PREA AUDIT REPORT ☐ INTERIM ☒ FINAL
JUVENILE FACILITIES

Date of Report: June 23, 2017

Auditor Information			
Auditor Name: Sharon G. Robertson			
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Email: sharongr@bellsouth.net			
Telephone number: (828) 765-8180			
Date of facility visit: June 5-6, 2017			
Facility Information			
Facility name: Illinois Youth Center - Chicago			
Facility physical address: 136 North Western Avenue, Chicago, IL 60612			
Facility mailing address: (*if different from above)* P.O. Box 12247, Chicago, IL 60612			
Facility telephone number: (312) 633-5219			
The facility is:	☐ Federal ☐ Military ☐ Private not for profit	☒ State ☐ Municipal	☐ County ☐ Private for profit
Facility type:	☒ Correctional	☐ Detention	☐ Other
Name of facility's Chief Executive Officer: Olukayode Idowu			
Number of staff assigned to the facility in the last 12 months: 149			
Designed facility capacity: 146			
Current population of facility: 77 males			
Facility security levels/inmate custody levels: Minimum/Medium			
Age range of population: 13 to 20 years old			
Name of PREA Compliance Manager: Cara Murphy		**Title:** Treatment Unit Administrator	
Email address: Cara.Murphy@doc.illinois.gov		**Telephone number:** (312) 633-5219 x4072	
Agency Information			
Name of agency: Illinois Department of Juvenile Justice			
Governing authority or parent agency: *(if applicable)* N/A			
Physical address: 2715 West Monroe, Springfield, IL 62702			
Mailing address: (*if different from above)* N/A			
Telephone number: (217) 557-1030			
Agency Chief Executive Officer			
Name: Heidi E. Mueller		**Title:** Director	
Email address: Heidi.E.Mueller@doc.illinois.gov		**Telephone number:** (312) 814-0085	
Agency-Wide PREA Coordinator			
Name: Patrick Keane		**Title:** PREA Compliance Coordinator	
Email address: Patrick.Keane@doc.illinois.gov		**Telephone number:** (630) 584-0506 x530	

AUDIT FINDINGS

NARRATIVE

A Prison Rape Elimination Act (PREA) Audit of Illinois Youth Center (IYC) Chicago was conducted from April 6, 2017 to June 23, 2017. The purpose of the audit was to determine compliance with the Prison Rape Elimination Act standards which became effective August 20, 2012.

The audit consisted of a review of all PREA policies and procedures; a tour of IYC Chicago facility; a review of documentation; and interviews with agency staff, facility staff, contractors, volunteers, and residents. The Notice of the Audit was posted in various locations at IYC Chicago on April 12, 2017. The on-site audit was conducted June 5-6, 2017.

During the on-site audit, an entrance meeting was held with the Agency PREA Compliance Coordinator, and IYC Chicago Superintendent, Assistant Superintendent of Operations, Assistant Superintendent of Programs (and backup PREA Compliance Manager), PREA Compliance Manager and Treatment Unit Administrator, Chief of Security, and Investigator Officer to discuss the audit and schedule of activities. The Auditor toured IYC Chicago following the entrance meeting.

Twelve randomly selected male resident interviews were conducted. At the time of the on-site audit there were no residents who had self-identified as being lesbian, bisexual, gay, transgender or intersex. At the time of the on-site audit, there were no residents who had communication disabilities or who were limited English proficient.

Interviews were conducted with the Agency Director and the Agency PREA Compliance Coordinator, the PREA Compliance Manager (who is also the Treatment Unit Administrator), the IYC Chicago Superintendent, a medical staff member, a mental health staff member, the retaliation monitor, a staff member who preforms screening for risk victimization and abusiveness, a member of the incident review team, an intermediate or higher level staff member, a human resources staff member, 13 randomly selected line staff (known as Juvenile Justice Specialists), one contractor, and four volunteers. Staff was questioned regarding PREA training, the zero-tolerance policy, first responder responsibilities (including victim/perpetrator separation), reporting mechanisms and requirements, available interventions, conducting interviews, evidence collection, medical and mental health follow-up, and monitoring for retaliation.

Through interviews, the Auditor found the residents and staff to be very aware and knowledgeable of PREA. Staff was knowledgeable about the facility's zero-tolerance policy, their first responder responsibilities, mandated reporting responsibilities, and reporting/referral mechanisms to ensure a safe environment for residents and staff. Staff was aware of and followed the agency's prohibition of cross-gender viewing and cross-gender pat-down searches. No cross-gender strip searches are allowed by the agency or facility at IYC Chicago. Resident interviews support staff's compliance with the facility's prohibition of cross-gender viewing and cross-gender pat-down searches.

Staff received PREA related training as part of their initial orientation, annually as part of their cycle refresher training, and during roll call. This was verified by the Auditor's review of 10 randomly selected staff training records and observation of posters located throughout the facility. Residents are provided information with reporting mechanisms, including anonymous third-party sources for reporting. This was verified by the Auditor's review of 10 randomly selected resident records. The Auditor observed PREA information and posters posted in all three housing wings, visitation/multi-

purpose area, dining area, kitchen, gym, library, staff lounge, resource area, principal's office, and medical and mental health offices.

The Auditor also spoke with a representative from the mental health and victim advocates Rape Victim Advocates, The John Howard Association of Illinois who monitors the federal consent decree, and John H. Stroger, Jr. Hospital of Cook County located in Chicago, IL.

At the completion of the on-site audit, the Auditor held an exit meeting with the Agency Wide PREA Compliance Coordinator, the IYC Chicago Superintendent and PREA Compliance Manager to discuss audit findings. IYC Chicago was found to be fully compliant with PREA standards. Two standards were not applicable, and four standards were found to exceed requirements of the standard. This finding is based on the Auditor's review of policies; a review of extensive and lengthy files and documentation provided to the Auditor prior to the on-site audit and during the on-site audit; interviews with residents and staff during the on-site audit; interviews with the agency's Director and PREA Compliance Coordinator; and observations made during the tour of IYC Chicago during the on-site audit.

The Auditor wishes to thank the Agency PREA Compliance Coordinator and the entire staff at IYC Chicago for their hard work and cooperation during the audit process and for their dedication to the elimination sexual harassment and sexual assault in their facility.

DESCRIPTION OF FACILITY CHARACTERISTICS

The mission of the Illinois Department of Juvenile Justice (the agency) 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. The Mission Statement of IYC Chicago is: The management and staff at Illinois Youth Center-Chicago in partnership with the community and parents are committed to providing a variety of programs, activities and services specifically designed to address the specific needs of our youth and prepare them for a meaningful and productive reentry into their families and society. Our educational, mental health, behavioral and substance abuse programs are administered by qualified and trained staff and designed to provide our youth with the focus, opportunities and tools needed to make positive changes and build effective and lasting life skills.

IYC Chicago (the facility) is located in an urban area on the west side of Chicago, Illinois and opened in July 1999. The facility originally opened in July of 1999 and is located on the third floor of a refurbished warehouse building. The physical plant of the facility is shaped like a square with the gymnasium in the middle of the main floor. At the time of the audit there were three housing units, known as wings, being used go house residents. The facility has the benefit of being accessible to the family members of the residents, the majority of whom come from the surrounding Chicago/Cook County area. The reception area of the facility contains several lockers where visitors can store personal belongings, such as keys and cell phones that cannot enter the facility. The facility's school wing includes five classrooms and a library. The school staffing includes a principal and eight teachers.

The rated capacity of IYC Chicago is 146 males, ranging in age from 13 to 20 years, and the average population for the past 12 months was 74 males. At the time of the audit, the facility employed 119 staff; has contracts with 24 contractors who have contact with residents; and the total male resident population was 77.

The resident custody level is minimum/medium and the facility security level is medium. At the time of the audit, residents are housed in one of three housing areas at the facility, designated as A, B, and C Wings for an average length of 90–180 days. The younger youth, ages 13-16 years, and those with special needs are housed in A Wing, which has a capacity of 36. The older youth, ages 16-21 years, are housed in B Wing, located on the 4th floor, which has the capacity of 50. C Wing houses youth in the Youth Outreach Services drug treatment program and has a capacity of 22. At the time of the audit there were no residents being housed in D Wing and it was being used as a multipurpose area. The facility is planning on housing youth residents who remain on the "A grade" top behavioral level for an extended period of time in D Wing at some point during the late summer of 2017. Each housing wing includes a day room/common area with Juvenile Justice Specialists and other staff offices attached, and a separate room that can be viewed by staff with washers and dryers for the residents to do their own laundry. There is a separate bathroom and shower facilities on each wing, and residents shower separately. Resident's rooms have a large, unbarred window that allow outside light and viewing, and most rooms have two beds with a few having only one bed. At the time of the audit very few residents were double-bunked at the facility. The 12 cells in A Confinement Wing that had been previously designated as administrative and disciplinary segregation are being repurposed for use for medical isolation, time outs, changing areas for field trips outside the facility, and for temporary housing (on average of 24 hours or less) of residents who have violated their parole and waiting to be transferred to IYC St. Charles for reception. At the time of the audit, two residents had just arrived at the facility the night before and were being held for parole violation.

The IYC Chicago Superintendent has charged all upper management, known as the Duty Administrative Officers (DAO), who are the Superintendent, Assistant Superintendent of Operations, Assistant Superintendent of Programs, Chief of Security, and Clinical Services Supervisor, to make rounds and be visible on all the housing wings and, by designed, moved the offices for the Youth and Family Specialist (known as counselors) into the housing wings as well.

There is a visitation room with several table and vending machines for family visitation and attorney.

IYC Chicago has a video monitoring system that includes 47 video functional video cameras to enhance security and for the monitoring of residents in the housing units and all common areas. The video monitoring system includes digital video recorders which are capable of storing data for approximately 30 days. The cameras are monitored 24/7 by the control center and during the day by the Superintendent.

IYC Chicago has a 24/7 nursing station contracted through Correct Care Solutions. Off-site medical care is provided by John H. Stroger, Jr. Hospital of Cook County located in Chicago, IL. At the time of the audit, the Director of Nursing position was vacant. A medical doctor visits the facility weekly and is available on-call at all times. IYC Chicago contracts with the Youth Outreach Services to provide substance abuse treatment for the residents. Residents in the Youth Outreach Services program work through an incentive, level-based program (symbolized by models of cars Cavalier, Impala and Bentley which are painted on the walls of the wing) using a combination of individual and group therapy.

IYC Chicago provides the following programs: substance abuse treatment (mentioned above), mental health services, parenting group and family therapy, medical services, academic programming, recreational activities (movies, tablets, board games, gym, and field trips).

Community partners at IYC Chicago include Safe Humane (animal care and training), Living Word Christian Center (religious counseling), Urban Missionaries (religious counseling), StoryCatchers Theater, Apostolic Faith Church (religious counseling), Liberty Temple (religious counseling), Alcoholics Anonymous, Drug Out (religious counseling), Current Events Group, Mt. Pilgrim Missionary Baptist Church (religious counseling), School of Art Institute of Chicago (video production class), The Negaunee Music Institute at the Chicago Symphony Orchestra (song writing workshop), Urban Life Skills (gang mediation), and a variety of motivational speakers. Some volunteer programs include off-site activities. The goal of these programs is to promote public safety while providing an environment that improves the outcomes of the residents.

IYC Chicago has one Investigator who is trained to investigate staff misconduct and resident-on-resident allegations of sexual abuse, and three Intelligence Officers who are trained to investigate resident-on-resident reports of sexual abuse. The Investigator and the three Intelligence Officers have received annual refresher training for investigating allegations of sexual abuse.

SUMMARY OF AUDIT FINDINGS

After reviewing all information provided during the pre-audit and onsite audit, including, staff and inmate interviews, the auditor has determined the following:

Number of standards exceeded: 4
Number of standards met: 35
Number of standards not met: 0
Number of standards not applicable: 2

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.

Administrative Directive (AD) 04.01.301 – Sexual Abuse and Harassment Prevention and Intervention Program
I. POLICY
B. Policy Statement
The Department shall provide a safe and secure environment for all youth and shall maintain a program for the prevention of sexual abuse and sexual harassment. Prompt staff intervention shall be provided in the event of a suspected or reported youth sexual abuse and/or sexual harassment. The Department shall maintain a zero tolerance policy towards all forms of sexual abuse and sexual harassment.
II. PROCEDURE
F. General Provisions
1. Any sexual abuse or sexual harassment of youth by staff or youth by youth is prohibited.
2. The Sexual Abuse and Harassment Prevention and Intervention Program shall include, at a minimum:
a. A zero tolerance policy towards all forms of sexual abuse and sexual harassment;
b. Appropriate measures to protect all youth and staff who report sexual abuse or sexual harassment or cooperate with investigations from retaliation by other youth and staff;
c. Procedures to prevent sexually abusive, and sexually harassing behavior, including staff and volunteer training and the screening, classification, and education of youth;
d. Immediate reporting of any knowledge, suspicion or information regarding an incident of sexual abuse, sexual harassment, or retaliation that occurred at the youth center;
e. Prompt intervention if sexual abuse or sexual harassment is suspected or occurs, including medical, psychological, safety, and security aspects;
f. Multiple internal ways for youth to privately report sexual abuse, sexual harassment, retaliation for reporting such incidents, and staff neglect or violation of responsibilities that may have contributed to such incidents.
g. A method to receive third-party reports of sexual abuse and sexual harassment made on behalf of a youth;
h. Prompt investigation, disciplinary action, and referral for prosecution, where appropriate;
i. Identification of "vulnerable youth" and youth who are a "risk to others";
j. Services available to youth following a sexual abuse and/or sexual harassment;
k. Provided with information regarding outside community resources related sexual abuse and harassment support and advocacy services upon release or discharge from a Youth Center
3. The Department PREA Coordinator shall be designated by the Director and shall:
a. Develop or approve standardized training modules for issues such as signs of sexually abusive and/or sexually harassing behavior; signs of being a victim of sexual abuse and/or sexual harassment; protocols for initial response to alleged sexual abuse and/or sexual harassment, crisis intervention, treatment, and counseling.
b. Ensure that all youth have an equal opportunity to participate in or benefit from all aspects of the Sexual Abuse and Harassment Intervention and Prevention Program as required by 28 C.F.R § 115.316.
4. The Chief Administrative Officer of each youth center shall:
a. Identify a Facility PREA Compliance Manager, and designate an alternate Facility PREA Compliance Manager for the youth center. The Facility PREA Compliance Manager shall be a mental health professional. The alternate need not be a mental health professional provided the individual serves in a supervisory capacity, has received the specialized sexual abuse and sexual harassment training required of mental health professionals listed in Administrative Directive 04.04.100, and has the knowledge, skills, and abilities for program implementation and evaluation.

Memorandum from IDJJ Director Heidi Mueller, dated February 15, 2017, to Executive Staff, Deputy Directors, Superintendents and Patrick Keane, Subject: Designation of Agency Wide PREA Coordinator.

IYC-Chicago PREA Response Plan
IYC-Chicago will follow the PREA response plan when there is an alleged or suspected incident of sexual abuse or sexual harassment (youth on youth) or (youth by employee). IYC-Chicago has zero tolerance to sexual abuse and sexual harassment.

IYC Chicago PREA Response Plan mandates zero-tolerance toward all forms of sexual harassment and sexual abuse. The facility's PREA Response Plan and policies outline how the facility deals with preventing, detecting, and responding to sexual abuse and harassment.

The Illinois Department of Juvenile Justice (the agency) has a designated an agency wide PREA Compliance Coordinator who oversees the agency's compliance with PREA. Interview with the agency wide PREA Compliance Coordinator indicates he is allotted ample time to oversee the agency's efforts to ensure PREA compliance in all the Illinois Youth Centers. The PREA Compliance Coordinator reports to the agency's Director Heidi E. Mueller and Chief Counsel Marron Mahoney. IYC Chicago (the facility) has designated a PREA Compliance Manager who is also the Treatment Unit Administrator of the facility, and reports to Assistant Superintendent of Programs. Interview with the PREA Compliance Manager indicates she is allotted sufficient time and authority to coordinate the facility's efforts to ensure compliance with the PREA standards. The facility has recently designated the Assistant Superintendent of Operations as the backup PREA Compliance Manager.

Zero tolerance is also discussed on page 7 of the Youth Orientation Handbook, and is provided to all newly arriving residents upon intake. Zero tolerance posters are located throughout the facility. Copies of these posters are also located as Attachments A, B and C in the Youth Orientation Handbook.

Compliance with this standard was determined through policy reviews, interviews with specialized staff, and observations made during the on-site audit.

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)
☒ Not Applicable

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.

This 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 – Duty Administrative Officers
II. PROCEDURE
H. Duties
4. The Duty Administrative Officer shall conduct unscheduled inspection tours during off-duty hours in accordance with Administrative Directive 01.02.103.

AD 01.02.103 – Inspection Tours by Administrative Staff
I. POLICY
B. Policy Statement
To ensure that safety, sanitation, security, and maintenance procedures are being implemented, the Chief Administrative Officer and upper level administrative staff persons shall personally visit and conduct scheduled and unscheduled inspections of the youth center.
II. PROCEDURE
F. Requirements
The Chief Administrative Officer shall ensure a written procedure is established in accordance with the following provisions:
1. Inspections
b. The Chief Administrative Officer or any upper level administrative staff person, when acting as the Duty Administrative Officer, shall conduct unscheduled inspections of the youth center:
(1) Either during the evenings prior to major holidays or during the holidays; and
(2) Periodically throughout the year during evening and night shifts and on weekends.
d. Staff are prohibited from alerting other staff members that these inspections are occurring, unless such announcement is related to the legitimate operational functions of the facility.
2. Inspection Log
a. A bound inspection log shall be maintained at each youth center for recording inspection findings. Log entries shall include:
(1) Area inspected;
(2) Date of inspection;
(3) Hours of evening or night shift inspection;
(4) Initials of staff person making the inspection; and
(5) A brief summary of the results of the inspection.
b. All unscheduled inspections shall be reported in the monthly report to the Director.
c. Inspection logs shall be retained on file for at least one year after the date of the last entry in the bound book and in accordance with the approved records retention schedule.

AD 05.01.302 – Prohibited Cross-Gender Searches
II. PROCEDURE
F. Requirements
1. Searches of Youth
Each youth center shall implement policies, procedures, and a staffing plan that will ensure the following requirements for searches of youth observed:
f. Each youth center shall implement a staffing plan pursuant to Administrative Directive 05.01.101 that ensures adequate same-gender staff is available to conduct routine searches based on anticipated youth furloughs and searches conducted pursuant to Administrative Directive 05.01.113.
3. Youth Living Areas
a. Each youth center shall implement policies, procedures, and a staffing plan that enable youth 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 searches of living area conducted pursuant to Administrative Directive 05.01.111.
b. Each youth center shall require staff of the opposite gender to announce their presence when entering an area of a youth housing unit where youth may be viewed while showering, performing bodily functions, or changing clothes.

Memorandum from IDJJ Chief of Staff Michael Taylor, dated July 26, 2016, to Facility Superintendents; Subject: PREA Standard 115.313-Staffing Plan Narrative
The Illinois Department of Juvenile Justice ensures its best efforts to provide for adequate levels of staffing within its facilities to protect the youth in custody from sexual abuse, harassment or assault. When determining the staffing levels within each facility the department takes the following and other important factors into consideration:
1. Maintaining the staffing ratio of 1:8 during youth waking hours;
2. Maintaining the staffing ratio of 1:16 during youth sleeping hours;
3. Generally accepted detention and correctional practices;
4. Any judicial findings of inadequacy;
5. Any findings of inadequacy from federal investigative agencies;
6. Any findings of inadequacy from internal or external oversight bodies;
7. All components of the facility's physical plant;
8. The composition of the youth population;
9. The number and placement of supervisory staff members;
10. Institutional programs occurring on particular shifts;
11. Any applicable State or local laws;

12. The prevalence of substantiated and unsubstantiated incidents of sexual abuse, harassment or assault.

The agency is also under a Consent Decree with the Eastern Division of the United States District Court of North District of Illinois, docket number 1:12-CV-07289, dated December 6, 2012, and a corresponding Remedial Plan, dated April 7, 2014, which requires staffing levels that mirror the requirements of this standard of 1:8 during resident waking hours and 1:16 during resident sleeping hours.

Policy requires the facility to review the staffing plans on an annual basis. The facility reported that the staffing plan is predicated on a daily average of 68 residents, and the daily average is 68 residents. Since the last PREA audit on August 3, 2016, the facility reports its daily average number of residents has been 68 residents. On the date of the on-site audit, there were 77 male residents.

The Auditor was provided and reviewed the facility's annual IDJJ Facility Vulnerability Assessment, dated September 13, 2016. The review included consideration of the physical plant, location of blind spots, staffing levels, prevailing staffing patterns, video monitoring to protect residents against abuse, and the allocation of agency and facility resources to commit to the staffing plan to ensure compliance with the staffing plan.

The facility reports they have not deviated from their established staffing plan. The facility maintains a staffing ratio of 1 staff member to 8 residents during waking hours from 6:00AM to 10:00PM, and 1 staff member to 16 residents during sleeping hours from 10:00PM to 6:00AM. Minimum ratios were met at all times.

The facility has a video monitoring system which includes 47 video cameras for monitoring the facility. The video monitoring system includes digital video recorders which are capable of storing data for approximately 30 days. The cameras are monitored 24/7 by the control center and during the day by the Superintendent.

Unannounced rounds are made by the Duty Administrative Officers (DAO), who are the Superintendent, Assistant Superintendent of Operations, Assistant Superintendent of Programs, Chief of Security, and Clinical Services Supervisor. The DAOs are required to make and document unannounced rounds during all three shifts and staff are prohibited from alerting other staff when the unannounced rounds are occurring. During the on-audit, the Auditor was provided a random sample for the past 12 months of the facility's unannounced rounds that are logged in the log book for each wing that were completed by a DAO showing the name, position of the person, date and shift. During the on-site audit, the Auditor viewed the log books in various housing units and other locations in the facility, which showed the unannounced rounds by the DAOs are being conducted regularly on all three shifts.

Interviews with the facility Superintendent and the Agency Director confirmed compliance with PREA standards, and that safety and security procedures are the primary focus when considering staffing patterns and video monitoring. The facility Superintendent stated that every shift supervisor submits operational data needs reports showing how many staff and supervisors are needed well in advance for upcoming program needs and security needs, and the DAOs meet weekly to review these reports and discuss upcoming programs.

Compliance with this standard was determined through policy reviews, review of documentation, and interviews with specialized staff.

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 05.01.302 – Prohibited Cross-Gender Searches
II. PROCEDURE
F. Requirements
1. Searches of Youth
Each youth center shall implement policies, procedures, and a staffing plan that will ensure the following requirements for searches of youth observed:

a. Pat-down searches shall be conducted in a manner in which only youth's outer garments such as coats, jackets, sweaters covering shirts, shoes, hats and gloves may be removed in a manner that does not expose youth's body or undergarments. Pat-down searches shall be conducted by a staff member of the same gender as the youth, except in exigent circumstances or as provided in Part F.1.d. below.

b. Strip searches shall be conducted in an area where the search cannot be observed by persons not conducting the search. Strip searches shall be conducted by a staff member of the same gender, except in exigent circumstances or when performed by medical personnel or as provided in Part F.1.d. below.

c. All cross-gender pat-down, strip, and body cavity searches shall be documented and exigent circumstances explained.

d. Transgender youth shall be allowed to choose the gender of the staff who will conduct pat-down, strip, and body cavity searches. Pat-down and strip searches will be conducted by the transgender youth's staff gender preference, except in exigent circumstances. Body cavity searches shall be conducted by the transgender youth's staff gender preference, except in exigent circumstances or when performed by medical personnel. All searches that are not conducted by the transgender youth's staff gender preference shall be documented and exigent circumstances explained.

e. Exigent circumstances do not include routine searches of youth conducted pursuant to Administrative Directive 05.01.113.

f. Each youth center shall implement a staffing plan pursuant to Administrative Directive 05.01.101 that ensures adequate same-gender staff is available to conduct routine searches based on anticipated youth furloughs and searches conducted pursuant to Administrative Directive 05.01.113.

g. Staff shall not search or physically examine a transgender or intersex youth for the sole purpose of determining the youth's genital status.

2. Training
All security personnel shall be trained in how to conduct cross-gender pat-down searches and searches of transgender and intersex residents, in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs.

3. Youth Living Areas

a. Each youth center shall implement policies, procedures, and a staffing plan that enable youth 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 searches of living area conducted pursuant to Administrative Directive 05.01.111.

b. Each youth center shall require staff of the opposite gender to announce their presence when entering an area of a youth housing unit where youth may be viewed while showering, performing bodily functions, or changing clothes.

AD 05.01.113 – Routine Searches of Youth
II. PROCEDURE
F. Requirements
1. Youth Movement Searches

a. Each youth center shall develop procedures for group pat-down searches of youth conducted during youth movement, such as when a major line is between its point of origin and destination. Such searches shall be random, on varying shifts and lines or groups, and conducted in such a manner that youth cannot anticipate when they will occur.

b. Such searches may only be initiated by a Duty Administrative Officer, and may only be initiated when appropriate gendered staff are available to conduct the search as required by Administrative Directive 05.01.302.

c. Youth movement searches shall be documented daily in a report to the Chief Administrative Officer which shall include:
(1) The identity of the line (recreation line, school line, etc.);
(2) Time of the search;
(3) Where the search was conducted;
(4) A list of contraband found;
(5) Name of employee supervising the search; and
(6) Number of youth searched.

d. Youth movement search documentation shall be retained on file for at least one year.

IYC-Chicago PREA Response Plan
<u>Education/Prevention</u>

4. Staff will not search or physically examine a transgender or intersex inmate for the sole purpose of determining the inmate's genital status.
5. Cross-gender strip searches, cross-gender visual body cavity searches and cross-gender pat-down searches of youth shall only be conducted in exigent circumstances or when performed by medical personnel. Transgender youth shall be allowed to choose the gender of the staff who will conduct pat-down, strip, and body cavity searches. Any cross-gender searches of any type shall be documented on a DJJ 0434 Incident Report. A copy of the incident report shall be forwarded to the Facility PREA Compliance Manager. Female staff are required to announce their presence when entering an area where youth may be viewed while showering, performing bodily functions, or changing clothes. Female staff will announce their presence when entering a wing with "Female on the unit."

Policy prohibits staff from conducting cross-gender strip searches, cross-gender pat-down searches, and cross-gender visual body cavity searches. The facility reported they do not conduct any cross-gender strip searches, and cross-gender pat-down searches have only occurred when a transgender resident requested a staff member of the opposite gender.

During the pre-audit, the facility reported that 91% of security staff has received training on conducting cross-gender pat-down searches and searches of transgender and intersex residents in a professional and respectful manner, consistent with security needs. The remaining security staff are currently on a leave of absence and will receive their training upon return to the facility.

During the on-site audit, the Auditor reviewed random dates of the log of all strip searches which confirmed strip searches are being documented and are being performed by staff of the same gender. During the on-site audit, the Auditor viewed a random sample of training logs.

Interviews with staff indicated they received cross-gender pat-down search training during initial and annual cycle training sessions; and all stated it was against policy to perform cross-gender searches of any kind. Staff also indicated they had recently received specialized training on performing pat-down searches of transgender residents.

Residents and staff interviews indicated that residents are allowed to shower, dress, and use the toilet privately without being viewed by the opposite gender. As confirmed by resident and staff interviews and during the on-site audit, staff of the opposite gender announced their presence before entering a housing wing. Notices are posted in all of the housing wings indicating opposite gender staff presence. Staff was 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 determined through policy reviews, review of documentation, observations made during the on-site audit, and interviews with staff and residents.

Standard 115.316 Residents with disabilities and inmates 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 – ADA Accommodations
II. PROCEDURE

F. General Provisions

1. All decisions regarding ADA accommodation shall be made on an individual case-by-case basis. Approval of an accommodation request shall not constitute a precedent for other requests.

6. During communication, removal of security restraints for deaf or hard of hearing youth, who utilize their hands as a primary means of communication, including gesturing, sign language or written communication shall be evaluated on a case-by-case basis. Factors including, but not limited to, security risk shall be considered prior to removal of the restraints.

7. The Facility ADA Coordinator may approve requests for special permit items such as vibrating watches, talking books and amplifying headphones.

8. In youth centers that house youth that are deaf or hard of hearing, closed captioning shall be activated for day room televisions and recreational DVD programming.

G. Requirements

2. The Chief Administrator of each youth center shall:

a. Designate at least one individual to serve as the Facility ADA Coordinator. The name of the Facility ADA Coordinator shall:

(1) Be reported to the Agency ADA Compliance Officer and be updated as necessary.

(2) Be provided to youth via methods such as Superintendent's Bulletins or posted notices.

b. Ensure youth are provided with information regarding ADA disability accommodations. Procedures for requesting ADA disability accommodations shall be provided to youth in the Orientation Manual.

c. Establish a procedure for youth access to TTY equipment. Procedures for the youth telephone system shall be in accordance with Administrative Directive 05.03.150.

d. Ensure all emergency evacuation plans include provisions for evacuating youth with disabilities.

3. The Facility ADA Coordinator shall:

a. Upon receipt of DJJ 0286 for ADA disability accommodation:

(1) Review the request and meet with the youth for interactive dialogue.

(2) Consult with the youth center's operational and administrative staff and the Agency ADA Compliance Officer, as necessary, to ensure the proposed ADA disability accommodations are feasible or to identify effective alternatives.

(3) If required, schedule an individualized assessment with a licensed specialist for recommendations of auxiliary aids or services that may assist in providing effective communication.

(4) Approve or deny the request; and/or offer an alternative accommodation where appropriate, and in writing:

(a) Notify the Agency ADA Compliance Officer of the determination.

(b) Notify the youth of the determination.

NOTE: If a reasonable accommodation is offered to the youth and is subsequently rejected, the Department shall not be required to offer a second alternative accommodation.

(5) Document the determination and, if applicable, the approved accommodations in the youth data system of record.

b. Upon identification or referral of a deaf or hard of hearing youth:

(1) If the youth requires accommodation beyond the assistance of a hearing aid, develop an ADA Individualized Communication Plan, DJJ 0401. The original DJJ 0401 shall be maintained in the youth's master file and a copy shall be placed in the youth's medical file. Copies shall also be provided to the Agency ADA Compliance Officer and the youth. The communication plan may include, but shall not be limited to:

(a) Authorization for optional identification showing the youth as deaf or hard of hearing.

(b) Alternative notification methods for auditory announcements.

(c) Authorization for special permit items and auxiliary aids such as visual aids, written material, flashcards, word processing hardware, TTY, closed caption televisions and assistive listening system or devices used to amplify sound or qualified sign language interpreters.

(d) Coordination of communication accommodations, when the information being relayed is complex, exchanged for a lengthy period of time or involves legal due process. This includes, but is not limited to, communications, including:

i. Orientation;

ii. Counseling;

iii. Educational and vocational programming;

iv. Medical and mental health services;

v. Religious services;

vi. Due process hearings, including disciplinary hearings; and

vii. Pre-release instructions.

(2) Provide notification to vendors, community partners and other service providers with whom the youth interacts, to inform them when they need to provide accommodation. Such notification shall include the need for a sign interpreter for medical writs, custodial interviews with State agencies and court writs.

c. Monitor approved ADA disability accommodations and individualized communication plans to ensure effective implementation and continuance after implementation.

d. Submit to the Agency ADA Compliance Officer an annual compliance report. The report shall:

(1) Be submitted by June 30th of each year.

(2) Contain youth center specific ADA information as required by the Agency ADA Compliance Officer.

H. Training

1. All staff having regular contact with youth shall receive annual ADA training. Training may be provided during annual cycle training.

2. Facility ADA Coordinators shall receive additional specialized training on accommodation needs of deaf and hard of hearing youth.

Chicago Youth Orientation Handbook, page 12, Standard Unit Rules #18 – Non-English Communications: You may not communicate with youth or staff in code or any language other than English. If you have trouble understanding English, you should speak with your Youth and Family Specialist to develop a plan to assist you during your stay.

The agency and facility take appropriate steps to ensure residents with disabilities and residents with limited English proficiency 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, postings, and Youth Orientation Handbooks are provided in English and Spanish. The agency has a contract with a vendor to provide a translation services for all languages to each facility via telephonic services.

The facility reported that in the past 12 months there have been no instances where resident interpreters, resident readers, or other types of resident assistants have been used; and it was not the case that an extended delay in obtaining another interpreter could compromise the resident's safety, the performance of first-response duties under § 115.364, or the investigation of the resident's allegations. At the time of the on-site audit, there were no residents housed at the facility that were limited English proficient or who had communication disabilities.

During the on-site audit, the Auditor verified through random staff interviews and random resident interviews that residents readers or resident assistance are not used to explain PREA policy and procedures to other residents. Bilingual staff would be utilized if needed. Interviews with staff also stated that the agency does have a contract with interpreters or other professionals hired to ensure effect communication with residents are limited English proficient.

Compliance with this standard was determined through policy reviews, review of documentation, observations made during the on-site audit, and interviews with staff and residents.

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 – Filing Vacancies
I. POLICY
H. Minimum Qualification Application Requirements
1. An applicant must:
a. Be at least 18 years of age, however, applicants for the positions of Juvenile Justice Specialist Intern, Juvenile Justice Specialist, Juvenile Justice Supervisor, Juvenile Justice Youth and Family Specialist and Juvenile Justice Youth and Family Specialist Supervisor must be over the age of 21.
I. Selection Requirements
7. A background investigation of applicants recommended for hire shall be conducted in accordance with Administrative Directive 01.02.107.
K. Filing Requirements - All Positions
4. Information gathered during the screening process for background investigations, such as, Applicant Information Sheet, DJJ 0031; Summary of Background Investigation, DJJ 0038; Administrative Review, DJJ 0039; Authorization for Background Check, CFS689; Employment Release and Consent, DJJ 0035, and Employment Reference Checks, DJJ 0037, shall be filed in the Background Investigations Unit.

AD 03.02.105 – Qualifications and Screening for Juvenile Justice Specialist Intern

II. PROCEDURE
F. Minimum Qualifications
6. Have never been dishonorably discharged from the Armed Forces of the United States or convicted by any court of any crime punishable by imprisonment for a term exceeding one year; had a conviction of any child abuse or neglect offense or where he or she has plead down to a lesser offense; or had a misdemeanor crime of domestic violence. A misdemeanor crime of domestic violence is an offense that has, as an element, the use or attempted use of physical force, or the threatened use of a deadly weapon, committed by a current or former spouse, parent, or guardian of the victim, by a person with whom the victim shares a child in common, by a person who is cohabiting with or has cohabited with the victim as a spouse, parent, or guardian, or by a person similarly situated to a spouse, parent, or guardian of the victim. This definition of misdemeanor crime of domestic violence is intended to encompass any domestic violence crime as defined under the Federal Gun Control Act and it includes all misdemeanors that involve the use or attempted use of physical force if the offense is committed by one of the defined parties, regardless of whether or not the offense is labeled "domestic violence."
H. Screening Process
1. Applicants shall complete:
d. A Request for Background Investigation, DJJ 0032;
g. An Authorization for Background Check for Programs NOT Licensed by DCFS, CFS 689;
7. A complete background investigation, excluding fingerprinting and the drug test, shall be conducted on each applicant following successful completion of the screening examinations in accordance with Administrative Directive 01.02.107. Fingerprinting and the drug test shall be conducted at the youth center of hire upon a conditional offer of employment.

01.02.107 – Background Investigation
II. PROCEDURE
F. General Provisions
1. Background investigations shall be completed on persons prior to employment or prior to placement in a safety sensitive position and on persons who provide services for the Department.
2. Background investigations may also be conducted periodically to review the background of individuals identified in Paragraph II.F.1.
3. There shall be two levels of background investigations:
a. A computer criminal history check, including a check of an individual's criminal history through LEADS, shall be required for:
(1) Outside workers or consultants who will regularly work with youth or youth records and who will be escorted or directly supervised by staff at all times while on grounds of a youth center. The computer criminal history check shall not be required prior to the initial entrance when outside workers or consultants are called in on an emergency basis. However, the computer criminal history check shall still be initiated in accordance with Paragraph II.G.
b. A complete background investigation:
(1) Shall be required for all:
(a) Applicants, employees, contractual employees, student workers, and interns;
(2) Shall include, but not be limited to, a check of:
(a) LEADS;
(b) Fingerprint cards;
(c) Secretary of State Driver's License;
(d) Employment references;
(e) Offender Tracking System (OTS);
(f) Juvenile Tracking System (JTS);
(g) Visitor Tracking System (VTS);
(h) Military check, if applicable; and
(i) The use of any other name or social security number.
4. Background investigations, complete or computer criminal history only, and a Child Abuse and Neglect Tracking System (CANTS) check shall be completed on persons prior to employment or prior to placement in a safety sensitive position and on persons who provide services for the Department.
7. Annual background investigations complete or computer criminal history only, may be conducted at the discretion of the Director on any employee, intern, volunteer, consultant, outside worker, or student worker including, but not limited to, individuals in safety sensitive positions.
8. Annual background investigations shall be conducted of all individuals in safety sensitive positions.
9. At least every five years, a computer criminal history check, including a check of an individual's criminal history through LEADS and a CANTS check, shall be conducted for current employees and contractors who may have contact with youth.

During the pre-audit, the Auditor was provided a copy and reviewed the collective bargaining agreement between the Department of Central Management Services of the State of Illinois and the American Federation of State, County and Municipal Employees Council 31, AFL-CIO, effective July 1, 2012 until June 30, 2015. The Auditor verified with the agency Director that even though the contract has expired, it is still in effect until a new contract is approved and established. As of the date of the audit, a new agreement has not been reached and is still at an impasse.

Staff is required to complete an IDJJ Form 0034 Request for Background Check, and IDJJ Form 0469 PREA Pre-Employment Self-Report, a CFS 689 Authorization for Background Check, and a CANTS 22 Acknowledgement of Mandated Reporter. Background checks and follow-up background checks every five years for all staff and contractors are performed by the agency's background unit. During the on-site audit, the Auditor verified that all facility employees, contractors, and volunteers who have contact with residents have had criminal background record checks completed within the past five years, and reviewed a sample of employee background checks. During the pre-audit, the facility reported in the past 12 months 20 persons were hired who had criminal background record checks, and 4 contracts for services were criminal background record checks were conducted on all staff covered in the contract that might have contact with residents.

During the on-site audit, the Auditor interviewed the facility's Human Resources staff member and an agency wide Human Resources representative and confirmed that the agency and the facility conducts criminal background checks using national databases to perform extensive background checks on employees. Background checks are also conducted with the Illinois Child Abuse and Neglect Tracking System (CANTS) and LEADS. Background checks are conducted on contractors and volunteers who have regular contact with residents. The Auditor also confirmed that a system is in place to conduct background checks every five years on current employees, contractors and volunteers. Contractors performing infrequent services within the facility are escorted by facility staff during their visit.

Specialized staff interviewed stated that material omissions regarding related misconduct, or the provision of materially false information, is grounds for termination.

Compliance with this standard was determined through policy reviews, review of documentation, and interviews with specialized staff.

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)
☒ Not Applicable

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 and facility reported they have not acquired a new facility or made a substantial expansion or modification to the existing facility since the last audit completed on August 4, 2016. The facility reported no updates have been made to the video monitoring system, electronic surveillance system or other monitoring technology since the last PREA audit on August 3, 2016.

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 01.12.101 – Employee Criminal Misconduct
II. PROCEDURE
F. General Provisions
1. The Director shall be advised immediately of any allegations of employee criminal misconduct.
2. The Department of Corrections (DOC) Chief of Investigations and Intelligence shall act as the liaison for the Department and the Illinois State Police in reporting allegations of employee criminal misconduct.
3. Jurisdiction over investigations of suspected employee criminal misconduct shall be based on the April 1, 2004 Memorandum of Understanding between the Department of Corrections and the Illinois State Police.

AD 01.12.112 – Preservation of Physical Evidence
II. PROCEDURE
A. Purpose
The purpose of this directive is to provide guidelines for staff in regard to the collection, preservation, and protection of physical evidence.
E. Requirements
The collection, preservation, and protection of physical evidence of a crime scene shall be as follows:
1. Evidence shall be:
a. Collected subsequent to searches, sketches, and photographs of the scene. An exception to this would be removing weapons used in the crime, as is necessary for security.
b. Handled as little as possible, using gloves as appropriate.
c. Handled only by the collecting employee who shall limit the chain-of-custody by transferring said evidence to the Major Contraband Custodian or in his or her absence, the Shift Supervisor, to be processed in accordance with Administrative Directive 05.01.112.
2. If anyone touches a piece of evidence in a manner that leaves fingerprints, an incident report shall be generated and laboratory personnel shall be so advised.
3. The amount of evidence collected for analysis shall be determined by the type of evidence and the tests to be conducted. When necessary, a portion of a large piece of evidence may be detached for testing or evidentiary purposes such as a piece of mattress that may be cut to obtain a sample of a blood-stained area.
4. The investigator shall mark each item of evidence with his or her initials and the date so that the evidence may be identified at a later date.
a. Identifying marks shall be placed in an area least likely to affect the evidentiary value of the item.
b. Evidence that cannot be marked shall be placed in a container that shall be sealed and marked.
c. All evidence collected and marked shall be recorded as to location, type, serial numbers, trade names, and unusual marks.
5. Evidence shall also be tagged using the Search Record or Confiscated Contraband, DJJ 0300, to aid in identification, processing, storage, and retrieval.
6. Evidence may be released only to authorized persons such as property officer or laboratory officer and shall be receipted.
7. The crime scene shall not be released until all processing has been completed.
a. Release shall be effected at the earliest practicable time, particularly in instances where the area is on restrictive movement.
b. The decision shall be made jointly by the investigator, the Chief Administrative Officer, and when appropriate, the Illinois State Police Crime Scene Technician.
F. Training
All employees of a youth center shall receive training on the procedures for the preservation of physical evidence in conjunction with the procedures for reporting of deaths in accordance with Administrative Directive 01.12.111. The training shall be provided through the Office of Professional Development and Training or by a Training Coordinator using a curriculum approved by the Chief of Professional Development and Training

AD 01.12.115 – Internal Investigations
II. PROCEDURES
F. Requirements.
4. The Chief Administrative Officer shall:
a. Personally supervise Internal Affairs staff.
b. Ensure that each individual appointed as an investigator be registered for the next available investigative training program within ten days of temporary or permanent assignment as an investigator.
1) Training shall include topics such as investigative techniques, crime scene preservation, preservation of evidence, and investigative reporting.
2) In addition to the PREA training required by Administrative Directive 04.01.301, investigators shall receive specialized training which shall include conducting sexual abuse investigations, techniques for interviewing juvenile sexual abuse victims, proper

use of Miranda and Garrity warnings, sexual abuse evidence collection in confinement settings, and the criteria and evidence required to substantiate a case for administration action or prosecution referral.

3) Written documentation of training received or written verification that training on specific topics was not required due to prior training or experience shall be maintained in the employee's training file.

AD 01.12.120 – Investigations of Unusual Incidents
II. PROCEDURES
E. General Provisions
1. The Chief Administrator shall ensure that an internal investigation is conducted by facility staff or by staff assigned by the Chief of Investigations and Intelligence on each unusual incident reported if it is determined that further facts are required.
4. The appropriate investigative reports and forms identified in Administrative Directive 01.12.125 shall be utilized.
7. All employees shall be required to cooperate with any internal investigation conducted by the facility Internal Affairs Office, Investigations and Intelligence Unit, or any other investigative authority including the Office of Executive Inspector General (OEIG). Employees shall provide documentation and testimonial evidence as required by law. Information pertaining to an internal or OEIG investigation shall be considered confidential and shall be disseminated on a need-to-know basis only. Employees shall not disclose or be asked to disclose:

a. The existence of an investigation;
b. The information requested during an investigation;
c. The subject matter or questions asked during an interview; or
d. The identity of the employees under investigation.

8. Failure to cooperate with an investigation shall result in disciplinary action, up to and including discharge.
9. Following an investigation, the facility Internal Affairs Office or the Investigations and Intelligence Unit shall notify the Chief Administrator of completion of the investigation. The Chief Administrator shall submit an Employee Notification of Completed Investigation, DOC 0127, to the respective Employee and Bargaining Unit, if applicable. The form shall be signed by the employee acknowledging receipt. If the employee refuses to sign, the Chief Administrator shall so indicate and sign and date the DOC 0127.
F. Facility Investigations
1. Facility investigations shall include, but not be limited to:

a. Obtaining statements from all involved individuals;
b. Obtaining statements from all known and any possible witnesses, even if nothing was observed by the individual;
c. Securing and preserving all weapons, if any, including any firearm projectiles;
d. Securing and preserving any other evidence in accordance with Administrative Directive, 01.12.112;
e. Determining if all policies and procedures were followed immediately before, during, and after the incident;
f. Determining the quality of offender and staff supervision before, during, and after the incident;
g. Determining if use of force by staff, if any, was commensurate with the incident;
h. Determining if reasonable grounds exist to suspect that any actions on the part of offenders or staff constitute criminal acts and, if so, re-interviewing involved individuals;
i. When appropriate, conferring with the local State's Attorney to determine if criminal prosecution is warranted;
j. When appropriate, referring individuals to the prosecuting authority for criminal prosecution; and
k. Completing an Illinois Bureau of Investigations Arrest Card, ISP 6-402, and a Federal Bureau of Investigations Fingerprint Card, FD 249, in accordance with Administrative Directive 01.07.805.

2. The supervisor of the internal investigation team shall submit an initial report, verbal or written, to the Chief Administrator within 48 hours of the incident and shall submit a final written report using the Report of Investigation, DOC 0262 within 10 working days from the conclusion of the investigation.
H. Investigation Files
An investigation file that includes all information and reports regarding the investigation shall be established.
1. The investigation file shall be maintained by the Chief Administrator at the facility where the investigation was conducted.
2. An investigation file shall also be maintained by the Investigations and Intelligence Unit for each Department investigation conducted.
3. The Investigations and Intelligence Unit investigator and facility investigator shall ensure all investigation files containing employee information such as home address, telephone numbers, Social Security number, and other personal information not relevant to the criminal case are thoroughly reviewed and redacted (blacked out) prior to being forwarded to the State's Attorney's office. Only the portions of the file relevant to the prosecution shall be released.

AD 04.01.301 – Sexual Abuse and Harassment Prevention and Intervention Program
II. PROCEDURE
G. Requirements
3. Training
All employees who may have contact with youth shall receive Prison Rape Elimination Act (PREA) training in the initial pre-service training and annually thereafter, on the following topics:

a. The Department's zero-tolerance policy for sexual abuse and sexual harassment;
b. How to fulfill responsibilities under this sexual abuse and harassment prevention and intervention program, including the response procedures provided in Administrative Directive 04.01.301;
j. Compliance with relevant laws related to mandatory reporting of sexual abuse to outside authorities; and
k. Relevant laws including custodial sexual misconduct and the applicable age of consent.

5. Response Procedures

Youth center staff shall respond to any report, alleged, or possible sexual abuse or sexual harassment of a youth as provided in Administrative Directive 04.01.302.

AD 04.01.302 – Sexual Abuse and Harassment – Response Procedures
II. PROCEDURES
E. Requirements
4. Victim Advocate

a. If sexual abuse is alleged, the Facility PREA Compliance Manager shall, prior to transporting the youth to the hospital and at least within two hours of the initial report, contact a victim advocate from a rape crisis center. If a rape crisis center is not available, the Facility PREA Compliance Manager shall make available a qualified staff member from a community-based organization or from within the Department. The Facility PREA Compliance Manager shall document efforts to secure services from a rape crisis center.

b. The victim advocate or other qualified staff member shall, with the consent of the youth, accompany and support the victim through the forensic medical examination process in paragraph II.F.3, any investigatory interviews, and shall provide emotional support, crisis intervention, information, and referrals.

Mental Health Protocol MH-004 Mandated Abuse and Neglect Reporting
II. Policy and Procedure
B. All employees or volunteers within the department shall sign the CANTS 22 form indicating that they understand they are a mandated reporter during pre-service orientation.
C. Requirements regarding reporting:
3. The following steps shall be followed upon discovery of an incident of possible child abuse or neglect:

a. Immediately contact a supervisor.

b. The reporting employee or volunteer and the supervisor will contact the CAO.

c. The CAO will notify and review the case with the Deputy Director of Programs or Deputy Director of Operations for IDJJ. If neither Deputy Directors can be contacted, the CAO shall contact the Director.

The agency is responsible for administrative sexual abuse and sexual harassment investigations. Criminal sexual abuse investigations are conducted by the Illinois Department of Corrections (IDOC), the Illinois State Police, or the Illinois Department of Children and Family Services (DCFS).

Interviews with random staff indicated they were knowledgeable of procedures to immediately separate the victim and perpetrator; keep the youth safe; notify their supervisor; write out an incident report using a DJJ 0434 Incident Report form, and secure the area for useable physical evidence. Supervisory staff indicated they would also notify the Superintendent and the Duty Administrative Officer (DAO); makes appropriate referrals to medical and mental health; and, if needed, residents will be transported to John H. Stroger, Jr. Hospital of Cook County for forensic medical examination by qualified medical staff. Victim advocate services are provided by Rape Victim Advocates of Chicago, Illinois.

The Auditor verified through telephone conversation with John H. Stroger, Jr. Hospital of Cook County that they have SANEs/SAFEs staff on duty.

As referenced in AD 01.12.101, the agency has a Memorandum of Agreement with IDOC and the Illinois State Police stating that they agree to follow a uniform evidence protocol developmentally appropriate for youth when conducting investigations. The Agency also has a Memorandum of Agreement with DCFS. This was also confirmed through interview with the agency Director and facility Investigator.

During the on-site audit, the Auditor was provided with a copy of the MOU, dated July 1, 2016 and effective until July 1, 2017, between the facility and Rape Victim Advocates to provide outside confidential support services. The Auditor also verified through telephone conversation with Rape Victim Advocates that they have victim advocates and advocacy services available.

As of the date of the audit, the facility reported in the past 12 months there have been no forensic medical exams conducted; there have been no exams performed by SANEs/SAFEs; and no exams have been performed by a qualified medical practitioner.

Compliance with this standard was determined through policy reviews, review of documentation, and interviews with staff.

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 01.12.101 – Employee Criminal Misconduct
I. POLICY
B. Policy Statement
Allegations of employee criminal misconduct that may result in criminal prosecution of an employee shall be reported immediately in accordance with this directive. Handling of such reports shall be confidential.
F. General Provisions
1. The Director shall be advised immediately of any allegations of employee criminal misconduct.
2. The Department of Corrections (DOC) Chief of Investigations and Intelligence shall act as the liaison for the Department and the Illinois State Police in reporting allegations of employee criminal misconduct.
3. Jurisdiction over investigations of suspected employee criminal misconduct shall be based on the April 1, 2004 Memorandum of Understanding between the Department of Corrections and the Illinois State Police.
G. Requirements
All reports of employee criminal misconduct shall be made in writing and shall be marked "CONFIDENTIAL." Dissemination shall be restricted to a need-to-know basis. Reports of a more serious or urgent nature may be made via the telephone with the written report submitted within 24 hours.
3. The Chief of Investigations and Intelligence shall;
a. If the incident of alleged criminal misconduct is listed as a reportable offense in the Memorandum of Understanding, advise the Illinois State Police, Division of Internal Investigations and obtain instructions regarding investigations and further reporting.
b. If the incident of alleged criminal misconduct is listed as a non-reportable offense in the Memorandum of Understanding or the incident is referred back from the Illinois State Police, investigate the incident.

AD 01.12.105 – Reporting of Unusual Incidents
II. PROCEDURES
E. Requirements
2. The Chief Administrative Officer of a youth center or program site shall ensure that a written procedure on the reporting of all incidents is established. The written procedure shall require that the more serious and significant unusual incidents are reported in accordance with the provisions of this directive.
F. Types of Incidents and Immediate Reporting
1. The Chief Administrative Officer, or his or her designee, shall report immediately, by telephone, to the Deputy Director of the appropriate division any of the following types of incidents or situations that involve a youth or an employee on duty or on site:
a. A youth's physical assault on another youth or an employee where serious injury results;
G. Follow Up Reports
The Chief Administrative Officer, Regional Aftercare Administrator, or General Office Supervisor, after informing the Deputy Director by telephone of the incident, shall ensure:
1. An initial Incident Report, DJJ 0434, is completed and transmitted via electronic mail to the Deputy Director by the next working day or within 72 hours of the incident if the incident occurs on the weekend. The initial report may be designated as the final report.

AD 01.12.112 – Preservation of Physical Evidence
I. POLICY
B. Policy Statement
The Department shall collect, preserve, and protect physical evidence in accordance with the procedures established herein.
II. PROCEDURE
A. Purpose
The purpose of this directive is to provide guidelines for staff in regard to the collection, preservation, and protection of physical evidence.

AD 01.12.120 – Investigations of Unusual Incidents
II. PROCEDURE
E. General Provisions

1. The Chief Administrator shall ensure that an internal investigation is conducted by facility staff or by staff assigned by the Chief of Investigations and Intelligence on each unusual incident reported if it is determined that further facts are required.
2. The Chief of Operations shall ensure that all incidents reported where death or injury occurred as a result of firearms discharge are investigated immediately by the Shoot Team in accordance with Administrative Directive 01.12.106.
3. The Director or the respective Deputy Director or Chief may request that the Chief of Operations initiate a Department investigation of any other major incident. Department investigations shall be conducted by the Investigations and Intelligence Unit.
4. The appropriate investigative reports and forms identified in Administrative Directive 01.12.125 shall be utilized.
5. The master record file of any offender who is being investigated for possible criminal prosecution shall be flagged, in accordance with Paragraph II.I. to ensure the offender is not considered for restoration of good time or award of meritorious good time pending the results of the investigation for possible prosecution.
6. Any employee who knowingly provides false information, including but not limited to false information provided in statements, incident reports, correspondence, or an interview, shall be subject to disciplinary action, including discharge.
7. All employees shall be required to cooperate with any internal investigation conducted by the facility Internal Affairs Office, Investigations and Intelligence Unit, or any other investigative authority including the Office of Executive Inspector General (OEIG). Employees shall provide documentation and testimonial evidence as required by law. Information pertaining to an internal or OEIG investigation shall be considered confidential and shall be disseminated on a need-to-know basis only. Employees shall not disclose or be asked to disclose:
    a. The existence of an investigation;
    b. The information requested during an investigation;
    c. The subject matter or questions asked during an interview; or
    d. The identity of the employees under investigation.
8. Failure to cooperate with an investigation shall result in disciplinary action, up to and including discharge.

AD 01.12.125 – Uniform Investigative Reporting System
I. POLICY
B. Policy Statement
Employees and volunteers having reasonable cause to believe a child known to them in their professional or official capacity may be an abused or a neglected child shall report the suspected abuse or neglect in accordance with the Abused and Neglected Child Reporting Act.
II. PROCEDURE
A. Purpose
The purpose of this administrative directive is to establish instructions on the reporting of child abuse or neglect under the Abused and Neglected Child Reporting Act.

AD 01.12.135 – Reporting of Child Abuse and Neglect
I. POLICY
B. Policy Statement
Employees and volunteers having reasonable cause to believe a child known to them in their professional or official capacity may be an abused or a neglected child shall report the suspected abuse or neglect in accordance with the Abused and Neglected Child Reporting Act.
II. PROCEDURE
F. Requirements
1. All Department employees or volunteers shall sign the CANTS 22 form indicating that they understand they are a mandated reporter during pre-service orientation.
2. Each employee shall have training on how to be a mandated reporter within one year of initial employment and once every five years of service.
3. Incidents of child abuse, neglect, or inadequate supervision or a specific set of circumstances involving suspected child abuse, neglect, or inadequate supervision shall be:
    a. Reported to the Chief Administrative Officer (CAO), the Department of Children and Family Services (DCFS) Child Abuse Hotline and other appropriate officials and;
    b. Completely documented by any witnessing employee or volunteer, or any employee or volunteer who received the notification of same, on an Incident Report, DJJ 0434 and as otherwise required by this administrative directive.
4. An incident is reportable only if the alleged victim is a child under the age of 18 and the alleged perpetrator is:
    a. A parent;
    b. Legal guardian;
    c. Immediate family member;
    d. Any person responsible for the child's welfare, including any DJJ employee when the child is committed to the Department;
    e. Any individual residing in the same home as the child;
    f. A paramour of the child's parent; or
    g. A youth committed to the Department who is 18 years of age or older.
5. The witnessing employee or volunteer shall provide the Hotline with the following information, if available:
    a. The names, dates of birth, races, and genders for all adult and child subjects;
    b. The adult and child subjects' addresses;
    c. Information about the child's siblings and other family members; and

d. Specific information about the allegedly abusive incident or circumstances contributing to a substantial risk of harm, including any evidence of any previous injuries or disabilities.

5. The following steps shall be followed upon discovery of an incident of possible child abuse or neglect:

a. The witnessing employee or volunteer shall immediately notify his or her immediate supervisor.

b. The witnessing employee or volunteer and the supervisor will contact the Chief Administrative Officer

c. The Chief Administrative Officer will review the incident with the appropriate Deputy Director. If a Deputy Director cannot be contacted, the Chief Administrative Officer shall contact the Director.

e. The witnessing employee or volunteer shall:

1. Call the Child Abuse Hotline and report the facts listed in paragraph II.F.5.

2. Record the name of the Department of Children and Family Services staff contacted and the time and date of the telephone report.

3. Take notes during the conversation and submit this information to the supervisor who will then provide it to the Chief Administrative Officer.

Note: When more than one employee or volunteer is a witness, when possible, the person with the most direct knowledge of the suspected abuse or neglect should be the one to make the call and complete the written confirmation in paragraph F.5.f.below.

f. Within 48 hours of the initial report to the Hotline the witnessing employee or volunteer will complete and send via U.S. mail to DCFS the CANTS 4 form, used by medical staff, or the CANTS 5 form, used by other mandated reporters. The forms are to be completed and signed by the person making the initial report.

g. The Chief Administrative Officer shall ensure that any initial Incident Reports, DJJ 0434, are completed and transmitted via e-mail to the Deputy Director by the next working day. The initial report may be designated as the final report.

6. DCFS shall have unrestricted access to any youth alleging abuse. All employees shall fully cooperate with the Department of Child and Family Services.

7. All employees and volunteers are prohibited from revealing any information related to an abuse or neglect report to anyone, except as provided in this Administrative Directive or when otherwise necessary to make treatment, investigative, or other security or management decisions.

IYC-Chicago PREA Response Plan

Immediate Staff Response

1. Upon knowledge of an allegation that a resident was sexually abused, the first staff member to response to the report shall be required to:

- Separate the alleged victim and abuser. Ensure the alleged victim is in a safe environment (such as health care unit) immediately following the reporting of the alleged incident.
- Preserve and protect any crime scene until appropriate steps can be taken to collect evidence.
- Request the alleged victim and the alleged abuser does not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, drinking or eating.
- If the first person responding (made aware of the allegation) is not a security staff member, the responder shall be required to request that the alleged victim not take any actions that could destroy physical evidence and then notify security staff.

2. Upon knowledge of an alleged incident of sexual abuse or harassment, IYC-Chicago staff will immediately report the alleged or suspected incident to the Shift Supervisor. No other information regarding the incident will be reported to anyone other than to the extent necessary to treat, investigate and make other security management decisions. This will be done without retaliation against youth or staff.

3. The Shift Supervisor will ensure the area of the alleged occurrence is secured (if applicable).

4. In instances where there is a crime scene, the area will be preserved and protected until appropriate steps can be taken to collect evidence by those trained in evidence collection.

5. The Shift Supervisor will immediately notify the DAO (who will notify Intel) and Dr. Murphy.

Policy requires all employees and contractors to report any unusual incident immediately to his/her immediate supervisor. Sexual abuse and 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.

The facility reported during the previous 12 months, three allegations of sexual abuse and/or sexual harassment were received; three allegations resulted in an administrative investigation; and no allegations were referred for criminal investigation. All of these investigations were completed within the time frame as set forth in the above policy. During the on-site audit the Auditor reviewed the four investigation files and confirmed the investigation was done in accordance with policy and procedures. The Auditor also reviewed the facility Investigator's database for external and internal investigations completed by the facility.

The agency's website at https://www.illinois.gov/idjj/Pages/PrisonRapeEliminationAct.aspx states that all allegations of youth-on-youth sexual abuse and sexual misconduct are investigated.

Compliance with this standard was determined through policy reviews, review of documentation, and interviews with specialized staff.

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 04.01.301 – Sexual Abuse and Harassment Prevention and Intervention Program
I. POLICY
B. Policy Statement
The Department shall provide a safe and secure environment for all youth and shall maintain a program for the prevention of sexual abuse and sexual harassment. Prompt staff intervention shall be provided in the event of a suspected or reported youth sexual abuse and/or sexual harassment. The Department shall maintain a zero tolerance policy towards all forms of sexual abuse and sexual harassment.
II. PROCEDURE
G. Requirements
3. Training
All employees who may have contact with youth shall receive Prison Rape Elimination Act (PREA) training in the initial pre-service training and annually thereafter, on the following topics:

a. The Department's zero-tolerance policy for sexual abuse and sexual harassment;
b. How to fulfill responsibilities under this sexual abuse and harassment prevention and intervention program, including the response procedures provided in Administrative Directive 04.01.301;
c. Youth rights to be free from sexual abuse and sexual harassment;
d. Youth and employee rights to be free from retaliation for reporting sexual abuse and sexual harassment;
e. The dynamics of sexual abuse and sexual harassment in juvenile facilities;
f. The common reactions of juvenile victims of sexual abuse and sexual harassment;
g. How to detect and respond to signs of threatened and actual sexual abuse and how to distinguish between consensual sexual contact and sexual abuse between youth;
h. How to avoid inappropriate relationships with youth;
i. How to communicate effectively and professionally with youth, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents;
j. Compliance with relevant laws related to mandatory reporting of sexual abuse to outside authorities; and
k. Relevant laws including custodial sexual misconduct and the applicable age of consent.

AD 04.01.303 – Lesbian, Gay, Bisexual, Transgender, Questioning, and Intersex (LBGTQI) Youth
II. PROCEDURE
F. Requirements
1. Training
a. All employees who have direct contact with youth shall be trained on the provisions of this Administrative Directive as part of their annual cycle training. This training shall be developed by a qualified trainer with experience working with LGBTQI youth and shall include working with LGBTQI youth in a positive and respectful manner, supporting positive adolescent development including modeling desired behavior, demonstrating respect for all colleagues and youth, reinforcing respect for differences, encouraging healthy self-esteem, and helping to manage the stigma sometimes associated with difference.
b. Volunteers shall receive training on the provisions in this Administrative Directive as part of volunteer orientation.
2. Equal Treatment of LGBTQI Youth

a. Employees and volunteers shall treat all youth fairly and equally, without bias and in a professional and confidential manner, regardless of sexual orientation, gender identity or gender expression.

b. Employees and volunteers shall provide LGBTQI youth with access to educational, rehabilitative, recreational and other programming on the same basis as other youth. Youth shall not be denied access to programming because of actual or perceived sexual orientation, gender identity or gender expression.

c. Employees and volunteers shall use respectful language and terminology that does not stereotype LGBTQI people. In particular, employees and volunteers shall not imply or tell youth that their gender expression, identity, or sexual orientation are abnormal, deviant or sinful or that they can or should change their sexual orientation and/or gender identity.

AD 04.01.304 – Discrimination and Harassment of Youth
II. PROCEDURE
F. Training
1. Training on the Department's discrimination and harassment policy shall be included in pre-service and annual cycle training for employees and in volunteer orientation. This training shall include what behavior constitutes discrimination and harassment and procedures for preventing, addressing, and reporting discrimination and harassment.
2. All employees with supervisory responsibilities shall receiving additional training that includes strategies for maintaining an environment free of discrimination and harassment and the handling of complaints. This training shall be completed within the first six months of initial appointment to a supervisory position.

AD 03.03.102 – Employee Training
II. PROCEDURE
F. General Provisions
1. Training Coordinators shall:

a. Assist in coordinating pre-service training for staff not required to receive training at the Academy and on-going training for each employee at their youth center, office or program site.
2. Training Coordinators shall be designated, as follows:

b. The Chief Administrator of each youth center shall assign an individual to be the Training Coordinator for all employees within the youth center. The name of the Training Coordinator shall be submitted for approval to the Chief of Professional Development and Training.
3. The Training Coordinator shall maintain a master record of completed training for each employee at his or her worksite.

a. The training records shall include all training documentation of training received and an Employee Training Record, DJJ 0220, for each employee at their assigned worksite on a fiscal year basis.

b. All training received by an employee shall be properly documented and provided to the Training coordinator. Proper documentation includes:

(1) Credit memorandum or certificate issued by the Office of Professional Development and Training.

(2) Certificate issued by an outside instructor or vendor approved by the Office of Professional Development and Training.

(3) Training verification forms used by the worksite or outside training provider and signed by the person providing the training.

G. Pre-Service Training Requirements

b. Supervisors shall submit each new employee's name, date of hire, job title, and worksite to the assigned Training Coordinator and Training Manager in the Office of Professional Development and Training within one week of the employee's initial hire.

c. The Office of Professional Development and Training shall schedule all new employees for the next available pre-service training and, whenever possible, provide a one month advance notice to the new employee, supervisor and Training Coordinator of the date, time, and location of the pre-service training the new employee has been scheduled for.

d. Upon request of the Chief Administrator for an exception for cause, a new employee may receive pre-service training at the worksite rather than at a regularly scheduled pre-service training. Such exceptions may be made for special positions such as physicians, union electricians, or certain part-time employees or short-term paid interns. In all cases, the content and structure of such worksite pre-service training shall be approved by the Chief of Professional Development and Training.
3. Supervisors and Chief Administrators may require additional pre-service training for non-security positions and are encouraged to consult with the Office of Professional Development and Training to develop appropriate additional pre-service training.
4. Pre-service training for youth center security personnel shall be provided by the Office of Professional Development and Training.

a. This training shall begin on the employee's date of hire.

b. Successful completion of the pre-service training shall be a requirement for certification as a Juvenile Justice Specialist.

c. The Office of Professional Development and Training shall evaluate the employee's progress and participation in the pre-service training and send documentation of such evaluation to the employee's Chief Administrative Officer upon completion of the training.

H. On-going Training Requirements
1. All employees shall complete all applicable fiscal year training mandates distributed by the Office of Professional Development and Training and any additional training required by his or her supervisor or Chief Administrator.
2. The Training Coordinator at each worksite shall:

a. Ensure all participants attending worksite training are given the opportunity to complete a Professional Evaluation, DJJ 0198 for each training session.

b. Collect and review all completed DJJ 0198s.

c. Continuously assess and document the training needs of worksite staff and ways to improve worksite training.

IYC-Chicago PREA Response Plan
Education/Prevention
3. Staff education will be provided annually through cycle training and staff meetings.

The facility provides extensive PREA standards training to all new employees during their pre-service training and again annually during cycle training. A review of the PREA training course description revealed that all the topics and requirements for this standard are being met for employees; and that training is tailored to the unique needs an attributes of residents of juvenile facilities and to the gender of the residents at the facility.

During the pre-audit, the Auditor reviewed training curriculum verifying the training meets the 11 subsections listed in this standard.

Refresher training on PREA requirements is conducted annually during annual cycle training and during roll calls. During the on-site audit, the Auditor reviewed a random sample of 10 staff records which documented that staff has received PREA training during annual cycle training.

Random staff interviews indicate staff has received the required PREA training, had a good working knowledge of the standards, and receive refresher training during annual cycle training and during roll calls.

Compliance with this standard was determined through policy reviews, review of the PREA training course description, review of training files, observations made during the on-site audit, and interviews with staff.

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.

01.02.107 – Background Investigation
I. POLICY
B. Policy Statement
The Department shall conduct background investigations in accordance with this directive.
II. PROCEDURE
F. General Provisions
1. Background investigations shall be completed on persons prior to employment or prior to placement in a safety sensitive position and on persons who provide services for the Department.
2. Background investigations may also be conducted periodically to review the background of individuals identified in Paragraph II.F.1.
3. There shall be two levels of background investigations:
a. A computer criminal history check, including a check of an individual's criminal history through LEADS, shall be required for:
(1) Outside workers or consultants who will regularly work with youth or youth records and who will be escorted or directly supervised by staff at all times while on grounds of a youth center. The computer criminal history check shall not be required prior to the initial entrance when outside workers or consultants are called in on an emergency basis. However, the computer criminal history check shall still be initiated in accordance with Paragraph II.G.
(2) Volunteers who will provide services on an occasional or a one-time basis, but who are not providing regular, on-going services in accordance with Administrative Directive 04.01.122; and
(3) Individuals prior to approval to tour facilities, except as otherwise approved by the Director.
b. A complete background investigation:
(1) Shall be required for all:
(a) Applicants, employees, contractual employees, student workers, and interns;

(b) Volunteers who will provide regular, on-going services; and

(c) Consultants who will or may have contact with youth or regularly work with youth records and who will not be escorted or directly supervised by staff while on grounds of a youth center. However, in an emergency when time does not permit the computer criminal history check prior to initial entrance, the consultant may be admitted as approved by the Chief Administrative Officer and escorted or supervised by staff at all times while on grounds of a youth center until such time as the computer criminal history has been received.

(2) Shall include, but not be limited to, a check of:

(a) LEADS;

(b) Fingerprint cards;

(c) Secretary of State Driver's License;

(d) Employment references;

(e) Offender Tracking System (OTS);

(f) Juvenile Tracking System (JTS);

(g) Visitor Tracking System (VTS);

(h) Military check, if applicable; and

(i) The use of any other name or social security number.

4. Background investigations, complete or computer criminal history only, and a Child Abuse and Neglect Tracking System (CANTS) check shall be completed on persons prior to employment or prior to placement in a safety sensitive position and on persons who provide services for the Department.

7. Annual background investigations, complete or computer criminal history only, may be conducted at the discretion of the Director on any employee, intern, volunteer, consultant, outside worker, or student worker including, but not limited to, individuals in safety sensitive positions.

8. Annual background investigations shall be conducted of all individuals in safety sensitive positions.

9. At least every five years, a computer criminal history check, including a check of an individual's criminal history through LEADS and a CANTS check, shall be conducted for current employees and contractors who may have contact with youth.

AD 04.01.122 – Volunteer Services

I. POLICY

B. Policy Statement

The Department shall promote the use of volunteers to provide services and enrichment to the Department and its offenders.

II. PROCEDURE

F. General Provisions

1. The Office of Volunteer Services shall monitor volunteer activities within the Department, except as otherwise directed by the Chief of Operations to be handled through the Office of the Chief Chaplain. This shall include random external audits of volunteer activities at facilities in accordance with this directive

2. The Chief Administrative Officer of each facility or program site shall establish a local procedure in accordance with this directive and shall ensure that:

a. Appropriate staff, including security staff, are trained in the use of the Visitor Tracking System (VTS) volunteer profile and understand the importance of maintaining accurate volunteer records.

b. A separate sign in sheet is maintained for volunteers and a copy is provided to the facility Volunteer Coordinator on a daily basis.

3. Where applicable, the Chief Administrative Officer of each facility or program site shall appoint a volunteer coordinator. The name, title, and telephone number of the current volunteer coordinator shall be submitted to the Office of Volunteer Services.

4. The facility volunteer coordinator shall:

c. Screen applicants and ensure volunteers who will perform professional services are certified and licensed to do so.

e. Ensure a volunteer orientation manual is established and maintained that addresses all items listed on the Volunteer Services Orientation Checklist, DOC 0042. The manual shall be reviewed annually and updated as necessary.

j. Ensure volunteers receive orientation and training appropriate to the type of volunteer assignment at the facility or program site prior to service. Training shall include, but not be limited to, preparation of incident reports and volunteer rules of conduct.

k. Maintain individual volunteer files that include the volunteer's application and volunteer information or documentation, request for background investigation, signed volunteer statement, any certificates or licenses, documentation of required TB testing, and training documentation including document orientation and any additional training. Training documentation shall be signed and dated by the volunteer along with the volunteer coordinator, stating what training has been completed. Such files shall be maintained at each facility where the volunteer provides service; copies of documentation shall be obtained from the parent facility.

G. Volunteer Application Process

1. a. The facility volunteer coordinator shall submit a Request for Background Investigation, DOC 0032, to the Office of Volunteer Services who shall forward to the Background Investigations Unit. The name, date of birth, social security number, gender, and address of each prospective volunteer shall be provided.

b. Upon completion of the background investigation, the volunteer coordinator shall submit the written statement provided by the group or individual requesting to provide limited volunteer service to the Chief Administrative Officer.

2. Groups or individuals who wish to provide regular volunteer service shall be directed to complete and submit a Volunteer Services Application, DOC 0005, a Volunteer–Information Sheet, DOC 0267, and a Screening Release and Consent form, DOC 0108 to the volunteer coordinator of the parent facility or program site. Individual applications and information sheets shall be required for each member of a group.

a. If service will be performed at more than one facility, the application shall be screened and processed by the parent facility.

b. The volunteer coordinator shall submit a Request for Background Investigation, DOC 0032, to the Office of Volunteer Services who shall forward to the Background Investigations Unit.

(1) A computer criminal history check shall be obtained for all prospective volunteers.

(2) Regular volunteers shall be subject to a complete background investigation, including a drug test prior to service at sites designated by the Department. Regular volunteers shall also be subject to random drug testing in accordance with Administrative Directive 03.02.200.

AD 04.01.303 – Lesbian, Gay, Bisexual, Transgender Questioning, and Intersex (LBGTQI) Youth
II. PROCEDURE
F. Requirements
1. Training

b. Volunteers shall receive training on the provisions in this Administrative Directive as part of volunteer orientation.

2. Equal Treatment of LGBTQI Youth

a. Employees and volunteers shall treat all youth fairly and equally, without bias and in a professional and confidential manner, regardless of sexual orientation, gender identity or gender expression.

b. Employees and volunteers shall provide LGBTQI youth with access to educational, rehabilitative, recreational and other programming on the same basis as other youth. Youth shall not be denied access to programming because of actual or perceived sexual orientation, gender identity or gender expression.

c. Employees and volunteers shall use respectful language and terminology that does not stereotype LGBTQI people. In particular, employees and volunteers shall not imply or tell youth that their gender expression, identity, or sexual orientation are abnormal, deviant or sinful or that they can or should change their sexual orientation and/or gender identity.

AD 04.01.304 – Discrimination and Harassment of Youth
II. PROCEDURE
F. Training
1. Training on the Department's discrimination and harassment policy shall be included in pre-service and annual cycle training for employees and in volunteer orientation. This training shall include what behavior constitutes discrimination and harassment and procedures for preventing, addressing, and reporting discrimination and harassment.

Mental Health Protocol MH-004 Mandated Abuse and Neglect Reporting
II. Policy and Procedure
B. All employees or volunteers within the department shall sign the CANTS 22 form indicating that they understand they are a mandated reporter during pre-service orientation.
C. Requirements regarding reporting:
3. The following steps shall be followed upon discovery of an incident of possible child abuse or neglect:

a. Immediately contact a supervisor.

b. The reporting employee or volunteer and the supervisor will contact the CAO.

c. The CAO will notify and review the case with the Deputy Director of Programs or Deputy Director of Operations for IDJJ. If neither Deputy Directors can be contacted, the CAO shall contact the Director.

20 Illinois Administrative Code 2435 – Volunteer Services
Applies to any group or individual who is seeking to provide or is providing volunteer services within the Department of Juvenile Justice.
20 Illinois Administrative Code 2435 – Volunteer Services
2435.30 Applications for Volunteer Service: Individuals
a) Applicants for volunteer service shall be required to complete an application provided by the Department and to supply references and verification of qualifications. Applicants shall be subject to screening procedures, including drug testing, and selection criteria adopted by the facility to address security concerns or program requirements.
c) Applicants shall be required to notify each facility for which they wish to provide volunteer service and may be required to submit separate volunteer applications to each facility and to undergo screening and orientation by the respective facilities. The determination whether to require separate applications or screening shall be based, among other matters, on the type of program and safety and security of the facility.
Section 2435.40 Applications for Volunteer Service: Groups
a) Citizen groups wishing to provide volunteer service to a youth center or to committed youth in the community shall submit a written statement in advance, detailing: the purpose and goals of the proposed program; the intended frequency of visits to the facility or with committed youth; and if applicable, the identity of the target group of committed youth to whom the service would be directed.

1) Citizen groups proposing to provide such services on a continuing basis shall be required to submit a completed application for each participant and any subsequently added participants. Screening of individual members of the group shall be performed as required for individual volunteer applicants (Section 2435.30).

Section 2435.50 Placement Procedures for Approved Volunteers
This Section applies to applicants who will be providing volunteer services on a continuing basis.
a) Upon completion of the screening process, approved applicants shall be notified of their acceptance by the Volunteer Services Coordinator.
b) Prior to placement, the volunteer:

1) Shall be informed of and shall agree in writing to observe all applicable rules and to serve as a volunteer at the sole discretion of the Department;

4) Shall receive training and orientation appropriate to the volunteer assignment as required by the facility. Written documentation, signed and dated by the volunteer, shall be maintained to verify training and orientation received.

DJJ Form 0041 – Volunteer Services Agreement and Release
DJJ Form 0042 – Volunteer Service Orientation
DJJ Form 0267 – Volunteer Information Sheet (Regular Volunteers Only)

The facility provides PREA 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.

The facility reports they have 24 contractual staff and 98 volunteers who have been trained in agency's zero-tolerance policy regarding sexual abuse and sexual harassment, the agency's policies and procedures regarding sexual abuse and sexual harassment prevention, detection, and response. Background checks and follow-up background checks every five years for all volunteers are performed by the agency's background unit. The Auditor reviewed a sample documentation of volunteer files maintained by the facility confirming that volunteers and contractual staff have received PREA training and the completed the DJJ 0041, DJJ 0042 and DJJ 0267 were located in the sample files.

Interviews with random volunteers and contractual staff indicate they have been provided with PREA training regarding their responsibilities under the agency's policies concerning sexual abuse and sexual harassment prevention, detection, and response.

Compliance with this standard was determined through policy reviews, review of files, and interviews with volunteers and contractors.

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 – Sexual Abuse and harassment Prevention and Intervention Program
II. PROCEDURE
F. General Provisions
1. Any sexual abuse or sexual harassment of youth by staff or youth by youth is prohibited.
2. The Sexual Abuse and Harassment Prevention and Intervention Program shall include, at a minimum:

a. A zero tolerance policy towards all forms of sexual abuse and sexual harassment;

b. Appropriate measures to protect all youth and staff who report sexual abuse or sexual harassment or cooperate with investigations from retaliation by other youth and staff;

c. Procedures to prevent sexually abusive, and sexually harassing behavior, including staff and volunteer training and the screening, classification, and education of youth;

d. Immediate reporting of any knowledge, suspicion or information regarding an incident of sexual abuse, sexual harassment, or retaliation that occurred at the youth center;

e. Prompt intervention if sexual abuse or sexual harassment is suspected or occurs, including medical, psychological, safety, and security aspects;

f. Multiple internal ways for youth to privately report sexual abuse, sexual harassment, retaliation for reporting such incidents, and staff neglect or violation of responsibilities that may have contributed to such incidents.

g. A method to receive third-party reports of sexual abuse and sexual harassment made on behalf of a youth;
h. Prompt investigation, disciplinary action, and referral for prosecution, where appropriate;
i. Identification of "vulnerable youth" and youth who are a "risk to others";
j. Services available to youth following a sexual abuse and/or sexual harassment;
k. Provided with information regarding outside community resources related sexual abuse and harassment support and advocacy services upon release or discharge from a Youth Center

3. The Department PREA Coordinator shall be designated by the Director and shall:

a. Develop or approve standardized training modules for issues such as signs of sexually abusive and/or sexually harassing behavior; signs of being a victim of sexual abuse and/or sexual harassment; protocols for initial response to alleged sexual abuse and/or sexual harassment, crisis intervention, treatment, and counseling.

b. Ensure that all youth have an equal opportunity to participate in or benefit from all aspects of the Sexual Abuse and Harassment Intervention and Prevention Program as required by 28 C.F.R § 115.316.

4. The Chief Administrative Officer of each youth center shall:

f. Ensure youth receive the information and educational opportunities required by paragraph G.2

G. Requirements

The Chief Administrative Officer of each youth center shall ensure that a written procedure is developed that includes the following applicable requirements.

2. Youth Education

a. Upon admission to Classification and Reception, staff shall provide a brief presentation regarding HIV Disease, the Department's zero tolerance policy, and the youth center's Sexual Abuse and Harassment Prevention and Intervention Program. Youth shall be told how to report sexual abuse or harassment and informed that victims need not name their attacker to receive medical and mental health services.

b. Within 10 days of intake, youth shall be provided with comprehensive, age-appropriate education either in person or through video regarding:

1) Their rights to be free from sexual abuse, sexual harassment, and retaliation for reporting such incidents;
2) The Department's policies and procedures for responding to such incidents;
3) How to report incidents of sexual abuse, sexual harassment, and retaliation; and
4) How to access an outside victim advocate.

c. Such information shall also be provided to the youth, upon arrival at the assigned youth center, in the youth handbook and in the orientation program.

d. Youth's participation in these educational sessions shall be documented in the manner required by the Chief Administrative Officer.

e. Key information shall be continuously and readily available or visible to residents through posters or other written formats.

4. Confidential Communication with Outside Victim Advocates

Chief Administrative Officers shall establish local policies and procedures that enable reasonable communication between residents and these organizations in as confidential a manner as possible.

a. Such polices shall prohibit any auditory monitoring of such conversations, unless failing to do so in a particular case would present a safety or security risk.

b. Youth shall be informed, 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 to mandatory reporting laws.

IYC-Chicago PREA Response Plan

Education/Prevention

1. All youth will be educated on PREA through the orientation process.
2. Youth PREA notices will be posted in all housing unit wings, educational rooms, and the visiting room.

Residents receive information during the intake process that includes a PREA verbal orientation, and the facility's Youth Orientation Handbook which is provided in English and Spanish. Information on page 7 in the facility's Youth Orientation Handbook, explains the facility's zero tolerance regarding sexual abuse and sexual harassment; and information on the three options on reporting any sexual abuse, assault or misconduct procedures. The Youth Orientation Handbook also contains PREA posters in English (Attachment A, page 32) and Spanish (Attachment B, page 33), along with the sexual abuse hotline phone number and the availability of advocacy services from The John Howard Association. Attachment C, page 35, to the Youth Orientation Handbook lists the three options (talking to facility staff, calling the toll-free sexual abuse hotline, and sending a grievance and/or confidential grievance) for reporting sexual abuse or sexual misconduct. PREA posters are posted in the common areas throughout the facility that included the telephone hotline number to call to report sexual abuse or sexual harassment. Residents sign a form acknowledging they have received PREA information.

The facility reported that in the past 12 months 162 residents received comprehensive age-appropriate education on their rights to be free from sexual abuse and sexual harassment, from retaliation for reporting

such incidents, and on agency policies and procedures for responding to such incidents at intake and again within 10 days of intake.

During the on-site audit, the Auditor viewed posters, in both English and Spanish, providing residents with information on sexual abuse and sexual harassment, and how to report, including telephone hotline number. During the on-site audit, the Auditor also reviewed a random sample of resident files verifying resident signatures on the Orientation Checklist Form acknowledging they had received PREA training.

Interviews with random residents indicate they have been provided information on the facility's zero tolerance within hours of arrival; they have seen the posters posted in the facility; and they know how to make a report.

Compliance with this standard was determined through policy reviews, review of documentation, observations made during the on-site audit, and interviews with staff and residents.

Standard 115.334 Specialized training: Investigations.

☐ Exceeds Standard (substantially exceeds requirement of standard)
☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
☐ Does Not Meet Standard (requires corrective action)

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

AD 01.12.115 – Internal Investigations
F. Requirements
3. After receipt of written approval from the Chief of Investigations and Intelligence, the Chief Administrative Officer shall assign institutional investigators and shall coordinate training needs of staff with the Chief of Investigations and Intelligence.
4. The Chief Administrative Officer shall:
b. Ensure that each individual appointed as an investigator be registered for the next available investigative training program within ten days of temporary or permanent assignment as an investigator.
1) Training shall include topics such as investigative techniques, crime scene preservation, preservation of evidence, and investigative reporting.
2) In addition to the PREA training required by Administrative Directive 04.01.301, investigators shall receive specialized training which shall include conducting sexual abuse investigations, techniques for interviewing juvenile sexual abuse victims, proper use of Miranda and Garrity warnings, sexual abuse evidence collection in confinement settings, and the criteria and evidence required to substantiate a case for administration action or prosecution referral.
3) Written documentation of training received or written verification that training on specific topics was not required due to prior training or experience shall be maintained in the employee's training file.
5. Annually and as changes are made, the Chief Administrative Officer shall submit the names and titles of investigators assigned to the facility to the Chief of Investigations and Intelligence.

AD 03.03.102 – Employee Training
I. POLICY
B. Policy Statement
The Department shall ensure all employees receive pre-service and on-going training as appropriate for their position.
II. PROCEDURE
A. Purpose
The purpose of this directive is to establish a written procedure for the training and professional development of all Department employees.
3. The Training Coordinator shall maintain a master record of completed training for each employee at his or her worksite.
a. The training records shall include all training documentation of training received and an Employee Training Record, DJJ 0220, for each employee at their assigned worksite on a fiscal year basis.
b. All training received by an employee shall be properly documented and provided to the Training coordinator. Proper documentation includes:

(1) Credit memorandum or certificate issued by the Office of Professional Development and Training.
(2) Certificate issued by an outside instructor or vendor approved by the Office of Professional Development and Training.
(3) Training verification forms used by the worksite or outside training provider and signed by the person providing the training.
H. On-going Training Requirements
1. All employees shall complete all applicable fiscal year training mandates distributed by the Office of Professional Development and Training and any additional training required by his or her supervisor or Chief Administrator.
2. The Training Coordinator at each worksite shall:
a. Ensure all participants attending worksite training are given the opportunity to complete a Professional Evaluation, DJJ 0198 for each training session.
b. Collect and review all completed DJJ 0198s.
c. Continuously assess and document the training needs of worksite staff and ways to improve worksite training.
d. Submit training needs assessment by April 1st of each year to the Chief Administrator and Chief of Professional Development and Training.

The facility has one Investigator and three Intelligence Officers 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.

During the on-site audit, the Auditor interviewed the Investigator who demonstrated a thorough working knowledge of PREA and how to appropriately conduct investigations concerning allegations of sexual abuse or sexual harassment. During the on-site audit, the Auditor also reviewed the training records for the Investigator and the three Intelligence Officers documenting continuing successful completion of the specialized training.

Compliance with this standard was determined through policy reviews, review of documentation, and interviews with specialized staff.

Standard 115.335 Specialized training: Medical and mental health care.

☐ Exceeds Standard (substantially exceeds requirement of standard)
☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
☐ Does Not Meet Standard (requires corrective action)

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

AD 03.03.102 – Employee Training
I. POLICY
B. Policy Statement
The Department shall ensure all employees receive pre-service and on-going training as appropriate for their position.
II. PROCEDURE
A. Purpose
The purpose of this directive is to establish a written procedure for the training and professional development of all Department employees.
B. Applicability
This directive is applicable to all youth centers, offices, and program sites within the Department.
F. General Provisions
2. Training Coordinators shall be designated, as follows:
a. The Director or appropriate Deputy Director shall assign an individual(s) to be the Training Coordinator for his or her worksite or area of responsibility for General Office and Aftercare Staff whose work locations are not at a youth center. The name of each Training Coordinator shall be submitted for approval to the Chief of Professional Development and Training.

b. The Chief Administrator of each youth center shall assign an individual to be the Training Coordinator for all employees within the youth center. The name of the Training Coordinator shall be submitted for approval to the Chief of Professional Development and Training.

3. The Training Coordinator shall maintain a master record of completed training for each employee at his or her worksite.

a. The training records shall include all training documentation of training received and an Employee Training Record, DJJ 0220, for each employee at their assigned worksite on a fiscal year basis.

b. All training received by an employee shall be properly documented and provided to the Training coordinator. Proper documentation includes:

(1) Credit memorandum or certificate issued by the Office of Professional Development and Training.

(2) Certificate issued by an outside instructor or vendor approved by the Office of Professional Development and Training.

(3) Training verification forms used by the worksite or outside training provider and signed by the person providing the training.

H. On-going Training Requirements

1. All employees shall complete all applicable fiscal year training mandates distributed by the Office of Professional Development and Training and any additional training required by his or her supervisor or Chief Administrator.

2. The Training Coordinator at each worksite shall:

a. Ensure all participants attending worksite training are given the opportunity to complete a Professional Evaluation, DJJ 0198 for each training session.

b. Collect and review all completed DJJ 0198s.

c. Continuously assess and document the training needs of worksite staff and ways to improve worksite training.

d. Submit training needs assessment by April 1st of each year to the Chief Administrator and Chief of Professional Development and Training.

3. By May 1st of each year, the Chief of Professional Development and Training shall distribute fiscal year training mandates to all Chief Administrators and Training Coordinators.

a. Fiscal year training mandates shall include regular trainings required by law or Department policy and worksite specific trainings based on the training needs assessment.

b. Fiscal year training mandates shall contain, for each training topic, the following information:

(1) Target group;

(2) Approximate length of training;

(3) Department employees or outside sources approved to provide training on the topic;

(4) Required or suggested mode of presenting the training topic; and

(5) Location of trainings on the topic, for example, the worksite, Springfield Academy, or outside location.

Mental Health Protocol Manual TR-002 – Cycle Training

II. POLICY AND PROCEDURE

A. Cycle Training

1. All youth center employees shall receive a minimum of one hour of pre-service training on identification of mental health issues, the procedures for referring youth to Mental Health Services, and the procedures for reporting disturbed behavior to the Crisis Intervention Team. Training shall be reviewed annually during cycle training. The training curricula shall be developed by the Chief of Mental Health Services and approved by the Office of Staff Development and Training.

2. Training topics shall include, but are not limited to, the following topics:

a. Review of Administrative and Institutional Directives (60 minutes)

1. Non-Emergency Mental Health Services (04.04.101)

2. Emergency Mental Health Services (04.04.102)

3. Therapeutic Restraints (04.04.103)

4. Sexual Assault Prevention and Intervention (04.04.301)

b. Adolescent Development, MacArthur Module (60 minutes)

c. Child Trauma, MacArthur Module (45 minutes)

d. Facility Specific Training (60 minutes)

B. Health care and Youth and Family Specialists routinely responsible for processing and orientation of youths shall receive at least one hour of training annually by a mental health professional on:

1. Behavior indicative of mental or emotional disturbance, developmental disability, and chemical dependency;

2. Key medical and master file data to be reviewed on received youth,

3. The criteria and process to be used in referring youth for evaluation by a mental health professional; and

4. Confidentiality of mental health information.

The facility reported there are 12 medical and mental health care practitioners who work regularly and all have received the training required by the agency policy. At the time of the pre-audit, the facility's Director of Nursing position was vacant. Any resident victim is to be taken to John H. Stroger, Jr., Hospital of Cook County for medical treatment and forensic medical examination. Residents are referred to Rape Victim Advocates for outside mental health treatment and advocacy services.

During the pre-audit, the Auditor was provided with a copy of a cycle training designed specifically for mental health specialists in 2015, and a copy of the training certificate verifying training on Behavioral Health Care for Sexual Assault Victims in a Confinement Setting by the National Institute of Corrections.

During the on-site audit, the Auditor verified that all medical and mental health care practitioners have received the training as required by the above-stated policy.

Interviews were conducted with one on-site medical staff and one on-site mental health staff. Both indicated they have been provided with specialized training concerning their duties related to PREA, which included the following: 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 is to be taken to John H. Stroger, Jr., Hospital of Cook County for medical treatment and forensic medical examination. Residents are referred to Rape Victim Advocates for outside mental health treatment and advocacy services.

Compliance with this standard was determined through policy reviews, review of documentation, and interviews with specialized staff.

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 - Programs and Case Management
II. PROCEDURE
F. Requirements
The Chief Administrative Officer of each youth center shall establish and maintain written procedures to ensure, at a minimum, that the following case management functions are provided.
1. Orientation
Orientation to the youth center and program for each youth shall be completed within 15 days from the date of arrival at the youth center. The youth shall be requested to sign documentation of the completed orientation.
2. Establishment of Administrative Review Date
An Administrative Review Date shall be established for each delinquent within the first 60 days of the youth's incarceration within the Department in accordance with Administrative Directive 01.07.255.
3. Assessment and Assignment Process
a. A Program Assignment Committee shall initiate the assessment and assignment process within ten working days after a youth is placed at a youth center and shall complete the process within 30 days of admission to the youth center.
b. The committee shall review the following material in the youth's master file prior to making a recommendation for the youth's assignment:
(1) Academic or vocational records or both;
(2) Medical, psychiatric, and dental reports;
(3) Assessment reports from the referring reception unit;
(4) Sexual Abuse Risk Screening(s), DJJ 0429 and Bunk Issues Form(s), DJJ 0428 completed pursuant to Administrative Directive 04.01.301;
(5) Dates of the youth's commitment, recommitment, parole revocation, and custody date, when appropriate;
(6) Committing and prior offenses;
(7) Any pending charges and related court dates; and

(8) Reports regarding:

(a) The youth's need for security and protection;

(b) Outside agency involvement;

(c) The youth's need for special work with family guardian relationship regarding his or her reintegration with the family or guardian; and

(d) Special peer related concerns.

c. Minimally, the committee, whenever applicable, shall make recommendations for:

(1) The youth be assigned to a particular living unit or special program unit.

(2) A youth and family specialist is assigned for the youth.

(3) The individualized program plan that may include, but is not limited to, the academic or vocational program, employment training, behavioral health treatment, behavioral goals, and custody appropriate for the youth. The plan shall:

(a) Identify institutional programming responses to youth program needs and strengths as identified by the referring reception unit assessment reports.

(b) provide for a minimum of12 hours of program services and/or out-of-room activity during each weekday except State holidays, and a minimum of 8 hours of program services and/or out-of-room activity during State holidays and weekend which may include structured and unstructured activities provided by staff or volunteers, such as: leisure time, crafts, institution sponsored clubs and organizations, academic or vocational programs, counseling, work, religion, on or off grounds cultural and social events, organized athletic activities, and specialized activities for youth.

d. Assignments of lesbian, gay, bisexual, transgender, and intersex youth, shall meet the following additional requirements:

(1) Lesbian, gay, bisexual, transgender, or intersex youth shall not be placed in particular housing, bed, or other assignments solely on the basis of such identification or status.

(2) In making housing and programming assignments for a transgender or intersex youth, including whether to assign the youth to a facility for male or female residents, the committee shall include input from a mental health professional and consider on a cases-by-case basis whether a placement would ensure a youth's health and safety, and whether the placement would present management or security problems.

(a) A transgender or intersex youth's own views on his or her own safety shall be given serious consideration.

(b) 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.

e. The written program plan shall be reviewed and approved by the Chief Administrative Officer or the Assistant Chief Administrative Officer (no designee) and a copy shall be filed in the youth's master file.

f. The youth and family specialist shall:

(1) Review the approved program plan with the youth and document such review; and

(2) Inform the youth how he or she may request a change in his or her program and that if a request is made and denied, the youth shall be given the basis for the denial in writing and a copy of the denial shall be placed in the youth's master file.

4. Review of Program Plan

a. At least once per calendar month, a documented staffing of a youth's progress in relation to the objectives detailed in his or her program plan shall be completed.

b. For transgender or intersex youth, at least twice per year, such documented staffing shall include a review of any threats to safety experienced by the youth and the youth's current housing and programming assignments.

c. The Chief Administrative Officer shall identify the cross disciplinary team who shall be responsible for reviewing the youth's program plan during the monthly staffing. All members of the cross disciplinary team and the youth shall attend staffings, in person or by phone, except when attendance is impracticable. This attendance shall be documented. A youth's assigned aftercare specialist shall participate in at least one staffing within the first three months after a youth's commitment and one staffing within the three months prior to a youth's expected release date. Youth who will require alternate placement will need close coordination between the youth center and aftercare.

d. The chairperson shall facilitate and moderate the staffing and shall ensure:

(1) Input is obtained from staff concerning the youth's progress or problems since the initial program review or the last progress review.

(2) Current youth performance is compared to stipulations in the written program plan.

(3) New youth program goals are negotiated or identified and the program plan is modified where appropriate.

(4) Requests for authorized absences are recommended, reviewed, and submitted to the Program Assignment Committee for processing.

(5) Recommendations for awarding sentencing credit are made to the Chief Administrative Officer, where appropriate.

(6) Recommendations for revising the projected Administrative Review Date are made to the Chief Administrative Officer based on programming concerns, where appropriate.

(7) Youth Requests, DJJ 0286, are reviewed and submitted to the Program Assignment Committee.

e. The documented staffing of a youth's program plan shall be filed in the master file.

5. Review of Social Information

The youth's youth and family specialist shall review the documents relating to social information and initiate any indicated changes or corrections in the reception and classification documents, face sheet, or offense history.

6. Youth and Youth and Family Specialist Contact

A youth and family specialist shall have frequent and consistent face to face contact, at least weekly, with each youth in order to gain a better understanding of the youth's needs, progress and the appropriateness of youth's current program plan. Such contact shall be documented in the cumulative counseling summary. The youth's youth and family specialist will complete a new Sexual Abuse Risk Screening at least every 6 months and when there reason to believe the information previously obtained has changed.

AD 04.01.301 – Sexual Abuse and Harassment Prevention and Intervention Program
II. PROCEDURE
F. General Provisions
2. The Sexual Abuse and Harassment Prevention and Intervention Program shall include, at a minimum:
i. Identification of "vulnerable youth" and youth who are a "risk to others";
j. Services available to youth following a sexual abuse and/or sexual harassment;
G. Requirements
The Chief Administrative Officer of each youth center shall ensure that a written procedure is developed that includes the following applicable requirements.
1. Upon admission to a Reception and Classification Center all youth shall be screened for risk of sexual abuse:
a. Medical staff shall screen each youth for sexually abusive or sexually harassing behavior or victimization and inquire whether the youth has a history of such behavior or victimization.
b. Youth and Family Specialists shall, within 72 hours of youth's arrival and before a youth is assigned to a room:
(1) Review the pre-sentence report, statement of facts, and other material in the master file for any indication of past sexually abusive or sexually harassing behavior or victimization;
(2) Complete a Sexual Abuse Risk Screening, DJJ 0429 and Bunk Issues Form, DJJ 0428 as established by the Facility PREA Compliance Manager;
(3) Make recommendations regarding any treatment or counseling needs of victims and prior assailants; and
(4) Forward the DJJ 0428 and DJJ 0429 to the Facility PREA Compliance Manager if there is any indication of prior sexual victimization or prior sexually abusive behavior. Such youth shall be offered a follow-up meeting with medical staff or a mental health professional as soon as practical and within 5 days.
c. The Facility PREA Compliance Manager shall enter all relevant information from the DJJ 0428 and the DJJ 0429 into the youth data system of record, including any recommendations for identifying the youth as a "risk to others," "vulnerable youth," or both. If any "risk to others" and/or "vulnerable youth" recommendations are made, the Facility PREA Compliance Manager will forward the DJJ 0428 and the DJJ 0429 to the Chief of Mental Health for final determination.
d. The Chief of Mental Health, within two weeks of receiving a DJJ 0428 and DJJ 0429, shall review and approve or change identifier as indicated.
(1) Once this final determination has been made, the identifier cannot be changed without the concurrence of both the Chief of Mental Health and the Chief Administrative Officer. Only the Chief of Mental Health may change or override an identifying entry.
(2) A youth identified as a "vulnerable youth" shall not be housed in the same room with a youth identified as a "risk to others."
(3) Prior to housing a youth identified as a "vulnerable youth" or "risk to others" with another youth, the proposed housing assignment made pursuant to Administrative Directive 04.01.130 shall be reviewed and approved by the Chief Administrative Officer in consultation with the Facility PREA Compliance Manager

Mental Health Protocol Manual IN-001 Components of Mental Health Services
II. POLICY AND PROCEDURE
A. The components of the Illinois Department of Juvenile Justice effective mental health services are as follows:
1. A systematic program for screening for mental health problems upon intake with both inter-and intra-system transfers.
2. A systematic program for assessment of mental health problems available across the span of incarceration.

Mental Health Protocol Manual IN-002 IDJJ Mental Health Services
II. POLICY AND PROCEDURE
A. Illinois Department of Juvenile Justice's effective mental health services are as follows:
1. Screening and Assessment Services
a. Screening and assessment services provide valuable information to guide decisions about care, supervision, and services for youth. These services use tools that are structured, objective, and validated.
b. Upon intake, youth will receive the following screenings:
1. Medical screening to determine whether the youth is on any medication or has any health issues of an emergency nature.
2. Mental health screening to determine appropriate housing for a youth, including admission into a Special Treatment Unit, as well as any need for emergency crisis care.
3. Sexual abuse risk screening shall be completed and youth shall be provided with information on sexual abuse and harassment in accordance with paragraphs G.1 and G.2.a. of Administrative Directive 04.01.301.
c. Upon intake, youth will be administered the following assessments:
1. Voice Index of Self Injurious Actions Tool (VISA)
2. Massachusetts Youth Screening Instrument-2nd Version (MAYSI-2)
3. Risk of Victimization Tool
4. Youth Assessment and Screening Instrument (YASI)
5. Global Appraisal Inventory of Needs (GAIN)
6. Mental Health Protocol Manual SA-002

Mental Health Protocol Manual SA-002 Risk of Victimization Screening Tool
II. POLICY AND PROCEDURE
A. Upon admission to a Reception and Classification Center all youth shall be screened for risk of sexual abuse.

B. All youth shall be administered a Sexual Abuse Risk Screening, DJJ 0429, by a qualified staff member upon admission, and every six months afterwards until the youth's release from the facility.

Mental Health Protocol Manual SA-003 Mental Health Screening DJJ
II. POLICY AND PROCEDURE
A. Mental Health Screening

1. All youth entering into an Illinois Youth Center shall be screened by a Mental Health Professional (MHP), Crisis Team Member (CTM), or designee.

2. The screening shall be conducted prior to a youth's placement on a living unit in the facility. Until the screening is completed, the youth shall be constantly monitored until cleared by an MHP, CTM, or designee.

B. Mental Health Screening Tools

1. The screenings shall be conducted face-to-face and shall include the below when indicated:

a. The Massachusetts Youth Screening Instrument Version 2 (MAYSI-2) following the Mental Health Procedural Manual of the MAYSI-2, and

b. The Mental Health Intake Screening shall be facility specific and contain at a minimum the following information:

1. Date
2. Start and End Time of Screening
3. Youth Name
4. Youth Date of Birth
5. Psychiatric Hospitalization (Past/Recent/Date-Age/Reason)
6. Prior Mental Health Diagnosis/Concerns
7. Psychotropic Medications (Past/Current/Date-Age)
8. Past Suicidal Thoughts/Threats/Attempts/Plans (Date-Age/Reason)
9. If Suicide Attempt is in the past 3 months, CTL must be notified and this must be documented on the form
10. Past Self-Injurious Behaviors
11. Current Suicidal Thoughts
12. Prior Close Watch Situations (Internal and External to IDJJ)
13. Significant Recent Stressors
14. Family History (Mental Health/Suicide/Substance Abuse/Criminal)
15. DCFS Involvement
16. Substance Abuse History
17. History of Physical or Sexual Abuse (Who/When/Reported)
18. History of Witness or Experience of Trauma
19. History or Current PTSD symptoms
20. History of Sexual Offenses/Misconducts
21. Medical Concerns
22. Youth who has Children
23. Current Mental Health Status Evaluation
24. If indicated, Crisis Care Placement Designation
25. Notation if Youth is able to be Placed on a Cottage
26. Recommendations if needed to the Psychiatrist and/or Mental Health Professional (Utilizing the Mental Health Services Referral Form) or to the High Risk List
27. Additional Notes
28. The following statement shall be included at the bottom of each Mental Health Screening: "I have completed this form to the best of my ability with the resources and information available to me at the time of this assessment."
29. Signed by MHP or CTM conducting the interview
30. Reviewed and signed by the Treatment Unit Administrator or designee. When no CTL is available, then the CTM will need to sign and note that the CTL is not on grounds.

C. Mental Health Screening Procedure

1. Inter-facility transfers of youth and parole violators will include administration of the MAYSI-2 and the Mental Health Intake Screening at the receiving facility.

2. Intra-facility transfers of youth and parole violators will include administration of the MAYSI-2 or conducting a Mental Health Assessment that shall be documented on the DJJ 0282.

3. Youth on writs shall receive the MAYSI-2 if administered by a CTM. When conducted by a MHP, the MHP has the option of using the MAYSI-2 or conducting a Mental Health Assessment that shall be documented on the DJJ 0282. Court writs shall be assessed in all of the following circumstances:

a. Court writ that is returned from court.
b. Court writ entering a facility from another facility.
c. Court writ entering a facility, but getting paroled the same day or next day.
d. Court writ entering or returning from an interview.

Mental Health Protocol Manual SA-004 Mental Health Needs Assessment
II. POLICY AND PROCEDURE
A. The Treatment Unit Administrator at the parent facility will assign a Mental Health Professional (MHP) to review the mental health needs of each youth.

B. If the youth is assigned a Mental Health Level, then the assigned MHP will complete the Mental Health Needs Assessment (MHNA). The MHP shall review the youth's medical file and master file within 5 business days of the youth's admission to the parent facility to determine the youth's initial mental health needs. This review shall be documented on a Mental Health Needs Assessment Form. This review will be on a facility form, requires a facility form number and needs to be typed.
C. The MHNA needs to Include the following information:

1. Youth's age
2. Youth's current and history of committing charge
3. Parole violations
4. County
5. Criminal arrest and offense history
6. Mental health diagnoses
7. Psychotropic medication
8. Mental health treatment
9. History of verbal, physical and/or sexual abuse
10 .Pregnancy and/or children
11. Aggressive history
12. History of animal cruelty
13. History of fire setting behaviors
14. Mental health symptoms and history
15. Personality traits
16. Intellectual, emotional, social & trauma
17. Medical concerns
18. Substance abuse history
19. Guardian/parental and sibling identification
20. Parental and/or sibling criminal history, mental health history or concerns, and/or substance abuse.

D. Upon completion of the MHNA, the MHP will submit the MHNA with Treatment Recommendations to the Treatment Unit Administrator for final review, formal assignment of therapist, group assignment, and formal sign-off.
C. The MHNA will be placed in the youth's medical file and copies will be provided to the assigned Juvenile Justice Youth and Family Specialist, assigned MHP and others when applicable.

Mental Health Protocol Manual SA-006 Youth Assessment and Screening Instrument
II. POLICY AND PROCEDURE
A. The Youth Assessment and Screening Instrument (YASI) is a risk assessment tool that measures the risk of recidivism. The tool includes static and dynamic content across ten domains including legal history, family, school, community and peers, alcohol and drugs, mental health, aggression, attitudes, social/cognitive skills, free time and employment.
B. The YASI includes both pre-screen and full assessment components and is used to assist in making initial service decisions as well as case plan development. YASI provides a graphic profile of risk, need, and strength results for each youth including overall static and dynamic scores on risk and protective factors.
C. All youth entering an Illinois Youth Reception and Classification Center shall be screened using the YASI.
D. The YASI pre-screening and full assessment shall be initiated by an assigned staff member who has received training in the administration of the instrument as part of the intake process.
E. The YASI assessment results shall be placed in the youth's medical file.

Mental Health Protocol MH-004 Mandated Abuse and Neglect Reporting
A. Incidents of child abuse, neglect, or inadequate supervision or a specific set of circumstances involving suspected child abuse, neglect, or inadequate supervision shall be reported to the Chief Administrative Officer (CAO), the Department of Child and Family Services (DCFS) Child Abuse Hotline and other appropriate officials and completely documented by the witnessing employee or volunteer or the employee or volunteer who received the notification of the same. The purpose of this directive is to establish a written procedure for reporting and documenting mandated abuse and neglect reports. This directive is applicable to all employee of the Illinois Department of Juvenile Justice (IDJJ). The Abused and neglected Child Reporting Act (ANCRA) defines mandated reporters as professionals who may work with children in the course of their professional duties.
B. All employees or volunteers within the department shall sign the CANTS 22 form indicating that they understand they are a mandated reporter during pre-service orientation.

Form DJJ 0428 – Bunk Issues Criteria
Form DJJ 0507 – Accommodations for Transgender and Gender Non-Conforming Youth

The facility uses an objective screening instrument known as Youth Assessment Screening Instrument (YASI) to determine proper housing, bed assignment, education, and other programs assignments with the goal of keeping residents at high risk of being sexually abused and sexually harassed separate from residents who are at high risk of being sexually abusive. The Auditor was provided with a blank copy of the YASI screening form. A Youth and Family Specialist, commonly referred to as a counselor, reviews all housing and program assignments as shown on the DJJ 0428 Bunk Assessment form and DJJ 0429 Screening form which are made

on a case-by-case basis for all residents usually within the first hour of arrival, and continued follow-up and monitoring 30 days. The facility does not have dedicated housing for gay, bisexual, transgender or intersex residents. All residents, including transgender and intersex residents, shower separately from other residents.

Male residents are initially screened at IYC St. Charles before being transferred to the facility and are reassessed upon arrival at the facility by their Youth and Family Specialist usually within the first two hours of arrival. In the past 12 months the facility reported that 68 residents whose length of stay in the facility was for 72 hours or more were screened for risk of sexual victimization or risk of sexually abusing other residents within 72 hours of their entry into the facility.

Interviews with an on-site Nurse and Shift Supervisor confirmed that all residents are screened for risk of victimization and abusiveness within the 24-hour period.

Compliance with this standard was determined through policy reviews, review of documentation, and interviews with specialized staff and residents.

Standard 115.342 Use of screening information.

☒ Exceeds Standard (substantially exceeds requirement of standard)
☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
☐ Does Not Meet Standard (requires corrective action)

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

AD 04.01.130 - Programs and Case Management
II. PROCEDURE
F. Requirements
The Chief Administrative Officer of each youth center shall establish and maintain written procedures to ensure, at a minimum, that the following case management functions are provided.
2. Establishment of Administrative Review Date
An Administrative Review Date shall be established for each delinquent within the first 60 days of the youth's incarceration within the Department in accordance with Administrative Directive 01.07.255.
3. Assessment and Assignment Process
a. A Program Assignment Committee shall initiate the assessment and assignment process within ten working days after a youth is placed at a youth center and shall complete the process within 30 days of admission to the youth center.
b. The committee shall review the following material in the youth's master file prior to making a recommendation for the youth's assignment:
(1) Academic or vocational records or both;
(2) Medical, psychiatric, and dental reports;
(3) Assessment reports from the referring reception unit;
(4) Sexual Abuse Risk Screening(s), DJJ 0429 and Bunk Issues Form(s), DJJ 0428 completed pursuant to Administrative Directive 04.01.301;
(5) Dates of the youth's commitment, recommitment, parole revocation, and custody date, when appropriate;
(6) Committing and prior offenses;
(7) Any pending charges and related court dates; and
(8) Reports regarding:
(a) The youth's need for security and protection;
(b) Outside agency involvement;
(c) The youth's need for special work with family guardian relationship regarding his or her reintegration with the family or guardian; and
(d) Special peer related concerns.
c. Minimally, the committee, whenever applicable, shall make recommendations for:

(1) The youth be assigned to a particular living unit or special program unit.

(2) A youth and family specialist is assigned for the youth.

(3) The individualized program plan that may include, but is not limited to, the academic or vocational program, employment training, behavioral health treatment, behavioral goals, and custody appropriate for the youth. The plan shall:

(a) Identify institutional programming responses to youth program needs and strengths as identified by the referring reception unit assessment reports.

(b) provide for a minimum of12 hours of program services and/or out-of-room activity during each weekday except State holidays, and a minimum of 8 hours of program services and/or out-of-room activity during State holidays and weekend which may include structured and unstructured activities provided by staff or volunteers, such as: leisure time, crafts, institution sponsored clubs and organizations, academic or vocational programs, counseling, work, religion, on or off grounds cultural and social events, organized athletic activities, and specialized activities for youth.

d. Assignments of lesbian, gay, bisexual, transgender, and intersex youth, shall meet the following additional requirements:

(1) Lesbian, gay, bisexual, transgender, or intersex youth shall not be placed in particular housing, bed, or other assignments solely on the basis of such identification or status.

(2) In making housing and programming assignments for a transgender or intersex youth, including whether to assign the youth to a facility for male or female residents, the committee shall include input from a mental health professional and consider on a cases-by-case basis whether a placement would ensure a youth's health and safety, and whether the placement would present management or security problems.

(a) A transgender or intersex youth's own views on his or her own safety shall be given serious consideration.

(b) 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.

e. The written program plan shall be reviewed and approved by the Chief Administrative Officer or the Assistant Chief Administrative Officer (no designee) and a copy shall be filed in the youth's master file.

f. The youth and family specialist shall:

(1) Review the approved program plan with the youth and document such review; and

(2) Inform the youth how he or she may request a change in his or her program and that if a request is made and denied, the youth shall be given the basis for the denial in writing and a copy of the denial shall be placed in the youth's master file.

4. Review of Program Plan

a. At least once per calendar month, a documented staffing of a youth's progress in relation to the objectives detailed in his or her program plan shall be completed.

b. For transgender or intersex youth, at least twice per year, such documented staffing shall include a review of any threats to safety experienced by the youth and the youth's current housing and programming assignments.

c. The Chief Administrative Officer shall identify the cross disciplinary team who shall be responsible for reviewing the youth's program plan during the monthly staffing. All members of the cross disciplinary team and the youth shall attend staffings, in person or by phone, except when attendance is impracticable. This attendance shall be documented. A youth's assigned aftercare specialist shall participate in at least one staffing within the first three months after a youth's commitment and one staffing within the three months prior to a youth's expected release date. Youth who will require alternate placement will need close coordination between the youth center and aftercare.

d. The chairperson shall facilitate and moderate the staffing and shall ensure:

(1) Input is obtained from staff concerning the youth's progress or problems since the initial program review or the last progress review.

(2) Current youth performance is compared to stipulations in the written program plan.

(3) New youth program goals are negotiated or identified and the program plan is modified where appropriate.

(4) Requests for authorized absences are recommended, reviewed, and submitted to the Program Assignment Committee for processing.

(5) Recommendations for awarding sentencing credit are made to the Chief Administrative Officer, where appropriate.

(6) Recommendations for revising the projected Administrative Review Date are made to the Chief Administrative Officer based on programming concerns, where appropriate.

(7) Youth Requests, DJJ 0286, are reviewed and submitted to the Program Assignment Committee.

e. The documented staffing of a youth's program plan shall be filed in the master file.

5. Review of Social Information

The youth's youth and family specialist shall review the documents relating to social information and initiate any indicated changes or corrections in the reception and classification documents, face sheet, or offense history.

6. Youth and Youth and Family Specialist Contact

A youth and family specialist shall have frequent and consistent face to face contact, at least weekly, with each youth in order to gain a better understanding of the youth's needs, progress and the appropriateness of youth's current program plan. Such contact shall be documented in the cumulative counseling summary. The youth's youth and family specialist will complete a new Sexual Abuse Risk Screening at least every 6 months and when there reason to believe the information previously obtained has changed.

AD 04.01.303 – Lesbian, Gay, Bisexual, Transgender, Questioning, and Intersex (LBGTQI) Youth

I. POLICY

B. Policy Statement

The Department shall maintain and promote an environment that provides physical and emotional safety, and effective and culturally competent services and programming, to all youth regardless of their actual or perceived sexual orientation, gender identity, and/or gender expression.

AD 04.01.304 - Discrimination and Harassment of Youth
I. POLICY
B. Policy Statement
All youth are entitled to an environment free of discrimination and harassment.

AD 04.03.104 – Evaluations of Youth with Gender Dysphoria
I. POLICY
B. Policy Statement
The Department shall:
1. Provide appropriate accommodations and treatment for all youth who are identified as having gender identity issues, or who are diagnosed by the Department as having gender dysphoria; and
2. Extensively evaluate youth at a Reception and Classification Center to ensure appropriate youth center placement.
II. PROCEDURE
A. Purpose
The purpose of this directive is to establish a written procedure for conducting medical and mental health examinations of youth with gender dysphoria and to address adjustment to the youth center environment as it relates to the condition.
F. General Provisions
1. Youth who self-identify or are diagnosed as having gender dysphoria shall undergo a detailed medical history, physical examination, and mental health examination within 24 hours of arrival at Reception and Classification (R&C). This information will then be shared with the Health Care Unit Administrator who will contact the Facility Medical Director
H. Reception and Classification Requirements
1. The Chief Administrative Officer in consultation with the Facility Medical Director shall establish and maintain a written procedure for detailed medical and mental health examinations to be conducted during the reception and classification process of any youth who self-identifies or is diagnosed as having gender dysphoria. The procedure shall provide for the following:

a. Medical History

(1) As part of the detailed medical history obtained from the youth by a physician, including information about any past illnesses and family medical history, the physician shall also elicit information about:

(a) Sexual activity, specifically, homosexual, heterosexual, or bisexual activity;

(b) Previous operative procedures; and

(c) Hormone therapy.

(2) The physician shall also ask the youth other questions that would:

(a) Illuminate the youth's own sense of gender identity;

(b) Reveal any plans the youth may have with regard to future gender transition and/or cross-gender expression; and

(c) Reflect whether the youth has amended or plans to amend his or her state identification, driver's license, or original birth certificate.

b. Physical Examination

(1) The physician shall conduct a complete physical exam in accordance with physical exam guidelines noted in administrative directive 04.03.101.

(2) If possible, the physician shall contact the physician who was managing the youth's gender related treatment prior to placement in the custody of the Department for verification of the course of treatment and to obtain relevant medical records.

(3) The Facility Medical Director shall inform the youth of the Department's policy regarding gender reassignment surgery and hormone therapy

c. Mental Health Examination

(1) As part of the mental health examination, a psychiatrist shall evaluate the youth using the DSM-V criteria to determine if the youth has gender dysphoria and determine:

(a) The youth's competency;

(b) The youth's sexual activity, sexual orientation and current gender identification;

(c) The regularity and history of hormone therapy; and

(d) The presence or absence of any counseling activities and goals prior to placement in the custody of the Department.

(2) A Sexual Abuse Risk Screening, DJJ 0429, shall be completed in accordance with Administrative Directive 04.01.301.

2. Upon conclusion of the medical history and physical examination:

a. The Health Care Unit Administrator shall notify the Agency Medical Director the results of the history and physical examination including:

(1) Sex;

(2) Gender Identity;

(3) Sexual Orientation; and

(4) History of any medical or surgical treatment received for the gender dysphoria, including hormone therapy or gender reassignment surgery.

b. The Agency Medical Director shall document his or her preliminary recommendations, including, but not limited to, housing, showering restrictions and hormone therapy.

c. Upon receipt of the Agency Medical Director's determination, the Facility Medical Director shall:

(1) Document the recommendations of the Agency Medical Director in the progress notes of the medical record; and

(2) Notify the Health Care Unit Administrator and Mental Health Administrator of the preliminary recommendations of the Agency Medical Director.

3. The Health Care Unit Administrator shall notify the Supervisor or Administrator of the R & C of the determination of the youth's gender-related needs.
4. The Supervisor or Administrator of the R & C shall ensure the youth is housed in accordance with the youth's gender-related needs.

AD 01.07.110 – Record Maintenance – Master File Organization
II. Procedure
E. Master File Requirements
b. Bunk Issue Forms, DJJ 0428 and Sexual Abuse Risk Screenings, DJJ 0429 shall always be on the top of Section 2. The Bunk Issue Forms shall be placed on top of the Sexual Abuse Risk Screenings and previous Sexual Abuse Risk Screenings shall be maintained in the file.

Mental Health Protocol Manual SA-002 Risk of Victimization Screening Tool
DJJ Form 0429 – Screening Tool: Risk for Victimization
II. POLICY AND PROCEDURE
A. Upon admission to a Reception and Classification Center all youth shall be screened for risk of sexual abuse.
B. All youth shall be administered a Sexual Abuse Risk Screening, DJJ 0429, by a qualified staff member upon admission, and every six months afterwards until the youth's release from the facility.
C. Instructions for Screening:
1. Before discussing the screening with the youth, review the record to gather information for questions #1–4. For each of these questions, circle the appropriate response and write the corresponding score on the line for that question in the score column.
2. Once preliminary information listed above has been gathered, the assessor will meet with the youth to complete the screening process. At this time and if not already done, give the youth any available materials on how to report sexual abuse or harassment including the hotline phone number, the Department's zero tolerance policy, PREA, youth rights, etc.
3. Begin to establish rapport by conducting introductions and gathering background on the youth. Explain that the assessor will be asking some standard questions that are asked of every juvenile who is admitted to a DJJ youth center in order to facilitate the safety of every youth. (Note: For youth whose native language is Spanish, there should be Spanish interpretation available.)
4. For questions #5-11, ask the youth each question. Circle their response and write the corresponding score on the line for that question in the score column. If a youth's answer is contradictory to documented information in the record, note the contradiction and use the documented information to score.
5. The final question, #12, involves recording the staff perception of the youth. This addresses the likelihood that the youth will be able to "fit into" the youth center environment/culture. To answer, staff will need to observe physical features and behavior of the youth.
6. Once the assessor has responded to all of the questions on the screening tool and placed a score for each question on the line for that question in the score column, the assessor will need to tally the total of all the scores and place the total in the TOTAL SCORE line.
D. The scoring for the screening tool is as follows:
22+ = High risk for victimization
11-21 = Medium risk for victimization
0-10 = Low risk for victimization
E. Results from the assessment shall be reviewed by the Treatment Unit Administrator, or designated mental health professional, for mental health treatment considerations.

Mental Health Protocol MH-004 Mandated Abuse and Neglect Reporting
A. Incidents of child abuse, neglect, or inadequate supervision or a specific set of circumstances involving suspected child abuse, neglect, or inadequate supervision shall be reported to the Chief Administrative Officer (CAO), the Department of Child and Family Services (DCFS) Child Abuse Hotline and other appropriate officials and completely documented by the witnessing employee or volunteer or the employee or volunteer who received the notification of the same. The purpose of this directive is to establish a written procedure for reporting and documenting mandated abuse and neglect reports. This directive is applicable to all employee of the Illinois Department of Juvenile Justice (IDJJ). The Abused and neglected Child Reporting Act (ANCRA) defines mandated reporters as professionals who may work with children in the course of their professional duties.
B. All employees or volunteers within the department shall sign the CANTS 22 form indicating that they understand they are a mandated reporter during pre-service orientation.

Mental Health Protocol Manual SA-006 Youth Assessment and Screening Instrument
II. POLICY AND PROCEDURE
A. The Youth Assessment and Screening Instrument (YASI) is a risk assessment tool that measures the risk of recidivism. The tool includes static and dynamic content across ten domains including legal history, family, school, community and peers, alcohol and drugs, mental health, aggression, attitudes, social/cognitive skills, free time and employment.
B. The YASI includes both pre-screen and full assessment components and is used to assist in making initial service decisions as well as case plan development. YASI provides a graphic profile of risk, need, and strength results for each youth including overall static and dynamic scores on risk and protective factors.
C. All youth entering an Illinois Youth Reception and Classification Center shall be screened using the YASI.
D. The YASI pre-screening and full assessment shall be initiated by an assigned staff member who has received training in the administration of the instrument as part of the intake process.
E. The YASI assessment results shall be placed in the youth's medical file.

Form DJJ 0428 – Bunk Issues Criteria

The facility uses information from YASI and from the DJJ 0428 to determine proper housing, bed assignment, education, and other programs assignments with the goal of keeping all residents free from sexual abuse. The facility has a policy that residents at high risk of sexual abuse and sexually harassed are separated from residents who are at high risk of being sexually abusive. The facility prohibits the placement of lesbian, gay, bisexual, transgender, or intersex residents in particular housing, bed, or other assignments solely on the basis of such identification. The facility also prohibits considering lesbian, gay, bisexual, transgender, or intersex identification or status as an indicator of likelihood of being sexually abusive.

A Youth and Family Specialist reviews all housing and program assignments for transgender or intersex residents in the facility on a case-by-case basis, and continued follow-up and monitoring 30 days.

The facility reported that in the past 12 months no resident at risk of sexual victimization was placed in isolation.

During the on-site audit, the Auditor reviewed 10 random completed screening forms to verify that the facility uses information from the YASI risk screening and DJJ 0428 to inform housing, bed, education, and program assignments.

Staff interviews indicated that information from the risk screening assessment is used to determine where to place the child within the facility.

Interviews with the PREA Compliance Manager and Youth Family Specialist confirmed that risk screening is being completed pursuant to the agency's policy.

Compliance with this standard was determined through policy reviews, review of documentation, and interviews with specialized staff and resident.

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 – Sexual Abuse and Harassment Prevention and Intervention Program
II. PROCEDURE
F. General Provisions
2. The Sexual Abuse and Harassment Prevention and Intervention Program shall include, at a minimum:
f. Multiple internal ways for youth to privately report sexual abuse, sexual harassment, retaliation for reporting such incidents, and staff neglect or violation of responsibilities that may have contributed to such incidents.
g. A method to receive third-party reports of sexual abuse and sexual harassment made on behalf of a youth;
4. The Chief Administrative Officer of each youth center shall:
c. Ensure that youth are provided access to outside victim advocates for emotional support and medical advocacy services related to sexual abuse, by providing, posting, or otherwise making accessible mailing addresses and telephone numbers, including toll free hotline numbers where available, of local, State, or national advocacy or rape crisis organizations.
G. Requirements

5. Response Procedures
Youth center staff shall respond to any report, alleged, or possible sexual abuse or sexual harassment of a youth as provided in Administrative Directive 04.01.302.

Upon arrival each resident is provided with a copy of the Youth Orientation Handbook in English and in Spanish. The facility's zero tolerance policy is contained on page 7 in the Youth Orientation Handbook, and lists the following three options available to residents for reporting sexual abuse and sexual harassment: (1) reporting the incident on the sexual abuse toll-free hotline; (2) reporting to facility staff; and (3) sending confidential note or grievance. The Youth Orientation Handbook also contains a copy of the PREA posters in English (Attachment A, page 32) and Spanish (Attachment B, page 33), with the sexual abuse hotline phone number and the availability of advocacy services from The John Howard Association. Attachment C, page 35, to the Youth Orientation Handbook lists the three options (talking to facility staff, calling the toll-free sexual abuse hotline, and sending a grievance and/or confidential grievance) for reporting sexual abuse or sexual misconduct. Residents sign a form acknowledging that they received this information and understand it. There are PREA posters posted throughout the facility that provide residents with a telephone hot-line number for anonymously reporting sexual abuse or sexual harassment to Rape Victim Advocates, a private entity that is not part of the agency or facility. Staff are required to document all allegations of sexual abuse or sexual harassment made to them either verbally or in writing immediately or by the end of the shift on the same day. Staff are able to privately report sexual abuse and sexual harassment of residents to the Office of the Executive Inspector General. Staff are informed of these procedures by policy and during cycle training.

During the on-site audit, the Auditor viewed PREA posters, Rape Victim Advocates posters, John Howard Association posters, and other documents on display in all housing wings, the library, in all classrooms, gym, the dining room, visiting room, medical, mental health counselor offices, and in the hallways leading to these areas explaining methods for reporting sexual assault or sexual harassment.

Through telephone conversation with the Rape Victim Advocates, the Auditor confirmed they have agreed to receive reports from IYC Chicago residents and will immediately forward resident reports to the facility.

The facility does not accept residents detained solely for civil immigration purposes.

Through random staff and resident interviews it was determined that residents and staff can make private reports to any facility staff member and make anonymous calls to the Rape Victim Advocates.

At the time of the Audit, no verbal reports had been made to staff during the past 12 months prior to the audit.

Compliance with this standard was determined through policy reviews, review of documentation, observations made during the on-site audit, and interviews with staff, residents and advocacy services.

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 – Local Offender Grievance Procedure
II. Procedure
E. General Provisions
2. Offender grievances involving issues other than those listed in Paragraph II.E.1. and disciplinary reports shall be handled in accordance with the provisions of this directive.
3. Offender grievances must be filed within 60 days after the discovery of the incident, occurrence, or problem that gives rise to the grievance. Grievances not filed within this time frame shall be considered only if the offender can demonstrate good cause for the untimely filing. NOTE: that all grievances regarding sexual abuse, assault and sexual harassment will be considered emergency grievances by all Superintendents and investigated accordingly; and that there will be no time limit for the acceptance of any grievances regarding sexual abuse, sexual assault and sexual harassment.
4. Offenders shall be notified of the grievance procedures.
a. Written grievance procedures shall be available to all offenders.
b. Offenders who are unable to speak or read English may request that the procedure be explained in the offender's language.
5. Offender's Grievance, DOC 0046, shall be available to offenders in the living units and other locations approved by the Chief Administrative Officer.
6. Staff assistance shall be available as requested by any offender who is unable to prepare his or her grievance without assistance.
7. Staff shall be prohibited from reviewing and making a recommendation on a particular grievance in which he or she was directly involved, such as the subject of the grievance, a witness, the offender's counselor, or a member of the Program Unit or Adjustment Committee that heard the disciplinary report.
8. Staff shall be prohibited from imposing discipline due to use of the grievance process.
F. Requirements
1. The Chief Administrative Officer of each facility shall appoint two or more employees to serve as Grievance Officers.
2. The Chief Administrative Officer of each facility shall ensure that all staff legibly and accurately complete documents.
3. Reasonable efforts shall be made to resolve issues at the facility.
G. Grievance Process
Unless an offender can demonstrate delays due to good cause, only grievances filed within 60 days after the discovery of the incident, occurrence, or problem that gives rise to the incident shall be considered.
1. Offenders who are seeking resolution for non-resolved issues must:
a. Legibly complete an Offender's Grievance, DOC 0046, for all grievances other than protective custody denials. Grievances concerning protective custody denials shall be documented on the Protective Custody Status, DOC 0054.
b. Submit the grievance form and other pertinent information such as the disciplinary report, Program Unit or Adjustment Committee summary, or contraband slip to the:
(1) Chief Administrative Officer for emergency grievances in which there is substantial risk of imminent personal injury or other serious or irreparable harm to self.
(2) Administrative Review Board (ARB) for issues involving transfer denials by the Transfer Coordinator; involuntary administration of psychotropic medications; protective custody; another facility other than for personal property issues; or grievances not resolved by the Chief Administrative Officer.
(3) Counselor for all issues except those issues addressed in Paragraph II. E.1. and issues involving discipline.
(4) Grievance Officer for issues involving discipline at the present facility or issues that have not been resolved by the Counselor.
2. For issues being sent to the Chief Administrative Officer:
a. The Chief Administrative Officer shall review the offender's grievance to determine if there is a substantial risk of imminent personal injury or other serious harm to the offender. The Chief Administrative Officer shall document the review and determination in the "Emergency Review" section of the grievance form.
(1) If the grievance is marked as an emergency and is substantiated, the Chief Administrative Officer shall expedite the grievance review and response process. The Chief Administrative Officer shall notify the offender in writing of the decision.
(2) If the emergency grievance is not substantiated, the Chief Administrative Officer shall so indicate in writing and return the grievance form to the offender.
b. If the offender rejects the Chief Administrative Officer's decision, he or she must forward a copy of the grievance form that includes the Chief Administrative Officer's decision to the emergency request through the normal review process.
3. For issues being sent to the ARB, the ARB shall review and respond to the grievances in accordance with Administrative Directive 04.01.115.
4. For issues being sent to the Counselors:
a. The Counselor shall:
(1) Confer with the offender, if necessary, and clarify and attempt to resolve the issues grieved;
b. If the offender rejects the Counselor's response, he or she must forward a copy of the grievance form that includes the Counselor's Response to the Grievance Officer.

20 Illinois Administrative Code Section 2504 – Subpart C: Grievance Procedures for Youth
Section 2504.310 Filing of Grievances
a) A youth shall first attempt to resolve incidents, problems, or complaints other than complaints concerning disciplinary proceedings through his or her counselor. If a youth is unable to resolve the complaint informally or if the complaint concerns a disciplinary proceeding, the individual may file a written grievance on a grievance form that shall be made available in all living units. A grievance shall be filed within 60 days after the discovery of the incident, occurrence, or problem that gives rise to the grievance. However, if a youth can demonstrate that a grievance was not timely filed for good cause, the grievance shall be considered. The grievance

procedure shall not be utilized for complaints regarding decisions that are outside the authority of the Department, such as parole or aftercare decisions, clemency, or orders regarding length of sentence or decisions that have been rendered by the Director.
b) The grievance form shall be addressed to the Grievance Officer and shall be deposited in the living unit mailbox or other designated repository. The grievance shall contain factual details regarding each aspect of the youth's complaint, including what happened, when, where, and the name of each person who is the subject of or who is otherwise involved in the complaint. This provision does not preclude a youth from filing a grievance when the names of individuals are not known, but the youth must include as much descriptive information about the individual as possible.
c) Staff assistance shall be available as requested by those youth who cannot prepare their grievances unaided as determined by institutional staff.
1) All youth shall be entitled to file grievances regardless of their disciplinary status or classification.
2) Each youth center shall take reasonable steps to ensure that the grievance procedure is accessible to youth who are impaired, disabled, or unable to communicate in the English language.
d) Youth shall be informed of the grievance procedure at the admitting facility and may request further information regarding the procedure from their counselors.
1) The written procedure shall be available to all youth.
2) A youth unable to speak or read the English language may request that the procedure be explained in the individual's own language.
Section 2504.320 Grievance Officer
a) The Chief Administrative Officer shall appoint 2 or more employees who may serve as a Grievance Officer to attempt to resolve problems, complaints, and grievances that youth have been unable to resolve through routine channels.
b) No person who is directly involved in the subject matter of the grievance or who was a member of the Adjustment Committee that heard a disciplinary report concerning the grievance may serve as the Grievance Officer reviewing that particular case.
Section 2504.330 Grievance Procedures
b) The Grievance Officer shall promptly submit a copy of any grievance alleging discrimination based on disability or a request for an accommodation based upon disability to the facility ADA Coordinator. The facility ADA Coordinator shall conduct such investigation as deemed appropriate and make written recommendations to the Chief Administrative Officer for resolution of the grievance.
Section 2504.340 Emergency Procedures
A youth may request a grievance be handled on an emergency basis by forwarding the grievance directly to the Chief Administrative Officer.
a) If the Chief Administrative Officer determines that there is a substantial risk of imminent personal injury or other serious or irreparable harm to the youth, the grievance shall be handled on an emergency basis.
b) The Chief Administrative Officer shall expedite processing of the grievance and respond to the youth, indicating what action shall be or has been taken.
Section 2504.360 Records
Records regarding the filing and disposition of grievances shall be maintained in the youth's master file.

The Auditor was provided and reviewed the agency's Grievance Procedure for compliance with this standard, and the proposed revisions to 20 Illinois Administrative Code Section 2504, Subpart C: Grievance Procedures for Youth, that will be submitted for approval by the Illinois legislature to bring the statute in compliance with this standard. In the meantime, during the interview with the agency Director, the Auditor confirmed that residents will not have to first resolve their grievances informally through their counselor, that all grievances regarding sexual assault and sexual harassment will be considered emergency grievances by all Superintendents and investigated accordingly; and that there will be no time limit for the acceptance of any grievances regarding sexual abuse and sexual assault. The facility Superintendent also confirmed that he treats all grievances regarding sexual assault and sexual harassment as emergency grievances, a resident will not have to first resolve their grievance informally through their counselor, and the facility will investigate all grievances alleging sexual abuse and sexual harassment according to policy and procedure even though the grievance incident may be past the 60-day time limit. During the audit the Auditor was provided with a copy of the revisions to AD 04.01.114, included above, that brings the agency and facility into compliance with this standard.

Residents are not required to use an informal grievance process in order to file a formal grievance. Information about the grievance process is contained on page 29 of the Youth Orientation Handbook.

The Auditor was able to determine through interviews with random residents that residents are aware of the grievance process.

As of the date of the audit, the facility received one grievances alleging sexual abuse had been filed with facility staff, and facility staff had received one emergency grievances alleging substantial risk of imminent

sexual abuse within the past 12 months. During the on-site audit the Auditor reviewed this grievance for compliance with this standard.

Compliance with this standard was determined through policy reviews, review of documentation, and interviews with staff and residents.

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.

AD 05.01.106 – Offender Visitors
II. PROCEDURE
E. Definitions
Legal visitor - for purposes of this directive shall include visitors relating to the legal representation of the offender by the offender's attorney or an associate attorney, student lawyer certified under Supreme Court Rule 711, paralegals, law clerks, or investigators. An associate, student lawyer, paralegal, law clerk or investigator must be acting on behalf of the offender's attorney and be associated with the attorney's law firm or government agency. It shall not include social workers, psychiatrists, or psychologists, etc. employed or contracted by the law firm or government agency for legal purposes nor does it include attorneys or their associates that request to interview an offender as a possible witness in another individual's case.
F. General Provisions
1. During reception to the Department and during orientation to each newly assigned facility, each offender shall be required to complete an Offender Visiting List, DOC 0004, indicating adults, excluding children under 17 years of age, government officials, and legal visitors, with whom the offender wishes to visit. A form shall be completed and signed by every offender even if no visitors are requested. If the offender refuses to sign, a staff member shall so indicate and sign and date the DOC 0004.

AD 04.01.301 – Sexual Abuse and Harassment Prevention and Intervention Program
II. PROCEDURE
F. General Provisions
2. The Sexual Abuse and Harassment Prevention and Intervention Program shall include, at a minimum:
f. Multiple internal ways for youth to privately report sexual abuse, sexual harassment, retaliation for reporting such incidents, and staff neglect or violation of responsibilities that may have contributed to such incidents.
g. A method to receive third-party reports of sexual abuse and sexual harassment made on behalf of a youth;
4. The Chief Administrative Officer of each youth center shall:
c. Ensure that youth are provided access to outside victim advocates for emotional support and medical advocacy services related to sexual abuse, by providing, posting, or otherwise making accessible mailing addresses and telephone numbers, including toll free hotline numbers where available, of local, State, or national advocacy or rape crisis organizations.
e. Identify community agencies that may provide assistance to staff or youth in the prevention or intervention of sexual abuse and sexual harassment.
5. The Facility PREA Compliance Manager shall:
b. Identify community resources available for the provision or development of counseling and treatment services to youth.
2. Youth Education
a. Upon admission to Classification and Reception, staff shall provide a brief presentation regarding HIV Disease, the Department's zero tolerance policy, and the youth center's Sexual Abuse and Harassment Prevention and Intervention Program. Youth shall be told how to report sexual abuse or harassment and informed that victims need not name their attacker to receive medical and mental health services.
b. Within 10 days of intake, youth shall be provided with comprehensive, age-appropriate education either in person or through video regarding:
1) Their rights to be free from sexual abuse, sexual harassment, and retaliation for reporting such incidents;
2) The Department's policies and procedures for responding to such incidents;
3) How to report incidents of sexual abuse, sexual harassment, and retaliation; and

4) How to access an outside victim advocate.

c. Such information shall also be provided to the youth, upon arrival at the assigned youth center, in the youth handbook and in the orientation program.

G. Requirements

4. Confidential Communication with Outside Victim Advocates

Chief Administrative Officers shall establish local policies and procedures that enable reasonable communication between residents and these organizations in as confidential a manner as possible.

a. Such polices shall prohibit any auditory monitoring of such conversations, unless failing to do so in a particular case would present a safety or security risk.

b. Youth shall be informed, 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 to mandatory reporting laws.

Mental Health Protocol Manual SA-002 Risk of Victimization Screening Tool

II. POLICY AND PROCEDURE

C. Instructions for Screening:

2. Once preliminary information listed above has been gathered, the assessor will meet with the youth to complete the screening process. At this time and if not already done, give the youth any available materials on how to report sexual abuse or harassment including the hotline phone number, the Department's zero tolerance policy, PREA, youth rights, etc.

During the on-site audit, the Auditor reviewed the Memorandum of Understanding with the Rape Victim Advocates, located in Chicago, to provide outside confidential support services. Upon arrival each resident is provided with a copy of the Youth Orientation Handbook where a copy of the PREA posters (shown in English as Attachment A, page 32 and in Spanish as Attachment B, page 33), listing the sexual abuse hotline phone number and the availability of advocacy services from The John Howard Association.

During the on-site audit, the Auditor observed posters displaying the contact information in all housing wings, dining room, kitchen, library, all classrooms, gym, medical and mental health areas, and hallways of the facility.

The Auditor was able to determine through interviews with random staff and residents that residents are aware of how to access outside confidential support services in cases of sexual abuse and where the telephone numbers are located.

Compliance with this standard was determined through policy reviews, review of documentation, observations made during the on-site audit, and interviews with staff and residents.

Standard 115.354 Third-party reporting.

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

AD 04.01.301 – Sexual Abuse and Harassment Prevention and Intervention Program

II. PROCEDURE

F. General Provisions

2. The Sexual Abuse and Harassment Prevention and Intervention Program shall include, at a minimum:

g. A method to receive third-party reports of sexual abuse and sexual harassment made on behalf of a youth;

j. Services available to youth following a sexual abuse and/or sexual harassment;

k. Provided with information regarding outside community resources related sexual abuse and harassment support and advocacy services upon release or discharge from a Youth Center

4. The Chief Administrative Officer of each youth center shall:

c. Ensure that youth are provided access to outside victim advocates for emotional support and medical advocacy services related to sexual abuse, by providing, posting, or otherwise making accessible mailing addresses and telephone numbers, including toll free hotline numbers where available, of local, State, or national advocacy or rape crisis organizations.

e. Identify community agencies that may provide assistance to staff or youth in the prevention or intervention of sexual abuse and sexual harassment.

f. Ensure youth receive the information and educational opportunities required by paragraph G.2

G. Requirements

The Chief Administrative Officer of each youth center shall ensure that a written procedure is developed that includes the following applicable requirements.

2. Youth Education

a. Upon admission to Classification and Reception, staff shall provide a brief presentation regarding HIV Disease, the Department's zero tolerance policy, and the youth center's Sexual Abuse and Harassment Prevention and Intervention Program. Youth shall be told how to report sexual abuse or harassment and informed that victims need not name their attacker to receive medical and mental health services.

b. Within 10 days of intake, youth shall be provided with comprehensive, age-appropriate education either in person or through video regarding:

3) How to report incidents of sexual abuse, sexual harassment, and retaliation; and

4) How to access an outside victim advocate.

c. Such information shall also be provided to the youth, upon arrival at the assigned youth center, in the youth handbook and in the orientation program.

e. Key information shall be continuously and readily available or visible to residents through posters or other written formats.

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. The agency's website at www.illinois.gov/idjj/Pages/PrisonRapeEliminationAct.aspx also provides a way for third-party reporting by calling into a specific telephone number and the address at the bottom of the page.

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. The agency's website at www.illinois.gov/idjj/Pages/PrisonRapeEliminationAct.aspx also provides a way for third-party reporting by calling into a specific telephone number and the address at the bottom of the page.

During the on-site audit, the Auditor observed posters providing the DCFS hotline telephone number and address to report allegations of sexual abuse or sexual harassment to the John Howard Association and Ombudsman throughout the facility (including visitation, housing cottages, classrooms, library, gym, and dining room) with information on how to report resident sexual abuse or sexual harassment on behalf of a resident, including the telephone hot-line number and address to report allegations of sexual abuse or sexual harassment. The agency's website at www.illinois.gov/idjj/Pages/PrisonRapeEliminationAct.aspx also provides a way for third-party reporting by calling into a specific telephone number and the address at the bottom of the page.

The Auditor was able to determine through interviews with random residents and staff that both residents and staff are of the procedures for third-party reporting.

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 01.12.105 – Reporting Unusual Incidents
II. PROCEDURE
F. Types of Incidents and Immediate Reporting
1. The Chief Administrative Officer, or his or her designee, shall report immediately, by telephone, to the Deputy Director of the appropriate division any of the following types of incidents or situations that involve a youth or an employee on duty or on site:

a. A youth's physical assault on another youth or an employee where serious injury results;

b. An employee's physical assault on another employee;

J. Reporting of Sexual Abuse and Sexual Harassment
In addition to the procedures listed in this directive, the procedures for responding to allegations or reports of sexual abuse or sexual harassment listed in Administrative Directive 04.01.302 shall be followed.

AD 01.12.135 – Reporting of Child Abuse and Neglect
II. PROCEDURE
F. Requirements
1. All Department employees or volunteers shall sign the CANTS 22 form indicating that they understand they are a mandated reporter during pre-service orientation.
2. Each employee shall have training on how to be a mandated reporter within one year of initial employment and once every five years of service.
5. The witnessing employee or volunteer shall provide the Hotline with the following information, if available:

a. The names, dates of birth, races, and genders for all adult and child subjects;

b. The adult and child subjects' addresses;

c. Information about the child's siblings and other family members; and

d. Specific information about the allegedly abusive incident or circumstances contributing to a substantial risk of harm, including any evidence of any previous injuries or disabilities.

5. The following steps shall be followed upon discovery of an incident of possible child abuse or neglect:

a. The witnessing employee or volunteer shall immediately notify his or her immediate supervisor.

b. The witnessing employee or volunteer and the supervisor will contact the Chief Administrative Officer

c. The Chief Administrative Officer will review the incident with the appropriate Deputy Director. If a Deputy Director cannot be contacted, the Chief Administrative Officer shall contact the Director.

e. The witnessing employee or volunteer shall:

1. Call the Child Abuse Hotline and report the facts listed in paragraph II.F.5.

2. Record the name of the Department of Children and Family Services staff contacted and the time and date of the telephone report.

3. Take notes during the conversation and submit this information to the supervisor who will then provide it to the Chief Administrative Officer.

Note: When more than one employee or volunteer is a witness, when possible, the person with the most direct knowledge of the suspected abuse or neglect should be the one to make the call and complete the written confirmation in paragraph F.5.f.below.

f. Within 48 hours of the initial report to the Hotline the witnessing employee or volunteer will complete and send via U.S. mail to DCFS the CANTS 4 form, used by medical staff, or the CANTS 5 form, used by other mandated reporters. The forms are to be completed and signed by the person making the initial report.

g. The Chief Administrative Officer shall ensure that any initial Incident Reports, DJJ 0434, are completed and transmitted via e-mail to the Deputy Director by the next working day. The initial report may be designated as the final report.

AD 04.01.302 – Sexual Abuse and Harassment – Response Procedures
II. PROCEDURE
A. Purpose
The purpose of this directive is to establish internal instructions to coordinate actions taken in response to an incident of sexual abuse or sexual harassment among staff first responders, medical and mental health practitioners, investigators, and facility leadership.
E. Requirements
The Chief Administrative Officer of each youth center shall ensure that a written procedure is developed that includes the following applicable requirements.
2. Internal Reporting

a. All staff shall immediately report through chain of command as an unusual incident in accordance with Administrative Directive 01.12.105 the following:

(1) Any knowledge, suspicion or information they receive regarding a possible incident of sexual abuse or sexual harassment that occurred at any youth center or other correctional setting;

(2) Retaliation against youth or staff who reported such incident; and

(3) Any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation.

b. All staff shall accept reports made verbally, in writing, anonymously and from third parties, shall promptly ensure that an incident report is completed.

c. All staff who observe alleged or possible sexual abuse and/or sexual harassment or to whom the initial report was made and who were otherwise involved in or responded to an incident shall complete an incident report and may be required to be interviewed by an investigator or other staff designated by the Chief Administrative Officer prior to leaving the youth center at the end of their shift.

d. The Shift Supervisor shall immediately contact the Facility PREA Compliance Manager upon receiving such report.

5. Notification to Third Parties

a. Upon receiving a report of an alleged sexual abuse, the Chief Administrative Officer shall:

(1) If the alleged victim is under 18 years old, promptly report allegations of youth sexual abuse to the alleged victim's parents, legal guardians, unless there is official documentation showing they should not be notified, or the DCFS caseworker where applicable.

(2) Within 14 days, report to the youth's attorney or legal representative of record.

(3) If the sexual abuse is alleged to have occurred in a correctional setting, regardless of whether it was a DJJ youth center, notify the head of the facility or appropriate office of the agency where the alleged abuse occurred as soon as possible, but no later than 72 hours after receiving the allegation.

b. If an employee is a mandated reporter under the Abused and Neglected Child Reporting Act and suspects that an incident of child abuse or neglect has occurred, the employee shall first comply with the requirements for internal reporting and first responder duties in E.2.a. and E.6.a., and then the employee shall call the Child Abuse Hotline.

5. Confidentiality

a. All staff are prohibited from revealing any information related to a sexual abuse report to anyone, except as provided in this Administrative Directive or when otherwise necessary to make treatment, investigative, or other security or management decisions.

7. Investigation and Referral for Discipline or Prosecution

a. In investigating alleged or possible sexual abuse, investigators shall collect and tag evidence from the scene in accordance with Administrative Directive 01.12.112.

b. An investigation of all alleged and possible sexual abuse or sexual harassment shall be conducted in accordance with Administrative Directive 01.12.120, except the initial report shall be provided to the Chief Administrative Officer within 24 hours of the onset of the investigation. When notified, the Chief Administrative Officer shall notify the Deputy Director.

AD 04.01.304 – Discrimination and Harassment of Youth

II. PROCEDURE

H. Response Procedures

1. A youth may make a verbal and/or written complaint of harassment and/or discrimination under this policy to any employee for themselves or on behalf of another youth.

2. Witnessing Youth on Youth Harassment:

a. Any employee or volunteer who observes a youth harassing another youth shall:

i. Directly and clearly express objection to the offending youth and request that the behavior stop; and

ii. Complete disciplinary reports and unusual incident reports, as appropriate under the circumstances.

3. Incidents of Discrimination or Harassment by Employees or Volunteers:

a. Any employee who witnesses, suspects, receives a complaint from a youth, or is otherwise made aware of potential discrimination or harassment of a youth shall promptly:

i. Separate the individuals involved, if necessary;

ii. Report through the chain of command as an unusual incident in accordance with Administrative Directive 01.12.105;

iii. Advise the victim of his or her right to file a grievance pursuant to Administrative Directive 04.01.114; and

iv. Ensure the incident is documented on a DJJ 0434, Incident Report, by the end of his or her shift.

b. Any volunteer who witnesses, suspects, receives a complaint from a youth, or is otherwise made aware of potential discrimination or harassment of a youth shall promptly report the incident to a Shift Supervisor, Duty Administrative Officer, or Chief Administrative Officer.

I. Investigation

1. All alleged and reported incidents of discrimination or harassment shall be investigated in accordance with Administrative Directive 01.12.120.

3. Complaints made by youth under this policy are confidential except to the extent needed to report, investigate, and resolve the complaint. Complaints made by youth under this policy shall be kept separate from youth Master Record Files. Complaints shall be maintained by the Chief Administrative Officer of each youth center in a secure location.

AD 03.02.108 – Standards of Conduct

G. Requirements

g. Employees shall respect the confidentiality of information and are prohibited from accessing or disclosing information such as, but not limited to, investigations, youth records and personnel issues, except to the extent needed in the performance of their job duties.

Mental Health Protocol MH-004 Mandated Abuse and Neglect Reporting

II. Policy and Procedure

A. Incidents of child abuse, neglect, or inadequate supervision or a specific set of circumstances involving suspected child abuse, neglect, or inadequate supervision shall be reported to the Chief Administrative Officer (CAO), the Department of Child and Family Services (DCFS) Child Abuse Hotline and other appropriate officials and completely documented by the witnessing employee or volunteer or the employee or volunteer who received the notification of the same. The purpose of this directive is to establish a written procedure for reporting and documenting mandated abuse and neglect reports. This directive is applicable to all employee of the

Illinois Department of Juvenile Justice (IDJJ). The Abused and neglected Child Reporting Act (ANCRA) defines mandated reporters as professionals who may work with children in the course of their professional duties.
B. All employees or volunteers within the department shall sign the CANTS 22 form indicating that they understand they are a mandated reporter during pre-service orientation.
C. Requirements regarding reporting:

1. An incident is reportable only if the alleged victim is a child under the age of 18 and the alleged perpetrator is:
a. a parent;
b. a legal guardian;
c. immediate family member;
d. any person responsible for the child's welfare;
e. any individual residing in the same home as the child;
f. a paramour of the child's parent; or
g. a youth committed to the custody of the Department who is 18 years of age or older.
2. The witnessing employee or volunteer should be able to provide the Hotline with:
a. The names, dates of birth, races, and genders for all adults and child subjects, if available;
b. The adult and child subjects' addresses;
c. The information about the child's siblings and other family members, if available; and
d. Specific information about the allegedly abusive incident or circumstances contributing to a substantial risk of harm, including any evidence of any previous injuries or disabilities, if available.
3. The following steps shall be followed upon discovery of an incident of possible child abuse or neglect:
a. Immediately contact a supervisor.
b. The reporting employee or volunteer and the supervisor will contact the CAO.
c. The CAO will notify and review the case with the Deputy Director of Programs or Deputy Director of Operations for IDJJ. If neither Deputy Directors can be contacted, the CAO shall contact the Director.
d. The reporting employee or volunteer will, call DCFS at the hotline number 1-800-252-2873 or 1-800-25-ABUSE. Report the facts as listed above when available.
e. Record the name of the DCFS person contacted. Record the time and date of the telephone report. Take notes of the conversation. Submit this information to the supervisor who will then provide it to the Superintendent or CAO. Keep a copy for the file, along with the copy of the incident report.
f. The reporting employee or volunteer will complete the CANTS 5 forms within 48 hours of the initial report and mailed to DCFS.

IYC-Chicago PREA Response Plan
<u>Immediate Staff Response</u>
1. Upon knowledge of an allegation that a resident was sexually abused, the first staff member to response to the report shall be required to:

- Separate the alleged victim and abuser. Ensure the alleged victim is in a safe environment (such as health care unit) immediately following the reporting of the alleged incident.
- Preserve and protect any crime scene until appropriate steps can be taken to collect evidence.
- Request the alleged victim and the alleged abuser does not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, drinking or eating.
- If the first person responding (made aware of the allegation) is not a security staff member, the responder shall be required to request that the alleged victim not take any actions that could destroy physical evidence and then notify security staff.

2. Upon knowledge of an alleged incident of sexual abuse or harassment, IYC-Chicago staff will immediately report the alleged or suspected incident to the Shift Supervisor. No other information regarding the incident will be reported to anyone other than to the extent necessary to treat, investigate and make other security management decisions. This will be done without retaliation against youth or staff.
3. The Shift Supervisor will ensure the area of the alleged occurrence is secured (if applicable).
4. In instances where there is a crime scene, the area will be preserved and protected until appropriate steps can be taken to collect evidence by those trained in evidence collection.
5. The Shift Supervisor will immediately notify the DAO (who will notify Intel) and Dr. Murphy.

Agency and facility policies 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. All staff are 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.

Through interviews with a random sample of staff, as well as interviews with medical and mental health staff, it was determined that all staff have a duty to immediately report any knowledge, suspicion, or information related to sexual abuse or sexual harassment. Staff is also required to report any retaliation towards any inmate or staff for reporting and any staff neglect that may have contributed to an incident or retaliation.

Compliance with this standard was determined through policy reviews, review of documentation, observations made during the on-site audit, and interviews with staff and residents.

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 – Sexual Abuse and Harassment – Response Procedures
II. PROCEDURE
E. Requirements
The Chief Administrative Officer of each youth center shall ensure that a written procedure is developed that includes the following applicable requirements.
1. Intervention
a. Any youth who alleges to be a victim of sexual abuse and/or sexual harassment shall be:
(1) Promptly offered protection from the alleged assailant and the incident shall be investigated
(2) Evaluated by mental health services to assess the need for counseling and support services, such as psychological or chaplaincy services, group therapy, etc. If sexual abuse is alleged, the Crisis Intervention Team or mental health professional shall be immediately notified and shall respond pursuant to Administrative Directive 04.04.102.

AD 04.01.301 – Sexual Abuse and Harassment Prevention and Intervention Program
F. General Provisions
4. The Chief Administrative Officer of each youth center shall:
d. Provide notification to outside parties and alleged victims still in the Department's custody as provided in Administrative Directive 04.01.302 and document all such notifications or attempted notifications.
G. Requirements
The Chief Administrative Officer of each youth center shall ensure that a written procedure is developed that includes the following applicable requirements.

Mental Health Protocol MH-004 Mandated Abuse and Neglect Reporting
II. Policy and Procedure
A. Incidents of child abuse, neglect, or inadequate supervision or a specific set of circumstances involving suspected child abuse, neglect, or inadequate supervision shall be reported to the Chief Administrative Officer (CAO), the Department of Child and Family Services (DCFS) Child Abuse Hotline and other appropriate officials and completely documented by the witnessing employee or volunteer or the employee or volunteer who received the notification of the same. The purpose of this directive is to establish a written procedure for reporting and documenting mandated abuse and neglect reports. This directive is applicable to all employee of the Illinois Department of Juvenile Justice (IDJJ). The Abused and neglected Child Reporting Act (ANCRA) defines mandated reporters as professionals who may work with children in the course of their professional duties.
B. All employees or volunteers within the department shall sign the CANTS 22 form indicating that they understand they are a mandated reporter during pre-service orientation.

Through interviews with a random staff, it was determined that all staff 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 they would take immediate action to protect the resident.

As of the date of the audit, the facility reported in the past 12 months no resident has been determined to have been subject to substantial risk of imminent sexual abuse, and action would have been taken immediately if a report had been made.

Compliance with this standard was determined through policy reviews, review of documentation, and interviews with staff and residents.

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 – Sexual Abuse and Harassment – Response Procedures
II. PROCEDURE
A. Purpose
The purpose of this directive is to establish internal instructions to coordinate actions taken in response to an incident of sexual abuse or sexual harassment among staff first responders, medical and mental health practitioners, investigators, and facility leadership.
E. Requirements
The Chief Administrative Officer of each youth center shall ensure that a written procedure is developed that includes the following applicable requirements.
1. Intervention
d. The youth's housing needs shall be reviewed to determine appropriate placement.
(1) If the youth is transferred to another youth center, the Facility PREA Compliance Manager of the sending youth center shall promptly notify the Facility PREA Compliance Manager of the receiving youth center of the alleged sexual abuse and/or sexual harassment to ensure the youth receives proper follow-up services.

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 Superintendent of IYC Chicago. A resident who reports previous sexual abuse/sexual assault will have support services made available to him/her, including counseling and outside confidential support groups.

As of the date of the audit, the facility reported within the past 12 months they have not received any allegation that a resident was abused while confined at another facility, and they have not received any allegation from other facilities of sexual abuse.

Compliance with this standard was determined through policy reviews, and interviews with staff.

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 04.01.302 – Sexual Abuse and Harassment – Response Procedures
II. PROCEDURE
A. Purpose
The purpose of this directive is to establish internal instructions to coordinate actions taken in response to an incident of sexual abuse or sexual harassment among staff first responders, medical and mental health practitioners, investigators, and facility leadership.
E. Requirements
The Chief Administrative Officer of each youth center shall ensure that a written procedure is developed that includes the following applicable requirements.
1. Intervention
a. Any youth who alleges to be a victim of sexual abuse and/or sexual harassment shall be:
(1) Promptly offered protection from the alleged assailant and the incident shall be investigated
(2) Evaluated by mental health services to assess the need for counseling and support services, such as psychological or chaplaincy services, group therapy, etc. If sexual abuse is alleged, the Crisis Intervention Team or mental health professional shall be immediately notified and shall respond pursuant to Administrative Directive 04.04.102.
2. Internal Reporting
a. All staff shall immediately report through chain of command as an unusual incident in accordance with Administrative Directive 01.12.105 the following:
(1) Any knowledge, suspicion or information they receive regarding a possible incident of sexual abuse or sexual harassment that occurred at any youth center or other correctional setting;
(2) Retaliation against youth or staff who reported such incident; and
(3) Any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation.
b. All staff shall accept reports made verbally, in writing, anonymously and from third parties, shall promptly ensure that an incident report is completed.
c. All staff who observe alleged or possible sexual abuse and/or sexual harassment or to whom the initial report was made and who were otherwise involved in or responded to an incident shall complete an incident report and may be required to be interviewed by an investigator or other staff designated by the Chief Administrative Officer prior to leaving the youth center at the end of their shift.
d. The Shift Supervisor shall immediately contact the Facility PREA Compliance Manager upon receiving such report.
3. Sexual Abuse Medical Treatment
Medical treatment shall be provided, without financial cost, to any youth who is the alleged victim of a sexual abuse.
a. 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 a community hospital for a forensic medical examination. The youth shall be escorted to the hospital as soon as possible in accordance with the procedures provided for an emergency escorted medical furlough in Administrative Directive 05.03.124, except that:
(1) A strip search shall not be conducted
(2) Security restrains shall not be used, unless failing to do so would present a safety or security risk; and
(3) Security staff shall not be in the exam room with the youth when the exam is being conducted or when mental health staff or a victim advocate is present in the exam room, unless requested by the youth.
b. If the sexual abuse is not recent, medical treatment may be provided on site, at another youth center, or at a community hospital as determined by the parent youth center.
6. First Responder Duties
a. The first security staff member to respond to an alleged or possible sexual abuse shall:
(1) Separate the alleged victim and abuser;
(2) Preserve and protect the crime scene until appropriate steps can be taken to collect any evidence; and
(3) If the abuse occurred within a time period that still allows for the collection of physical evidence, request that the alleged victim and ensure that the alleged abuser does not take any actions that could destroy physical evidence including, as appropriate, washing, brushing teeth, changing cloths, urinating, defecating, smoking, drinking or eating.
If the first staff member to respond is not a security staff member, the responder shall request that the alleged victim not take any actions that could destroy physical evidence and then notify security staff.

AD 04.01.304 – Discrimination and Harassment of Youth
II. PROCEDURE
F. Training
1. Training on the Department's discrimination and harassment policy shall be included in pre-service and annual cycle training for employees and in volunteer orientation. This training shall include what behavior constitutes discrimination and harassment and procedures for preventing, addressing, and reporting discrimination and harassment.

2. All employees with supervisory responsibilities shall receiving additional training that includes strategies for maintaining an environment free of discrimination and harassment and the handling of complaints. This training shall be completed within the first six months of initial appointment to a supervisory position.
H. Response Procedures
1. A youth may make a verbal and/or written complaint of harassment and/or discrimination under this policy to any employee for themselves or on behalf of another youth.
2. Witnessing Youth on Youth Harassment:
a. Any employee or volunteer who observes a youth harassing another youth shall:
i. Directly and clearly express objection to the offending youth and request that the behavior stop; and
ii. Complete disciplinary reports and unusual incident reports, as appropriate under the circumstances.
3. Incidents of Discrimination or Harassment by Employees or Volunteers:
a. Any employee who witnesses, suspects, receives a complaint from a youth, or is otherwise made aware of potential discrimination or harassment of a youth shall promptly:
i. Separate the individuals involved, if necessary;
ii. Report through the chain of command as an unusual incident in accordance with Administrative Directive 01.12.105;
iii. Advise the victim of his or her right to file a grievance pursuant to Administrative Directive 04.01.114; and
iv. Ensure the incident is documented on a DJJ 0434, Incident Report, by the end of his or her shift.
b. Any volunteer who witnesses, suspects, receives a complaint from a youth, or is otherwise made aware of potential discrimination or harassment of a youth shall promptly report the incident to a Shift Supervisor, Duty Administrative Officer, or Chief Administrative Officer.

AD 04.01.301 – Sexual Abuse and Harassment Prevention and Intervention Program
II. PROCEDURE
G. Requirements.
3. Training
All employees who may have contact with youth shall receive Prison Rape Elimination Act (PREA) training in the initial pre-service training and annually thereafter, on the following topics:
b. How to fulfill responsibilities under this sexual abuse and harassment prevention and intervention program, including the response procedures provided in Administrative Directive 04.01.301;

IYC-Chicago PREA Response Plan
Immediate Staff Response
1. Upon knowledge of an allegation that a resident was sexually abused, the first staff member to response to the report shall be required to:
- Separate the alleged victim and abuser. Ensure the alleged victim is in a safe environment (such as health care unit) immediately following the reporting of the alleged incident.
- Preserve and protect any crime scene until appropriate steps can be taken to collect evidence.
- Request the alleged victim and the alleged abuser does not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, drinking or eating.
- If the first person responding (made aware of the allegation) is not a security staff member, the responder shall be required to request that the alleged victim not take any actions that could destroy physical evidence and then notify security staff.

2. Upon knowledge of an alleged incident of sexual abuse or harassment, IYC-Chicago staff will immediately report the alleged or suspected incident to the Shift Supervisor. No other information regarding the incident will be reported to anyone other than to the extent necessary to treat, investigate and make other security management decisions. This will be done without retaliation against youth or staff.
3. The Shift Supervisor will ensure the area of the alleged occurrence is secured (if applicable).
4. In instances where there is a crime scene, the area will be preserved and protected until appropriate steps can be taken to collect evidence by those trained in evidence collection.
5. The Shift Supervisor will immediately notify the DAO (who will notify Intel) and Dr. Murphy.

Through interviews with a random sample of staff it was determined that all staff are knowledgeable regarding their first responder duties upon first learning of any allegation of sexual abuse or sexual harassment. 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.

The facility reported that within the past 12 months they received one allegation that a resident was sexually abused, and the first security staff member to respond to the report separated the alleged victim and abuser. A non-security staff member was not the first responder for this allegation. This report was reviewed by the Auditor during the on-site audit.

Compliance with this standard was determined through policy reviews, review of documentation, and interviews with staff.

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 – Sexual Abuse and Harassment – Response Procedures
II. PROCEDURE
A. Purpose
The purpose of this directive is to establish internal instructions to coordinate actions taken in response to an incident of sexual abuse or sexual harassment among staff first responders, medical and mental health practitioners, investigators, and facility leadership.
E. Requirements
The Chief Administrative Officer of each youth center shall ensure that a written procedure is developed that includes the following applicable requirements.

IYC-Chicago PREA Response Plan
Immediate Staff Response
1. Upon knowledge of an allegation that a resident was sexually abused, the first staff member to response to the report shall be required to:

- Separate the alleged victim and abuser. Ensure the alleged victim is in a safe environment (such as health care unit) immediately following the reporting of the alleged incident.
- Preserve and protect any crime scene until appropriate steps can be taken to collect evidence.
- Request the alleged victim and the alleged abuser does not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, drinking or eating.
- If the first person responding (made aware of the allegation) is not a security staff member, the responder shall be required to request that the alleged victim not take any actions that could destroy physical evidence and then notify security staff.

2. Upon knowledge of an alleged incident of sexual abuse or harassment, IYC-Chicago staff will immediately report the alleged or suspected incident to the Shift Supervisor. No other information regarding the incident will be reported to anyone other than to the extent necessary to treat, investigate and make other security management decisions. This will be done without retaliation against youth or staff.
3. The Shift Supervisor will ensure the area of the alleged occurrence is secured (if applicable).
4. In instances where there is a crime scene, the area will be preserved and protected until appropriate steps can be taken to collect evidence by those trained in evidence collection.
5. The Shift Supervisor will immediately notify the DAO (who will notify Intel) and Dr. Murphy.

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.

During the on-site audit, the Superintendent and specialized staff confirmed during their interviews that they are aware of their duties as set forth in this standard.

Compliance with this standard was determined through policy reviews, review of documentation, observations made during the on-site audit, and interviews with staff.

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.

During the pre-audit, the Auditor was provided a copy and reviewed the collective bargaining agreement between the Department of Central Management Services of the State of Illinois and the American Federation of State, County and Municipal Employees Council 31, AFL-CIO, effective July 1, 2012 until June 30, 2015. The Auditor verified with the agency Director that even though the contract has expired, it is still in effect until a new contract is approved and established. As of the date of the audit, a new agreement has not been reached and is still at an impasse.

After review of the collective bargaining agreement, the agreement does not contain language that limits or prohibits the facility from removing an alleged staff sexual abuser from contact with any resident pending the outcome of an investigation or a determination of whether and to what extent discipline is warranted.

During the interview with the agency Director and the facility Superintendent, they confirmed the facility operates with collective bargaining agreement; however, this agreement does not restrict the facility from removing alleged staff abuser from contact with residents under these terms.

Compliance with this standard was determined through policy reviews, review of documentation, and interviews with specialized staff.

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 – Sexual Abuse and Harassment – Response Procedures
II. PROCEDURE
E. Requirements
The Chief Administrative Officer of each youth center shall ensure that a written procedure is developed that includes the following applicable requirements.
7. Investigation and Referral for Discipline or Prosecution
d. For at least 90 days following a report of sexual abuse, the Facility PREA Compliance Manager shall monitor the conduct or treatment of residents or staff who reported the sexual abuse and of youth who were reported to have suffered sexual abuse to see if there are any changes that may suggest possible retaliation by youth or staff, and shall act promptly to remedy any such retaliation.

(1) Items the Facility PREA Compliance Manager should monitor include any disciplinary reports, housing or program changes, or negative performance reviews or reassignments of staff, and in case of youth monitoring, shall also include periodic status checks. Youth conduct and treatment shall be documented on the PREA Retaliation Monitor – Youth, DJJ 0498. Staff misconduct and treatment shall be documented on the PREA Retaliation Monitor – Staff, DJJ 0499.

(2) Such monitoring shall continue beyond 90 days if the monitoring indicates a continuing need.

IYC-Chicago PREA Response Plan
Immediate Staff Response
2. Upon knowledge of an alleged incident of sexual abuse or harassment, IYC-Chicago staff will immediately report the alleged or suspected incident to the Shift Supervisor. No other information regarding the incident will be reported to anyone other than to the extent necessary to treat, investigate and make other security management decisions. This will be done without retaliation against youth or staff.

Form DJJ 0498 PREA Retaliation Monitor – Youth
Form DJJ 0499 PREA Retaliation Monitor – Staff

The policy prohibits any type of retaliation to any resident or staff who has reported sexual abuse or sexual harassment or who has cooperated in any PREA allegation investigation. The agency has created the following forms for monitoring retaliation: DJJ 0498 PREA Retaliation Monitor - Youth, and DJJ 0499 PREA Retaliation Monitor - Staff. The PREA Compliance Manager/Treatment Unit Administrator has been designated as the retaliation monitor for staff, and the mental health treatment staff monitor residents.

During the interview with the Treatment Unit Administrator she stated that 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 as long as the resident resides at the facility, including longer than 90 days, to make sure the resident and/or staff member is protected and safe from retaliation.

As of the date of the audit, the facility reported no incidents of retaliation has occurred within the past 12 months.

Compliance with this standard was determined through policy reviews and interview with specialized staff.

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 – Sexual Abuse and Harassment – Response Procedures
II. PROCEDURE
E. Requirements
The Chief Administrative Officer of each youth center shall ensure that a written procedure is developed that includes the following applicable requirements.
1. Intervention
d. The youth's housing needs shall be reviewed to determine appropriate placement.
(2) Youth may only be isolated from others as a last resort.

The facility does not use isolation or room confinement under any circumstances.

Interview with the facility's Superintendent, residents and staff, the Auditor confirmed that the facility does not utilize protective custody or segregated housing.

Compliance with this standard was determined through policy reviews, observations made during the on-site audit, and interviews with staff and residents.

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 – Sexual Abuse and Harassment – Response Procedures
II. PROCEDURE
E. Requirements
The Chief Administrative Officer of each youth center shall ensure that a written procedure is developed that includes the following applicable requirements.
7. Investigation and Referral for Discipline or Prosecution
a. In investigating alleged or possible sexual abuse, investigators shall collect and tag evidence from the scene in accordance with Administrative Directive 01.12.112.
b. An investigation of all alleged and possible sexual abuse or sexual harassment shall be conducted in accordance with Administrative Directive 01.12.120, except the initial report shall be provided to the Chief Administrative Officer within 24 hours of the onset of the investigation. When notified, the Chief Administrative Officer shall notify the Deputy Director.
c. If a youth is determined to be the possible assailant, he or she shall be placed in investigatory status, unless to do so may jeopardize the investigation.

AD 01.12.120 – Investigations of Unusual Incidents
II. PROCEDURE
E. General Provisions
1. The Chief Administrator shall ensure that an internal investigation is conducted by facility staff or by staff assigned by the Chief of Investigations and Intelligence on each unusual incident reported if it is determined that further facts are required.
4. The appropriate investigative reports and forms identified in Administrative Directive 01.12.125 shall be utilized.
7. All employees shall be required to cooperate with any internal investigation conducted by the facility Internal Affairs Office, Investigations and Intelligence Unit, or any other investigative authority including the Office of Executive Inspector General (OEIG). Employees shall provide documentation and testimonial evidence as required by law. Information pertaining to an internal or OEIG investigation shall be considered confidential and shall be disseminated on a need-to-know basis only. Employees shall not disclose or be asked to disclose:
a. The existence of an investigation;
b. The information requested during an investigation;
c. The subject matter or questions asked during an interview; or
d. The identity of the employees under investigation.
F. Facility Investigations
1. Facility investigations shall include, but not be limited to:
a. Obtaining statements from all involved individuals;
b. Obtaining statements from all known and any possible witnesses, even if nothing was observed by the individual;
c. Securing and preserving all weapons, if any, including any firearm projectiles;
d. Securing and preserving any other evidence in accordance with Administrative Directive, 01.12.112;
e. Determining if all policies and procedures were followed immediately before, during, and after the incident;
f. Determining the quality of offender and staff supervision before, during, and after the incident;
g. Determining if use of force by staff, if any, was commensurate with the incident;
h. Determining if reasonable grounds exist to suspect that any actions on the part of offenders or staff constitute criminal acts and, if so, re-interviewing involved individuals;

i. When appropriate, conferring with the local State's Attorney to determine if criminal prosecution is warranted;

j. When appropriate, referring individuals to the prosecuting authority for criminal prosecution; and

k. Completing an Illinois Bureau of Investigations Arrest Card, ISP 6-402, and a Federal Bureau of Investigations Fingerprint Card, FD 249, in accordance with Administrative Directive 01.07.805.

2. The supervisor of the internal investigation team shall submit an initial report, verbal or written, to the Chief Administrator within 48 hours of the incident and shall submit a final written report using the Report of Investigation, DOC 0262 within 10 working days from the conclusion of the investigation.

3. The Chief Administrator shall forward a copy of the final report to the respective Deputy Director or Chief and the Chief of Operations with a recommendation for further action-such as, commendation, discipline, or criminal prosecution, if any.

4. The Chief of Operations, Chief, or the Deputy Director, as appropriate, shall submit a copy of the facility's final investigative report to the Director with recommendations for further action, if any.

5. Medical records shall be available for review by the facility Internal Investigator, but shall be limited to the minimum reasonably needed for the purpose of the investigation. The Internal Investigator may request a written summary or copies of pertinent medical information for the investigative file. Unrelated medical information shall be redacted (blacked out) from the copies.

G. Department Investigations

1. Department investigations conducted by the Shoot Team or the Investigations Unit shall be consistent with the requirements for facility investigations.

2. The Chief Administrator at the facility shall ensure that all information, such as reports and evidence, are made available to the Department's investigators or Shoot Team and that all staff fully cooperate during the investigation.

3. Medical records shall be available for review by the Investigations and Intelligence Unit, but shall be limited to the minimum reasonably needed for the purpose of the investigation. The Department Investigator may request a written summary or copies of pertinent medical information for the investigative file. Unrelated medical information shall be redacted (blacked out) from the copies.

4. The Shoot Team Leader or the Chief Investigator shall prepare and submit an initial report, verbal or written, to the Chief of Staff within two working days of the onset of the investigation and shall submit a final written report within 10 working days from the conclusion of the investigation. A copy of all reports shall be forwarded to the Chief Administrator and the respective Deputy Director or Chief.

5. The Chief of Staff shall submit a copy of the final investigative report to the Director with recommendations for further action, if any.

H. Investigation Files

An investigation file that includes all information and reports regarding the investigation shall be established.

1. The investigation file shall be maintained by the Chief Administrator at the facility where the investigation was conducted.

2. An investigation file shall also be maintained by the Investigations and Intelligence Unit for each Department investigation conducted.

3. The Investigations and Intelligence Unit investigator and facility investigator shall ensure all investigation files containing employee information such as home address, telephone numbers, Social Security number, and other personal information not relevant to the criminal case are thoroughly reviewed and redacted (blacked out) prior to being forwarded to the State's Attorney's office. Only the portions of the file relevant to the prosecution shall be released.

NOTE: A copy of the Offender Polygraph Examination Review, DOC 0259, shall be placed in the offender's master file. Copies of any other investigative material shall be maintained only in the investigation file.

I. Investigation Pending Prosecution

1. When an offender is being referred for possible criminal acts, the facility Internal Affairs office shall immediately notify the facility Record Office using the Notification of Prosecution, DOC 0260.

2. Upon receipt of the DOC 0260, the Record Office shall immediately:

a. Enter the appropriate flag code in the time adjustment transaction of the Offender Tracking System or Juvenile Tracking System, respectively.

b. Place an index card marked "Prosecution Pending" on top of the face sheet in the offender's master file. The index card shall include a reference to the DOC 0260.

NOTE: The offender shall not be considered for restoration of good conduct credits or an award of meritorious good time without special approval from the Chief of Operations (no designees).

c. File the DOC 0260 in Section 2 of the offender's master file.

3. The facility Internal Affairs office shall immediately notify the Record Office using the DOC 0260 when it is determined that prosecution will not be pursued.

4. Upon receipt of the DOC 0260 indicating criminal prosecution will not be pursued or the case has been resolved, the Record Office shall immediately:

a. Remove the flag code in the time adjustment transaction of the Offender Tracking System or Juvenile Tracking System, respectively.

b. Remove the "Prosecution Pending" index card from the offender's master file.

c. File the DOC 0260 in Section 2 of the offender's master file.

d. Review the offender's master file for possible restoration or award of good time.

NOTE: If the offender has been transferred to another facility, the Record Office shall immediately advise, via telephone, the receiving facility Record Office to flag or remove a flag for a pending prosecution and forward the DOC 0260 for inclusion in the master file.

AD 01.12.101 – Employee Criminal Misconduct

F. General Provisions

1. The Director shall be advised immediately of any allegations of employee criminal misconduct.

2. The Department of Corrections (DOC) Chief of Investigations and Intelligence shall act as the liaison for the Department and the Illinois State Police in reporting allegations of employee criminal misconduct.
3. Jurisdiction over investigations of suspected employee criminal misconduct shall be based on the April 1, 2004 Memorandum of Understanding between the Department of Corrections and the Illinois State Police.

AD 01.12.115 – Internal Investigations
F. Requirements
4. The Chief Administrative Officer shall:
a. Personally supervise Internal Affairs staff.
b. Ensure that each individual appointed as an investigator be registered for the next available investigative training program within ten days of temporary or permanent assignment as an investigator.
1) Training shall include topics such as investigative techniques, crime scene preservation, preservation of evidence, and investigative reporting.
2) In addition to the PREA training required by Administrative Directive 04.01.301, investigators shall receive specialized training which shall include conducting sexual abuse investigations, techniques for interviewing juvenile sexual abuse victims, proper use of Miranda and Garrity warnings, sexual abuse evidence collection in confinement settings, and the criteria and evidence required to substantiate a case for administration action or prosecution referral.

IYC-Chicago PREA Response Plan
Immediate Staff Response
1. Upon knowledge of an allegation that a resident was sexually abused, the first staff member to response to the report shall be required to:
- Separate the alleged victim and abuser. Ensure the alleged victim is in a safe environment (such as health care unit) immediately following the reporting of the alleged incident.
- Preserve and protect any crime scene until appropriate steps can be taken to collect evidence.
- Request the alleged victim and the alleged abuser does not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, drinking or eating.
- If the first person responding (made aware of the allegation) is not a security staff member, the responder shall be required to request that the alleged victim not take any actions that could destroy physical evidence and then notify security staff.

2. Upon knowledge of an alleged incident of sexual abuse or harassment, IYC-Chicago staff will immediately report the alleged or suspected incident to the Shift Supervisor. No other information regarding the incident will be reported to anyone other than to the extent necessary to treat, investigate and make other security management decisions. This will be done without retaliation against youth or staff.
3. The Shift Supervisor will ensure the area of the alleged occurrence is secured (if applicable).
4. In instances where there is a crime scene, the area will be preserved and protected until appropriate steps can be taken to collect evidence by those trained in evidence collection.
5. The Shift Supervisor will immediately notify the DAO (who will notify Intel) and Dr. Murphy.

Interview with the Investigator confirmed that the facility would not terminate an investigation solely because a resident recants the original allegation, and any substantiated allegation of sexual abuse that appears to be criminal would be referred to the external agency for prosecution.

As of the date of the audit, the facility reported there have been no administrative findings of resident-on-resident sexual abuse or criminal findings of guilt for resident-on-resident sexual abuse with the past 12 months.

The agency retains all written reports pertaining to administrative or criminal investigation of alleged sexual abuse or sexual harassment for as long as the alleged abuser is incarcerated or employed by the agency, plus five years.

Compliance with this standard was determined through policy reviews, review of documentation, and interviews with specialized staff.

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 01.12.115 – Internal Investigations
II. PROCEDURE
F. Requirements
4. The Chief Administrative Officer shall:

a. Personally supervise Internal Affairs staff.

b. Ensure that each individual appointed as an investigator be registered for the next available investigative training program within ten days of temporary or permanent assignment as an investigator.

1) Training shall include topics such as investigative techniques, crime scene preservation, preservation of evidence, and investigative reporting.

2) In addition to the PREA training required by Administrative Directive 04.01.301, investigators shall receive specialized training which shall include conducting sexual abuse investigations, techniques for interviewing juvenile sexual abuse victims, proper use of Miranda and Garrity warnings, sexual abuse evidence collection in confinement settings, and the criteria and evidence required to substantiate a case for administration action or prosecution referral.

During the interview with the Investigator, the Auditor confirmed that the evidence standard is a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated.

Compliance with this standard was determined through policy review and interviews with specialized staff.

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 – Sexual Abuse and Harassment – Response Procedures
II. PROCEDURE
E. Requirements
7. Investigation and Referral for Discipline or Prosecution

(4) The Chief Administrative Officer shall inform the youth as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded.

(a) If the youth alleged that a staff member had committed the sexual abuse the Facility PREA Compliance Manager shall inform the youth (unless the Department has determined that the allegation is unfounded) whenever (i) the staff member is no longer posted within the youth's unit or is no longer employed at the facility, or (ii) the Department learns that the staff member has been indicted or convicted on a charge related to sexual abuse within the youth center.

(b) If the youth alleged that another youth committed the sexual abuse, the Facility PREA Compliance Manager shall inform the youth whenever the Department learns that the alleged abuser has been indicted or convicted on a charge related to sexual abuse within the youth center.

NOTE: If the Department did not conduct the investigation, the Chief Administrative Officer of the youth center shall request the relevant information from the investigative agency in order to inform the youth.

Form DJJ 0321 – Report of Investigative Outcome

At the conclusion of an investigation into allegation of sexual abuse or sexual harassment, policy requires the 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.

During the pre-audit, the Auditor was provided with a copy of the DJJ Form 0321 Report of Investigative Outcome form developed and implemented by the agency for the purpose of documenting any investigation and notification. The DJJ Form 0321 includes a signature line for the Superintendent, the investigating officer, and the resident where the parties acknowledge notification of the findings of the investigation, monitoring for retaliation, and the availability of mental health counselor.

As of the date of the on-site audit, the facility reported in the past 12 months there has been one administrative investigation of alleged resident sexual abuse been completed by the agency at this facility. The Auditor reviewed the DJJ Form 0321 completed at the end of the investigation showing where the victim received notification of the results of the investigation. There were no investigations of alleged resident sexual abuse in the facility that were completed by an outside agency in the past 12 months. There has not been any substantiated, unsubstantiated, or unfounded complaint of sexual abuse committed by a staff member against a resident in the past 12 months.

Compliance with this standard was determined through policy reviews, review of documentation, and observations made during the on-site audit.

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 03.02.108 – Standards of Conduct
II. PROCEDURE
G. Requirements
h. Employees shall not violate any Department Policy regarding youth sexual abuse or youth sexual harassment.
(1) Employees who have committed sexual abuse, as defined in Administrative Directive 04.01.301, shall be terminated.
(2) Disciplinary sanctions for violations of Department policies relating to sexual abuse or sexual harassment (other than actually committing sexual abuse) shall be commensurate with the nature and circumstances of the acts committed, the employee's disciplinary history and the sanctions imposed for comparable offenses by other employees with similar histories.
(3) All terminations for violations of Department sexual abuse or sexual harassment policies, or resignations by employees who would have been terminated if not for their resignation, shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and shall be reported to any relevant licensing bodies, regardless of whether or not the activity was criminal.

AD 03.01.307 – Sexual Harassment, Unlawful Discrimination, and Harassment
II. PROCEDURE
G. Internal Complaint Process
5. The Chief Administrator shall consider ways to minimize the possibility of continued sexual harassment, unlawful discrimination, or harassment and/or retaliation while the allegations are under review or investigation such as reassigning the accused employee. Prior to reassigning the alleged victim, the Chief Administrator shall consult with the Office of Affirmative Action.
6. The Chief Administrator shall initiate a review of the allegations and respond as soon as possible within five working days or upon the employee's return to work by taking one or more of the following actions:
a. Discuss the allegations with the reporting employee;

b. Discuss the allegations with the charged employee;
c. Refer the incident to the Office of Affirmative Action for formal investigation;
d. Refer the charged employee for disciplinary action, if warranted; or
e. Take other corrective action.
7. Allegations of conduct which may constitute criminal activity shall also be reported in accordance with Administrative Directive 01.12.101.
8. In all cases, the Chief Administrator shall:
a. Within five working days of being advised of the allegations, or upon the employee's return to work, inform the alleged victim in writing of the action being taken.
b. Submit to the Office of Affirmative Action a copy of any written complaint, a summary of any verbal complaint, and a copy of the response to the alleged victim.
c. When it is determined that sexual harassment, unlawful discrimination, or harassment has occurred, take prompt, appropriate corrective action, including discipline, lock out, or other similar measures. If the evidence is inconclusive, the Chief Administrator shall consider whether preventative measures such as training or monitoring should be taken.
d. Submit to the Office of Affirmative Action a copy of all employee disciplinary decisions involving sexual harassment, unlawful discrimination, or harassment.

AD 03.01.310 – Sexual Harassment
II. PROCEDURE
H. Internal Complaint Process
6. The Chief Administrator shall initiate a review of the allegations and respond as soon as possible within five working days, or upon the employee's return to work, by taking one or more of the following actions:
a. Discuss the allegations with the reporting employee;
b. Discuss the allegations with the charged employee;
c. Refer the incident to the Office of Affirmative Action for formal investigation;
d. Refer the charged employee for disciplinary action, if warranted; or
e. Take other corrective action.
7. Allegations of conduct which may constitute criminal activity shall be reported in accordance with Administrative Directive 01.12.101.
8. In all cases, the Chief Administrator shall:
a. Within five working days of being advised of the allegations, or upon the employee's return to work, inform the alleged victim in writing of the action being taken;
b. Submit to the Office of Affirmative Action a copy of any written complaint, a summary of any verbal complaint, and a copy of the response to the alleged victim; and
c. When it is determined that sexual harassment has occurred, take prompt, appropriate corrective action, including discipline, lock out, or other similar measures. If the evidence is inconclusive, the Chief Administrator shall consider whether preventative measures such as training or monitoring should be taken.
d. Submit to the Office of Affirmative Action a copy of all employee disciplinary decisions involving sexual harassment.

Staff that are determined to have violated agency sexual abuse or sexual harassment policies are subject to disciplinary action, up to and including termination. This was confirmed by the Auditor during the interview with the Superintendent.

As of the date of the audit, the facility reported, in the past 12 months, no staff from the facility have violated the agency's sexual abuse and sexual harassment policies; no staff have been terminated or resigned prior to termination for violating the agency's sexual abuse and sexual harassment policies; no staff have been disciplined, short of termination, for violating the agency's sexual abuse and sexual harassment policies; and no staff from the facility have been reported to law enforcement or licensing boards following their termination or resignation for violating the agency's sexual abuse and sexual harassment policies.

Compliance with this standard was determined through policy reviews and interview with specialized staff.

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 – Volunteer Services
II. PROCEDURE
H. Restriction or Termination of Volunteers
1. Volunteers or volunteer groups may be temporarily restricted or dismissed as approved by the Chief Administrative Officer with concurrence by the Chief of Operations or for other divisions the respective Deputy Director based upon facility needs and concerns.
2. Any individual or volunteer group whose conduct has resulted in temporary restriction or termination from one facility shall be temporarily restricted or terminated from participation in volunteer activities at all facilities or program sites. The Chief Administrative Officer shall ensure:

a. The Office of Volunteer Services, and for religious volunteers the Chief Chaplain, is notified if termination or restriction is recommended.

b. The VTS volunteer profile is updated accordingly.

c. The volunteer is notified in writing of the action that his or her volunteer activity has been temporarily restricted or terminated.

d. The volunteer is advised in writing of the appeal process in accordance with paragraph II.I.

3. Volunteers may not have restrictions lifted or be reinstated following termination without the approval of the Chief of Operations or for other divisions the respective Deputy Director.

AD 03.01.307 – Sexual Harassment, Unlawful Discrimination, and Harassment
II. PROCEDURE
J. Department Volunteers, Interns, Contractual Personnel, and Persons Employed by Contractors
1. Volunteers, interns, contractual personnel, and employees of contractors shall refrain from sexual harassment, unlawful discrimination, and harassment.
2. Training on the Department's sexual harassment, unlawful discrimination, and harassment policy shall be included in orientation of volunteers and interns and pre-service training of contractual personnel and employees of contractors.
3. A volunteer, intern, contractor, or employee of a contractor who believes that he or she has been subjected to sexual harassment, unlawful discrimination, and harassment in connection with their service to the Department shall immediately report the incident in writing to the Department employee overseeing the services of the volunteer, intern, contractor, or person employed by a contractor, the Volunteer Service Coordinator, when applicable, the Chief Administrator, or the Office of Affirmative Action.
4. Reports of sexual harassment, unlawful discrimination, or harassment involving a volunteer, intern, contractual personnel, or employee of a contractor in cases where the alleged perpetrator or victim is an employee of the Department shall be investigated by the Department. The Chief Administrator and the Office of Affirmative Action shall take the same actions to respond as is required in Paragraph II.H.
5. Reports of sexual harassment, unlawful discrimination, or harassment involving a volunteer, intern, contractual personnel, or employee of a contractor that do not involve an employee of the Department shall be reported to the Office of Affirmative Action for a determination of the appropriate action to be taken.
6. Volunteers, interns, contractual personnel, and employees of contractors are required to cooperate in any sexual harassment, unlawful discrimination, or harassment investigation conducted by the Department.

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. This was confirmed by the Auditor during the interview with the facility Superintendent.

As of the date of the audit, the facility reported, in the past 12 months, no contractor and/or volunteer have been reported to law enforcement agencies or licensing bodies for engaging in sexual abuse of a resident.

Compliance with this standard was determined through policy reviews and interviews with specialized staff.

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.

20 Illinois Administrative Code 2504 – Disciplinary and Grievances
Section 2504.20 Offenses and Maximum Penalties
Disciplinary offenses are defined in Appendix A. Maximum penalties for conduct that constitutes a disciplinary offense are set forth in Table A.
a) No youth shall be found guilty of any violation of these rules without a hearing before the Adjustment Committee or Program Unit. If a youth is transferred from one facility to another while pending a hearing, the individual shall be provided with an opportunity to present a defense at any subsequent disciplinary hearing held at the receiving facility that is comparable to that which would have been afforded, in accordance with this Subpart, at the sending facility.
b) In determining the appropriate sanctions, the Adjustment Committee or Program Unit, the Chief Administrative Officer, and the Director may consider, among other matters, mitigating or aggravating factors such as:
1) The youth's mental state at the time of committing the offense;
2) The extent and degree of participation in the commission of the offense;
3) The amount or nature of stolen property, contraband, or injury; and
4) The youth's prior disciplinary record.
c) Corporal punishment, disciplinary restrictions on diet, medical or sanitary facilities, clothing, bedding, mail, or access to legal materials and reductions in the frequency of use of toilets, washbowls, and showers shall be prohibited.
d) Disciplinary restrictions on visitation, work, education, or program assignments and use of the library shall be related as closely as practicable to the abuse of such privileges. This subsection shall not apply to confinement or isolation of youth for purposes of institutional control.
Section 2504.40 Temporary Confinement
a) The shift supervisor shall determine whether or not it is necessary to place the youth in investigative status or in temporary confinement status pending a disciplinary hearing or a determination whether or not to issue a disciplinary or investigative report in accordance with Section 2504.30. The Chief Administrative Officer shall also have the authority to release the youth from temporary confinement. The decision to place a youth in temporary confinement may be based, among other matters, on:
1) The aggressiveness of the youth;
2) The threat posed to the safety and security of the facility or any person;
3) The need to restrict the youth's access to general population to protect the individual from injury or to conduct the investigation; or
4) The seriousness of the offense.
b) A youth shall not be placed in temporary confinement status pending a disciplinary hearing for more than 4 days unless the individual is in investigative status.
Section 2504.50 Review of Disciplinary Reports
a) The Chief Administrative Officer of each facility shall designate one or more Reviewing Officers.
b) The Reviewing Officer shall review the decision to place a youth in temporary confinement within 3 days after such placement, whenever possible, and may order release from or placement in temporary confinement. Among other matters, the factors listed in Section 2504.40(a) may be considered. If a disciplinary or investigative report has not been written within 3 days after placement in temporary confinement, the Reviewing Officer shall inform the Chief Administrative Officer.
Section 2504.220 Placement in Confinement
a) Confinement may be imposed only under the following conditions:
1) When an youth has committed or is under investigation for commission of a rule violation;
2) When the behavior of the youth poses a serious threat to his or her own safety, the safety of others, or the security of the facility; or
3) When a youth is awaiting transfer to a more secure setting.
b) Youth may be confined in their rooms or living areas or in any other area designated by the Chief Administrative Officer.
Section 2504.230 Confinement Procedures
a) A youth confined to his or her room for 24 hours or more shall be interviewed daily by his or her counselor or any other staff member approved by the Chief Administrative Officer.
b) Confinement may not exceed 7 consecutive days or 15 days in any 30 day period except in cases of violence or attempted violence against another person, assault or attempted assault of a person, or damage or attempted damage of property. Under such circumstances, an additional period of confinement may be ordered by the Chief Administrative Officer.
c) Medical staff and the shift supervisor shall be notified of all confinement placements. Any medical complaint registered by the youth while in confinement shall be reported immediately to the medical staff, if on duty, or to the shift supervisor who shall contact a member of the medical staff immediately.
d) Visual checks shall be made of all youth in confinement no less than every 15 minutes and shall be documented.
e) Use of physical restraints on youth in confinement must comply with 20 Ill. Adm. Code 2501.Subpart B.
f) Youth in confinement shall be provided time outside the room for daily showers, personal grooming, and recreation.

1) Youth confined for more than 24 hours shall be provided a minimum of 2 hours outside the room for every 24-hour period, whenever possible.

2) Time outside a confinement room may be restricted on orders of the Chief Administrative Officer when release of the youth poses a threat to the safety of the individual or others or to the security of the facility.

g) Youth in confinement shall be permitted to have family, attorney, and clergy visits. Family and clergy visits may be restricted by order of the Chief Administrative Officer when the youth poses a threat to the physical safety of the individual or others or to the security of the youth center.

h) Reading materials shall be provided to the youth for use in the room provided the materials are not abused. Youth shall be provided access to writing materials daily, outside the room. Any abuse of reading or writing materials must be documented on a disciplinary report and may result in temporary restriction except for communication to counsel or the court.

AD 04.01.304 – Discrimination and Harassment of Youth
II. PROCEDURE
I. Investigation
2. A reporting youth may not be disciplined unless the investigation concludes that the alleged discrimination or harassment was unfounded and the reporting youth did not make the allegation in good faith and based on reasonable belief.

The facility may only sanction a resident 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 and facility policies prohibit residents from any sexual activity with other residents.

As of the date of the audit, the facility reported in the past 12 months there have been no administrative findings of resident-on-resident sexual abuse; and there have been no criminal findings of guilt for resident-on-resident sexual abuse.

The facility offers therapy, counseling, or other interventions designed to address and correct the underlying reasons or motivations for abuse which does not consider whether to require the offending resident to participate in such interventions as a condition of access to any rewards-based behavior management system or other behavior-based incentives. Access to general programming or education is not conditional on participation in such interventions.

As of the date of the audit, the facility reported in the past 12 months there have been no residents placed in isolation as a disciplinary sanction of resident-on-resident sexual abuse. The facility does not use isolation or room confinement as a punishment.

Compliance with this standard was determined through policy reviews, review of documentation, observations made during the on-site audit, and interviews with staff and residents.

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 – Sexual Abuse and Harassment Prevention and Intervention Program
II. PROCEDURE

G. Requirements

The Chief Administrative Officer of each youth center shall ensure that a written procedure is developed that includes the following applicable requirements.

1. Upon admission to a Reception and Classification Center all youth shall be screened for risk of sexual abuse:

a. Medical staff shall screen each youth for sexually abusive or sexually harassing behavior or victimization and inquire whether the youth has a history of such behavior or victimization.

Mental Health Protocol Manual IN-001 Components of Mental Health Services

II. POLICY AND PROCEDURE

A. The components of the Illinois Department of Juvenile Justice effective mental health services are as follows:

1. A systematic program for screening for mental health problems upon intake with both inter-and intra-system transfers.
2. A systematic program for assessment of mental health problems available across the span of incarceration.

Mental Health Protocol Manual IN-002 IDJJ Mental Health Services

II. POLICY AND PROCEDURE

A. Illinois Department of Juvenile Justice's effective mental health services are as follows:

1. Screening and Assessment Services

a. Screening and assessment services provide valuable information to guide decisions about care, supervision, and services for youth. These services use tools that are structured, objective, and validated.

b. Upon intake, youth will receive the following screenings:

1. Medical screening to determine whether the youth is on any medication or has any health issues of an emergency nature.
2. Mental health screening to determine appropriate housing for a youth, including admission into a Special Treatment Unit, as well as any need for emergency crisis care.
3. Sexual abuse risk screening shall be completed and youth shall be provided with information on sexual abuse and harassment in accordance with paragraphs G.1 and G.2.a. of Administrative Directive 04.01.301.

c. Upon intake, youth will be administered the following assessments:

1. Voice Index of Self Injurious Actions Tool (VISA)
2. Massachusetts Youth Screening Instrument-2nd Version (MAYSI-2)
3. Risk of Victimization Tool
4. Youth Assessment and Screening Instrument (YASI)
5. Global Appraisal Inventory of Needs (GAIN)
6. Mental Health Protocol Manual SA-002

Mental Health Protocol Manual SA-002 Risk of Victimization Screening Tool

II. POLICY AND PROCEDURE

A. Upon admission to a Reception and Classification Center all youth shall be screened for risk of sexual abuse.

B. All youth shall be administered a Sexual Abuse Risk Screening, DJJ 0429, by a qualified staff member upon admission, and every six months afterwards until the youth's release from the facility.

Mental Health Protocol Manual SA-003 Mental Health Screening

II. POLICY AND PROCEDURE

A. Mental Health Screening

1. All youth entering into an Illinois Youth Center shall be screened by a Mental Health Professional (MHP), Crisis Team Member (CTM), or designee.
2. The screening shall be conducted prior to a youth's placement on a living unit in the facility. Until the screening is completed, the youth shall be constantly monitored until cleared by an MHP, CTM, or designee.

C. Mental Health Screening Procedure

1. Inter-facility transfers of youth and parole violators will include administration of the MAYSI-2 and the Mental Health Intake Screening at the receiving facility.
2. Intra-facility transfers of youth and parole violators will include administration of the MAYSI-2 or conducting a Mental Health Assessment that shall be documented on the DJJ 0282.
3. Youth on writs shall receive the MAYSI-2 if administered by a CTM. When conducted by a MHP, the MHP has the option of using the MAYSI-2 or conducting a Mental Health Assessment that shall be documented on the DJJ 0282. Court writs shall be assessed in all of the following circumstances:

a. Court writ that is returned from court.
b. Court writ entering a facility from another facility.
c. Court writ entering a facility, but getting paroled the same day or next day.
d. Court writ entering or returning from an interview.

Mental Health Protocol Manual SA-004 Mental Health Needs Assessment

II. POLICY AND PROCEDURE

A. The Treatment Unit Administrator at the parent facility will assign a Mental Health Professional (MHP) to review the mental health needs of each youth.

B. If the youth is assigned a Mental Health Level, then the assigned MHP will complete the Mental Health Needs Assessment (MHNA). The MHP shall review the youth's medical file and master file within 5 business days of the youth's admission to the parent facility to

determine the youth's initial mental health needs. This review shall be documented on a Mental Health Needs Assessment Form. This review will be on a facility form, requires a facility form number and needs to be typed.
D. Upon completion of the MHNA, the MHP will submit the MHNA with Treatment Recommendations to the Treatment Unit Administrator for final review, formal assignment of therapist, group assignment, and formal sign-off.
C. The MHNA will be placed in the youth's medical file and copies will be provided to the assigned Juvenile Justice Youth and Family Specialist, assigned MHP and others when applicable.

Mental Health Protocol Manual SA-006 Youth Assessment and Screening Instrument
II. POLICY AND PROCEDURE
A. The Youth Assessment and Screening Instrument (YASI) is a risk assessment tool that measures the risk of recidivism. The tool includes static and dynamic content across ten domains including legal history, family, school, community and peers, alcohol and drugs, mental health, aggression, attitudes, social/cognitive skills, free time and employment.
B. The YASI includes both pre-screen and full assessment components and is used to assist in making initial service decisions as well as case plan development. YASI provides a graphic profile of risk, need, and strength results for each youth including overall static and dynamic scores on risk and protective factors.
C. All youth entering an Illinois Youth Reception and Classification Center shall be screened using the YASI.
D. The YASI pre-screening and full assessment shall be initiated by an assigned staff member who has received training in the administration of the instrument as part of the intake process.
E. The YASI assessment results shall be placed in the youth's medical file.

Form DJJ 0507 – Accommodations for Transgender and Gender Non-Conforming Youth
Form DJJ 0284 – Mental Health Treatment Plan

Upon arrival all resident are screened and assessed by a qualified staff member for their risk of being sexually abused or sexually harassed by other residents, or for being sexually abusive towards other residents. The initial screening for male residents is done at Reception and Classification at IYC St. Charles. Male residents who disclosed prior victimization during screening at are offered a follow-up meeting with a medical or mental health practitioner upon their arrival at the facility. Residents are not disciplined for refusing to answer PREA screening questions. The facility uses YASI, an objective checklist or template screening tool form. The YASI screening form addresses the items required by this standard. A Youth and Family Specialist review all relevant information from other facilities and continue to reassess when additional information is received within a day of the resident's arrival at the facility. Staff are required to offer a follow-up meeting with mental health staff within 14 days of initial screening.

During the pre-audit, the Auditor was provided with a copy of the DJJ 0284 – Mental Health Treatment Plan screening form showing questions about prior sexual assault that are asked by the screening staff and medical staff during the initial health and safety assessment and again upon arrival at the facility for male residents. The DJJ 0284 includes a statement letting residents know that the mental health professional is required to disclose any information regarding unreported child or elder abuse/neglect and a consent to treatment. The DJJ 0284 has a signature line for the resident to sign saying the resident understands or refuses to sign, for the mental health professional's signature, and a place for a parent/guardian review signature. A consent form is provided for any resident 18 years of age or older.

During the on-site audit, the Auditor reviewed a random sample of 10 files with completed DJJ 0284, medical and mental health logs and secondary materials.

Interview with a Youth and Family Specialist also confirmed the use of the screening tool and reassessment which is usually completed within the first day of the arrival of the resident.

Compliance with this standard was determined through policy reviews, review of documentation, and interviews with specialized staff and residents.

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 – Sexual Abuse and Harassment – Response Procedures
II. PROCEDURE
E. Requirements
The Chief Administrative Officer of each youth center shall ensure that a written procedure is developed that includes the following applicable requirements.
1. Intervention

a. Any youth who alleges to be a victim of sexual abuse and/or sexual harassment shall be:

(1) Promptly offered protection from the alleged assailant and the incident shall be investigated

(2) Evaluated by mental health services to assess the need for counseling and support services, such as psychological or chaplaincy services, group therapy, etc. If sexual abuse is alleged, the Crisis Intervention Team or mental health professional shall be immediately notified and shall respond pursuant to Administrative Directive 04.04.102.

(3) Provided medical treatment and evidence collection in accordance with Paragraphs II.F.3.and II.F.7., if sexual abuse is alleged.

3. Sexual Abuse Medical Treatment

Medical treatment shall be provided, without financial cost, to any youth who is the alleged victim of a sexual abuse.

a. 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 a community hospital for a forensic medical examination. The youth shall be escorted to the hospital as soon as possible in accordance with the procedures provided for an emergency escorted medical furlough in Administrative Directive 05.03.124, except that:

(1) A strip search shall not be conducted

(2) Security restrains shall not be used, unless failing to do so would present a safety or security risk; and

(3) Security staff shall not be in the exam room with the youth when the exam is being conducted or when mental health staff or a victim advocate is present in the exam room, unless requested by the youth.

b. If the sexual abuse is not recent, medical treatment may be provided on site, at another youth center, or at a community hospital as determined by the parent youth center. The medical examination provided by Department facilities shall include, but not be limited to:

(1) A blood test (RPR serology for Syphilis) - repeat at three months;

(2) Culture smears for seminal fluid, Gonorrhea, Chlamydia and other Sexually Transmitted Diseases (STD) as appropriate; STD and Gonorrhea and Chlamydia testing repeat at three weeks;

(3) Collection of evidence by use of the Evidence Collection Kit when determined necessary by the physician;

(4) Timely information about and access to emergency contraception when medically appropriate; and

(5) Youth shall be informed that they have to right to refuse medical treatment.

c. An HIV test and counseling shall be offered to any youth who is the alleged victim in accordance with Administrative Directive 04.03.115. The HIV test shall be repeated at three, six, and nine months after the initial test.

d. The progress notes in the medical record shall:

(1) Identify the youth's name and identification number;

(2) Include a statement by the youth indicating the date and time of the alleged incident;

(3) Identify the type or description of sexual abuse (oral, anal, vaginal, etc.);

(4) Include the results of the physical examination, tests, and if applicable, use of the Evidence Collection Kit;

(5) Contain documentation of the presence or absence of cuts, scratches, and bruises and any trauma; and

(6) Include documentation of counseling; but

(7) Not reflect any conclusions regarding whether a crime occurred.

e. All reports contained in the Evidence Collection Kit shall be completed and distributed appropriately, when applicable.

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 resident shall be immediately transported to John H. Stroger, Jr. Hospital of Cook County for a forensic medical examination and treatment. Residents are referred to Rape Victim Advocates for mental health treatment. Staff are also trained to preserve any on-site evidence for criminal investigation. Residents are offered information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance

with professionally acceptable standards of care, where medically appropriate. The treatment is offered at no financial costs to the resident irrespective of whether the victim/resident names the abuser or cooperates with any investigation arising from the incident.

During the pre-audit, the Auditor was provided with a copy of the Mental Health Intake Screening where questions about prior sexual abuse are asked by medical staff during the initial health and safety assessments at IYC St. Charles and again upon transfer to the facility, and samples of medical and mental health logs.

Compliance with this standard was determined through policy reviews, review of documentation, and interviews with specialized staff and residents.

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 – Sexual Abuse and Harassment – Response Procedures
II. PROCEDURE
E. Requirements
The Chief Administrative Officer of each youth center shall ensure that a written procedure is developed that includes the following applicable requirements.
1. Intervention
a. Any youth who alleges to be a victim of sexual abuse and/or sexual harassment shall be:
(1) Promptly offered protection from the alleged assailant and the incident shall be investigated
(2) Evaluated by mental health services to assess the need for counseling and support services, such as psychological or chaplaincy services, group therapy, etc. If sexual abuse is alleged, the Crisis Intervention Team or mental health professional shall be immediately notified and shall respond pursuant to Administrative Directive 04.04.102.
(3) Provided medical treatment and evidence collection in accordance with Paragraphs II.F.3.and II.F.7., if sexual abuse is alleged.
3. Sexual Abuse Medical Treatment
Medical treatment shall be provided, without financial cost, to any youth who is the alleged victim of a sexual abuse.
a. 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 a community hospital for a forensic medical examination. The youth shall be escorted to the hospital as soon as possible in accordance with the procedures provided for an emergency escorted medical furlough in Administrative Directive 05.03.124, except that:
(1) A strip search shall not be conducted
(2) Security restrains shall not be used, unless failing to do so would present a safety or security risk; and
(3) Security staff shall not be in the exam room with the youth when the exam is being conducted or when mental health staff or a victim advocate is present in the exam room, unless requested by the youth.
b. If the sexual abuse is not recent, medical treatment may be provided on site, at another youth center, or at a community hospital as determined by the parent youth center. The medical examination provided by Department facilities shall include, but not be limited to:
(1) A blood test (RPR serology for Syphilis) - repeat at three months;
(2) Culture smears for seminal fluid, Gonorrhea, Chlamydia and other Sexually Transmitted Diseases (STD) as appropriate; STD and Gonorrhea and Chlamydia testing repeat at three weeks;
(3) Collection of evidence by use of the Evidence Collection Kit when determined necessary by the physician;
(4) Timely information about and access to emergency contraception when medically appropriate; and
(5) Youth shall be informed that they have to right to refuse medical treatment.
c. An HIV test and counseling shall be offered to any youth who is the alleged victim in accordance with Administrative Directive 04.03.115. The HIV test shall be repeated at three, six, and nine months after the initial test.

d. The progress notes in the medical record shall:
(1) Identify the youth's name and identification number;
(2) Include a statement by the youth indicating the date and time of the alleged incident;
(3) Identify the type or description of sexual abuse (oral, anal, vaginal, etc.);
(4) Include the results of the physical examination, tests, and if applicable, use of the Evidence Collection Kit;
(5) Contain documentation of the presence or absence of cuts, scratches, and bruises and any trauma; and
(6) Include documentation of counseling; but
(7) Not reflect any conclusions regarding whether a crime occurred.
e. All reports contained in the Evidence Collection Kit shall be completed and distributed appropriately, when applicable.

Mental Health Protocol Manual IN-002 IDJJ Mental Health Services
II. POLICY AND PROCEDURE
A. Illinois Department of Juvenile Justice's effective mental health services are as follows:
6. Crisis Services
a. A crisis is an episode or situation in which emergency services are indicated due to evidence that a youth may be at risk for mental health distress, self-harm ideation or behavior, suicide ideation or behavior, harm to others, and other dysfunctional signs or symptoms. Allegations of sexual abuse shall be treated as a crisis. The youth's crisis may be an identifiable event such as family illness or death, denial of parole or placement, bad news, and or conflicts with others etc. The youth's crisis may also include a noticeable change in presentation or behavior such as crying, agitation, poor appetite or sleep, refusal of program or activities, paranoia, hallucinations, aggression, and/or impulsivity etc.

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.

There are no females housed at this facility.

Medical and mental health staff interviewed stated that the care that would be offered immediately and would be consistent with the community level of care. The treatment is to be offered immediately upon being reported to medical and mental health staff at no financial cost to the resident irrespective of whether the resident/victim names the abuser or cooperates with any investigation arising from the incident.

Compliance with this standard was determined through policy reviews, review of documentation, observations made during the on-site audit, and interviews with specialized 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 – Sexual Abuse and Harassment – Response Procedures
II. PROCEDURE
E. Requirements
The Chief Administrative Officer of each youth center shall ensure that a written procedure is developed that includes the following applicable requirements.
1. Intervention
a. Any youth who alleges to be a victim of sexual abuse and/or sexual harassment shall be:
(1) Promptly offered protection from the alleged assailant and the incident shall be investigated

(2) Evaluated by mental health services to assess the need for counseling and support services, such as psychological or chaplaincy services, group therapy, etc. If sexual abuse is alleged, the Crisis Intervention Team or mental health professional shall be immediately notified and shall respond pursuant to Administrative Directive 04.04.102.

(3) Provided medical treatment and evidence collection in accordance with Paragraphs II.F.3.and II.F.7., if sexual abuse is alleged.

3. Sexual Abuse Medical Treatment

Medical treatment shall be provided, without financial cost, to any youth who is the alleged victim of a sexual abuse.

a. 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 a community hospital for a forensic medical examination. The youth shall be escorted to the hospital as soon as possible in accordance with the procedures provided for an emergency escorted medical furlough in Administrative Directive 05.03.124, except that:

(1) A strip search shall not be conducted

(2) Security restrains shall not be used, unless failing to do so would present a safety or security risk; and

(3) Security staff shall not be in the exam room with the youth when the exam is being conducted or when mental health staff or a victim advocate is present in the exam room, unless requested by the youth.

b. If the sexual abuse is not recent, medical treatment may be provided on site, at another youth center, or at a community hospital as determined by the parent youth center. The medical examination provided by Department facilities shall include, but not be limited to:

(1) A blood test (RPR serology for Syphilis) - repeat at three months;

(2) Culture smears for seminal fluid, Gonorrhea, Chlamydia and other Sexually Transmitted Diseases (STD) as appropriate; STD and Gonorrhea and Chlamydia testing repeat at three weeks;

(3) Collection of evidence by use of the Evidence Collection Kit when determined necessary by the physician;

(4) Timely information about and access to emergency contraception when medically appropriate; and

(5) Youth shall be informed that they have to right to refuse medical treatment.

c. An HIV test and counseling shall be offered to any youth who is the alleged victim in accordance with Administrative Directive 04.03.115. The HIV test shall be repeated at three, six, and nine months after the initial test.

d. The progress notes in the medical record shall:

(1) Identify the youth's name and identification number;

(2) Include a statement by the youth indicating the date and time of the alleged incident;

(3) Identify the type or description of sexual abuse (oral, anal, vaginal, etc.);

(4) Include the results of the physical examination, tests, and if applicable, use of the Evidence Collection Kit;

(5) Contain documentation of the presence or absence of cuts, scratches, and bruises and any trauma; and

(6) Include documentation of counseling; but

(7) Not reflect any conclusions regarding whether a crime occurred.

e. All reports contained in the Evidence Collection Kit shall be completed and distributed appropriately, when applicable.

IYC-Chicago PREA Response Plan

<u>Data Collection/Review</u>

1. The facility shall conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation, unless the allegation has been determined to be unfounded.
2. Reviews will occur within 30 days of the conclusion of the investigation.
3. The review team shall include upper-level management officials, with input from line supervisors, investigators, and medical or mental health professionals.

The review team shall:

1. Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse.

2. Consider whether the incident or allegation was motivated by race, ethnicity, gender identity, lesbian, gay, bisexual, transgender, or intersex identification, status or perceived status, or gang affiliation, or was motivated or otherwise caused by other group dynamics at the facility.

3. Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse.

4. Assess the adequacy of staffing levels in that area during different shifts.

5. Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff.

6. Prepare a report of its finding, including but not necessarily limited to determinations made and any recommendations for improvement and submit such report to the facility and PREA compliance manager.

7. The facility shall implement the recommendations for improvement or shall document its reasons for not doing so.

Policy states that the facility shall conduct a sexual abuse incident review of every sexual abuse investigation, except that have been determined to be unfounded. During the on-site audit, the Auditor was provided with a copy of the facility's Sexual Abuse Incident Review form that is used by the incident review team.

Interview with a members of the incident review team 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 Sexual Abuse Incident Review team reviews the incident to determine what may have led to the incident, specifically looking to see if there may be problems with policies, practices, physical barriers, staffing levels, and/or monitoring. The Auditor was informed that the agency and facility would implement the recommendations for improvement or document its reasons for not implementing the recommendations of the Sexual Abuse Incident Review team's report. The Agency Director reported that all investigations and incident reports, including unfounded investigations, are reviewed by the agency's Director, Assistant Director and PREA Compliance Coordinator looking for information in particular areas of the facility, shift problems, identification of areas and patterns, and they review all videos of the incidents looking for teachable moments and possible disciplinary actions against staff and youths.

As of the date of the audit, the facility reported in the past 12 months one criminal and/or administrative investigations of alleged sexual abuse has been completed at the facility.

Compliance with this standard was determined through policy reviews, review of documentation, observations made during the on-site audit, and interviews with specialized staff.

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- Sexual Abuse and Harassment Prevention and Intervention Program
II. PROCEDURE
G. Requirements
6. Statistical Reporting
The Department shall maintain a record of:

a. The number of alleged sexual abuse and the number of alleged sexual harassment reports received, and within those categories the number or reports that were youth-on-youth and number that involved staff misconduct.

b. The number of substantiated, unsubstantiated, unfounded and ongoing investigations within all the categories in paragraph a.

c. The discipline imposed for sexual abuse and sexual harassment.

d. Referrals for criminal prosecution, including the current status.

e. The number of criminal indictments for sexual abuse and sexual harassment.

AD 04.01.302 – Sexual Abuse and Harassment – Response Procedures
II. PROCEDURE
E. Requirements
The Chief Administrative Officer of each youth center shall ensure that a written procedure is developed that includes the following applicable requirements.
7. Investigation and Referral for Discipline or Prosecution

f. Upon conclusion of the investigation:

(1) Disciplinary reports shall be completed, served, and processed, where warranted.

(i) A reporting youth may not be disciplined unless the investigation concludes that the alleged sexual abuse, and/or sexual harassment was unfounded and the reporting youth did not make the allegation on good faith and based on reasonable belief, or that the reporting youth inflicted or attempted to inflict self-injury.

(ii) A youth may not be disciplined for sexual contact with staff unless a finding is made that the staff member did not consent to such contact.

(2) The results shall be forwarded to the Deputy Director of Operations or his or her designee who shall report the incident to the Illinois State Police, where appropriate.

(3) Substantiated allegations of conduct that appears to be criminal shall be referred to the appropriate State's Attorney for prosecution.

(4) The Chief Administrative Officer shall inform the youth as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded and provide the youth with a completed Report of Investigative Outcome, DJJ 0321.

(a) If the youth alleged that a staff member had committed the sexual abuse the Facility PREA Compliance Manager shall inform the youth (unless the Department has determined that the allegation is unfounded) whenever (i) the staff member is no longer posted within the youth's unit or is no longer employed at the facility, or (ii) the Department learns that the staff member has been indicted or convicted on a charge related to sexual abuse within the youth center.

(b) If the youth alleged that another youth committed the sexual abuse, the Facility PREA Compliance Manager shall inform the youth whenever the Department learns that the alleged abuser has been indicted or convicted on a charge related to sexual abuse within the youth center.

NOTE: If the Department did not conduct the investigation, the Chief Administrative Officer of the youth center shall request the relevant information from the investigative agency in order to inform the youth.

(5) Within 30 days of the conclusion of the investigation, unless the allegation has been determined to be unfounded, the Chief Administrative Officer shall appoint a review team that shall include upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners. The review team shall:

(a) Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse;

(b) Consider whether the incident or allegation was motivated by race, ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status or perceived status; or, gang affiliation; or was motivated or otherwise caused by other group dynamics at the youth center.

(c) Examine the area in the youth center where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse;

(d) Assess the adequacy of staffing levels in that area during different shifts;

(e) Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff; and

(f) Prepare a report of its findings, including but not necessarily limited to determinations made pursuant to paragraphs (5)(a)-(5)(3) of this section, and any recommendations for improvement and submit such report to the Chief Administrative Officer and Facility PREA Compliance Monitor.

AD 01.12.120
II. PROCEDURE
F. Facility Investigations
1. Facility investigations shall include, but not be limited to:

a. Obtaining statements from all involved individuals;

b. Obtaining statements from all known and any possible witnesses, even if nothing was observed by the individual;

c. Securing and preserving all weapons, if any, including any firearm projectiles;

d. Securing and preserving any other evidence in accordance with Administrative Directive, 01.12.112;

e. Determining if all policies and procedures were followed immediately before, during, and after the incident;

f. Determining the quality of offender and staff supervision before, during, and after the incident;

g. Determining if use of force by staff, if any, was commensurate with the incident;

h. Determining if reasonable grounds exist to suspect that any actions on the part of offenders or staff constitute criminal acts and, if so, re-interviewing involved individuals;

i. When appropriate, conferring with the local State's Attorney to determine if criminal prosecution is warranted;

j. When appropriate, referring individuals to the prosecuting authority for criminal prosecution; and

k. Completing an Illinois Bureau of Investigations Arrest Card, ISP 6-402, and a Federal Bureau of Investigations Fingerprint Card, FD 249, in accordance with Administrative Directive 01.07.805.

2. The supervisor of the internal investigation team shall submit an initial report, verbal or written, to the Chief Administrator within 48 hours of the incident and shall submit a final written report using the Report of Investigation, DOC 0262 within 10 working days from the conclusion of the investigation.
3. The Chief Administrator shall forward a copy of the final report to the respective Deputy Director or Chief and the Chief of Operations with a recommendation for further action such as, commendation, discipline, or criminal prosecution, if any.
4. The Chief of Operations, Chief, or the Deputy Director, as appropriate, shall submit a copy of the facility's final investigative report to the Director with recommendations for further action, if any.

IYC-Chicago PREA Response Plan
<u>Data Collection/Review</u>
The review team shall:

6. Prepare a report of its finding, including but not necessarily limited to determinations made and any recommendations for improvement and submit such report to the facility and PREA compliance manager.

Form DJJ 0321 – Report of Investigative Outcome
Form DJJ 0262 – Report of Investigation

The agency annually collects accurate uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions, which includes the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence (SSV) conducted by the Department of Justice. The agency maintains, reviews, and collects data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews.

The agency does not contract for the confinement of its residents.

The agency Director and facility Superintendent stated that they would use any information revealed as a result of the review of any sexual assault or sexual harassment investigation to enhance or upgrade monitoring technology.

Compliance with this standard was determined through policy reviews, and interviews with specialized staff.

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- Sexual Abuse and Harassment Prevention and Intervention Program
II. PROCEDURE
G. Requirements
6. Statistical Reporting
The Department shall maintain a record of:
a. The number of alleged sexual abuse and the number of alleged sexual harassment reports received, and within those categories the number or reports that were youth-on-youth and number that involved staff misconduct.
b. The number of substantiated, unsubstantiated, unfounded and ongoing investigations within all the categories in paragraph a.
c. The discipline imposed for sexual abuse and sexual harassment.
d. Referrals for criminal prosecution, including the current status.
e. The number of criminal indictments for sexual abuse and sexual harassment.

The agency reviews all sexual abuse and sexual harassment data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, response policies, training, identifying problem areas in facilities and patterns, staffing patterns, taking corrective action, and preparing the annual report for each facility and the agency as a whole. The annual report, which is approved by the Director, includes a comparison of the current year's data and corrective actions to those from prior years; and provides an assessment of the agency's progress in addressing sexual abuse. The annual report is available on the agency's website at www.illinois.gov/idjj/Pages/PrisonRapeEliminationAct.aspx.

Compliance with this standard was determined through policy reviews, review of documentation, and interviews with specialized staff.

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's policy ensures that incident-based and aggregate data are securely retained, and requires that aggregated sexual abuse data from facilities under its direct control are readily available to the public on the agency's website at www.illinois.gov/idjj/Pages/PrisonRapeEliminationAct.aspx. The agency maintains sexual abuse data collected pursuant to § 115.387 for at least 10 years after the date of the initial collection.

Compliance with this standard was determined through policy reviews, review of documentation, observations made during the on-site audit, and interviews with staff and residents.

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.

Sharon G. Robertson *June 23, 2017*
Sharon G. Robertson **Date**