PREA AUDIT REPORT ☐ INTERIM ☒ FINAL

JUVENILE FACILITIES

Date of report: 09/21/2016

Auditor Information			
Auditor name: Glynn Maddox			
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Email: Glynn.Maddox@nakamotogroup.com			
Telephone number: 478-278-8022			
Date of facility visit: August 10, 2016			
Facility Information			
Facility name: Illinois Youth Center – Pere Marquette			
Facility physical address: 17808 State Highway 100 West, Grafton, IL 62037			
Facility mailing address: *(if different from above)* N/A			
Facility telephone number: 618-786-2371			
The facility is:	☐ Federal	☒ State	☐ County
	☐ Military	☐ Municipal	☐ Private for profit
	☐ Private not for profit		
Facility type:	☒ Correctional	☐ Detention	☐ Other
Name of facility's Chief Executive Officer: Jamie A. House, Superintendent			
Number of staff assigned to the facility in the last 12 months: 20 new hires			
Designed facility capacity: 40			
Current population of facility: 27			
Facility security levels/inmate custody levels: Minimum			
Age range of the population: 13 to 21			
Name of PREA Compliance Manager: Charie A. Motley		**Title:** Treatment Unit Administrator	
Email address: Charie.motley@doc.illinois.gov		**Telephone number:** 618-786-2376	
Agency Information			
Name of agency: Illinois Department of Juvenile Justice			
Governing authority or parent agency: *(if applicable)* N/A			
Physical address: 707 N. 15th St. Springfield, IL 62702			
Mailing address: *(if different from above)* N/A			
Telephone number: 217-557-1030			
Agency Chief Executive Officer			
Name: Jesse Montgomery		**Title:** Acting Director	
Email address: Jesse.Montgomery@doc.illinois.gov		**Telephone number:** 312-814-4403	

Agency-Wide PREA Coordinator	
Name: Patrick Keane	**Title:** PREA Coordinator
Email address: Patrick.Keane@doc.illinois.gov	**Telephone number:** 630-584-0506

AUDIT FINDINGS

NARRATIVE

The on-site visit to conduct a Prison Rape Elimination Act (PREA) compliance audit of IYC Pere Marquette was conducted August 10, 2016. The standards used for this audit became effective August 20, 2012. The Agency Wide PREA Coordinator and a designee of the Acting Agency Director were interviewed during the audit. As part of the audit, a review of all PREA policies and a tour of the facility was completed. At the time of this audit the facility employed 61 staff. The total resident population was 27 youth.

An entrance meeting was held with the facility PREA Compliance Manager/Treatment Unit Administrator, the Agency Wide PREA Coordinator, the Facility Superintendent and other key facility staff to discuss the audit and schedule of activities. Following the entrance meeting, the auditor toured the entire facility.

The audit consisted of an entrance meeting, a tour of the facility, review of documentation and interviews with staff and residents. The staff were questioned regarding PREA training, the zero-tolerance policy and first responder responsibilities including victim/perpetrator separation, reporting mechanisms and requirements, available interventions, conducting interviews, evidence collection, follow up and monitoring retaliation.

Ten randomly selected resident/youth interviews were conducted. At the time of the audit, the population did not include residents who self-identified as being transgender, intersex, gay or bisexual. Additionally, there were no residents who had communication disabilities or who were limited English proficient. Also there were no residents who disclosed prior sexual victimization during risk screening. No residents refused to be interviewed.

Interviews were conducted with the Agency Wide PREA Coordinator, the Treatment Unit Administrator/PREA Compliance Manager, the Facility Superintendent, a medical staff member, a mental health staff member, the retaliation monitor, a staff member who performs screening for risk of victimization and abusiveness, an intake staff member, a member of the incident review team, an intermediate or higher level staff member, a human resources staff member, ten randomly selected line staff (Juvenile Justice Specialists) and a contractor. Through interviews, the auditor found the residents and staff to be very aware and knowledgeable of the PREA. Staff were knowledgeable about the facility's zero-tolerance policy and of their first responder responsibilities, reporting responsibilities and reporting/referral mechanisms to ensure a safe environment for residents and staff. Staff were aware of and follow the agency's policy prohibition of cross-gender viewing and cross-gender pat searches. There are no strip searches allowed at this facility. Resident interviews support staff's compliance with the facility's prohibition of cross-gender viewing and pat searches. Staff receive PREA related training as part of their initial orientation and annually as part of refresher training. Residents receive information regarding the PREA during intake. The residents are provided information with reporting mechanisms, to include anonymous third-party sources for reporting. PREA information is also posted in the housing areas.

DESCRIPTION OF FACILITY CHARACTERISTICS

The mission of the Illinois Department of Juvenile Justice is to enhance public safety and positive youth outcomes by providing strength-based individualized services to youth in a safe learning and treatment environment so that they may successfully reintegrate into their communities.

IYC-Pere Marquette is located in Grafton, Illinois, approximately 20 miles west of Alton. The Center was initially constructed in 1932 as a cattle farm, known as Glencliffe Estates, by Harry Hill Ferguson. When Mr. Ferguson died in 1943, he left the Glencliffe property to the state of Illinois. The former estate was initially occupied by the Illinois Department of Conservation for offices and woodworking shops. In 1961 the property was transferred to the Illinois Youth Commission to be used as a Forestry Camp. It was officially opened March 1, 1963, and housed 25 young juvenile offenders from all over the state. In 1973, it became a Boys Residential Center and housed juvenile offenders from southern Illinois. In 1981, it was adopted under the Illinois Department of Corrections as a male juvenile correctional institution, known as the Illinois Youth Center - Pere Marquette. In October 2004, IYC-Pere Marquette changed their population to female youth and could house up to 40 youth. In July 2011, the population returned back to male youth and can currently house up to 40 boys.

It is the vision of the Illinois Youth Center - Pere Marquette to develop youth who are selected for the 90-day step-down program to become productive, responsible, confident members of the communities to which they will be returning. This will be achieved by forming a partnership between families, communities, IYC - Pere Marquette staff and the Department of Juvenile Justice to provide the youth with the necessary support and resources essential for successful reentry, decreased risk of re-offending or violating parole and to promote public safety. IYC Pere Marquette will provide a safe and structured learning milieu using age appropriate evidenced-based treatment, best educational practice and mentoring, with an individualized approach. This will be achieved by providing them with the individualized experiences, skills, tools and resources they need to succeed. Further, a culture of treatment within will be built where qualified staff, interns and volunteers understand the program and language through continued training and team building opportunities. In addition, all parents/guardians will be encouraged to participate in goal development and progress in the step–down program as much as is possible for them.

SUMMARY OF AUDIT FINDINGS

When the on-site audit was completed, another meeting was held with the Treatment Unit Administrator/PREA Coordinator and the Agency Wide PREA Coordinator, to discuss audit findings. The facility was found to be fully compliant to the PREA. One standard was not-applicable. The auditor had been provided with extensive and lengthy files prior to the audit for review to support a conclusion of compliance to the PREA. All interviews also supported compliance. The facility staff were found to be extremely courteous, cooperative and professional. Staff morale appeared to be very high, and the observed staff/youth relationships were seen as appropriate. All areas of the facility were observed to be clean and well maintained. At the conclusion of the audit, the auditor thanked the Facility Superintendent and staff for their hard work and dedication to the PREA process.

Number of standards exceeded: 0

Number of standards met: 40

Number of standards not met: 0

Number of standards not applicable: 1

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The IYC- Pere Marquette PREA Response Plan, Administrative Directive (AD) 04.01.301 and AD 04.01.302 mandate zero-tolerance toward all forms of sexual abuse and sexual harassment. The Plan and policies outline how the facility deals with preventing, detecting and responding to sexual abuse and harassment. The agency has a designated agency wide PREA Coordinator who oversees the agency's compliance with PREA. Zero tolerance is discussed in the youth orientation handbook that is provided to all newly arriving residents upon intake. Zero tolerance postings are located throughout the facility. The review of training records and staff interviews confirmed that staff, volunteers and contractors who have regular or frequent contact with residents receive PREA related training during initial orientation and again, annually. Compliance with this standard was determined through interviews with staff and residents and through policy reviews.

Standard 115.312 Contracting with other entities for the confinement of residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The standard is not applicable. Neither the agency nor the facility contracts with other entities for the confinement of residents.

Standard 115.313 Supervision and monitoring

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

AD 01.02.102, 01.02.103 and 01.02.105 address this standard. The agency is also under a Consent Decree with the United States District Court for the Northern District of Illinois, Eastern Division dated 12/06/2012 and a corresponding Remedial Plan dated 04/07/2014 which has staffing levels that mirror the requirements of this standard. Policy requires the facility to review the staffing plans on an annual basis. Interviews with the Facility Superintendent's designee and the Agency Head's designee confirmed compliance with the PREA; safety and security procedures are the primary focus when considering staffing patterns and video monitoring. The facility has a good video monitoring system which includes 41 video cameras for monitoring the facility. The system also includes digital video recorders which are capable of storing data for approximately 22 days. The cameras are monitored by the control center. The facility does not deviate from their established staffing plan and when vacancies occur, the facility endeavors to quickly fill the positions with qualified employees. The facility maintains a staffing ratio of 1 staff member to 8 residents during waking hours and 1 to 16 during sleeping hours. Minimum ratios were met at all times except in the case of unforeseen and temporary circumstances. Duty Administrative Officers (DAO) are required to make and document unannounced rounds. The DAO's interviewed stated that a primary area of focus during their unannounced rounds was to observe staffing levels. Compliance with this standard was confirmed through interviews with staff and a review of policies.

Standard 115.315 Limits to cross-gender viewing and searches

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

AD 05.01.113 addresses the requirements of this standard. Policy prohibits staff from conducting cross-gender strip searches or cross-gender visual body cavity searches. The policy also prohibits cross-gender pat searches as well. All interviewed staff indicated they received cross-gender pat search training during initial and annual training sessions, but all stated it was against policy to perform cross-gender searches of any kind. Residents and staff indicated that residents are allowed to shower, dress and use the toilet privately without being viewed by the opposite gender. As confirmed by interviews and observation, staff of the opposite gender announce their presence before entering a housing unit. There are notices posted in the housing units indicating opposite gender staff presence. Staff were observed announcing cross-gender presence during the facility tour. Staff interviews confirmed that they were aware of the policy prohibiting searches of transgender or intersex residents for the sole purpose of determining their genital status. Compliance with this standard was confirmed through staff and resident interviews and a review of policy.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

AD 04.01.111 addresses the requirements of this standard. The facility takes appropriate steps to ensure residents with disabilities and residents with limited English proficiency have an opportunity to participate in and benefit from the facilities efforts to prevent, detect and respond to sexual abuse and harassment. PREA handouts, postings, and youth orientation handbooks are provided in English and Spanish. Interviews with staff indicated they were aware that under no circumstance are residents permitted to act as interpreters or assistants when dealing with PREA issues. There were no residents on site during the audit that were limited English proficient or who had communication disabilities. Compliance with this standard was confirmed through staff and resident interviews and a review of policy.

Standard 115.317 Hiring and promotion decisions

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

AD 03.02.106 and 01.02.107 address the requirements of this standard. A local facility human resources staff member and an agency wide human resources representative were interviewed and confirmed that the agency and the facility conducts criminal background checks using national databases to perform extensive background checks on employees. Additionally, background checks are conducted with the Illinois Child Abuse and Neglect Tracking System (CANTS). Staff interviewed stated that material omissions regarding related misconduct, or the provision of materially false information, are grounds for termination. Background checks are conducted on contractors or volunteers who have frequent or regular contact with residents. Contractors performing infrequent services within the facility are escorted by facility staff during their visit. Background checks are updated at least every five years on every employee. Compliance with this standard was confirmed through staff interviews and a review of policy.

Standard 115.318 Upgrades to facilities and technologies

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The facility has not made a substantial expansion or upgrade to the existing physical plant other than the addition of security video cameras since August 20, 2012. The facility has in place 41 functional video cameras to enhance security and the monitoring of residents in the housing units and all common areas. The system also includes digital video recorders which are capable of storing data for approximately 22 days. The cameras are also monitored by central control. The Superintendent's designee stated that the facility would use any information revealed as a result of the review any sexual assault or sexual harassment investigation to enhance or upgrade monitoring technology. Compliance with this standard was confirmed through staff interviews and observations of the facility by the auditor.

Standard 115.321 Evidence protocol and forensic medical examinations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

AD 1.12.120 addresses the requirements of this standard. The agency is responsible for administrative sexual abuse/sexual harassment investigations. Criminal sexual abuse investigations are conducted by the Illinois Department of Corrections (IDOC), the Illinois State Police and/or the Illinois Department of Children and Family Services (DCFS). Staff interviewed were knowledgeable of procedures to separate the victim and perpetrator; isolating any witnesses; chain of command notifications; appropriate referrals and securing and obtaining usable physical evidence when sexual abuse is alleged. If needed, residents will be transported to Alton Memorial Hospital, for a forensic medical examination by qualified medical staff. Victim advocate services are provided by Call for Help, Inc. There have been no investigations requiring forensic medical examinations in the past 12 months. Compliance with this standard was confirmed through staff interviews and policy review.

Standard 115.322 Policies to ensure referrals of allegations for investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

AD 1.12.101, 1.12.135 and 1.12.120 addresses the requirements of this standard. Policy requires all employees and contractors to report any unusual incident immediately to his/her immediate supervisor. Sexual abuse or sexual harassment allegations are considered unusual incidents. Sexual abuse or sexual harassment allegations that are criminal in nature are referred to the IDOC, Illinois State Police and DCFS for criminal investigation. Allegations of sexual abuse or sexual harassment that are not criminal in nature are referred to agency investigators for an administrative investigation. All agency employees, contractors and volunteers are considered mandated reporters and are provided training on reporting any incident of child abuse or neglect to DCFS. The policies ensure that all allegations of sexual abuse or sexual harassment are thoroughly investigated. During the previous 12 months there were three allegations of sexual abuse/sexual harassment that were referred for an administrative investigation. There were no allegations of sexual abuse or sexual harassment that resulted in referrals for a criminal investigation. Compliance with this standard was confirmed through staff interviews and a review of policy.

Standard 115.331 Employee training

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

AD 03.03.102 addresses the requirement of this standard. The facility provides extensive PREA standards training to all new employees during their pre service training and again annually. A review of the PREA training course description revealed that all the requirements for the standard are being met for employees. In addition, all staff interviews and a review of the staff records revealed that staff did receive the training and had a good working knowledge of the standards. Compliance with this standard was confirmed through staff interviews, a review of policies and a review of the PREA training course description.

Standard 115.332 Volunteer and contractor training

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

AD 04.01.122 addresses the requirement of this standard. The facility provides PREA standards training and training on the agency's zero tolerance policy relating to sexual abuse and sexual harassment to all volunteers and contractors who have contact with residents. Documentation is maintained confirming all volunteers and contractors have had PREA training. Two contractors were interviewed during the audit. The contractors confirmed that they had been provided training regarding their responsibilities under the agency's policies concerning sexual abuse and sexual harassment prevention, detection and response. Compliance with this standard was confirmed through staff interviews, contractor interviews, policy review and a review of training files.

Standard 115.333 Resident education

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

AD 04.01.301 and AD 04.01.302 address the requirement of this standard. Residents receive information during the intake process that includes a PREA verbal orientation and the youth orientation handbook which is provided in English and Spanish. Newly arriving youth are also provided a pamphlet entitled "What Youth Should Know About Sexual Abuse, Assault and Misconduct". This pamphlet has been developed and implemented by the Illinois Department of Juvenile Justice. The pamphlet defines sexual abuse and sexual assault, explains how to prevent sexual abuse and assault and it explains how to report any sexual abuse/misconduct. The information in the youth orientation handbook explains the facility's zero tolerance policy regarding sexual abuse and sexual harassment. Residents are also provided information regarding reporting procedures, their right to be free from retaliation and the availability of advocacy services. There are posters in the common areas throughout the facility including the hotline telephone number to call to report abuse or harassment. Residents sign a form acknowledging they have received the PREA information. Interviews with residents confirmed they had received the required information. Staff and resident interviews, as well as documentation review, support the facility meeting compliance with this standard.

Standard 115.334 Specialized training: Investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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The agency has four investigators who have successfully completed a training course for Conducting Sexual Abuse and Sexual Harassment Investigations in Confinement Settings provided by the Moss Group, Inc. These investigators conduct all administrative investigations concerning allegations of sexual abuse or sexual harassment that are not criminal in nature. One investigator was interviewed during this audit and demonstrated a thorough working knowledge of the PREA and how to appropriately conduct investigations concerning allegations of sexual abuse or sexual harassment in confinement settings consistent with PREA standards. Compliance with this standard was determined through document reviews and staff interviews.

Standard 115.335 Specialized training: Medical and mental health care

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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The facility does provide on-site medical and mental health services. One on-site medical staff and one on-site mental health staff were interviewed concerning this standard. They both stated that they had been provided specialized training concerning their duties related to the PREA to include: how to detect and assess signs of sexual abuse and sexual harassment; how to preserve evidence of sexual abuse; how to respond effectively to juvenile victims of sexual abuse and sexual harassment and how and to whom to report allegations or suspicions of sexual abuse and sexual harassment. Any resident victim of sexual abuse is to be taken to Alton Memorial Hospital for medical treatment and a forensic medical examination. Residents are referred to the Call for Help, Inc. for outside mental health treatment/advocacy services. The review of this standard included staff interviews.

Standard 115.341 Screening for risk of victimization and abusiveness

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

AD 04.01.130 and Screening and Assessment (SA) 002 address the requirements of this standard. Upon arrival all residents are screened and assessed by a qualified staff member for their risk of being sexually abused or harassed by other residents or for being sexually abusive towards other residents. Residents are not disciplined for refusing to answer PREA screening questions. The facility uses an objective checklist or template screening tool form. The screening form addresses the items required by the standard. The Youth and Family Specialists review all relevant information from other facilities and continue to reassess when additional information is received within 30 days. Compliance with this standard was confirmed through staff interviews, policy reviews and a review of the intake screening form.

Standard 115.342 Use of screening information

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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AD 04.01.130 addresses the requirements of this standard. The facility uses a screening instrument to determine proper housing, bed assignment, education and other program assignments with the goal of keeping residents at high risk of being sexually abused/harassed separate from those residents who are at a high risk of being sexually abusive. Housing and program assignments are made on a case by case basis for all residents with continued follow-up and monitoring. The facility does not have dedicated housing for gay, bisexual, transgender or intersex residents. Per policy, a transgender or intersex youth's own views on his or her own safety shall be given serious consideration. Transgender and intersex youth shall be given the opportunity to shower separately from other residents. This opportunity shall be provided discretely to avoid singling out the transgender or intersex youth in front of the other youths. A review of policy, screening documentation and interviews with staff and residents, including the one self-identified gay resident, confirmed compliance to the standard.

Standard 115.351 Resident reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

AD 04.01.301 addresses the requirements of this standard. Upon arrival, each resident is provided written information concerning the PREA as a part of the orientation process. The information is included in the youth orientation handbook. Additionally, residents are provided information concerning the PREA in a pamphlet entitled "What Youth Should Know About Sexual Abuse, Assault and Misconduct". All written information is provided in both English and Spanish. There are postings throughout the facility that provide residents with a telephone hotline for anonymously reporting sexual abuse or sexual harassment. The handbook and pamphlet provide residents information on how to report sexual abuse or sexual harassment which includes telling a staff member, submitting a grievance or confidential note and using the hotline. Residents sign a form acknowledging that they received this information and understand it. Staff are required to document all allegations of sexual abuse or sexual harassment. Posters and other documents were noted on display in the common areas of the facility which also explain reporting methods. Staff are able to privately report sexual abuse and sexual harassment of residents to the Office of the Executive Inspector General. Interviews with staff and residents confirmed awareness of reporting methods. Compliance with this standard was confirmed through staff and resident interviews, a review of the youth orientation handbook and a review of policy.

Standard 115.352 Exhaustion of administrative remedies

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

AD 04.01.114 addresses the requirement of this standard. Residents may file a grievance, however, all allegations of sexual abuse or sexual harassment, when received by staff, would be considered an emergency grievance and would be referred to the Facility Superintendent and would be subject to an administrative or criminal investigation. Residents are not required to first use an informal grievance process in order to file a formal grievance. There were no grievances filed involving sexual abuse or sexual harassment during the previous 12 months. Interviews with staff and residents confirmed that they were aware of the grievance procedures and how to file and respond to a grievance. Compliance with this standard was determined by staff and resident interviews and policy review.

Standard 115.353 Resident access to outside confidential support services

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The facility has a Memorandum of Understanding with the Call for Help, Inc. to provide outside confidential support services. As confirmed by observation during the facility tour, posters displaying the contact information are in common areas of the facility. Interviews with staff and residents confirmed that they were aware of the access to outside confidential support services and where the telephone numbers are located. Compliance with this standard was determined through staff and resident interviews and observations of postings during the facility tour.

Standard 115.354 Third-party reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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AD 04.01.304 addresses the requirement of this standard. Third parties, including other residents, staff members, family members, attorneys and outside advocates, may assist residents in filing allegations of sexual abuse and may file such requests on behalf of the reporting resident. As confirmed by observation and interviews, the facility provides the residents with all the information needed for third party reporting. Upon arrival, each resident receives and signs for a youth orientation handbook that address the requirements of this standard. There are postings in the areas of the facility used for visitation that provide the Illinois Department of Children and Family Services hotline number and the address to report allegations of sexual abuse or sexual harassment. There are also postings with contact information for the John Howard Association (victim advocacy organization) of Illinois. Compliance with this standard was confirmed through a review of policy, the youth orientation handbook and interviews with staff and residents.

Standard 115.361 Staff and agency reporting duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☒ Does Not Meet Standard (requires corrective action)

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

AD 01.12.135, 04.01.302 and Mental Health (MH) 004 address the requirements of this standard. Policy requires all staff to immediately report any knowledge, suspicion or information regarding an incident of sexual abuse or sexual harassment that occurred in the facility, retaliation against residents or staff who reported such incidents and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. Policy states that apart from reporting to designated supervisors or officials, staff shall not reveal 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. Staff interviewed were aware of their duty to immediately report all allegations of sexual abuse, harassment and retaliation relevant to PREA standards and appropriate reporting methods. All staff are also considered mandatory reporters and are required to report any knowledge, suspicion or information regarding an incident of sexual abuse or sexual harassment to DCFS as child abuse or child neglect. Compliance to the standard was verified through staff interviews and a review of policies.

Standard 115.362 Agency protection duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

AD 04.01.302 addresses the requirements of this standard. All staff interviewed were aware of their duties and responsibilities if they become aware of a resident that is subject to substantial risk of imminent sexual abuse. All staff interviewed stated that they would take immediate action to protect the resident. In the previous 12 months there were no instances where a resident or staff felt that he/she was subject to imminent risk of sexual abuse. Compliance to this standard was confirmed through staff interviews and a review of policy.

Standard 115.363 Reporting to other confinement facilities

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

AD 04.01.302 addresses the requirements of this standard. Policy requires the immediate reporting of any allegation of sexual abuse and/or sexual harassment by a resident that occurred at another facility to the Chief Administrative Officer of that facility. A resident who reports previous sexual abuse/sexual assault will have support services made available to them including counseling and outside confidential support groups. There were no allegations of sexual abuse or sexual harassment reported to have occurred at another facility during the previous 12 months. The facility did not receive any allegations of sexual abuse or sexual harassment from any other facilities during the previous 12 months. Compliance to this standard was confirmed through staff interviews and a review of policy.

Standard 115.364 Staff first responder duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

AD 04.01.301 and 04.01.302 address the requirements of this standard. All staff interviewed were knowledgeable regarding their first responder duties upon learning of a sexual abuse or sexual harassment allegation. The staff stated they would immediately separate the residents, secure the scene as a possible crime scene and protect possible evidence, not allow the victim to bath, smoke, brush their teeth, defecate, urinate, eat, drink or change clothes, not allow other residents to destroy possible evidence and contact their supervisor and the Facility Superintendent. Compliance to this standard was confirmed through staff interviews and a review of policy.

Standard 115.365 Coordinated response

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Ad 04.01.302 and the PREA Response Plan address the requirements of this standard. There is a written plan to coordinate actions taken in response to allegations of sexual abuse or sexual harassment that includes first responders, referral to medical and mental health practitioners, investigators and facility leadership. Compliance to this standard was confirmed through staff interviews and a review of policy.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The collective bargaining agreement does not prohibit the facility from removing 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. Staff interviews confirmed compliance to this standard.

Standard 115.367 Agency protection against retaliation

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

AD 04.01.302 addresses the requirements of this standard. The policy prohibits any type of retaliation to any staff or resident who has reported sexual abuse or sexual harassment or who has cooperated in any PREA allegation investigation. The Treatment Administrator/PREA Compliance Manager has been designated as the retaliation monitor. She stated she would meet with and monitor any resident who made an allegation of sexual abuse or sexual harassment on at least a weekly basis for at least 90 days or longer if needed to make sure the resident is protected and safe from retaliation. Compliance to this standard was confirmed through staff interviews and a review of policy.

Standard 115.368 Post-allegation protective custody

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

AD 04.01.302 addresses the requirements of this standard. The facility does not use isolation or room confinement under any circumstances. Compliance to this standard was confirmed through interviews with the Facility Superintendent's designee and a review of policy.

Standard 115.371 Criminal and administrative agency investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

AD 04.01.302 addresses the requirements of this standard. An interview with an investigator confirmed that the facility would not terminate an investigation solely because a resident recants the original allegation. Any substantiated allegation of sexual abuse that appears to be criminal would be referred for prosecution. There were no allegations of sexual abuse or during the previous 12 months. There were five allegations of sexual harassment during the previous 12 months that were referred for administrative investigation. Two of those investigations were determined to be unsubstantiated and three were currently under investigation. Compliance with this standard included a review of policy and staff interviews.

Standard 115.372 Evidentiary standard for administrative investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

AD 04.01.302 addresses the requirements of this standard. The evidence standard is a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated. Compliance to this standard was confirmed through an interview with an investigator and a review of policy.

Standard 115.373 Reporting to residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

AD 04.01.302 addresses the requirements of this standard. At the conclusion of an investigation into an allegation of sexual abuse or sexual harassment, policy requires the Facility Superintendent to notify the resident who made the original allegation as to the determination of the investigation if the allegation has been determined to be substantiated, unsubstantiated or unfounded. The agency has developed and implemented a form, the "Report of Investigative Outcome" form, for that purpose. The form includes a signature line for the Facility Superintendent, the investigating officer and the youth. There were no allegations of sexual abuse during the previous 12 months. There were two unsubstantiated case of sexual harassment during the previous 12 months. The youth were properly notified per the standard. Compliance to this standard was confirmed through staff interviews and a review of policy.

Standard 115.376 Disciplinary sanctions for staff

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

AD 03.01.310 addresses the requirements of this standard. Staff who are determined to have violated agency sexual abuse or sexual harassment policies are subject to disciplinary action, up to and including termination. During the previous 12 months no staff member has been disciplined for violating agency sexual abuse or sexual harassment policies. Compliance to this standard was confirmed through staff interviews and a review of policy.

Standard 115.377 Corrective action for contractors and volunteers

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

AD 04.01.122 and 01.12.120 address the requirements of this standard. Any contractor or volunteer who engages in sexual abuse would be immediately prohibited from contact with residents and would be reported to law enforcement and to relevant licensing bodies, unless the activity was clearly not criminal. During the past 12 months there were no volunteers or contractors accused of sexual abuse or sexual harassment of a resident. Compliance to this standard was confirmed through staff interviews and a review of policy.

Standard 115.378 Disciplinary sanctions for residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Illinois Administrative Code 2504, Title 20 addresses the requirements of this standard. The facility may only sanction a youth for sexual assault or sexual misconduct following a thorough investigation and a due process hearing by the facility Adjustment Committee. The maximum sanction for sexual assault is one year loss of restriction or privileges, one year of good time revocation and/or one year delay in recommendation to the parole board. Isolation or room confinement is not used as a sanction. The agency does prohibit residents from any sexual activity with other residents or with staff. Compliance with this standard included a review of the code and staff interviews.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

AD 04.01.301 and SA 002 address the requirements of this standard. Upon arrival all residents are screened and assessed by a qualified staff member for their risk of being sexually abused or harassed by other residents or for being sexually abusive towards other residents. Residents are not disciplined for refusing to answer PREA screening questions. The facility uses an objective checklist or template screening tool form. The screening form addresses the items required by the standard. The Youth and Family Specialists review all relevant information from other facilities and continue to reassess when additional information is received within 30 days. Staff are required to offer a follow up meeting with mental health staff within 14 days of initial screening. Compliance with this standard was confirmed through staff interviews, policy reviews and a review of the intake screening form...

Standard 115.382 Access to emergency medical and mental health services

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

AD 04.01.302 addresses the requirements of this standard. Policy requires that any time a resident makes an allegation of sexual abuse a medical staff member and a mental health professional shall be immediately notified. If the sexual abuse is recent, reported within 48 hours of vaginal or anal sexual abuse or within 24 hours of oral sexual abuse, the youth shall be immediately transported to Alton Memorial Hospital for a forensic medical examination and treatment. Residents are referred to the Call for Help, Inc. for mental health treatment. Staff are also trained to preserve any on site evidence for criminal investigations. Residents are offered information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate. The treatment is to be offered at no financial cost to the residents irrespective of whether the victim names the abuser or cooperates with any investigation arising from the incident. Compliance to this standard was confirmed through staff interviews and a review of policy.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

AD 04.01.302 addresses the requirements of this standard. Residents who are victims of sexual abuse are offered ongoing medical and mental health care whether the abuse occurred prior to incarceration, at another facility or at this facility. The evaluation and treatment includes follow up services, treatment plans and referrals for care in other facilities. Professional staff interviewed stated that the care that would be offered would be consistent with the community level of care. The treatment is to be offered at no financial cost to the residents irrespective of whether the victim names the abuser or cooperates with any investigation arising from the incident. Compliance to this standard was confirmed through interviews with mental health staff and medical staff.

Standard 115.386 Sexual abuse incident reviews

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

AD 04.01.302 addresses the requirements of this standard. Policy states that the facility shall conduct a sexual abuse incident review of every sexual abuse investigation, except those that have been determined to be unfounded. Staff interviews confirmed that an incident review team does convene and review each allegation of sexual abuse or sexual harassment, except those that have been determined to be unfounded, within 30 days of the completion of the investigative process. The incident review team reviews the incident to determine what may have led to the incident. They specifically look to see if there may be problems with policies, practices, physical barriers, staffing levels or monitoring. Compliance of this standard was confirmed through policy review and staff interviews.

Standard 115.387 Data collection

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

AD 04.01.301 addresses the requirement of this standard. The facility collects accurate uniform data for every allegation of sexual abuse or sexual harassment by using a standardized instrument. The incident-based and aggregate data collected is provided to the agency PREA Coordinator. Compliance to this standard was confirmed through staff interviews and a review of policy.

Standard 115.388 Data review for corrective action

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

AD 04.01.301 addresses the requirement of this standard. The facility reviews and assesses all sexual abuse and sexual harassment data at least annually to improve the effectiveness of its sexual abuse prevention, detection and response policies and to identify any issues or problematic areas and take corrective action, if needed. Compliance to this standard was confirmed through staff interviews and a review of policy.

Standard 115.389 Data storage, publication, and destruction

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The agency reviews and assesses all sexual abuse and sexual harassment data at least annually to improve the effectiveness of its sexual abuse prevention, detection and response policies and to identify any issues or problematic areas and take corrective action, if needed. On an annual basis, the agency PREA Coordinator will publish the data and make it available to the public on the agency's website. Compliance to this standard was confirmed through staff interviews.

AUDITOR CERTIFICATION
I certify that:

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

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

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

Glynn Maddox 09/21/2016

Auditor Signature Date