Prison Rape Elimination Act (PREA) Audit Report
Community Confinement Facilities

☐ **Interim** ☒ **Final**

Date of Report 7/30/2020

Auditor Information

Name: James L. Roland, Jr.	**Email:** james.roland@nakamotogroup.com
Company Name: The Nakamoto Group, Inc.	
Mailing Address: 11820 Parklawn Drive	**City, State, Zip:** Rockville, MD 20852
Telephone: 301-468-6535	**Date of Facility Visit:** 7/20-21/2020

Agency Information

Name of Agency: 5th Judicial District Department of Correctional Services		**Governing Authority or Parent Agency** *(If Applicable)*: None	
Physical Address: 910 Washington		**City, State, Zip:** Des Moines, IA 50314	
Mailing Address: Same as Above		**City, State, Zip:** Same as Above	
The Agency Is:	☐ Military	☐ Private for Profit	☐ Private not for Profit
☐ Municipal	☐ County	☒ State	☐ Federal

Agency Website with PREA Information: www.fifthdcs.com

Agency Chief Executive Officer

Name: Jerry Evans	
Email: Jerry.Evans@iowa.gov	**Telephone:** 515-242-6677

Agency-Wide PREA Coordinator

Name: Carly Millsap	
Email: Carly.Millsap@iowa.gov	**Telephone:** 515-242-6677
PREA Coordinator Reports to: Mike Brown, Division Manager	**Number of Compliance Managers who report to the PREA Coordinator:** 5

Facility Information

Name of Facility: Fresh Start For Women			
Physical Address: 1917 Hickman Road		**City, State, Zip:** Des Moines, IA 50314	
Mailing Address (if different from above):		**City, State, Zip:**	
The Facility Is:	☐ Military	☐ Private for Profit	☐ Private not for Profit
☐ Municipal	☐ County	☒ State	☐ Federal
Facility Website with PREA Information: http://fifthdcs.com/PREA			
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:

☒ N/A

If the facility has completed any internal or external audits other than those that resulted in accreditation, please describe:

.

Facility Director	
Name: Angela Karaidos	
Email: Angela.Karaidos@iowa.gov	**Telephone:** 515-202-6905
Facility PREA Compliance Manager	
Name: Carly Millsap	
Email: carly.millsap@iowa.gov	**Telephone:** 515-954-8490
Facility Health Service Administrator ☒ N/A	
Name:	
Email:	**Telephone:**

Facility Characteristics		
Designated Facility Capacity:	48	
Current Population of Facility:	36	
Average daily population for the past 12 months:	46.6	
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:	22-52	
Average length of stay or time under supervision	3.8 months	
Facility security levels/resident custody levels	Probation/Work Release/Bureau of Prisons	
Number of residents admitted to facility during the past 12 months		172
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for *72 hours or more*:		170
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for *30 days or more:*		154
Does the audited facility hold residents for one or more other agencies (e.g. a State correctional agency, U.S. Marshals Service, Bureau of Prisons, U.S. Immigration and Customs Enforcement)?		☒ Yes ☐ No
Select all other agencies for which the audited facility holds residents: Select all that apply (N/A if the audited facility does not hold residents for any other agency or agencies):	☒ Federal Bureau of Prisons ☐ U.S. Marshals Service ☐ U.S. Immigration and Customs Enforcement ☐ Bureau of Indian Affairs ☐ U.S. Military branch ☒ State or Territorial correctional agency ☐ County correctional or detention agency ☐ Judicial district correctional or detention facility ☐ City or municipal correctional or detention facility (e.g. police lockup or city jail) ☐ Private corrections or detention provider ☐ Other - please name or describe: ☐ N/A	
Number of staff currently employed by the facility who may have contact with residents:		24

Number of staff hired by the facility during the past 12 months who may have contact with residents:	5
Number of contracts in the past 12 months for services with contractors who may have contact with residents:	0
Number of individual contractors who have contact with residents, currently authorized to enter the facility:	0
Number of volunteers who have contact with residents, currently authorized to enter the facility:	18
Physical Plant	
Number of buildings: **Auditors should count all buildings that are part of the facility, whether residents are formally allowed to enter them or not. In situations where temporary structures have been erected (e.g., tents) the auditor should use their discretion to determine whether to include the structure in the overall count of buildings. As a general rule, if a temporary structure is regularly or routinely used to hold or house residents, or if the temporary structure is used to house or support operational functions for more than a short period of time (e.g., an emergency situation), it should be included in the overall count of buildings.**	1
Number of resident housing units: **Enter 0 if the facility does not have discrete housing units. DOJ PREA Working Group FAQ on the definition of a housing unit: How is a "housing unit" defined for the purposes of the PREA Standards? The question has been raised 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.**	1
Number of single resident cells, rooms, or other enclosures:	0
Number of multiple occupancy cells, rooms, or other enclosures:	13
Number of open bay/dorm housing units:	0
Does the facility have a video monitoring system, electronic surveillance system, or other monitoring technology (e.g. cameras, etc.)?	☒ Yes ☐ No
Has the facility installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology in the past 12 months?	☒ Yes ☐ No

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

Investigations	
Criminal Investigations	
Number of investigators employed by the agency and/or facility who are responsible for conducting CRIMINAL investigations into allegations of sexual abuse or sexual harassment:	6
When the facility received allegations of sexual abuse or sexual harassment (whether staff-on-resident or resident-on-resident), CRIMINAL INVESTIGATIONS are conducted by: Select all that apply.	☒ Facility investigators ☒ Agency investigators ☒ An external investigative entity
Select all external entities responsible for CRIMINAL INVESTIGATIONS: Select all that apply (N/A if no external entities are responsible for criminal investigations)	☒ Local police department ☐ Local sheriff's department ☐ State police ☐ A U.S. Department of Justice component ☐ Other (please name or describe:) ☐ 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?	6
When the facility receives allegations of sexual abuse or sexual harassment (whether staff-on-resident or resident-on-resident), ADMINISTRATIVE INVESTIGATIONS are conducted by: Select all that apply	☒ Facility investigators ☐ Agency investigators ☐ An external investigative entity
Select all external entities responsible for ADMINISTRATIVE INVESTIGATIONS: Select all that apply (N/A if no external entities are responsible for administrative investigations)	☐ Local police department ☐ Local sheriff's department ☐ State police ☐ A U.S. Department of Justice component ☐ Other (please name or describe:) ☒ 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.

Overview

The on-site Prison Rape Elimination Act (PREA) compliance audit of Fresh Start for Women (FSFW), located in Des Moines, Iowa, was conducted on July 20-21, 2020 by U.S. Department of Justice (DOJ) certified PREA Auditor, James L. Roland Jr. from The Nakamoto Group, Inc. The standards used for this audit became effective August 20, 2012. The Auditor conducted an opening meeting, toured the entire facility, interviewed a randomized sample of staff and residents and reviewed PREA related staff and resident documentation. Upon completion of the audit process, a closing meeting was held with the administrative staff to discuss the audit process, preliminary findings and the post-audit process. Employees at the facility were extremely courteous, cooperative and professional. All areas of the facility were found to be clean and well maintained. During the closing meeting, the Auditor thanked the staff for their hard work and dedication to the PREA process.

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.

Pre-Audit Phase

On April 14, 2020, PREA Audit Notices (in English and Spanish) were sent to the facility to be posted. Due to the delay caused by the Corona Virus, these notices remained in place and in effect until the date of the rescheduled audit. The Auditor observed these postings during the tour. These notices were posted in the living units, at the main entrance and in the common area. These notices were posted for six weeks pre-audit. The Auditor received no correspondence from residents prior to the on-site visit.

FSFW staff members were asked to complete the Pre-Audit Questionnaire (PAQ) also provided to the facility on April 14, 2020. The completed PAQ and supporting documentation was received by the Auditor on April 24, 2020. All documentation was reviewed by the Auditor, including educational materials, training logs, posters, brochures, agency policies, institution

supplements, procedures, forms, organizational charts and other PREA related documentation.

On July 11, 2020, the Auditor requested additional information including, but not limited to, staff rosters, inmate rosters, investigations, residents self-identified as being lesbian, bi-sexual, transgender, or intersex (LGBTI), resident reports of sexual abuse/sexual harassment, residents who are Limited English Proficient (LEP), and additional examples of the FSFW screening instrument. These documents were provided and reviewed at the time of the audit.

On-Site Audit Phase

The Auditor held an opening meeting on the morning of July 20, 2020 at the Fresh Start for Women facility with administrative staff. The audit schedule and process were discussed during the meeting. Including the Auditor, those present at the meeting were:

- Facility Director (FD)
- Facility PREA Compliance Manager/Agency PREA Compliance Coordinator (PCM)
- Facility Supervisor

The Auditor was provided a private area in which to work and conduct confidential interviews. All requested files and rosters, both staff and residents, were made available to the Auditor for review.

Immediately following the opening meeting, a tour of the facility was completed. The Auditor was escorted by the FD and the PCM. During the tour, the Auditor reviewed PREA related documentation and materials located on bulletin boards and pertinent entries made in electronic logs. The Auditor assessed camera surveillance, physical supervision and electronic monitoring capabilities. Other areas of focus during the facility tour included, but were not limited to, levels of staff supervision and limits to cross-gender viewing. All signs and postings were in both English and Spanish. Residents can shower, dress and use the toilet facilities without exposing themselves to employees of the opposite gender. Informal and formal conversations with employees and residents regarding the PREA standards were conducted. Postings regarding PREA violation reporting and the agency's zero-tolerance policy for sexual abuse and sexual harassment were prominently displayed in all living units, meeting areas and throughout the facility. Audit notice postings with the PREA Auditor's contact information were posted in the same areas. The Auditor notice postings were posted 60 days prior to the original date of the on-site visit. Unimpeded access to all areas of the facility was provided to the Auditor.

Resident Interviews

At the time of the audit there were 29 female residents housed at FSFW. A total of 14 residents were interviewed. There were no Limited English Proficient (LEP) or physically disabled residents at the facility. No cognitively disabled resident was interviewed. Staff indicated there was one bi-sexual resident and no transgender or intersex residents at the facility. The Auditor interviewed no residents who reported sexual abuse or who reported

sexual victimization during risk screening. No residents refused to be interviewed. Interviews were conducted using the Department of Justice (DOJ) protocols to assess a resident's knowledge of the PREA and the reporting mechanisms available to them.

Staff Interviews

FSFW employs a staff of 23 individuals. Fourteen staff interviews were conducted; these interviews included 14 random staff (from all three shifts) and nine administrative/specialized staff. The administrative staff included the District Director (DD), PCM, FD and Human Resource Manager (HRM). The specialized staff included a Volunteer, Probation and Parole Officers, Residential Supervisor, Residential Officers and an Investigator. All staff members have been trained to act as first responders when a PREA related incident occurs.

File Review

Following the interviews, the Auditor reviewed the files requested during the pre-audit phase. The Auditor reviewed personnel files to establish compliance with PREA training mandates and background checks. The facility has no contractors. In the event a contractor would be required within the facility, all contractors would be escorted by staff. Screening and intake procedures were evaluated by reviewing random resident files which included a vulnerability assessment instrument.

Investigations

During the current auditing period, there were no reported allegations of sexual abuse/sexual harassment. All criminal investigations are conducted by the Des Moines Police Department (DSPD), in conjunction with the Iowa Department of Corrections (IDOC). The District Director (DD), FD and the PCM are responsible for receiving verbal and telephonic referrals 24 hours a day, seven days a week. Additionally, sexual abuse investigation outcomes and general protective services assessment outcomes are submitted to, reviewed and finalized by the District Director and the PCM. No resident correspondence was received by the Auditor prior to the visit.

Closeout

A closing meeting was held with the Auditor and the administrative staff on the morning of July 21, 2020. Discussions centered on the audit process, preliminary findings and the post-audit process. The Auditor thanked the staff for their hard work and dedication to the PREA process.

Facility Characteristics

The Women's Residential Correctional Facility has been in operation since June 1993. In 2013 the Women's Residential Correctional Center was renamed the Fresh Start for Women Facility. The residential portion of the Fresh Start for Women Facility operates as a forty-eight bed facility housing female offenders. The legal status of residents at the facility varies. Residents may be admitted to this facility as a condition of probation or parole, as a state work release resident, as an Operating While Intoxicated (OWI) offender, as a federal resident or as a resident on pretrial or jail transfer status. The program houses women with their children. This innovative program is unique to Iowa. It allows the resident to participate in the program, along with a maximum of two children under the age of five. This component of the program has been offered since May 1994. Due to the Corona Virus shutdown, there were no children present at the time of the audit. The mission of the Fresh Start for Women's Program is to provide a safe and holistic approach to supervision that seeks to educate, support and advocate for all women to transform their lives. The program emphasizes gender responsivity and a trauma informed approach to case management.

FSFW provides a safe, secure and nurturing environment. They strive to provide client-centered, transitional care for residents by providing intensive individualized case management and goal planning.

FSFW is a one building, 48 bed transitional housing center, located in Des Moines, Iowa. The building provides a multiple occupancy living environment for residents at the facility. The facility complies with current Des Moines, Iowa building and occupancy code.

Residents in all programs are expected to pay weekly rent, obtain employment and participate in treatment programming. Each resident is assigned a Probation/Parole Officer upon admission to the facility. The Probation/Parole Officer (PPO) handles the resident's employment, legal issues, budgeting needs, specific treatment requirements and community referrals and interfaces with probation/parole officers and the judicial system. The Probation/Parole Officer does an assessment and is responsible for addressing many of the resident's treatment needs. The program helps residents address criminal thinking/criminal behavior, substance addictions and addictive behaviors, including their pathway into the criminal justice system. The resident may attend weekly treatment groups, such as AA/NA/ACOA, or other support groups, as well as one-on-one sessions with her PPO. The programming includes a series of lectures ranging from job seeking, stress management, financial education, nutrition, parenting and trauma. Additionally, the women journal, watch treatment films and learn cognitive skills. The facility staff can make referrals to outside agencies for aftercare or to address specific issues. Numerous service providers began outreach services in 2013 which allow in-house resources to the residents.

FSFW residents complete a Sexual Violence Propensity Tool (SVP) within 72 hours of intake. The results of the assessment are utilized in determining housing. Staff members are aware of the social history of the offenders and use this information in both program referrals and housing assignments. SVP's are administered, as necessary, throughout the resident's stay at FSFW. That information is utilized to ensure the safety of the resident and that adequate programming has been provided.

FSFW utilizes an electronic computer program entitled Iowa Correctional Offender Network (ICON), provided by the Iowa Department of Corrections. This tool determines the amount of time each resident is permitted to be out of the facility per day (unit time). Residents can be out of the facility for eight to fourteen hours per day, depending on their employment status. Residents are also granted furloughs and passes to leave the facility for recreation and family reunification.

Residents are monitored on-site by Iowa Probation and Parole Agents. This ensures participation in all mandated treatment, including drug and alcohol, mental health and any other prescribed specialized treatment.

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: 0
List of Standards Exceeded: N/A

Standards Met

Number of Standards Met: 41

Standards Not Met

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

PREVENTION PLANNING

Standard 115.211: Zero tolerance of sexual abuse and sexual harassment; PREA coordinator

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

115.211 (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

115.211 (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

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.

Evidence Reviewed (on-site visit, documentation, staff and resident interviews):

1. FSFW Pre-Audit Questionnaire
2. Policy PREA 1 Prevention Planning
3. Table of Organization
4. Interviews with the following:
    a. Staff (Specialized/Random)

The agency's zero-tolerance policy against sexual abuse was clearly established in the above documentation and via interviews. The policy also outlines the agency's approach to preventing, detecting and responding to sexual abuse and sexual harassment allegations. The PCM reports to the District Director. Zero-tolerance posters are displayed throughout every area of the facility. The agency and facility directives outline a zero-tolerance policy for all forms of sexual abuse and sexual harassment. Residents are informed orally about the zero-tolerance policy and the PREA program during in-processing and are required to view a video during admission and orientation presentations. Additional program information is contained in the Resident Handbook and is posted throughout the facility, as observed by the Auditor during the tour. All PREA information, both video and written, is available in English and Spanish. Interpretive services are available for residents who do not speak or read English or Spanish. Both FSFW staff and residents are provided with multiple opportunities to become informed of PREA policies and procedures. All employees receive initial training and Annual Refresher Training (ART), as well as updates throughout the year.

Corrective action: None required

Standard 115.212: Contracting with other entities for the confinement of residents

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

115.212 (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 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

115.212 (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

115.212 (c)

- If the agency has entered into a contract with an entity that fails to comply with the PREA standards, did the agency do so only in emergency circumstances after making all reasonable attempts to find a PREA compliant private agency or other entity to confine residents? (N/A if the agency has not entered into a contract with an entity that fails to comply with the PREA standards.) ☐ Yes ☐ No ☒ NA

- In such a case, does the agency document its unsuccessful attempts to find an entity in compliance with the standards? (N/A if the agency has not entered into a contract with an entity that fails to comply with the PREA standards.) ☐ 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.

Evidence Reviewed (on-site visit, documentation, staff and resident interviews):

1. FSFW Pre-Audit Questionnaire
2. FSFW Organizational Chart
3. Federal Bureau of Prisons (BOP) Statement of Work
4. Interviews with the following:
    a. Staff (Specialized)

FSFW does have a contract with the Federal Bureau of Prisons (BOP). The contract was reviewed by the auditor. The contract includes the obligation to comply with PREA standards and to monitor the conditions of the contract. At the time of the audit, the facility did not have any BOP inmates.

Corrective action: None required

Standard 115.213: Supervision and monitoring

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

115.213 (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: The physical layout of each facility? ☒ 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 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

115.213 (b)

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

115.213 (c)

- In the past 12 months, has the facility 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 assessed, determined, and documented whether adjustments are needed to prevailing staffing patterns? ☒ Yes ☐ No

- In the past 12 months, has the facility 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 assessed, determined, and documented whether adjustments are needed to the resources the facility has available to commit to ensure adequate staffing levels? ☒ 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.

Evidence Reviewed (on-site visit, documentation, staff and resident interviews):

1. FSFW Pre-Audit Questionnaire
2. Policy PREA 1 Prevention Planning
3. FSFW Staffing Plan
4. Review of Electronic Data from Iowa Correctional Offender Network (ICON)
5. FSFW Camera Layout
6. FSFW Staffing Plan Review
7. Review of Daily Count Sheets
8. Interviews with the following:
    a. Staff (Specialized/Random)

Agency policy requires the facility to review the staffing plans on an annual basis. Interviews with the FD and PCM revealed compliance with the PREA and that other safety and security issues are always a primary focus when considering and reviewing their respective staffing plans. FSFW has been provided with all necessary resources to support the programs and procedures which ensure compliance with PREA standards. The audit included an examination of all video monitoring systems, resident access to telephones, resident computer access, staff interviews and rosters. Supervisory/Administrative staff members routinely make unannounced rounds covering all shifts and these rounds are documented. Interviews with staff confirmed unannounced rounds to all areas of the facility are conducted on a weekly basis, with no warning to employees. During the tour, camera locations were observed by the Auditor.

Corrective action: None required

Standard 115.215: Limits to cross-gender viewing and searches

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

115.215 (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

115.215 (b)

- Does the facility always refrain from conducting cross-gender pat-down searches of female residents, except in exigent circumstances? (N/A if the facility does not have female residents.) ☒ Yes ☐ No ☐ NA

- Does the facility always refrain from restricting female residents' access to regularly available programming or other outside opportunities in order to comply with this provision? (N/A if the facility does not have female residents.) ☒ Yes ☐ No ☐ NA

115.215 (c)

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

- Does the facility document all cross-gender pat-down searches of female residents? (N/A if the facility does not have female residents). ☒ Yes ☐ No ☐ NA

115.215 (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 enables 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 an area where residents are likely to be showering, performing bodily functions, or changing clothing? ☒ Yes ☐ No

115.215 (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

115.215 (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.

Evidence Reviewed (on-site visit, documentation, staff and resident interviews):

1. FSFW Pre-Audit Questionnaire
2. Policy PREA 1 Prevention Planning: IV
3. Policy PREA 3 Training and Education
4. Interoffice Communication Re: Standard: 115.215(a)
5. PREA Training Curriculum
6. PREA Training Acknowledgement
7. FSFW Job Description/Post Orders
8. Interviews with the following:
    a. Staff (Specialized/Random)

Policies and documentation address this standard. Cross-gender strip or cross-gender body cavity searches are prohibited, except in emergency situations or when performed and documented by a medical practitioner. Staff interviewed indicated they received cross-gender pat search training during initial and annual training. The Auditor observed that each unit has

individual shower stalls for privacy. The facility has implemented a policy that all staff working the shift will announce themselves prior to walking the units to allow residents the opportunity to prepare themselves from a privacy perspective. The residents interviewed acknowledged they can shower, dress and use the toilet privately, without being viewed by staff of the opposite gender. Staff, along with residents interviewed, indicated that employees of the opposite gender announce their presence before entering a unit. Staff members were aware of the policy prohibiting the search of a transgender or intersex resident for the sole purpose of determining the resident's genital status. During the past 12 months, there were no exigent circumstances that required cross-gender viewing of a resident by a staff member at Fresh Start for Women.

Corrective action: None required

Standard 115.216: Residents with disabilities and residents who are limited English proficient

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

115.216 (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

115.216 (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

115.216 (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 §115.264, 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.

Evidence Reviewed (on-site visit, documentation, staff and resident interviews):

1. FSFW Pre-Audit Questionnaire
2. Policy PREA 1 Prevention Planning: V
3. Policy PREA 3 Training and Education
4. Employee E-Learning Training Curriculum
5. E-Learning Report Sign-in Sheets
6. Policy PREA 1 Prevention Planning: IV
7. Interviews with the following:
    a. Staff (Specialized/Random)

FSFW takes appropriate steps to ensure residents with disabilities and residents with Limited English Proficiency (LEP) have an opportunity to participate in and benefit from the facility's efforts to prevent, detect and respond to sexual abuse and sexual harassment. PREA handouts, bulletin board postings and resident handbooks are available in both English and Spanish. These documents were submitted to and reviewed by the Auditor. Interviewed staff members were aware of the policy that, under no circumstances, is any resident interpreter or assistant to be used regarding PREA issues. Where interpreters are necessary, yet unavailable, the contracting authority will be notified for assistance and an interpreter will be assigned to review intake and handbook information, to include all PREA information, training and procedures. FSFW has an extensive list of interpreters to assist clients, if it is required. At the time of the audit, there were no LEP residents, no residents with physical disabilities and no residents that were unable to understand the PREA. The review of documentation and staff and resident interviews support a finding that the facility is compliant with this standard.

Corrective action: None required

Standard 115.217: Hiring and promotion decisions

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

115.217 (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

115.217 (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

115.217 (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, 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

115.217 (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

115.217 (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

115.217 (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

115.217 (g)

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

115.217 (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.

Evidence Reviewed (on-site visit, documentation, staff and resident interviews):

1. FSFW Pre-Audit Questionnaire
2. Policy PREA 1 Prevention Planning: VI
3. Employment Application
4. Employee Background Checks, One and Five Year (examples)
5. Employment Application
6. Employee Handbook
7. Interviews with the following:
    a. Staff (Specialized/Random)

Policies and interviews confirm compliance with this standard. All employees and volunteers have background checks completed through the National Criminal Information Center (NCIC). There are no contract staff members at the facility. Staff promotions require a background check before a promotion is approved. A tracking system is in place to ensure that updated background checks are conducted every five years. Policy states that false information submitted by the applicant is grounds for termination. The auditor reviewed employment documentation which supports the facility's compliance with this standard.

Corrective action: None required

Standard 115.218: Upgrades to facilities and technologies

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

115.218 (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

115.218 (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.

Evidence Reviewed (on-site visit, documentation, staff and resident interviews):

1. FSFW Pre-Audit Questionnaire
2. Policy PREA 1 Prevention Planning: VII
3. FSFW Camera Layout
4. Interviews with the following:
    a. Staff (Specialized)

Policies and interviews confirm compliance with this standard. The FSFW has not upgraded their video monitoring system, which includes 23 video surveillance cameras, since the previous audit. Cameras are placed strategically throughout the facility to ensure the safety and security of both residents and staff.

Corrective action: None required

RESPONSIVE PLANNING

Standard 115.221: Evidence protocol and forensic medical examinations

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

115.221 (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

115.221 (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

115.221 (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

115.221 (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 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

115.221 (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

115.221 (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

115.221 (g)

- Auditor is not required to audit this provision.

115.221 (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.

Evidence Reviewed (on-site visit, documentation, staff and resident interviews):

1. FSFW Pre-Audit Questionnaire
2. Posted Flier: Victim Advocacy Information
3. Polk County Crisis and Advocacy Center Webpage: **https://polkcountyiowa.gov**
4. Memorandum of Understanding (MOU) with Des Moines Police Department (DMPD)
5. Memorandum of Understanding with Polk County Crisis and Advocacy Services
6. Memorandum of Understanding with Polk County Attorney's Office
7. Policy PREA 2 Responsive Planning: I
8. Resident Handbook
9. Interviews with the following:
    a. Staff (Specialized/Random)
    b. Sexual Assault Nurse Examiner (SANE) - Broadlawns Medical Center

FSFW staff members were interviewed concerning this standard and all were knowledgeable of the procedures required to secure and obtain usable physical evidence when sexual abuse is alleged. Staff members were aware that agency investigators conduct administrative investigations of sexual abuse allegations. All criminal investigations are reported to and conducted by the DMPD. All forensic medical examinations are conducted by SANE staff at Broadlawns Medical Center. A telephone interview with the SANE representative at Broadlawns Medical Center was conducted and the provider was aware of the provisions of the PREA standards. The representative indicated that a SANE is available 24 hours a day, seven days a week. There were no SANE examinations conducted during the past 12 months. Rape crisis intervention and short-term counseling for victims of rape and sexual assault are provided by Polk County Crisis and Advocacy Center (PCCAC), a rape crisis advocacy center. The MOU between FSFW and PCCAC was reviewed by the Auditor. Follow up treatment is completed by personnel within the community, as directed by PCCAC. There have been no allegations or investigations during this auditing period.

Corrective action: None required

Standard 115.222: Policies to ensure referrals of allegations for investigations

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

115.222 (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

115.222 (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

115.222 (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 conducting criminal investigations. See 115.221(a).) ☒ Yes ☐ No ☐ NA

115.222 (d)

- Auditor is not required to audit this provision.

115.222 (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.

Evidence Reviewed (on-site visit, documentation, staff and resident interviews):

1. FSFW Pre-Audit Questionnaire
2. Policy PREA 2 Responsive Planning: II
3. Memorandum of Understanding (MOU) with Des Moines Police Department (DMPD)
4. Memorandum of Understanding with Polk County Attorney's Office

5. Interviews with the following:
    a. Staff (Specialized/Random)

Policies and documents address the mandates of this standard. The policy requires that all criminal allegations of sexual abuse and sexual harassment be referred for investigation to the appropriate law enforcement authorities: DMPD. An interview was conducted with the PCM concerning the reporting process for PREA allegations. Allegations are submitted via an electronic database and assigned to an investigator. If the investigator determines that the allegation could be of a criminal nature, the DMPD is called and continues with the investigation to its conclusion. The entire investigation process is monitored by the IDOC. Standard compliance was also demonstrated via interviews with the FD and an investigator. The agency reported no allegations of sexual abuse during the past 12 months.

Corrective action: None required

TRAINING AND EDUCATION

Standard 115.231: Employee training

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

115.231 (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 confinement? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: The common reactions of sexual abuse and sexual harassment victims? ☒ 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? ☒ 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

115.231 (b)

- 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

115.231 (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

115.231 (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.

Evidence Reviewed (on-site visit, documentation, staff and resident interviews):

1. FSFW Pre-Audit Questionnaire
2. Policy PREA 3 Responsive Planning: I
3. Employee Training Sign-off Sheets
4. FSFW PowerPoint Training Objectives
5. Interviews with the following:
    a. Staff (Specialized/Random

FSFW provides PREA training to employees. FSFW also provides PREA standards training which all staff are required to complete. All staff members are mandated to receive training annually and the curriculum includes an extensive review of the PREA requirements. The training curriculum, sign-in sheets and other related training documentation was reviewed by the Auditor. Interviewed staff verified the requirement to acknowledge, in writing, not only that they received the PREA training, but that they understood it, as well.

Corrective action: None required

Standard 115.232: Volunteer and contractor training

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

115.232 (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

115.232 (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

115.232 (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.

Evidence Reviewed (on-site visit, documentation, staff and resident interviews):

1. FSFW Pre-Audit Questionnaire
2. Policy PREA 3 Training and Education: II
3. Employee Training Sign-off Sheets
4. FSFW PowerPoint Training Objectives
5. Signed Training Documents Acknowledging Receipt and Understanding of Information
6. Interviews with the following:
    a. Staff (Specialized)
    b. Volunteer

FSFW presently has one volunteer. All volunteers and contractors (if hired), receive the PREA training, including the zero-tolerance policy, reporting and responding requirements. The training is documented and maintained on file per facility policy. The FSFW volunteer was interviewed and demonstrated an understanding of the PREA policies.

Corrective action: None required

Standard 115.233: Resident education

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

115.233 (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

- During intake, do residents receive information explaining: Their rights to be free from sexual abuse and sexual harassment? ☒ Yes ☐ No
- During intake, do residents receive information explaining: Their rights to be free from retaliation for reporting such incidents? ☒ Yes ☐ No
- During intake, do residents receive information regarding agency policies and procedures for responding to such incidents? ☒ Yes ☐ No

115.233 (b)

- Does the agency provide refresher information whenever a resident is transferred to a different facility? ☒ Yes ☐ No

115.233 (c)

- 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

115.233 (d)

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

115.233 (e)

- 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.

Evidence Reviewed (on-site visit, documentation, staff and resident interviews):

1. FSFW Pre-Audit Questionnaire
2. Policy PREA 3 Training and Education: III
3. FSFW Resident Handbook
4. Polk County Crisis and Advocacy Center Webpage: **https://polkcountyiowa.gov**
5. PREA Posters (example 1)
6. Resident Services Support Phone Numbers List
7. PREA Intake Packet
8. PREA Intake Video (English)
9. PREA Intake Video (Spanish)
10. PREA Acknowledgement Signature Sheets (examples)
11. Interviews with the following:
    a. Staff (Specialized/Random)
    b. Residents

Policies and documentation address the components of this standard. The facility puts forth its best efforts to educate the residents regarding the PREA. Residents receive information during the intake process including a PREA packet and Resident Handbook, printed in English and Spanish. A staff member conducts an education program regarding the PREA for all residents within 30 days of their arrival at the facility. Most PREA education is conducted with 24 hours of arrival to FSFW. The program includes definitions of sexually abusive behavior and sexual harassment, prevention strategies and reporting modalities. Residents also view a comprehensive orientation video that explains the facility's zero-tolerance policy and covers the resident's right to be free from sexual abuse, sexual harassment and retaliation. There are PREA posters displayed throughout the facility and in each housing unit and a "Hotline" telephone number, which may be called to report sexual abuse or sexual harassment. Since the "Hotline" telephone number is an 800-toll-free number, residents can call from any of the available telephones. The mailing address is listed in the Resident Handbook and posted in each housing unit for resident correspondence concerning any sexual abuse or sexual harassment allegation. There is also a translation language line available to LEP residents. The Auditor was provided a random sampling of PREA Acknowledgement Signature Sheets to verify that residents, admitted during the auditing period, received the PREA education and

relevant written materials. All residents are required to acknowledge, in writing, completion of PREA education. During the interview process, randomly selected residents indicated they received information about the facility's rules against sexual abuse/sexual harassment, when they arrived at the facility. They further indicated they were advised about their right not to be sexually abused/sexually harassed, how to report sexual abuse/sexual harassment, and their right not be punished for reporting sexual abuse/sexual harassment. Residents were aware of available services outside of the facility for dealing with sexual abuse.

Corrective action: None required

Standard 115.234: Specialized training: Investigations

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

115.234 (a)

- In addition to the general training provided to all employees pursuant to §115.231, does the agency ensure that, to the extent the agency itself conducts sexual abuse investigations, its investigators receive 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 115.221(a).)
  ☒ Yes ☐ No ☐ NA

115.234 (b)

- Does this specialized training include: Techniques for interviewing sexual abuse victims? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(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 115.221(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 115.221(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 115.221(a).)
  ☒ Yes ☐ No ☐ NA

115.234 (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 115.221(a).)
  ☒ Yes ☐ No ☐ NA

115.234 (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.

Evidence Reviewed (on-site visit, documentation, staff and resident interviews):

1. FSFW Pre-Audit Questionnaire
2. Policy PREA 3 Training and Education: IV
3. Investigator Certifications
4. Interviews with the following:
    a. Staff (Specialized)

The 5th Judicial District Department of Correctional Services has six investigators in the District. All administrative investigations are conducted by the investigative staff of the 5th District in cooperation with the IDOC. All allegations are reported immediately to the IDOC via electronic data entry. Once an allegation is received, the investigations are conducted internally as an administrative investigation. If it is determined that there is adequate evidence of a criminal nature, the case is assigned to the DMPD. The FD is kept informed during the investigative process and at the conclusion of the investigation.

Corrective action: None required

Standard 115.235: Specialized training: Medical and mental health care

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

115.235 (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 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

115.235 (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 does not employ medical staff or the medical staff employed by the agency do not conduct forensic exams.)
  ☐ Yes ☐ No ☒ NA

115.235 (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

115.235 (d)

- Do medical and mental health care practitioners employed by the agency also receive training mandated for employees by §115.231? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners employed by the agency.) ☒ Yes ☐ No ☐ NA

- Do medical and mental health care practitioners contracted by and volunteering for the agency also receive training mandated for contractors and volunteers by §115.232? (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.

Evidence Reviewed (on-site visit, documentation, staff and resident interviews):

1. FSFW Pre-Audit Questionnaire
2. Policy PREA 3 Training and Education; V
3. Polk County Crisis and Advocacy Center Webpage: **https://polkcountyiowa.gov**
4. Memorandum of Understanding (MOU) with Polk County Crisis and Advocacy Services
5. Specialized Mental Health Training Curriculum Objectives
6. Interviews with the following:
    a. Staff (Specialized/Random)

All medical services are provided by Broadlawns Medical Center. All mental health services are provided by Polk County Crisis and Advocacy Center. The facility has a MOU with Polk County Crisis and Advocacy Center to provide mental health services. FSFW staff members receive specialized training in mental health services which focuses on the female residents who are at the facility.

Corrective action: None required

SCREENING FOR RISK OF SEXUAL VICTIMIZATION AND ABUSIVENESS

Standard 115.241: Screening for risk of victimization and abusiveness

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

115.241 (a)

- Are all residents assessed during an intake screening for their risk of being sexually abused by other residents or sexually abusive toward other residents? ☒ Yes ☐ No

- Are all residents assessed upon transfer to another facility for their risk of being sexually abused by other residents or sexually abusive toward other residents? ☒ Yes ☐ No

115.241 (b)

- Do intake screenings ordinarily take place within 72 hours of arrival at the facility? ☒ Yes ☐ No

115.241 (c)

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

115.241 (d)

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has a mental, physical, or developmental disability? ☒ Yes ☐ No

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: The age of the resident? ☒ Yes ☐ No

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: The physical build of the resident? ☒ Yes ☐ No

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has previously been incarcerated? ☒ Yes ☐ No

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident's criminal history is exclusively nonviolent? ☒ Yes ☐ No

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has prior convictions for sex offenses against an adult or child? ☒ Yes ☐ No

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident is or is perceived to be gay, lesbian, bisexual, transgender, intersex, or gender nonconforming (the facility affirmatively asks the resident about his/her sexual orientation and gender identity AND makes a subjective determination based on the screener's perception whether the resident is gender non-conforming or otherwise may be perceived to be LGBTI)? ☒ Yes ☐ No

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has previously experienced sexual victimization? ☒ Yes ☐ No

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: The resident's own perception of vulnerability? ☒ Yes ☐ No

115.241 (e)

- In assessing residents for risk of being sexually abusive, does the initial PREA risk screening consider, when known to the agency: prior acts of sexual abuse? ☒ Yes ☐ No

- In assessing residents for risk of being sexually abusive, does the initial PREA risk screening consider, when known to the agency: prior convictions for violent offenses? ☒ Yes ☐ No

- In assessing residents for risk of being sexually abusive, does the initial PREA risk screening consider, when known to the agency: history of prior institutional violence or sexual abuse? ☒ Yes ☐ No

115.241 (f)

- Within a set time period not more than 30 days from the resident's arrival at the facility, does the facility reassess the resident's risk of victimization or abusiveness based upon any additional, relevant information received by the facility since the intake screening? ☒ Yes ☐ No

115.241 (g)

- Does the facility reassess a resident's risk level when warranted due to a: Referral? ☒ Yes ☐ No

- Does the facility reassess a resident's risk level when warranted due to a: Request? ☒ Yes ☐ No

- Does the facility reassess a resident's risk level when warranted due to a: Incident of sexual abuse? ☒ Yes ☐ No

- Does the facility reassess a resident's risk level when warranted due to a: Receipt of additional information that bears on the resident's risk of sexual victimization or abusiveness? ☒ Yes ☐ No

115.241 (h)

- Is it the case that residents are not ever disciplined for refusing to answer, or for not disclosing complete information in response to, questions asked pursuant to paragraphs (d)(1), (d)(7), (d)(8), or (d)(9) of this section? ☒ Yes ☐ No

115.241 (i)

- 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.

Evidence Reviewed (on-site visit, documentation, staff and resident interviews):

1. FSFW Pre-Audit Questionnaire
2. PREA 4 - Screening for Risk of Sexual Victimization and Abusiveness: I
3. PREA Sexual Violence Propensity Assessment (SVP)
4. SVP Document
5. SVP Examples
6. Interviews with the following:
    a. Staff (Specialized/Random)

Policy addresses the requirements of this standard. Facility policy requires the use of a screening instrument (SVP) to determine proper housing, bed assignment, work assignment, education and other program assignments, with the goal of keeping residents at a high risk of being sexually abused/sexually harassed separate from those residents who are at a high risk of being sexually abusive. Facility policy also requires all residents to be screened within 72 hours of arrival; however, they are routinely screened on the day of arrival. Risk management staff review all relevant pre-sentence documentation and information from other confinement facilities and reassess a resident's risk level, as necessary, within 30 days of arrival. Facility policy prohibits residents from being disciplined for refusing to answer, or for not disclosing complete information in response to questions regarding their mental/physical health, developmental disability, sexual preferences, sexual victimization history and perception of vulnerability. Housing and program assignments are made on a case-by-case basis and residents are not placed in housing units based solely on their sexual identification or status. Interviews with risk management staff and a random review of risk screening assessments support the finding that the facility is compliant with this standard.

Corrective action: None required

Standard 115.242: Use of screening information

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

115.242 (a)

- Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Housing Assignments? ☒ Yes ☐ No

- Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Bed assignments? ☒ Yes ☐ No

- Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Work Assignments? ☒ Yes ☐ No

- Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Education Assignments? ☒ Yes ☐ No

- Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Program Assignments? ☒ Yes ☐ No

115.242 (b)

- Does the agency make individualized determinations about how to ensure the safety of each resident? ☒ Yes ☐ No

115.242 (c)

- 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

115.242 (d)

- 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

115.242 (e)

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

115.242 (f)

- Unless placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting lesbian, gay, bisexual, transgender, or intersex residents, does the agency always refrain from placing: lesbian, gay, and bisexual residents in dedicated facilities, units, or wings solely on the basis of such identification or status? (N/A if the agency has a dedicated facility, unit, or wing solely for the placement of LGBT or I residents pursuant to a consent decree, legal settlement, or legal judgement.) ☒ Yes ☐ No ☐ NA

- Unless placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting lesbian, gay, bisexual, transgender, or intersex residents, does the agency always refrain from placing: transgender residents in dedicated facilities, units, or wings solely on the basis of such identification or status? (N/A if the agency has a dedicated facility, unit, or wing solely for the placement of LGBT or I residents pursuant to a consent decree, legal settlement, or legal judgement.) ☒ Yes ☐ No ☐ NA

- Unless placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting lesbian, gay, bisexual, transgender, or intersex residents, does the agency always refrain from placing: intersex residents in dedicated facilities, units, or wings solely on the basis of such identification or status? (N/A if the agency has a dedicated facility, unit, or wing solely for the placement of LGBT or I residents pursuant to a consent decree, legal settlement, or legal judgement.) ☒ 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.

Evidence Reviewed (on-site visit, documentation, staff and resident interviews):

1. FSFW Pre-Audit Questionnaire
2. PREA 4 - Screening for Risk of Sexual Victimization and Abusiveness: I
3. PREA Sexual Violence Propensity Assessment (SVP)
4. SVP Document
5. SVP Examples
6. Facility Count Sheet
7. Interviews with the following:
    a. Staff (Specialized/Random)

Policies, screening forms and interviews address the requirements of this standard. Facility policy requires the use of a screening instrument to determine proper housing, bed assignment, work assignment, education and other program assignments, with the goal of keeping residents at a high risk of being sexually abused/sexually harassed separate from residents at a high risk of being sexually abusive. Housing and program assignments are made on a case-by-case basis and residents are not placed in housing units based solely on their sexual identification or status. Based on information provided by the facility, one LGBTI resident was housed in FSFW at the time of the audit. Additionally, no resident indicated sexual victimization or abusiveness during risk screening. All the residents mentioned above were interviewed in support of this standard. During the audit, risk management staff indicated transgender and intersex residents would be reassessed biannually and the residents' own views with respect to their safety would be given serious consideration. Additionally, all residents are given the opportunity to shower separately from other residents. Staff and resident interviews, the review of supporting documentation and the Auditor's observations support the facility being in compliance with the standard.

Corrective action: None required

REPORTING

Standard 115.251: Resident reporting

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

115.251 (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

115.251 (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

115.251 (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

115.251 (d)

- 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.

Evidence Reviewed (on-site visit, documentation, staff and resident interviews):

1. FSFW Pre-Audit Questionnaire
2. PREA 4 - Screening for Risk of Sexual Victimization and Abusiveness: I
3. Polk County Crisis and Advocacy Center Webpage: **https://polkcountyiowa.gov**
4. Memorandum of Understanding (MOU) with Polk County Crisis and Advocacy Services
5. PREA Poster (example 1)
6. Resident Handbook
7. Interviews with the following:
    a. Staff (Specialized/Random)
    b. Residents

Policies, the PREA Notices and Resident Handbook address the requirements of the standard. A review of supporting documentation and staff/resident interviews indicated that there are multiple ways (verbally, in writing, anonymously, privately and from a third party) for residents to report sexual abuse/sexual harassment. The facility has procedures in place for staff to document all allegations. There are posters and other documents on display throughout the facility which explain reporting methods. Staff members promptly accept and document all verbal, written, anonymous, private and third-party reports of alleged abuse. Residents may report sexual abuse/sexual harassment by using the IDOC website, phoning the PREA "Hotline" number, contacting the Iowa Statewide Sexual Abuse Hotline, Polk County Crisis and Advocacy Center, National Sexual Assault Hotline, or contacting facility staff. Family and friends also have access to these methods of reporting. All interviewed residents confirmed awareness of the multiple methods of reporting sexual abuse/assault allegations. Interviews with staff and residents, observation of posters addressing reporting methods and an examination of policies and documentation confirm that FSFW is in compliance with this standard.

Corrective action: None required

Standard 115.252: Exhaustion of administrative remedies

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

115.252 (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

115.252 (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

115.252 (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

115.252 (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 115.252(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

115.252 (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 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

115.252 (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

115.252 (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.

Evidence Reviewed (on-site visit, documentation, staff and resident interviews):

1. FSFW Pre-Audit Questionnaire
2. PREA 5 - Reporting
3. Grievance Form
4. Grievance Form (examples)
5. Employee PREA Training Curriculum and Completion Sheets
6. Resident Handbook
7. Interviews with the following:
    a. Staff (Specialized/Random)
    b. Residents

Residents may file a grievance; however, all allegations of sexual abuse/sexual harassment, when received by staff, will immediately be referred to the FD. Residents are not required to use an informal grievance process and procedures also allow a resident to submit a grievance alleging sexual abuse without submitting it to the staff member who is the subject of the complaint. Additionally, policy prohibits the investigation of the allegation by either staff alleged to be involved in the incident or any staff who may be under their supervision. Policy states that there is no time frame for filing a grievance relating to sexual abuse or sexual harassment. Allegations of physical abuse by staff shall be referred to management, in accordance with procedures established for such referrals. Policy addresses the filing of emergency administrative remedy requests. If a resident files an emergency grievance with the facility and believes she is under a substantial risk of imminent sexual abuse, an expedited response is required to be provided within 48 hours. There is no prohibition that limits third parties, including fellow residents, staff members, family members, attorneys and outside victim advocates in assisting residents in filing requests for grievances relating to allegations of sexual abuse or filing such requests on behalf of residents. There were no grievances filed involving PREA related issues during the past 12 months. There were no grievances alleging sexual abuse that involved an extension due to the final decision not being reached within 90 days. Additionally, there were no grievances alleging sexual abuse filed by residents in which the resident declined third-party assistance. Residents are held accountable for manipulative behavior and false allegations. Generally, disciplinary action would be taken if a grievance was filed in bad faith.

Corrective action: None required

Standard 115.253: Resident access to outside confidential support services

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

115.253 (a)

- Does the facility provide residents with access to outside victim advocates for emotional support services related to sexual abuse by giving residents 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 enable reasonable communication between residents and these organizations and agencies, in as confidential a manner as possible? ☒ Yes ☐ No

115.253 (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

115.253 (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

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.

Evidence Reviewed (on-site visit, documentation, staff and resident interviews):

1. FSFW Pre-Audit Questionnaire
2. PREA 5 - Reporting
3. MOU with Polk County Crisis and Advocacy Center (PCCAC)
4. Resident Handbook
5. Advocacy Posters
6. Hotline Telephone Numbers Near All Resident Telephones
7. Publications Near All Resident Telephones
8. Interviews with the following:
    a. Staff (Specialized/Random)
    b. Residents

Policies and the Resident Handbook address the requirements of this standard. The facility has a MOU with Polk County Crisis and Advocacy Center, a rape crisis advocacy service. Contact information for the PCCAC is posted in the housing units. Residents are provided with a rape crisis advocacy toll free hotline number and have other numerous support group telephone numbers located near every phone accessible to the residents.

Corrective action: None required

Standard 115.254: Third-party reporting

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

115.254 (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.

Evidence Reviewed (on-site visit, documentation, staff and resident interviews):

1. FSFW Pre-Audit Questionnaire
2. PREA 5 - Reporting; III, IV
3. Resident Handbook
4. Resident Education Curriculum
5. Advocacy Posters
6. Listing of All Community Resources
7. Publications Near All Resident Telephones
8. Interviews with the following:
    a. Staff (Specialized/Random)
    b. Residents

Policy and procedures, Resident Handbook, PREA Posters, victim services numbers and the resident training curriculum meet the mandates of this standard. The website and posted notices assist third party reporters in reporting allegations of sexual abuse/sexual harassment. The residents interviewed indicated they were aware of third-party reporting and would probably feel more comfortable reporting an incident of sexual abuse to someone at the facility. Calls to toll-free telephone numbers can be placed at any time and the contact information is located near all resident telephones.

Corrective action: None required

OFFICIAL RESPONSE FOLLOWING A RESIDENT REPORT

Standard 115.261: Staff and agency reporting duties

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

115.261 (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

115.261 (b)

- Apart from reporting to designated supervisors or officials, do staff always refrain 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

115.261 (c)

- Unless otherwise precluded by Federal, State, or local law, are medical and mental health practitioners required to report sexual abuse pursuant to paragraph (a) of this section? ☒ Yes ☐ No

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

115.261 (d)

- If the alleged victim is under the age of 18 or considered a vulnerable adult under a State or local vulnerable persons statute, does the agency report the allegation to the designated State or local services agency under applicable mandatory reporting laws? ☒ Yes ☐ No

115.261 (e)

- 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.

Evidence Reviewed (on-site visit, documentation, staff and resident interviews):

1. FSFW Pre-Audit Questionnaire
2. PREA 3 - Education and Training

3. PREA 6 - Official Response Following an Offender Report
4. Employee PREA Training Curriculum and Sign-in Sheets
5. Interviews with the following:
    a. Staff (Specialized/Random)

Policies and the training curriculum address the requirements of this standard. Staff, contractors (if hired) and volunteers must report and respond to allegations of sexually abusive behavior, regardless of the source of the report. Interviewed staff members were aware of their duty to immediately report all allegations of sexual abuse, sexual harassment and retaliation relevant to the PREA standards. The reporting is ordinarily made to the PCM, Assistant Director (AD) and the DD, but could be made privately or to a third party. Policy requires the information concerning the identity of the alleged resident victim and the specific facts of the case to be shared with staff on a need-to-know basis, due to the staff involvement with the victim's welfare and/or the investigation of the incident. A review of policy and interviews with staff support the finding that the facility is in compliance with this standard.

Corrective action: None required

Standard 115.262: Agency protection duties

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

115.262 (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.

Evidence Reviewed (on-site visit, documentation, staff and resident interviews):

1. FSFW Pre-Audit Questionnaire
2. PREA 6 - Official Response Following an Offender Report; II
3. Employee PREA Training Curriculum and Sign-in Sheets
4. Interviews with the following:
    a. Staff (Specialized/Random)

Policy addresses the requirements of this standard. Interviewed staff members were aware of their duties and responsibilities, if they become aware or suspect that a resident is being sexually abused or sexually harassed. All staff indicated they would act immediately to protect the resident, including separating the victim/predator, securing the scene to protect potential evidence, preventing the destruction of potential evidence and contacting the PCM or on-call supervisor. In the past 12 months, there were no instances in which FSFW staff determined that a resident was subject to a substantial risk of imminent sexual abuse.

Corrective action: None required

Standard 115.263: Reporting to other confinement facilities

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

115.263 (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

115.263 (b)

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

115.263 (c)

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

115.263 (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.

Evidence Reviewed (on-site visit, documentation, staff and resident interviews):

1. FSFW Pre-Audit Questionnaire
2. PREA 6 - Official Response Following an Offender Report: III
3. Employee PREA Training Curriculum and Sign-in Sheets
4. Interviews with the following:
    a. Staff (Specialized/Random)

Policy addresses the requirements of this standard. Policy requires that any resident allegation of sexual abuse occurring while confined at another facility be reported to the PCM who, in turn, notifies the head of the facility or appropriate office of the agency where the alleged abuse occurred. This must occur within 72 hours of receipt of the allegation. Policy also requires that an investigation be initiated. In the past 12 months, FSFW received no allegations from residents that they were abused while confined at another facility.

Corrective action: None required

Standard 115.264: Staff first responder duties

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

115.264 (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

115.264 (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.

Evidence Reviewed (on-site visit, documentation, staff and resident interviews):

1. FSFW Pre-Audit Questionnaire
2. PREA 6 - Official Response Following an Offender Report: IV
3. Employee PREA Training Curriculum and Sign-in Sheets
4. Interviews with the following:
    a. Staff (Specialized/Random)

Policy and the training curriculum address the requirements of this standard. All interviewed staff members were extremely knowledgeable concerning their first responder duties and responsibilities upon learning of an allegation of sexual abuse/sexual harassment. Staff indicated they would separate the residents, secure the scene, prevent the destruction of any evidence and contact the FD or PCM. In the past 12 months, there were no allegations that a resident was sexually abused and a first responder was required to separate the victim and the abuser.

Corrective action: None required

Standard 115.265: Coordinated response

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

115.265 (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.

Evidence Reviewed (on-site visit, documentation, staff and resident interviews):

1. FSFW Pre-Audit Questionnaire
2. PREA 6 - Official Response Following an Offender Report: V
3. Written Plan Flowcharts
4. Employee PREA Training Curriculum and Sign-in Sheets
5. Interviews with the following:
    a. Staff (Specialized/Random)

Policy addresses the requirements of this standard. The policies were reviewed by the Auditor. The local policy specifies the guidelines and procedures that prevent sexual abuse/sexual assault and provides for prompt and effective intervention, in the event abuse or assault occurs. During the audit period, there were no allegations of sexual abuse/harassment.

Corrective action: None required

Standard 115.266: Preservation of ability to protect residents from contact with abusers

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

115.266 (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

115.266 (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.

Evidence Reviewed (on-site visit, documentation, staff and resident interviews):

1. FSFW Pre-Audit Questionnaire
2. PREA 6 - Official Response Following an Offender Report: VI
3. Employee PREA Training Curriculum and Sign-in Sheets
4. Interviews with the following:
    a. Staff (Specialized/Random)

The facility has no collective bargaining agreement with any entity. Employees are subject to discipline, including removal, if they engage in any sexual abuse/sexual harassment of a resident.

Corrective action: None required

Standard 115.267: Agency protection against retaliation

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

115.267 (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

115.267 (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

115.267 (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

115.267 (d)

- In the case of residents, does such monitoring also include periodic status checks? ☒ Yes ☐ No

115.267 (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

115.267 (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.

Evidence Reviewed (on-site visit, documentation, staff and resident interviews):

1. FSFW Pre-Audit Questionnaire
2. PREA 6 - Official Response Following an Offender Report: VII
3. Interviews with the following:

a. Staff (Specialized/Random)

Policy addresses the requirements of this standard. The policy prohibits any type of retaliation against any staff person or resident who reports sexual abuse or sexual harassment or cooperates in related investigations. The PCM is charged with monitoring retaliation. During the interview, she indicated that she follows up on all 30, 60 and 90-day reviews to ensure policy is being enforced and conducts periodic status checks on the frequency of incident reports, housing reassignments and negative performance reviews/staff job reassignments, as required in 115.67c. In the event of possible retaliation, the PCM indicated she would monitor the situation indefinitely. There have been no incidents of retaliation in the past 12 months. Compliance with this standard was determined by a review of policy/documentation and staff interviews.

Corrective action: None required

INVESTIGATIONS

Standard 115.271: Criminal and administrative agency investigations

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

115.271 (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 115.221(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 115.221(a).) ☒ Yes ☐ No ☐ NA

115.271 (b)

- Where sexual abuse is alleged, does the agency use investigators who have received specialized training in sexual abuse investigations as required by 115.234? ☒ Yes ☐ No

115.271 (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

115.271 (d)

- 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

115.271 (e)

- 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

115.271 (f)

- 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

115.271 (g)

- 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

115.271 (h)

- Are all substantiated allegations of conduct that appears to be criminal referred for prosecution? ☒ Yes ☐ No

115.271 (i)

- Does the agency retain all written reports referenced in 115.271(f) and (g) for as long as the alleged abuser is incarcerated or employed by the agency, plus five years? ☒ Yes ☐ No

115.271 (j)

- 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

115.271 (k)

- Auditor is not required to audit this provision.

115.271 (l)

- When an outside entity investigates sexual abuse, does the facility cooperate with outside investigators and endeavor to remain informed about the progress of the investigation? (N/A if an outside agency does not conduct administrative or criminal sexual abuse investigations. See 115.221(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.

Evidence Reviewed (on-site visit, documentation, staff and resident interviews):

1. FSFW Pre-Audit Questionnaire
2. PREA - 7 Investigations: I
3. Investigator Certification
4. Interviews with the following:
    a. Staff (Specialized/Random)

Policy addresses the components of this standard. All investigations are conducted by trained investigators of the 5th District. If the investigation results in the possibility of criminal intent, it is referred to the DMPD to determine if prosecution will be pursued. According to the FD, the facility fully cooperates with any outside agency that initiates an investigation. The FD serves

as the facility liaison and provides requested information to outside investigative agencies, as well as access to the resident. The credibility of an alleged victim, suspect or witness is assessed on an individual basis and is not determined by the individual's status as resident or staff. The agency does not require a resident who alleges sexual abuse to submit to a polygraph examination or other truth assessment device as a condition for proceeding with the investigation of such an allegation. There were zero PREA sexual abuse/sexual harassment allegations investigated at FSFW during the auditing period. Residents are notified of the outcome of an investigation. Compliance with this standard was determined by a review of policy/documentation and staff interviews.

Corrective action: None required

Standard 115.272: Evidentiary standard for administrative investigations

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

115.272 (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.

Evidence Reviewed (on-site visit, documentation, staff and resident interviews):

1. FSFW Pre-Audit Questionnaire
2. PREA - 7 Investigations: II
3. Interviews with the following:
    a. Staff (Specialized/Random)

Policy and interviews address the requirement of this standard. The evidence standard is a preponderance of the evidence in determining whether allegations of sexual abuse/sexual harassment are substantiated.

Corrective action: None required

Standard 115.273: Reporting to residents

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

115.273 (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

115.273 (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

115.273 (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

115.273 (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

115.273 (e)

- Does the agency document all such notifications or attempted notifications? ☒ Yes ☐ No

115.273 (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.

Evidence Reviewed (on-site visit, documentation, staff and resident interviews):

1. FSFW Pre-Audit Questionnaire
2. PREA - 7 Investigations: III
3. Investigator Certification
4. Interviews with the following:
    a. Staff (Specialized/Random)

Policy addresses the mandates of this standard. All investigations are referred to the IDOC through the electronic data system. There were no allegations of sexual abuse/sexual

harassment in the last 12 months. Residents involved in the allegation are to be notified, in writing, of the outcome of the investigation. Documentation is maintained in the investigative file. Compliance with this standard was determined by a review of policy and staff interviews.

Corrective action: None required

DISCIPLINE

Standard 115.276: Disciplinary sanctions for staff

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

115.276 (a)

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

115.276 (b)

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

115.276 (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

115.276 (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.

Evidence Reviewed (on-site visit, documentation, staff and resident interviews):

1. FSFW Pre-Audit Questionnaire
2. PREA - 8 Discipline: I
3. Employee Handbook
4. Employee Code of Conduct
5. Work Rules and Related Policies Employee Training Sign-off Sheet (examples)
6. Interviews with the following:
    a. Staff (Specialized/Random)

Policy addresses the requirements of this standard. Employees are subject to disciplinary sanctions for violating facility sexual abuse or sexual harassment policies. There have been no reported cases of residents engaging in sexual activity with staff in the past 12 months and no staff members were disciplined or terminated for violation of facility policy. All terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff that would have been terminated if not for their resignation, may be reported to criminal investigators and to any law enforcement or relevant professional/certifying/licensing agencies, unless the activity was clearly not criminal. Employees are subject to discipline, including removal, if they engage in any sexual abuse/sexual harassment of a resident. Compliance with this standard was determined by a review of policy/documentation and staff interviews.

Corrective action: None required

Standard 115.277: Corrective action for contractors and volunteers

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

115.277 (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

115.277 (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.

Evidence Reviewed (on-site visit, documentation, staff and resident interviews):

1. FSFW Pre-Audit Questionnaire
2. PREA - 8 Discipline: II
3. Interviews with the following:
    a. Staff (Specialized/Random)
    b. Volunteer

Policy addresses the requirements of the standard. Any contractor (if hired) or volunteer who engages in sexual abuse/sexual harassment would be prohibited from contact with residents and would be reported to the appropriate investigator, law enforcement, or relevant professional/licensing/certifying bodies, unless the activity was clearly not criminal in nature. In non-criminal cases, FSFW would take appropriate remedial measures and consider whether to prohibit further contact with residents. During the past 12 months, there were no incidents in which a contractor (none on staff) or volunteer was accused of sexual abuse or sexual harassment. Compliance with this standard was determined by a review of policy and volunteer/contractor training files, as well as staff and volunteer interviews.

Corrective action: None required

Standard 115.278: Interventions and disciplinary sanctions for residents

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

115.278 (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, are residents subject to disciplinary sanctions pursuant to a formal disciplinary process? ☒ Yes ☐ No

115.278 (b)

- Are 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

115.278 (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

115.278 (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 require the offending resident to participate in such interventions as a condition of access to programming and other benefits? ☒ Yes ☐ No

115.278 (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

115.278 (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

115.278 (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.

Evidence Reviewed (on-site visit, documentation, staff and resident interviews):

1. FSFW Pre-Audit Questionnaire
2. PREA - 8 Discipline: III
3. Resident Handbook
4. Interviews with the following:
    a. Staff (Specialized/Random)

Policy addresses the requirements of this standard. The policy defines sexual assault of any person, involving non-consensual touching by force or threat of force, as the greatest severity level prohibited act. The policy identifies residents engaging in sexual acts and making sexual proposals or threats to another as a high severity level prohibited act. Non-consensual sex or sexual harassment of any nature is prohibited and will result in discipline. Consensual sex between residents does not constitute sexual abuse. Sanctions are commensurate with the nature and circumstances of the abuse committed, along with the resident's disciplinary history and the sanctions imposed for comparable offenses by other residents with similar histories. Residents are subject to disciplinary sanctions pursuant to the formal disciplinary process defined by policy. The facility does not discipline residents who make an allegation in good faith, even if an investigation does not establish evidence sufficient to substantiate the allegation. The disciplinary process considers whether a resident's mental disabilities or mental illness contributed to the resident's behavior when determining what type of sanction, if any, should be imposed. If mental disabilities or mental illness is a factor, the facility considers the offer of therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse. Compliance with this standard was determined by a review of policy/documentation, an examination of the resident discipline process and staff interviews.

Corrective action: None required

MEDICAL AND MENTAL CARE

Standard 115.282: Access to emergency medical and mental health services

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

115.282 (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

115.282 (b)

- If no qualified medical or mental health practitioners are on duty at the time a report of recent sexual abuse is made, do security staff first responders take preliminary steps to protect the victim pursuant to § 115.262? ☒ Yes ☐ No

- Do security staff first responders immediately notify the appropriate medical and mental health practitioners? ☒ Yes ☐ No

115.282 (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

115.282 (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.

Evidence Reviewed (on-site visit, documentation, staff and resident interviews):

1. FSFW Pre-Audit Questionnaire
2. PREA - 9 Medical and Mental Care: I
3. Memorandum of Understanding (MOU) with Polk County Advocacy and Crisis Center
4. Employee PREA Training Curriculum and Sign-in Sheets
5. Resident Handbook
6. Interviews with the following:
    a. Staff (Specialized/Random)
    b. BMC Emergency Department Registered Nurse
    c. Passages Victim Advocacy Center Representative

Policy addresses the requirements of this standard. Residents have access to emergency medical services at Broadlawns Medical Center. Contact was made with the Center to ensure that the facility had SANE personnel to provide forensic treatment. The treatment is offered at no financial cost to the residents. PCACC, the Victim Advocacy Center, provides all advocacy services relevant to this standard. Contact was made with a representative at PCACC who reported there is a good relationship with the facility. Advocates provide support, crisis intervention, information and referral services to the victim. There are other community advocate groups that will provide emergency support.

Corrective action: None required

Standard 115.283: 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

115.283 (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

115.283 (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

115.283 (c)

- Does the facility provide such victims with medical and mental health services consistent with the community level of care? ☒ Yes ☐ No

115.283 (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

115.283 (e)

- If pregnancy results from the conduct described in paragraph § 115.283(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

115.283 (f)

- Are resident victims of sexual abuse while incarcerated offered tests for sexually transmitted infections as medically appropriate? ☒ Yes ☐ No

115.283 (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

115.283 (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.

Evidence Reviewed (on-site visit, documentation, staff and resident interviews):

1. FSFW Pre-Audit Questionnaire
2. PREA - 9 Medical and Mental Care: II
3. Interviews with the following:
    a. Staff (Specialized/Random)
    b. Broadlawns Medical Center Emergency Department Registered Nurse
    c. Polk County Advocacy and Crisis Center Representative

Policy addresses the requirements of this standard. Residents have access to emergency medical services at Broadlawns Medical Center (BMC). Contact was made with BMC to ensure that the facility had SANE personnel available to provide forensic treatment. The treatment is offered at no financial cost to the residents. PCACC, a Victim Advocacy Center provides all advocacy services relevant to this standard. Contact was made with a representative from PCACC who reported that there is a good relationship with the facility. Advocates provide support, crisis intervention, information and referral services to the victim. There are other community advocate groups that will provide emergency support.

Corrective action: None required

DATA COLLECTION AND REVIEW

Standard 115.286: Sexual abuse incident reviews

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

115.286 (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

115.286 (b)

- Does such review ordinarily occur within 30 days of the conclusion of the investigation? ☒ Yes ☐ No

115.286 (c)

- Does the review team include upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners? ☒ Yes ☐ No

115.286 (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 §§ 115.286(d)(1) - (d)(5), and any recommendations for improvement and submit such report to the facility head and PREA compliance manager? ☒ Yes ☐ No

115.286 (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.

Evidence Reviewed (on-site visit, documentation, staff and resident interviews):

1. FSFW Pre-Audit Questionnaire
2. PREA - 10 Data Collection: I
3. Interviews with the following:
    a. Staff (Specialized)

Policy addresses the requirements of this standard. FSFW has an incident review team in place. The review team includes upper-level management and line supervisors. In the event of a PREA incident, the review team would prepare a report and implement any recommendations for improvement. The review 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; or gang affiliation; or by the vulnerability of mentally or physically disabled offenders; or was motivated or otherwise caused by other group dynamics at the facility. The team also considers the location in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse and assess the adequacy of staffing levels in that area during different shifts. The team also assesses whether monitoring technology should be deployed or augmented to supplement supervision by staff. Criminal and/or administrative investigations are completed on all allegations of sexual abuse or sexual harassment as directed by the IDOC. There were no allegations of sexual abuse/sexual harassment during the auditing period.

Corrective action: None required

Standard 115.287: Data collection

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

115.287 (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

115.287 (b)

- Does the agency aggregate the incident-based sexual abuse data at least annually? ☒ Yes ☐ No

115.287 (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

115.287 (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

115.287 (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

115.287 (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.

Evidence Reviewed (on-site visit, documentation, staff and resident interviews):

1. FSFW Pre-Audit Questionnaire
2. PREA - 10 Data Collection: II
3. Interviews with the following:
    a. Staff (Specialized)

Policy addresses this standard. The agency collects accurate, uniform data for every allegation of sexual abuse at facilities under its direct control and uses a standardized instrument and set of definitions. The agency aggregates the data annually and prepares a report. The agency

PREA policy and practice requires the collection of the data per this standard. The agency PREA Coordinator is responsible for preparing this aggregated data report for the agency.

Corrective action: None required

Standard 115.288: Data review for corrective action

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

115.288 (a)

- Does the agency review data collected and aggregated pursuant to § 115.287 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 § 115.287 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 § 115.287 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

115.288 (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

115.288 (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

115.288 (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.

Evidence Reviewed (on-site visit, documentation, staff and resident interviews):

1. FSFW Pre-Audit Questionnaire
2. PREA - 10 Data Collection: III
3. FSFW Staffing Plan
4. FSFW Website
5. Interviews with the following:
    a. Staff (Specialized)

Policy supports this standard. The agency reviews the data collected in order to access and improve the effectiveness of its sexual abuse prevention, detection and response policies, practices and training. Problem areas are identified, and corrective action is taken, as needed. The annual report reflects the findings of the facility and compares current year's reports with previous year's reports. The annual report is made available at **www.fifthdcs.com**. The annual report is approved by the agency head. Sensitive information is redacted to protect the residents.

Standard 115.289: Data storage, publication, and destruction

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

115.289 (a)

- Does the agency ensure that data collected pursuant to § 115.287 are securely retained? ☐☒ Yes ☐ No

115.289 (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

115.289 (c)

- Does the agency remove all personal identifiers before making aggregated sexual abuse data publicly available? ☒ Yes ☐ No

115.289 (d)

- Does the agency maintain sexual abuse data collected pursuant to § 115.287 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.

Evidence Reviewed (on-site visit, documentation, staff and resident interviews):

1. FSFW Pre-Audit Questionnaire
2. PREA - 10 Data Collection: IV
3. IDOC Annual PREA Report 2017, 2018 and 2019
4. Website **www.fifthdcs.com**
5. 2020 Daily Population (1st, 10th and 20th day of the month for past 12 months)
6. Interviews with the following:
    a. Staff (Specialized)

The agency's PCM reports that the annual report is published on the website at www.fifthdcs.com. Interviews with the DD, FD and PCM demonstrate compliance with this standard. The data is securely retained and maintained for at least ten years.

Corrective action: None 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.

Evidence Reviewed (on-site visit, documentation, staff and resident interviews):

This was the second PREA audit of this facility. The Auditor was allowed access to all areas of the facility and had access to all required supporting documentation. The Auditor was able to conduct private interviews with both residents and staff. The Auditor was provided supporting documentation before and during the audit. Notifications of the audit posted throughout FSFW allowed residents to send confidential letters to the Auditor prior to the audit. No confidential letters were received by the Auditor as a result of the audit postings.

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. 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.

Evidence Reviewed (on-site visit, documentation, staff and resident interviews):

Fresh Start for Women has fully implemented all policies, practices and procedures outlined in the PREA standards. The Auditor reviewed applicable standards and, through the review of supporting documentation, interviews with staff/residents and the observation of physical evidence, concluded that this facility fully meets and substantially complies in all material ways with the PREA standards for the relevant review period. Facility policies are directly tied to the PREA standards and staff expectations. The facility's leadership is fully committed to eliminating sexual abuse/sexual harassment, as evidenced in the realistic staffing analysis and staff's on-going efforts to ensure all policies, procedures and practices comply with the Prison Rape Elimination Act. PREA training for staff and residents is documented and all stakeholders receive the appropriate level of training and are knowledgeable of the intent of the PREA and the tools available to ensure prevention, detection, reporting and response to sexual abuse incidents. Sexual abuse and victimization propensity screening is well established and tracked in an organized fashion. Referrals for mental health counseling are integrated in the intake and allegations of sexual abuse processes. Medical networks for the residents are established in the community. The public has access to reporting mechanisms and the agency PREA trends data via the agency website. Fresh Start for Women currently complies with all applicable PREA standards and no corrective actions are 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.

James L. Roland, Jr. July 30, 2020

Auditor Signature **Date**

[1] See additional instructions here: https://support.office.com/en-us/article/Save-or-convert-to-PDF-d85416c5-7d77-4fd6-a216-6f4bf7c7c110 .

[2] See *PREA Auditor Handbook*, Version 1.0, August 2017; Pages 68-69.