states if a resident remains in the program after being found by DCS investigation to have committed sexual abuse or sexual harassment, he will be referred for a mental health evaluation within 60 days of learning of such abuse history.

The therapist confirmed the facility conducts a mental health evaluation of all known resident-on-resident abusers and offers treatment if appropriate. After learning about the abuse history of a resident, an evaluation is conducted within 60 days.

**Corrective Action**
Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding ongoing medical and mental health care for sexual abuse victims and abusers. No corrective action is required.

# DATA COLLECTION AND REVIEW

## Standard 115.386: Sexual abuse incident reviews

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

**115.386 (a)**

- Does the facility conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation, including where the allegation has not been substantiated, unless the allegation has been determined to be unfounded? ☒ Yes ☐ No

**115.386 (b)**

- Does such review ordinarily occur within 30 days of the conclusion of the investigation? ☒ Yes ☐ No

**115.386 (c)**

- Does the review team include upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners? ☒ Yes ☐ No

**115.386 (d)**

- Does the review team: Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse? ☒ Yes ☐ No
- Does the review team: Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; gang affiliation; or other group dynamics at the facility? ☒ Yes ☐ No
- Does the review team: Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse? ☒ Yes ☐ No
- Does the review team: Assess the adequacy of staffing levels in that area during different shifts? ☒ Yes ☐ No
- Does the review team: Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff? ☒ Yes ☐ No
- Does the review team: Prepare a report of its findings, including but not necessarily limited to determinations made pursuant to §§ 115.386(d)(1) - (d)(5), and any recommendations for improvement and submit such report to the facility head and PREA compliance manager? ☒ Yes ☐ No

**115.386 (e)**

- Does the facility implement the recommendations for improvement, or document its reasons for not doing so? ☒ Yes ☐ No

**Auditor Overall Compliance Determination**

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

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

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

**Instructions for Overall Compliance Determination Narrative**

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

**The following evidence was analyzed in making the compliance determination:**

**Documents:**

1. WHWH Policy 6.13.a Zero-Tolerance Standards and Guidelines for Sexual Harassment, Assault or Rape Incidents and PREA
2. DCS Policy 18.8 Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
3. STMC Pre-Audit Questionnaire responses
4. Sexual Abuse Incident Review Form

**Interviews:**

1. Interview with Facility Director
2. Interview with PREA Compliance Manager
3. Interview with Incident Review Team Member

**Site Review Observations:**
Observations during on-site review of physical plant

**Findings (by provision):**
**115.386 (a)**
PAQ: The facility conducts a sexual abuse incident review at the conclusion of every sexual abuse criminal or administrative investigation unless the allegation has been determined to be unfounded. In the past 12 months, the number of criminal and/or administrative investigations of alleged sexual abuse completed at the facility, excluding only "unfounded" incidents: Zero (0).

Two (2) allegations of staff sexual harassment were substantiated, and the individuals were referred to law enforcement.

Standing Tall Music City will conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation involving a PREA-related incident, including where the allegation has not been substantiated, unless the allegation has been determined to be unfounded. The review will occur within thirty (30) days of the close of every sexual abuse investigation and Standing Tall Music City notification by DCS of the close of the investigation involving a PREA-related incident unless the outcome was unfounded.

**115.386 (b)**
PAQ: The facility ordinarily conducts a sexual abuse incident review within 30 days of the conclusion of the criminal or administrative sexual abuse investigation.
In the past 12 months, the number of criminal and/or administrative investigations of alleged sexual abuse completed at the facility that were followed by a sexual abuse incident review within 30 days, excluding only “unfounded” incidents: Zero (0)

**115.386 (c)**
PAQ: The sexual abuse incident review team includes upper-level management officials and allows for input from line supervisors, investigators, and medical or mental health practitioners.

WHWH policy states the review team will consist of management level staff/designees, as applicable, with input from line supervisors, investigators, and medical and/or mental health practitioners.

The Facility Director confirmed the facility has a sexual abuse incident review team.

**115.386 (d)**
PAQ: The facility prepares a report of its findings from sexual abuse incident reviews, including but not necessarily limited to determinations made pursuant to paragraphs (d)(1)-(d)(5) of this section, and any recommendations for improvement and submits such report to the facility head and PREA compliance manager.

The Facility Director confirmed the sexual abuse incident review team uses the information from the sexual abuse incident review to identify problems and make corrective actions. The team considers whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; gang affiliation; and/or other group dynamics at the facility; the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse; assess the adequacy of staffing levels in that area during different shifts; and assess whether monitoring technology should be deployed or augmented to supplement supervision by staff.

The PREA Compliance Manager confirmed if the facility conducts a sexual abuse incident review, the facility prepares a report of its findings from the review, including any determinations any recommendations for improvement. The PREA Coordinator is a member of the sexual abuse incident review team.

**115.386 (e)**
PAQ: The facility implements the recommendations for improvement or documents its reasons for not doing so.

WHWH policy states the review team will prepare a report of its findings and recommendations including for improvement and will implement the recommendations or will document reasons for not doing so and provide this information to the Department of Children's Services as required.

**Corrective Action**
Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding sexual abuse incident reviews. No corrective action is required.

## Standard 115.387: Data collection

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

**115.387 (a)**

- Does the agency collect accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions? ☒ Yes ☐ No

**115.387 (b)**

- Does the agency aggregate the incident-based sexual abuse data at least annually? ☒ Yes ☐ No

**115.387 (c)**

- Does the incident-based data include, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice? ☒ Yes ☐ No

**115.387 (d)**

- Does the agency maintain, review, and collect data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews? ☒ Yes ☐ No

**115.387 (e)**

- Does the agency also obtain incident-based and aggregated data from every private facility with which it contracts for the confinement of its residents? (N/A if agency does not contract for the confinement of its residents.) ☐ Yes ☐ No ☒ NA

**115.387 (f)**

- Does the agency, upon request, provide all such data from the previous calendar year to the Department of Justice no later than June 30? (N/A if DOJ has not requested agency data.) ☐ Yes ☐ No ☒ NA

**Auditor Overall Compliance Determination**

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

**Instructions for Overall Compliance Determination Narrative**

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

**The following evidence was analyzed in making the compliance determination:**

**Documents:**

1. WHWH Policy 6.13.a Zero-Tolerance Standards and Guidelines for Sexual Harassment, Assault or Rape Incidents and PREA
2. DCS Policy 18.8 Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
3. STMC Pre-Audit Questionnaire responses
4. Survey of Sexual Victimization Substantiated Incident Form (Juvenile)

**Site Review Observations:**
Observations during on-site review of physical plant

**Findings (by provision):**
**115.387 (a)**
PAQ: The agency collects accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions. The standardized instrument includes, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice.

WHWH policy states Wayne Halfway House, Inc. will collect accurate, uniform data for every allegation of sexual abuse at its facility and from each of its subcontractors using Serious Incident Reports, the Sexual Abuse Incident Review form, and the State of Tennessee Department of Children's Services Survey of Alleged PREA Incidents. The full set of definitions from DCS Policy 18.8 Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and Prison Rape Elimination Act (PREA) is included in the glossary at the end of these procedures.

The auditor suggests the facility update the name of the form in policy. The form is now the Survey of Sexual Victimization Substantiated Incident Form.

**115.387 (b)**

PAQ: The agency aggregates the incident-based sexual abuse data at least annually.

**115.387 (c)**
PAQ: The incident-based data collected shall include, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice.

WHWH policy states the form (instrument) includes the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice.

The auditor reviewed the instrument for verification.

**115.387 (d)**
PAQ: The agency maintains, reviews, and collects data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews.

WHWH policy states Wayne Halfway House, Inc. will collect accurate, uniform data for every allegation of sexual abuse at its facility and from each of its subcontractors using Serious Incident Reports, the Sexual Abuse Incident Review form, and the State of Tennessee Department of Children's Services Survey of Alleged PREA Incidents.

**115.387 (e)** N/A
The agency also shall obtain incident-based and aggregated data from every private facility with which it contracts for the confinement of its residents.

STMC does not contract with other facilities for the confinement of its residents.

**115.387 (f)** N/A
Upon request, the agency shall provide all such data from the previous calendar year to the Department of Justice no later than June 30.

The DOJ did not request STMC provide all such data from the previous calendar year. STMC opened in October of 2019.

**Corrective Action**
Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding data collection. No corrective action is required.

## Standard 115.388: Data review for corrective action

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

**115.388 (a)**

- Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Identifying problem areas? ☒ Yes ☐ No

- Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Taking corrective action on an ongoing basis? ☒ Yes ☐ No

- Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Preparing an annual report of its findings and corrective actions for each facility, as well as the agency as a whole? ☒ Yes ☐ No

**115.388 (b)**

- Does the agency's annual report include a comparison of the current year's data and corrective actions with those from prior years and provide an assessment of the agency's progress in addressing sexual abuse ☒ Yes ☐ No

**115.388 (c)**

- Is the agency's annual report approved by the agency head and made readily available to the public through its website or, if it does not have one, through other means? ☒ Yes ☐ No

**115.388 (d)**

- Does the agency indicate the nature of the material redacted where it redacts specific material from the reports when publication would present a clear and specific threat to the safety and security of a facility? ☒ Yes ☐ No

**Auditor Overall Compliance Determination**

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

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

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

**Instructions for Overall Compliance Determination Narrative**

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

**The following evidence was analyzed in making the compliance determination:**

**Documents:**

1. WHWH Policy 6.13.a Zero-Tolerance Standards and Guidelines for Sexual Harassment, Assault or Rape Incidents and PREA
2. DCS Policy 18.8 Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
3. STMC Pre-Audit Questionnaire responses

**Interviews:**

1. Interview with the Agency Head Designee (Operations Manager)
2. Interview with the PREA Coordinator
3. Interview with the PREA Compliance Manager

**Site Review Observations:**
Observations during on-site review of physical plant

**Findings (by provision):**
**115.388 (a)**
PAQ: The agency reviews data collected and aggregated pursuant to §115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, and training, including:

1. Identifying problem areas;
2. Taking corrective action on an ongoing basis; and
3. Preparing an annual report of its findings from its data review and any corrective actions for each facility, as well as the agency as a whole.

The Operations Manager stated the facility uses incident-based sexual abuse data to assess and improve sexual abuse prevention, detection, response policies, practices, and training to identify problem areas and take corrective action as needed. The PREA Coordinator and PREA Compliance Manager confirmed the agency reviews data collected and aggregated in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, and training. The agency ensures that data collected is securely retained on a password protected in-house network.

**115.388 (b)**
PAQ: The annual report includes a comparison of the current year's data and corrective actions with those from prior years. The annual report provides an assessment of the agency's progress in addressing sexual abuse.

The facility will complete and publish an annual report at the end of the year.

**115.388 (c)**
PAQ: The agency makes its annual report readily available to the public at least annually through its website. The annual reports are approved by the agency head.

WHWH policy states the report will be approved by the Executive Director and made readily available to the public through inclusion in the Performance and Quality Improvement Annual Report and the Standing Tall Music City website.

The Operations Manager confirmed the Executive Director approves annual reports.

The facility will complete and publish an annual report at the end of the year.

**115.388 (d)**
PAQ: When the agency redacts material from an annual report for publication the redactions are limited to specific materials where publication would present a clear and specific threat to the safety and security of the facility. The agency indicates the nature of material redacted.

WHWH policy states Wayne Halfway House, Inc. may redact specific material from the reports when publication would present a clear and specific threat to the safety and security of the facility but will indicate the nature of the material redacted.

The PREA Coordinator stated names and identifying information will be redacted from the annual report.

The auditor observed no personal identifiers were included in the annual report.

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

## Standard 115.389: Data storage, publication, and destruction

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

**115.389 (a)**

- Does the agency ensure that data collected pursuant to § 115.387 are securely retained? ☒ Yes ☐ No

**115.389 (b)**

- Does the agency make all aggregated sexual abuse data, from facilities under its direct control and private facilities with which it contracts, readily available to the public at least annually through its website or, if it does not have one, through other means? ☒ Yes ☐ No

**115.389 (c)**

- Does the agency remove all personal identifiers before making aggregated sexual abuse data publicly available? ☒ Yes ☐ No

**115.389 (d)**

- Does the agency maintain sexual abuse data collected pursuant to § 115.387 for at least 10 years after the date of the initial collection, unless Federal, State, or local law requires otherwise? ☒ Yes ☐ No

**Auditor Overall Compliance Determination**

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

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

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

**Instructions for Overall Compliance Determination Narrative**

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

**The following evidence was analyzed in making the compliance determination:**

**Documents:**

1. WHWH Policy 6.13.a Zero-Tolerance Standards and Guidelines for Sexual Harassment, Assault or Rape Incidents and PREA
2. DCS Policy 18.8 Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
3. STMC Pre-Audit Questionnaire responses
4. Wayne Halfway House, Inc. Annual Reports

**Interview:**

1. Interview with the PREA Coordinator

**Site Review Observations:**
Observations during on-site review of physical plant

**Findings (by provision):**
**115.389 (a)**
PAQ: The agency ensures that incident-based and aggregate data are securely retained.

WHWH policy states Wayne Halfway House, Inc. will ensure that data collected pursuant to PREA Standards § 115.387 are securely retained.

The PREA Coordinator confirmed the agency reviews data collected and aggregated in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, and training. Files retained for the purposes of PREA/CPS Investigation are kept confidential by the Facility Administrators.

**115.389 (b)**
PAQ: Agency policy requires that aggregated sexual abuse data from facilities under its direct control and private facilities with which it contracts be made readily available to the public, at least annually, through its website.

WHWH policy states Wayne Halfway House, Inc. will 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.

The facility will complete and publish an annual report at the end of the year.

**115.389 (c)**
PAQ: Before making aggregated sexual abuse data publicly available, the agency removes all personal identifiers.

WHWH policy states before making aggregated sexual abuse data publicly available, Wayne Halfway House, Inc. will remove all personal identifiers.

The facility will complete and publish an annual report at the end of the year.

**115.389 (d)**
PAQ: The agency maintains sexual abuse data sexual abuse data collected pursuant to §115.387 for at least 10 years after the date of initial collection, unless Federal, State, or local law requires otherwise.

WHWH policy states Wayne Halfway House, Inc. will maintain sexual abuse data collected pursuant to PREA Standard § 115.387 for at least ten (10) years after the date of its initial collection unless Federal, State, or local law requires otherwise.

The auditor reviewed sexual abuse data from October 2019 to September 2020.

**Corrective Action**
Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding data storage, publication, and destruction. No corrective action is required.

# AUDITING AND CORRECTIVE ACTION

## Standard 115.401: Frequency and scope of audits

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

**115.401 (a)**

- During the prior three-year audit period, did the agency ensure that each facility operated by the agency, or by a private organization on behalf of the agency, was audited at least once? (*Note: The response here is purely informational. A "no" response does not impact overall compliance with this standard.*) ☒ Yes ☐ No

**115.401 (b)**

- Is this the first year of the current audit cycle? (*Note: a "no" response does not impact overall compliance with this standard*.) ☐ Yes ☒ No

- If this is the second year of the current audit cycle, did the agency ensure that at least one-third of each facility type operated by the agency, or by a private organization on behalf of the agency, was audited during the first year of the current audit cycle? (N/A if this is **not** the *second* year of the current audit cycle.) ☒ Yes ☐ No ☐ NA

- If this is the third year of the current audit cycle, did the agency ensure that at least two-thirds of each facility type operated by the agency, or by a private organization on behalf of the agency, were audited during the first two years of the current audit cycle? (N/A if this is **not** the *third* year of the current audit cycle.) ☐ Yes ☐ No ☒ NA

**115.401 (h)**

- Did the auditor have access to, and the ability to observe, all areas of the audited facility? ☒ Yes ☐ No

**115.401 (i)**

- Was the auditor permitted to request and receive copies of any relevant documents (including electronically stored information)? ☒ Yes ☐ No

**115.401 (m)**

- Was the auditor permitted to conduct private interviews with residents? ☒ Yes ☐ No

**115.401 (n)**

- Were residents permitted to send confidential information or correspondence to the auditor in the same manner as if they were communicating with legal counsel? ☒ Yes ☐ No

**Auditor Overall Compliance Determination**

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

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

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

**Instructions for Overall Compliance Determination Narrative**

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

**The following evidence was analyzed in making the compliance determination:**

1. STMC Pre-Audit Questionnaire responses
2. Policy Review
3. Research
4. Documentation Review
5. Interviews
6. Observations during onsite review of facility

Conclusion:
During the three-year period starting on August 20, 2013, and the current audit cycle, Wayne Halfway House, Inc. was audited in 2014, 2017, and 2020. This is the first audit for Standing Tall Music City.

The auditor was given access to, and the ability to observe, all areas of the audited facility. The auditor was permitted to conduct private interviews with residents at the facility. The auditor sent an audit notice to the facility more than six weeks prior to the on-site audit. The facility confirmed the audit notice was posted by emailing pictures of the posted audit notices. The audit notice contained contact information for the auditor. The residents were permitted to send confidential information or correspondence to the auditor in the same manner as if they were communicating with legal counsel. No confidential information or correspondence was received.

**Corrective Action**
Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding frequency and scope of audits. No corrective action is required.

## Standard 115.403: Audit contents and findings

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

**115.403 (f)**

- The agency has published on its agency website, if it has one, or has otherwise made publicly available, all Final Audit Reports. The review period is for prior audits completed during the past three years PRECEDING THIS AGENCY AUDIT. The pendency of any agency appeal pursuant to 28 C.F.R. § 115.405 does not excuse noncompliance with this provision. (N/A if there have been no Final Audit Reports issued in the past three years, or in the case of single facility agencies that there has never been a Final Audit Report issued.) ☒ Yes ☐ No ☐ NA

**Auditor Overall Compliance Determination**

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

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

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

**Instructions for Overall Compliance Determination Narrative**

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

**The following evidence was analyzed in making the compliance determination:**

1. STMC Pre-Audit Questionnaire responses
2. Policy Review
3. Documentation Review
4. Interviews
5. Observations during onsite review of facility

Conclusion:
All Wayne Halfway House, Inc. PREA Audit Reports are published on the agency's website at: https://www.hollisacademytn.com/resources. This is the first audit for Standing Tall Music City.

**Corrective Action**
Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding audit contents and findings. No corrective action is required.

# 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.

Robert Burns Latham April 26, 2021

**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.