

Prison Rape Elimination Act (PREA) Audit Report Juvenile Facilities

Interim Final

Date of Interim Audit Report: Click or tap here to enter text. N/A

If no Interim Audit Report, select N/A

Date of Final Audit Report: 8/30/2021

Auditor Information

Name: James L. Roland Jr. **Email:** james.roland@nakamotogroup.com

Company Name: The Nakamoto Group, Inc.

Mailing Address: 11820 Parklawn Drive, Suite 240 **City, State, Zip:** Rockville, MD. 20852

Telephone: 302-468-6535 **Date of Facility Visit:** 7/14-15/2021

Agency Information

Name of Agency: Department of Juvenile Justice

Governing Authority or Parent Agency (If Applicable): Click or tap here to enter text.

Address: 2715 West Monroe Street **City, State, Zip:** Springfield, IL. 62704

Mailing Address: Click or tap here to enter text. **City, State, Zip:** Click or tap here to enter text.

The Agency Is: Military Private for Profit Private not for Profit

Municipal County State Federal

Agency Website with PREA Information: <https://djj.portal.illinois.gov/PREA/default.aspx> (Internal)
<https://www2.illinois.gov/idjj/Pages/PrisonRapeEliminationAct.aspx> (public)

Agency Chief Executive Officer

Name: Heidi Mueller

Email: Heidi.Mueller@illinois.gov **Telephone:** 217-557-1030

Agency-Wide PREA Coordinator

Name: William Peyton

Email: William.H.Peyton@illinois.gov **Telephone:** 618-521-3267

PREA Coordinator Reports to: Heidi Mueller **Number of Compliance Managers who report to the PREA Coordinator:** 5

Facility Information

Name of Facility: Illinois Youth Center, Harrisburg (IYCH)

Physical Address: 1202 W. Poplar Street

City, State, Zip: Harrisburg, Illinois 62946

Mailing Address: Click or tap here to enter text.

City, State, Zip: Click or tap here to enter text.

The Facility Is:

Military

Private for Profit

Private not for Profit

Municipal

County

State

Federal

Facility Website with PREA Information: <https://djj.portal.illinois.gov/PREA/default.aspx> (Internal)
<https://www2.illinois.gov/idjj/Pages/PrisonRapeEliminationAct.aspx> (public)

Has the facility been accredited within the past 3 years? Yes No

If the facility has been accredited within the past 3 years, select the accrediting organization(s) – select all that apply (N/A if the facility has not been accredited within the past 3 years):

ACA

NCCHC

CALEA

Other (please name or describe: Click or tap here to enter text.)

N/A

If the facility has completed any internal or external audits other than those that resulted in accreditation, please describe:
 Internal performance based facility review – continual basis per facility audit schedule

Facility Administrator/Superintendent/Director

Name: Jeremy Burtis

Email: Jeremy.burtis@illinois.gov

Telephone: 618-252-8681 ext. 234

Facility PREA Compliance Manager

Name: Ashley Miller

Email: ashley.miller@illinois.gov

Telephone: 618-252-8681

Facility Health Service Administrator N/A

Name: Sarah Hendrix

Email: sarah.hendrix@illinois.gov

Telephone: 618-252-8681 ext. 294

Facility Characteristics

Designated Facility Capacity: 257

30

Current Population of Facility:	30	
Average daily population for the past 12 months:	39	
Has the facility been over capacity at any point in the past 12 months?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Which population(s) does the facility hold?	<input type="checkbox"/> Females <input checked="" type="checkbox"/> Males <input type="checkbox"/> Both Females and Males	
Age range of population:	13-20	
Average length of stay or time under supervision	80.53 days	
Facility security levels/resident custody levels	Minimum/Medium	
Number of residents admitted to facility during the past 12 months	162	
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 72 hours or more:	161	
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 10 days or more:	158	
Does the audited facility hold residents for one or more other agencies (e.g. a State correctional agency, U.S. Marshals Service, Bureau of Prisons, U.S. Immigration and Customs Enforcement)?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Select all other agencies for which the audited facility holds residents: Select all that apply (N/A if the audited facility does not hold residents for any other agency or agencies):	<input type="checkbox"/> Federal Bureau of Prisons <input type="checkbox"/> U.S. Marshals Service <input type="checkbox"/> U.S. Immigration and Customs Enforcement <input type="checkbox"/> Bureau of Indian Affairs <input type="checkbox"/> U.S. Military branch <input type="checkbox"/> State or Territorial correctional agency <input type="checkbox"/> County correctional or detention agency <input type="checkbox"/> Judicial district correctional or detention facility <input type="checkbox"/> City or municipal correctional or detention facility (e.g. police lockup or city jail) <input type="checkbox"/> Private corrections or detention provider <input type="checkbox"/> Other - please name or describe: Click or tap here to enter text. <input checked="" type="checkbox"/> N/A	
Number of staff currently employed by the facility who may have contact with residents:	211	
Number of staff hired by the facility during the past 12 months who may have contact with residents:	6	
Number of contracts in the past 12 months for services with contractors who may have contact with residents:	1	
Number of individual contractors who have contact with residents, currently authorized to enter the facility:	20	
Number of volunteers who have contact with residents, currently authorized to enter the facility:	16	

Physical Plant

<p>Number of buildings:</p> <p>Auditors should count all buildings that are part of the facility, whether residents are formally allowed to enter them or not. In situations where temporary structures have been erected (e.g., tents) the auditor should use their discretion to determine whether to include the structure in the overall count of buildings. As a general rule, if a temporary structure is regularly or routinely used to hold or house residents, or if the temporary structure is used to house or support operational functions for more than a short period of time (e.g., an emergency situation), it should be included in the overall count of buildings.</p>	12
<p>Number of resident housing units:</p> <p>Enter 0 if the facility does not have discrete housing units. DOJ PREA Working Group FAQ on the definition of a housing unit: How is a "housing unit" defined for the purposes of the PREA Standards? The question has been raised in particular as it relates to facilities that have adjacent or interconnected units. The most common concept of a housing unit is architectural. The generally agreed-upon definition is a space that is enclosed by physical barriers accessed through one or more doors of various types, including commercial-grade swing doors, steel sliding doors, interlocking sally port doors, etc. In addition to the primary entrance and exit, additional doors are often included to meet life safety codes. The unit contains sleeping space, sanitary facilities (including toilets, lavatories, and showers), and a dayroom or leisure space in differing configurations. Many facilities are designed with modules or pods clustered around a control room. This multiple-pod design provides the facility with certain staff efficiencies and economies of scale. At the same time, the design affords the flexibility to separately house residents of differing security levels, or who are grouped by some other operational or service scheme. Generally, the control room is enclosed by security glass, and in some cases, this allows residents to see into neighboring pods. However, observation from one unit to another is usually limited by angled site lines. In some cases, the facility has prevented this entirely by installing one-way glass. Both the architectural design and functional use of these multiple pods indicate that they are managed as distinct housing units.</p>	11
Number of single resident cells, rooms, or other enclosures:	281
Number of multiple occupancy cells, rooms, or other enclosures:	0
Number of open bay/dorm housing units:	0
Number of segregation or isolation cells or rooms (for example, administrative, disciplinary, protective custody, etc.):	281
Does the facility have a video monitoring system, electronic surveillance system, or other monitoring technology (e.g. cameras, etc.)?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Has the facility installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology in the past 12 months?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

Medical and Mental Health Services and Forensic Medical Exams

Are medical services provided on-site?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Are mental health services provided on-site?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

<p>Where are sexual assault forensic medical exams provided? Select all that apply.</p>	<input type="checkbox"/> On-site <input checked="" type="checkbox"/> Local hospital/clinic <input type="checkbox"/> Rape Crisis Center <input type="checkbox"/> Other (please name or describe: Click or tap here to enter text.)
<p>Investigations</p>	
<p>Criminal Investigations</p>	
<p>Number of investigators employed by the agency and/or facility who are responsible for conducting CRIMINAL investigations into allegations of sexual abuse or sexual harassment:</p>	<p>1</p>
<p>When the facility received allegations of sexual abuse or sexual harassment (whether staff-on-resident or resident-on-resident), CRIMINAL INVESTIGATIONS are conducted by: Select all that apply.</p>	<input type="checkbox"/> Facility investigators <input type="checkbox"/> Agency investigators <input checked="" type="checkbox"/> An external investigative entity
<p>Select all external entities responsible for CRIMINAL INVESTIGATIONS: Select all that apply (N/A if no external entities are responsible for criminal investigations)</p>	<input type="checkbox"/> Local police department <input type="checkbox"/> Local sheriff's department <input checked="" type="checkbox"/> State police <input type="checkbox"/> A U.S. Department of Justice component <input type="checkbox"/> Other (please name or describe: Click or tap here to enter text.) <input type="checkbox"/> N/A
<p>Administrative Investigations</p>	
<p>Number of investigators employed by the agency and/or facility who are responsible for conducting ADMINISTRATIVE investigations into allegations of sexual abuse or sexual harassment?</p>	<p>2</p>
<p>When the facility receives allegations of sexual abuse or sexual harassment (whether staff-on-resident or resident-on-resident), ADMINISTRATIVE INVESTIGATIONS are conducted by: <i>Select all that apply</i></p>	<input checked="" type="checkbox"/> Facility investigators <input checked="" type="checkbox"/> Agency investigators <input type="checkbox"/> An external investigative entity
<p>Select all external entities responsible for ADMINISTRATIVE INVESTIGATIONS: Select all that apply (N/A if no external entities are responsible for administrative investigations)</p>	<input type="checkbox"/> Local police department <input type="checkbox"/> Local sheriff's department <input checked="" type="checkbox"/> State police <input type="checkbox"/> A U.S. Department of Justice component <input checked="" type="checkbox"/> Other (please name or describe: Illinois Department of Corrections (DOC)/Department of Children and Family Services (DCFS)) <input type="checkbox"/> N/A

Audit Findings

Audit Narrative (including Audit Methodology)

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

Overview

The on-site Prison Rape Elimination Act (PREA) compliance audit of Illinois Youth Center Harrisburg (IYCH), located in Harrisburg, Illinois, was conducted on July 14-15, 2021, by U.S. Department of Justice (DOJ) certified PREA Auditor James L. Roland Jr., Nakamoto Group, Inc. The standards used for this audit became effective August 20, 2012. The Auditor conducted an opening meeting, toured the entire facility, interviewed a randomized sample of staff and residents, and reviewed PREA related staff and resident documentation. Upon completing the audit process, a closing meeting was held with the administrative staff to discuss the audit process, preliminary findings, and the post-audit process. Employees at the facility were found to be extremely courteous, cooperative, and professional. All areas of the facility were clean and well maintained. During the completion meeting, the Auditor thanked the staff for their hard work and dedication to the PREA process.

Pre-Audit Phase

On May 21, 2021, PREA Audit Notices in English and Spanish were provided to the facility to be posted. The Auditor observed the notices posted in the living units, at the main entrance, and in the visitation area. The notices were posted for six weeks pre-audit, and the Auditor did not receive any correspondence from residents before the on-site visit.

IYCH staff members were asked to complete the Pre-Audit Questionnaire (PAQ), also provided to the facility on May 21, 2021. The Auditor received the completed PAQ and supporting documentation on May 30, 2021. The Auditor reviewed all documentation, including educational materials, training logs, posters, brochures, agency policies and procedures, forms, organizational charts, and other PREA related documentation.

On May 31, 2019, the Auditor requested additional information including, but not limited to, staff rosters, resident rosters, investigations for review, residents self-identified as lesbian, gay, bisexual, transgender, intersex (LGBTI), resident reports of sexual abuse/harassment, residents who are Limited English Proficient (LEP), and additional examples of the IYCH screening instrument. These documents were provided and reviewed at the time of the audit.

On-Site Audit Phase

The Auditor held an opening meeting on the morning of July 14, 2021, at the IYCH facility with administrative staff. The audit schedule and process were discussed during the meeting. Including the Auditor, those present at the meeting were:

- Deputy Director
- Superintendent
- Assistant Superintendent of Operations
- Assistant Superintendent of Programs
- PREA Compliance Manager/Social Worker III (PCM)
- Mental Health Treatment Unit Administrator
- Harrisburg Facility Investigator
- Chief of Security and Statewide Investigator (Agency Investigator)
- Healthcare Unit Administrator

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

Site Review

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

Resident Interviews

At the time of the audit, there were 34 male residents housed at IYCH. A total of 16 residents were interviewed. The facility indicated that they had no residents with Limited English Proficiency (LEP), no residents who self-identified as LGBTI, no residents who reported sexual victimization during risk screening, and no residents with cognitive or physical disabilities. No residents refused to be interviewed. Interviews were conducted using the Department of Justice (DOJ) protocols to determine residents' knowledge of PREA and the reporting mechanisms available to them.

Staff Interviews

IYCH employs a staff of 260 individuals. Twenty-nine staff members were interviewed, including 15 random staff (from all three shifts) and 14 administrative/specialized staff. The administrative staff included the Superintendent, Assistant Superintendent of Operations, Assistant Superintendent of Programs, PCC, and the PCM. The specialized staff interviewed included a human resources representative, a Mental Health Treatment Unit Administrator, Healthcare Unit Administrator, Agency Investigator, Juvenile Justice Youth, and Family Specialist, and three shift supervisors. All staff members have been trained to act as first responders when a PREA related incident occurs. All staff members are considered first responders.

The Auditor connected telephonically with the Program Director of Women's Center, Inc., regarding the Memorandum of Understanding (MOU) between Women's Center Inc. and the facility. It was confirmed that Women's Center Inc. would provide services to IYCH, including, but not limited to, a 24 hour per day, seven days per week Sexual Assault Hotline, medical accompaniment, and advocacy for a resident victim of sexual assault. The Auditor connected telephonically with an emergency room representative at Harrisburg Medical Center and confirmed that forensic examinations by a Sexual Assault Nurse Examiner (SANE) are available 24 hours per day, seven days per week.

File Review

Following the interviews, the Auditor reviewed the files requested during the pre-audit phase. The Auditor reviewed five personnel files to establish compliance with PREA training mandates and background checks. The Auditor also reviewed the training file and background checks for a facility contractor. Screening and intake procedures were evaluated by reviewing five random resident files which included a vulnerability assessment instrument and resident education verification documentation.

Investigations

There were three reported allegations of sexual harassment and/or sexual abuse during the current auditing period. Administrative investigations were completed for all three allegations, and all were determined to be unfounded. The Auditor reviewed this documentation.

The Agency Investigator conducts all administrative investigations. If an investigation reveals potentially criminal evidence, the case is referred to the Illinois State Police (ISP). The Agency Investigator is responsible for receiving verbal and telephonic referrals 24 hours a day, seven days a week. Additionally, abuse investigation outcomes and general protective services assessment outcomes are submitted to, reviewed, and finalized by the Superintendent and forwarded to the agency PCC.

Closeout

A closing meeting was held with the Auditor and the administrative staff on the evening of July 15, 2021. Discussions centered around the audit process, preliminary findings, and the post-audit process. The Auditor thanked the staff for their hard work and dedication to the PREA process.

Facility Characteristics

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

IYC-Harrisburg (IYCH), located in southern Illinois, serves as one of the secure medium-security Level 2 facilities for the Illinois Department of Juvenile Justice, currently housing an average daily population of 39 male youth.

IYC-Harrisburg provides a broad range of services to youth at the facility. These services include remedial and secondary education, a GED program, library services, vocational training, guidance, and work training programs. Harrisburg School District 428 is partnered with Lake Land College to offer Culinary Arts, Custodial Maintenance, Horticulture programs & certificates. Substance abuse treatment, diagnostic, evaluative services, special education programs, and various mental health programs are also provided. IYCH provides a full-time mental health & health care staff to provide services around the clock.

Harrisburg provides on-site physician, dental, & psychiatric care at regularly scheduled intervals. It hosts one of two statewide mental health special treatment programs, in addition to the only accredited sex offender programs in the juvenile division. A variety of off-ground activities are made available to youth, both recreational and educational.

Summary of Audit Findings

*The summary should include the number of standards exceeded, number of standards met, and number of standards not met, **along with a list of each of the standards in each category.** If relevant, provide a summarized description of the corrective action plan, including deficiencies observed, recommendations made, actions taken by the agency, relevant timelines, and methods used by the auditor to reassess compliance.*

Overview

During the auditing period, IYCH reported three incidents of sexual harassment/abuse. There is a well-established zero-tolerance culture throughout, with documentation addressing all areas of PREA. The agency, the Illinois Department of Juvenile Justice (IDJJ), maintains a central administration set of PREA policies and specific, detailed policies for the facility. A random review of personnel files for background checks and employee training files

established compliance with PREA training mandates and revealed that hiring and promotion practices are consistent with sexual abuse safety measures.

The Auditor found the facility administration maintaining a strong commitment to PREA and the zero-tolerance policies. Significant time and resources have been employed to ensure a sexually safe environment for the residents and staff of IYCH.

Staff Interviews

Interviews with staff revealed a good understanding of PREA policies. Staff members were knowledgeable about their roles in prevention, reporting, and their responsibilities in the event of a PREA related incident, particularly first responder duties. Staff members could verbalize the steps required if they were a first-responder in a PREA related incident. Reporting mechanisms were displayed conspicuously, and residents and staff were aware of all reporting methods available to them. A review of the IYCH staff training curriculum was completed by the Auditor and records supported the finding that all staff have received comprehensive PREA training. Staff appeared truly interested and vested with the residents and expressed a desire to see them succeed.

Resident Interviews

Interviews with residents revealed a good understanding of the PREA and the zero-tolerance policy. Comprehensive resident PREA education is provided in written form (i.e., Youth Orientation Manual, Entrance Packet), personal instruction, and posters. Twenty vulnerability assessment instruments reviewed by the Auditor revealed that intake and classification assessments are efficient and seamless in addressing referrals based on victimization or abusiveness screening data. Residents acknowledged that the admissions screening process included questions regarding any history of sexual abuse or victimization and whether they would like to identify a sexual preference. Residents expressed during interviews that they were aware of how to report abuse internally and externally. Residents verbalized trust in the IYCH staff and a willingness to report abuse to them. The residents demonstrated an understanding that the facility has appropriate medical and victim advocacy networks in place. Residents affirmed that they felt safe in the facility. Staff and resident interactions were observed by the Auditor and appeared respectful and positive.

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

Number of Standards Exceeded: 0

Number of Standards Met: 45

Number of Standards Not Met: 0

Summary of Corrective Action (if any)

PREVENTION PLANNING

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

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

115.311 (a)

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

115.311 (b)

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

115.311 (c)

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

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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

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

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

1. IYCH Pre-Audit Questionnaire
2. Policy: Illinois Department of Juvenile Justice (IDJJ) 01.02.102 Duty Administrative Officers
3. Policy: IDJJ 04.01.301 Sexual Abuse and Harassment Prevention and Intervention
4. Policy: IDJJ 04.01.302 Sexual Abuse and Harassment - Response Procedures
5. Policy: IDJJ 04.01.3010 Sexual Abuse and Harassment Prevention and Intervention Program
6. 115.311 Facility Memo: Key Staff Responsibilities
7. Policy: IDJJ 04.01.3020 Sexual Abuse and Harassment – Response Procedures
8. Policy: IDJJ 01.02.103 Inspection Tours by Administrative Staff
9. Policy: IDJJ MH-004 Mandated Abuse and Neglect Reporting
10. PREA Response Plan
11. Facility Organizational Chart
12. Mental Health Department Organizational Chart
13. IDJJ Organizational Chart
14. Youth Orientation Manual
15. 2019 Staffing Plan
16. Interviews with the following:
 - a. Specialized and Random Staff

The agency's zero-tolerance policy against sexual abuse was clearly established in the above documentation and via interviews. The policy also outlines the agency's approach to preventing, detecting, and responding to sexual abuse and sexual harassment allegations. The Social Worker III serves as the PCM. In addition to the PCM, there is a designated agency PREA Compliance Coordinator to ensure adherence to the PREA. The PCM reports to the agency PREA Compliance Coordinator (PCC). Zero-tolerance posters are displayed throughout every area of IYCH. Agency and facility directives outline a zero-tolerance policy for all forms of sexual abuse and sexual harassment. Residents are informed orally about the zero-tolerance policy and the PREA program during intake and are required to view a video during orientation presentations. Additional program information is contained in the Youth Orientation Manual and is posted throughout the facility, as observed during the tour by this Auditor. PREA information is given to the resident in an intake packet. All PREA information, both video and written, is available in English and Spanish. Interpretive services are available for residents who do not speak or read English or Spanish. Both institution staff and residents are provided with multiple opportunities to become familiar with PREA policies and procedures. All employees receive initial training and Annual Refresher Training (ART) and updates throughout the year.

Corrective action: None required

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

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

115.312 (a)

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

115.312 (b)

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

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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

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

1. IYCH Pre-Audit Questionnaire
2. Interviews with the following:
 - a. Specialized Staff

The IYCH does not contract with other entities for the confinement of its residents.

Corrective action: None required

Standard 115.313: Supervision and monitoring

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

115.313 (a)

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

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

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

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

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

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

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

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

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

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

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

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

115.313 (b)

- Does the agency comply with the staffing plan except during limited and discrete exigent circumstances? Yes No
- In circumstances where the staffing plan is not complied with, does the facility document all deviations from the plan? (N/A if no deviations from staffing plan.) Yes No NA

115.313 (c)

- Does the facility maintain staff ratios of a minimum of 1:8 during resident waking hours, except during limited and discrete exigent circumstances? (N/A if the facility is not a secure juvenile facility per the PREA standards definition of "secure".) Yes No NA
- Does the facility maintain staff ratios of a minimum of 1:16 during resident sleeping hours, except during limited and discrete exigent circumstances? (N/A if the facility is not a secure juvenile facility per the PREA standards definition of "secure".) Yes No NA
- Does the facility fully document any limited and discrete exigent circumstances during which the facility did not maintain staff ratios? (N/A if the facility is not a secure juvenile facility per the PREA standards definition of "secure".) Yes No NA
- Does the facility ensure only security staff are included when calculating these ratios? (N/A if the facility is not a secure juvenile facility per the PREA standards definition of "secure".) Yes No NA
- Is the facility obligated by law, regulation, or judicial consent decree to maintain the staffing ratios set forth in this paragraph? Yes No

115.313 (d)

- In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: The staffing plan established pursuant to paragraph (a) of this section? Yes No
- In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: Prevailing staffing patterns? Yes No
- In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: The facility's deployment of video monitoring systems and other monitoring technologies? Yes No

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

115.313 (e)

- Has the facility implemented a policy and practice of having intermediate-level or higher-level supervisors conduct and document unannounced rounds to identify and deter staff sexual abuse and sexual harassment? (N/A for non-secure facilities) Yes No NA
- Is this policy and practice implemented for night shifts as well as day shifts? (N/A for non-secure facilities) Yes No NA
- Does the facility have a policy prohibiting staff from alerting other staff members that these supervisory rounds are occurring, unless such announcement is related to the legitimate operational functions of the facility? (N/A for non-secure facilities) Yes No NA

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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

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

1. IYCH Pre-Audit Questionnaire
2. Chief of Staff Memo
3. Policy: Illinois Department of Juvenile Justice (IDJJ) 01.02.102 Duty Administrative Officers
4. Policy: IDJJ 04.01.301 Sexual Abuse and Harassment Prevention and Intervention
5. Policy: IDJJ 01.02.103 Inspection Tours by Administrative Staff
6. Policy: IDJJ 01.02.102 Duty Administrative Officers
7. Policy: IDJJ MH-004 Mandated Abuse and Neglect Reporting
8. IDJJ Facility Vulnerability Assessment Review
9. Operational Data IYCH 2020

- 10. Operational Data IYCH 2021
- 11. Staffing Plan 2021
- 12. Unannounced Rounds (Examples)
- 13. Interviews with the following:
 - a. Specialized and Random Staff

Agency policies require each facility to review the staffing plans on an annual basis. Interviews with the Superintendent detailed compliance with the PREA and that other safety and security issues are always a primary focus when considering and reviewing respective staffing plans. The Superintendent meets weekly with his administrative staff, including the PCM, to address staffing issues as it relates to the PREA. The facility has been provided with all necessary resources to support the programs and procedures to ensure compliance with PREA standards. The audit included examining all video monitoring systems, resident access to grievance forms, staff interviews, and rosters. Supervisory and administrative staff members routinely make unannounced rounds covering all shifts, and these rounds are documented. Interviews with staff confirmed unannounced rounds occur in all areas of the facility and are conducted weekly, without prior notification to employees. The IYCH utilizes video cameras to monitor the facility. The Auditor observed these cameras during the facility tour. The facility also utilizes convex mirrors to supplement security in areas with numerous corners or potential blind spots.

Corrective action: None required

Standard 115.315: Limits to cross-gender viewing and searches

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

115.315 (a)

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

115.315 (b)

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

115.315 (c)

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

115.315 (d)

- Does the facility have policies that enable residents to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks? Yes No
- Does the facility have procedures that enable residents to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks? Yes No
- Does the facility require staff of the opposite gender to announce their presence when entering a resident housing unit? Yes No
- In facilities (such as group homes) that do not contain discrete housing units, does the facility require staff of the opposite gender to announce their presence when entering an area where residents are likely to be showering, performing bodily functions, or changing clothing? (N/A for facilities with discrete housing units) Yes No NA

115.315 (e)

- Does the facility always refrain from searching or physically examining transgender or intersex residents for the sole purpose of determining the resident's genital status? Yes No
- If a resident's genital status is unknown, does the facility determine genital status during conversations with the resident, by reviewing medical records, or, if necessary, by learning that information as part of a broader medical examination conducted in private by a medical practitioner? Yes No

115.315 (f)

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

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

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

Instructions for Overall Compliance Determination Narrative

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

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

1. IYCH Pre-Audit Questionnaire
2. Superintendent's Bulletin #18 Knock and Announce
3. Policy: IDJJ 05.01.302 Prohibited Cross-Gender Searches
4. Policy: IDJJ 04.01.301 Sexual Abuse and Harassment Prevention and Intervention Program
5. Policy: IDJJ 05.01.113 Routine Searches of Youth
6. PREA PowerPoint Training slides
7. IYCH PREA Response Plan
8. Interviews with the following:
 - a. Specialized and Random Staff
 - b. Residents

Policies and documentation address this standard. Cross-gender strip or cross-gender body cavity searches are prohibited, except in emergencies or when performed and documented by a medical practitioner. Staff interviews indicated they received cross-gender pat search training during initial and annual training. The Auditor observed that each unit has multiple shower stalls; however, youth must shower one at a time. Scheduling of showers is monitored by staff. The facility has implemented a policy that all staff working the unit will announce themselves before entering the unit to allow residents the opportunity to prepare themselves from a privacy perspective. The residents interviewed acknowledged they could shower, dress, and use the toilet privately without being viewed by the staff of the opposite gender. Staff, along with most of the residents interviewed, indicated that employees of the opposite gender announce their presence before entering a housing unit. Staff members were aware of the policy prohibiting the search of a transgender or intersex resident for the sole purpose of determining the resident's genital status. During the past 12 months, no exigent circumstances required cross-gender viewing of a resident by a staff member at IYCH.

Corrective action: None required

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

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

115.316 (a)

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who are deaf or hard of hearing? Yes No
- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who are blind or have low vision? Yes No
- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have intellectual disabilities? Yes No
- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have psychiatric disabilities? Yes No
- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have speech disabilities? Yes No
- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Other? (if "other," please explain in overall determination notes.) Yes No
- Do such steps include, when necessary, ensuring effective communication with residents who are deaf or hard of hearing? Yes No
- Do such steps include, when necessary, providing access to interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary? Yes No
- Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Have intellectual disabilities? Yes No
- Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Have limited reading skills? Yes No

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

115.316 (b)

- Does the agency take reasonable steps to ensure meaningful access to all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment to residents who are limited English proficient? Yes No
- Do these steps include providing interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary? Yes No

115.316 (c)

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

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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

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

1. IYCH Pre-Audit Questionnaire
2. Policy: IDJJ 05.05.101 Youth Reception and Classification Process
3. Policy: IDJJ 05.04.111 ADA Accommodations
4. LanguageLine Solutions Contract
5. Options for Reporting Sexual Abuse and Harassment Pamphlet
6. Employee Training Acknowledgements
7. IYCH PREA Response Plan

8. Youth Orientation Manual
9. Speak up Speak out- Sexual Abuse Hotline Pamphlet
10. 2018 Annual Refresher Training Curriculum
11. Interviews with the following:
 - a. Specialized and Random Staff
 - b. Residents

IYCH takes appropriate steps to ensure residents with disabilities and residents with LEP have an opportunity to participate in and benefit from the facility's efforts to prevent, detect, and respond to sexual abuse and sexual harassment. PREA handouts, bulletin board postings, and Youth Orientation Manuals are in both English and Spanish. The documents mentioned above were submitted to and reviewed by the Auditor. Staff members interviewed were aware of the policy that, under no circumstances, are resident interpreters or assistants to be used when dealing with PREA issues. Translation services are provided by LanguageLine Solutions and are available to residents who do not have a basic command of the English language. There were no LEP residents at the facility at the time of the audit. The review of documentation, staff, and resident interviews support a finding that the facility complies with this standard.

Corrective action: None required

Standard 115.317: Hiring and promotion decisions

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

115.317 (a)

- Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997)? Yes No
- Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse? Yes No
- Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has been civilly or administratively adjudicated to have engaged in the activity described in the question immediately above? Yes No
- Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997)? Yes No
- Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse? Yes No

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

115.317 (b)

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

115.317 (c)

- Before hiring new employees, who may have contact with residents, does the agency perform a criminal background records check? Yes No
- Before hiring new employees, who may have contact with residents, does the agency consult any child abuse registry maintained by the State or locality in which the employee would work? Yes No
- Before hiring new employees who may have contact with residents, does the agency, consistent with Federal, State, and local law, make its best efforts to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse? Yes No

115.317 (d)

- Does the agency perform a criminal background records check before enlisting the services of any contractor who may have contact with residents? Yes No
- Does the agency consult applicable child abuse registries before enlisting the services of any contractor who may have contact with residents? Yes No

115.317 (e)

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

115.317 (f)

- Does the agency ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in written applications or interviews for hiring or promotions? Yes No
- Does the agency ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in any interviews or written self-evaluations conducted as part of reviews of current employees? Yes No
- Does the agency impose upon employees a continuing affirmative duty to disclose any such misconduct? Yes No

115.317 (g)

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

115.317 (h)

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

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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

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

1. IYCH Pre-Audit Questionnaire
2. Department of Children and Family Services (DCFC), Child Abuse and Neglect Tracking System (CANTS) Authorization for Background Check (form CFS 689)

3. Department of Children and Family Services (DCFC), Child Abuse and Neglect Tracking System (CANTS)
4. System (CANTS) Authorization for Background Check (1 and 5 year examples)
5. Policy: IDJJ 03.02.106 Filing Vacancies
6. IDJJ Request for Background Investigation Form
7. Policy: IDJJ 03.02.100 Administrative Review of Personnel or Service Issues
8. DCFS Acknowledgement of Mandated Reporter Status (Form)
9. Policy: IDJJ 03.02.105 Qualifications and Screening for Juvenile Specialist Interns
10. Policy: IDJJ 01.02.107 Background Investigation
11. Policy: IDJJ 01.12.101 Employee Criminal Misconduct
12. Policy: IDJJ 03.02.108 Standards of Conduct
13. IDJJ PREA Pre-Employment Self-Report (Form DJJ0469)
14. Interviews with the following:
 - a. Specialized and Random Staff

Policies and interviews confirm compliance with this standard. Employee files were reviewed for compliance with this standard. A human resource representative was interviewed, stating that all aspects of this standard have been met. Background checks have been completed on all employees, contractors, and volunteers. The DCFC CANTS conducts background checks. Background checks must be passed before approving staff hiring or promotions. A tracking system is in place to ensure that updated background checks are conducted every five years. The policy clearly states that the submission of false information by any applicant is grounds for termination. The agency does its best to contact all prior institution employers regarding substantiated allegations of sexual abuse or resignations occurring during a pending investigation of sexual abuse. The agency also provides information on substantiated allegations of sexual abuse/sexual harassment involving former employees when requested by a potential institutional employer, unless prohibited by law. Appropriate licensing and certifying agencies are notified when professional employees are terminated for substantiated sexual abuse/sexual harassment allegations. Documentation on file supports a finding that the facility complies with this standard.

Corrective action: None require

Standard 115.318: Upgrades to facilities and technologies

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

115.318 (a)

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

115.318 (b)

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

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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

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

1. Interviews with the following:
 - a. Superintendent

Policies and interviews confirm compliance with this standard. There have been no modifications or upgrades to the monitoring systems during the auditing period. IYCH utilizes a video camera system for video surveillance. Cameras are placed strategically throughout the complex to ensure the safety and security of both residents and staff.

Corrective action: None required

RESPONSIVE PLANNING

Standard 115.321: Evidence protocol and forensic medical examinations

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

115.321 (a)

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

115.321 (b)

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

115.321 (c)

- Does the agency offer all residents who experience sexual abuse access to forensic medical examinations, whether on-site or at an outside facility, without financial cost, where evidentiarily or medically appropriate? Yes No
- Are such examinations performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) where possible? Yes No
- If SAFEs or SANEs cannot be made available, is the examination performed by other qualified medical practitioners (they must have been specifically trained to conduct sexual assault forensic exams)? Yes No
- Has the agency documented its efforts to provide SAFEs or SANEs? Yes No

115.321 (d)

- Does the agency attempt to make available to the victim a victim advocate from a rape crisis center? Yes No
- If a rape crisis center is not available to provide victim advocate services, does the agency make available to provide these services a qualified staff member from a community-based organization, or a qualified agency staff member? (N/A if the agency *always* makes a victim advocate from a rape crisis center available to victims.) Yes No NA
- Has the agency documented its efforts to secure services from rape crisis centers?
 Yes No

115.321 (e)

- As requested by the victim, does the victim advocate, qualified agency staff member, or qualified community-based organization staff member accompany and support the victim through the forensic medical examination process and investigatory interviews? Yes No
- As requested by the victim, does this person provide emotional support, crisis intervention, information, and referrals? Yes No

115.321 (f)

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

115.321 (g)

- Auditor is not required to audit this provision.

115.321 (h)

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

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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

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

1. IYCH Pre-Audit Questionnaire
2. Policy: IDJJ 04.01.301 Sexual Abuse and Harassment Prevention and Intervention
3. Policy: IDJJ 04.01.3020 Sexual Abuse and Harassment Prevention and Intervention Procedures
4. Policy: IDJJ 04.01.302 Sexual Abuse and Harassment Prevention and Intervention Procedures
5. Memorandum of Understanding (MOU) with Women's Center 2021
6. Youth Orientation Manual
7. Locating Sexual Assault Advocates Handout
8. PREA Response Plan IYC Harrisburg
9. Interviews with the following:
 - a. Specialized and Random Staff

Policies and interviews confirm compliance with this standard. The facility has a full-time infirmary for medical services. Forensic medical examinations are conducted off-grounds at Harrisburg Medical Center (HMC), located in Harrisburg, Illinois. All staff has been trained in evidence protocol. In the event of a sexual assault, a shift supervisor is notified, followed by the Superintendent. The Superintendent determines when the resident(s) should be transported to the hospital for a Sexual Assault Nurse Examiner (SANE) exam or other medical treatment. The facility has an MOU with Women's Center Inc. to provide quality and comprehensive services for victims of sexual assault. The Hotline number is posted in each housing unit. The Illinois State Police conduct all criminal investigations (ISP). The Agency Investigator conducts all administrative investigations.

Corrective action: None required

Standard 115.322: Policies to ensure referrals of allegations for investigations

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

115.322 (a)

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

115.322 (b)

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

- Has the agency published such policy on its website or, if it does not have one, made the Policy:: available through other means? Yes No
- Does the agency document all such referrals? Yes No

115.322 (c)

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

115.322 (d)

- Auditor is not required to audit this provision.

115.322 (e)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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

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

1. IYCH Pre-Audit Questionnaire
2. Memorandum of Understanding (MOU) with Women's Center
3. Policy: IDJJ 04.01.301 Sexual Abuse and Harassment Prevention and Intervention
4. Policy: IDJJ 04.01.302 Sexual Abuse and Harassment Prevention and Intervention Procedures
5. Policy: IDJJ 01.12.105 Reporting of Unusual Incidents
6. Policy: IDJJ 01.12.125 Uniform Investigative Reporting System
7. Policy: IDJJ 01.12.112 Preservation of Evidence
8. Policy: IDJJ 01.12.115 Institutional Investigative Assignments
9. Policy: IDJJ 01.12.120 Investigations of Unusual Incidents

- 10. Policy: IDJJ 01.12.125 Uniform Investigative Reporting System
- 11. PREA Response Plan
- 12. Report of Investigative Outcome Form
- 13. Report of Investigative Outcome (Examples)
- 14. Interviews with the following:
 - a. Random and Specialized Staff

Facility and medical staff members were interviewed concerning this standard, and all were knowledgeable of the procedures required to secure and obtain usable physical evidence when sexual abuse is alleged. Staff members were aware that the Agency Investigator conducts administrative investigations. In addition, they indicated that Illinois State Police (ISP) conduct criminal investigations. All forensic medical examinations are conducted by SANE staff at Harrisburg Medical Center (HMC). A telephonic interview with the SANE representative at HMC was conducted, and the provider is aware of the provisions of the PREA standards. The representative indicated that a SANE is available 24 hours a day, seven days a week. There were no SANE examinations conducted during the past 12 months. The Women's Center, Inc. was contacted regarding advocacy services for residents at IYCH, and the Memorandum of Understanding (MOU) was reviewed for compliance with the standard.

Corrective action: None required

TRAINING AND EDUCATION

Standard 115.331: Employee training

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

115.331 (a)

- Does the agency train all employees who may have contact with residents on its zero-tolerance policy for sexual abuse and sexual harassment? Yes No
- Does the agency train all employees who may have contact with residents on how to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures? Yes No
- Does the agency train all employees who may have contact with residents on residents' right to be free from sexual abuse and sexual harassment Yes No
- Does the agency train all employees who may have contact with residents on the right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment? Yes No
- Does the agency train all employees who may have contact with residents on the dynamics of sexual abuse and sexual harassment in juvenile facilities? Yes No

- Does the agency train all employees who may have contact with residents on the common reactions of juvenile victims of sexual abuse and sexual harassment? Yes No
- Does the agency train all employees who may have contact with residents on how to detect and respond to signs of threatened and actual sexual abuse and how to distinguish between consensual sexual contact and sexual abuse between residents? Yes No
- Does the agency train all employees who may have contact with residents on how to avoid inappropriate relationships with residents? Yes No
- Does the agency train all employees who may have contact with residents on how to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents? Yes No
- Does the agency train all employees who may have contact with residents on how to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities? Yes No
- Does the agency train all employees who may have contact with residents on relevant laws regarding the applicable age of consent? Yes No

115.331 (b)

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

115.331 (c)

- Have all current employees who may have contact with residents received such training? Yes No
- Does the agency provide each employee with refresher training every two years to ensure that all employees know the agency's current sexual abuse and sexual harassment policies and procedures? Yes No
- In years in which an employee does not receive refresher training, does the agency provide refresher information on current sexual abuse and sexual harassment policies? Yes No

115.331 (d)

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

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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

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

1. IYCH Pre-Audit Questionnaire
2. Policy: IDJJ 03.03.102 Employee Training
3. Policy: IDJJ 04.01.301 Sexual Abuse and Harassment Prevention and Intervention
4. Policy: IDJJ 04.01.3010 Sexual Abuse and Harassment Prevention and Intervention Procedures
5. PREA Training: Weeks 1 through 4 (documents)
6. Yearly Cycle Training Verification form
7. Yearly Cycle Training Verification form (examples)
8. PREA Training Module Curriculum
9. Interviews with the following:
 - a. Specialized and Random Staff

IYCH provides extensive PREA training at their facility. All newly hired employees must attend and successfully complete the course curriculum. All employees were aware of PREA First Responder's responsibilities in the event of a reported PREA incident. All staff members are mandated to receive training annually, and the curriculum includes an extensive review of PREA requirements. The Auditor reviewed the training curriculum, training sign-in sheets, and other related training documentation. Interviewed staff verified the requirement to acknowledge, in writing, not only that they received PREA training but that they understood it.

Corrective action: None required

Standard 115.332: Volunteer and contractor training

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

115.332 (a)

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

115.332 (b)

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

115.332 (c)

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

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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

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

1. IYCH Pre-Audit Questionnaire
2. Policy: IDJJ 04.01.122 Contract Personnel Training
3. Policy: IDJJ 04.01.1220 Volunteer Services
4. Policy: IDJJ 0042 Volunteer Service Orientation Document
5. IYCH Volunteer Notice of Zero Tolerance Policy
6. Volunteer Manual 017 Retaining
7. Volunteer Manual 021 Sexual Harassment
8. Volunteer Manual 023 Confidentiality

9. Current and Active Volunteer Roster
10. Contract Personnel Pre-Screen Questionnaire
11. PREA Volunteer and Contractor Sign-off Sheet
12. PREA Volunteer and Contractor Sign-off Sheet (Examples)
13. PREA Training Sign-in Sheets
14. PREA Response Plan
15. IDJJ PowerPoint Presentation
16. Interviews with the following:
 - a. Specialized and Random Staff

Policies, Annual Training 2021 Lesson Plan, and Annual Training 2021 Agenda/Presentation address the mandates of this standard. All contractors and volunteers receive the PREA training, including the zero-tolerance policy, reporting, and responding requirements. The training is documented and maintained on file. The Auditor reviewed copies of training sign-in sheets and other related documents at the facility. During the on-site portion of the audit, one contractor was interviewed.

Corrective action: None required

Standard 115.333: Resident education

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

115.333 (a)

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

115.333 (b)

- Within 10 days of intake, does the agency provide age-appropriate comprehensive education to residents either in person or through video regarding: Their rights to be free from sexual abuse and sexual harassment? Yes No
- Within 10 days of intake, does the agency provide age-appropriate comprehensive education to residents either in person or through video regarding: Their rights to be free from retaliation for reporting such incidents? Yes No
- Within 10 days of intake, does the agency provide age-appropriate comprehensive education to residents either in person or through video regarding: Agency policies and procedures for responding to such incidents? Yes No

115.333 (c)

- Have all residents received the comprehensive education referenced in 115.333(b)?
 Yes No
- Do residents receive education upon transfer to a different facility to the extent that the policies and procedures of the resident's new facility differ from those of the previous facility?
 Yes No

115.333 (d)

- Does the agency provide resident education in formats accessible to all residents including those who: Are limited English proficient? Yes No
- Does the agency provide resident education in formats accessible to all residents including those who: Are deaf? Yes No
- Does the agency provide resident education in formats accessible to all residents including those who: Are visually impaired? Yes No
- Does the agency provide resident education in formats accessible to all residents including those who: Are otherwise disabled? Yes No
- Does the agency provide resident education in formats accessible to all residents including those who: Have limited reading skills? Yes No

115.333 (e)

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

115.333 (f)

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

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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

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

1. IYCH Pre-Audit Questionnaire
2. PREA PowerPoint Training Presentation
3. Policy: IDJJ 04.01.105 Youth Center Orientation
4. Policy: IDJJ MH-004 Mandated Abuse and Neglect Reporting
5. Policy: SA-002 Risk of Victimization Screening Tool
6. Policy: IDJJ 04.01.302 Sexual Abuse and Harassment - Response Procedures
7. Policy: IDJJ 04.01.301 Sexual Abuse and Harassment and Intervention Program
8. Policy: IDJJ 04.01.3010 Sexual Abuse and Harassment and Intervention Program Procedures
9. PREA Youth Curriculum with Video
10. End Silence - PREA Comic Training Tool for Youth
11. Reception and Classification Youth Receipt of PREA Information Document
12. Orientation Checklist/Signature Sheets
13. Youth Orientation Manual
14. Attachment to Youth Orientation Manual
15. IDJJ: What You Should Know About Sexual Abuse and Harassment Handout
16. Speak Up Speak Out- Sexual abuse information and hotline number
17. General Population Orientation Checklist
18. Mental Health Diagnostic and Treatment Note (Form DJJ 0282)
19. Receipt of PREA Training (Examples)
20. Screening Tool: Risk of Victimization (Form DJJ 0429)
21. Interviews with the following:
 - a. Specialized and Random Staff
 - b. Residents

Policies, training curriculum, signed acknowledgments, and Orientation Checklist/Signature Sheets address the mandates of this standard. The facility puts forth its best efforts to educate the residents regarding the PREA. Residents receive information during the intake process, including a Youth Orientation Manual, printed in English and Spanish. A staff member conducts an education program regarding the PREA for all residents within 30 days of their arrival at the facility. The program includes definitions of sexually abusive behavior and sexual harassment, prevention strategies, and reporting modalities. Residents also view a comprehensive orientation video that explains the facility's zero-tolerance policy and covers the resident's right to be free from sexual abuse, sexual harassment, and retaliation. There are PREA posters displayed throughout the facility and in each housing unit. These posters offer a "Hotline" telephone number, which may be called to report sexual abuse or sexual harassment. Since the "Hotline" telephone number is an 800-toll-free number, residents are advised that they can contact any staff member to place the call. PREA information is posted

in the Youth Orientation Manual and posted in each housing unit for resident correspondence concerning any sexual abuse or sexual harassment allegation. There is also a translation language line available to LEP residents. The Auditor was provided a random sampling of PREA Checklists/Signature Sheets to verify that residents admitted during the auditing period, received education and relevant written materials. All residents are required to acknowledge, in writing, the completion of PREA education. When they arrived at the facility during the interview process, randomly selected residents indicated they received information about the facility's rules against sexual abuse/sexual harassment. They further indicated they were advised about their right not to be sexually abused/sexually harassed, how to report sexual abuse/sexual harassment, and their right not to be punished for reporting sexual abuse/sexual harassment. Residents were aware of available services outside of the facility for dealing with sexual abuse.

Corrective action: None required

Standard 115.334: Specialized training: Investigations

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

115.334 (a)

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

115.334 (b)

- Does this specialized training include techniques for interviewing juvenile sexual abuse victims? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).) Yes No NA
- Does this specialized training include proper use of Miranda and Garrity warnings? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).) Yes No NA
- Does this specialized training include sexual abuse evidence collection in confinement settings? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).) Yes No NA
- Does this specialized training include the criteria and evidence required to substantiate a case for administrative action or prosecution referral? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).)
 Yes No NA

115.334 (c)

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

115.334 (d)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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

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

1. IYCH Pre-Audit Questionnaire
2. Investigator Certifications
3. Policy: IDJJ 01.12.101 Employee Criminal Misconduct
4. Policy: IDJJ 01.12.105 Reporting of Unusual Incidents
5. Policy: IDJJ 01.12.112 Preservation of Physical Evidence
6. Policy: IDJJ 01.12.115 Institutional Investigative Assignments
7. Policy: IDJJ 01.12.120 Reporting of Unusual Incidents
8. Policy: IDJJ 01.12.135 Reporting of Child Abuse and Neglect
9. Interviews with the following:
 - a. Specialized and Random Staff

The Agency Investigator conducts preliminary gathering of information related to alleged PREA incidents. The ISP conducts criminal investigations. There were three allegations of sexual abuse/harassment in the past 12 months. The Auditor conducted a comprehensive review of the investigative documentation in all three cases. The comprehensive document review revealed that all allegations were unfounded. Investigative documentation indicates that the facility took appropriate action based on policies and procedures outlined by the IDJJ.

Corrective action: None required

Standard 115.335: Specialized training: Medical and mental health care

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

115.335 (a)

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

115.335 (b)

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

115.335 (c)

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

115.335 (d)

- Do medical and mental health care practitioners employed by the agency also receive training mandated for employees by §115.331? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)

Yes No NA

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

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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

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

1. IYCH Pre-Audit Questionnaire
2. Policy: IDJJ MH-004 Mandated Abuse and Neglect Reporting
3. Policy: AD 04.04.100 General Mental Health Provisions
4. Training Verification Report
5. Specialized Training Sign-in Sheets
6. Risk of Screening Victimization tool
7. Interviews with the following:
 - a. Specialized and Random Staff

Policies, Annual Training Lesson Plan, and the PowerPoint presentation address the mandates of this standard. Other training includes online specialized training for psychologists and victim advocacy training. The agency ensures that all full and part-time medical and mental health practitioners, who regularly work in its facilities, have been trained according to the practitioner's status in the organization. All mental health and medical staff have received specialized training on victim identification, interviewing, reporting, and clinical interventions. Employees receive training annually, and support documentation is on file. Medical and mental health care staff acknowledged, in writing, that they both received and understood the training as it relates to the PREA. Interviews with medical and mental health staff confirmed awareness of their responsibilities regarding the PREA. All cases requiring the processing of sexual assault evidence collection kits are transported to the HMC, where a SANE is always available

(a SANE at HMC was interviewed and confirmed access to these services). A review of the training documentation and policy confirms compliance with this standard.

Corrective action: None required

SCREENING FOR RISK OF SEXUAL VICTIMIZATION AND ABUSIVENESS

Standard 115.341: Screening for risk of victimization and abusiveness

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

115.341 (a)

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

115.341 (b)

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

115.341 (c)

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (1) Prior sexual victimization or abusiveness? Yes No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (2) Any gender nonconforming appearance or manner or identification as lesbian, gay, bisexual, transgender, or intersex, and whether the resident may therefore be vulnerable to sexual abuse? Yes No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (3) Current charges and offense history? Yes No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (4) Age? Yes No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (5) Level of emotional and cognitive development? Yes No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (6) Physical size and stature? Yes No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (7) Mental illness or mental disabilities? Yes No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (8) Intellectual or developmental disabilities? Yes No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (9) Physical disabilities? Yes No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (10) The residents' own perception of vulnerability? Yes No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (11) Any other specific information about individual residents that may indicate heightened needs for supervision, additional safety precautions, or separation from certain other residents? Yes No

115.341 (d)

- Is this information ascertained through conversations with the resident during the intake process and medical mental health screenings? Yes No
- Is this information ascertained during classification assessments? Yes No
- Is this information ascertained by reviewing court records, case files, facility behavioral records, and other relevant documentation from the resident's files? Yes No

115.341 (e)

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

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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

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

1. IYCH Pre-Audit Questionnaire
2. Mental Health Intake Screening Tool
3. PREA Screening Tool
4. Policy: MH-004 Mandated Abuse and Neglect Reporting
5. Policy: IDJJ 04.01.125 Specialized Housing Units
6. Policy: IDJJ 04.01.130 Programs and Case Management
7. Policy: IDJJ 04.01.301 Sexual Abuse and Harassment and Intervention Program
8. Policy: IDJJ 04.01.302 Sexual Abuse and Harassment - Response Procedures
9. Policy: IDJJ 04.01.303 Lesbian, Gay, Bisexual, Transgender, Questioning, and Intersex (LGBTQI) Youth
10. Policy: IDJJ 04.04.100 General Mental Health Provisions
11. Policy: IDJJ 04.01.304 Discrimination and Harassment of Youth
12. Staff Training Agenda 2021 Annual Refresher Training
13. Training Logs/Records for Medical and Mental Health Practitioners
14. Interviews with the following:
 - a. Specialized and Random Staff

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

Corrective action: None required

Standard 115.342: Use of screening information

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

115.342 (a)

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

115.342 (b)

- Are residents isolated from others only as a last resort when less restrictive measures are inadequate to keep them and other residents safe, and then only until an alternative means of keeping all residents safe can be arranged? (N/A if the facility *never* places residents in isolation for any reason.) Yes No NA
- During any period of isolation, does the agency always refrain from denying residents daily large-muscle exercise? (N/A if the facility *never* places residents in isolation for any reason.) Yes No NA
- During any period of isolation, does the agency always refrain from denying residents any legally required educational programming or special education services? (N/A if the facility *never* places residents in isolation for any reason.) Yes No NA
- Do residents in isolation receive daily visits from a medical or mental health care clinician? (N/A if the facility *never* places residents in isolation for any reason.) Yes No NA
- Do residents in isolation also have access to other programs and work opportunities to the extent possible? (N/A if the facility *never* places residents in isolation for any reason.) Yes No NA

115.342 (c)

- Does the agency always refrain from placing lesbian, gay, and bisexual (LGB) residents in particular housing, bed, or other assignments solely on the basis of such identification or status? Yes No
- Does the agency always refrain from placing transgender residents in particular housing, bed, or other assignments solely on the basis of such identification or status? Yes No
- Does the agency always refrain from placing intersex residents in particular housing, bed, or other assignments solely on the basis of such identification or status? Yes No
- Does the agency always refrain from considering lesbian, gay, bisexual, transgender, or intersex (LGBTI) identification or status as an indicator or likelihood of being sexually abusive? Yes No

115.342 (d)

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

115.342 (e)

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

115.342 (f)

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

115.342 (g)

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

115.342 (h)

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

115.342 (i)

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

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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

1. IYCH Pre-Audit Questionnaire
2. Mental Health Intake Screening-IYC-Harrisburg
3. PREA Screening Tool
4. Bunk Issues Criteria Form
5. Policy: IDJJ MH-004 Mandated Abuse and Neglect Reporting
6. Policy: IDJJ 04.01.125 Specialized Housing Units
7. Policy: IDJJ 04.01.130 Programs and Case Management
8. Policy: IDJJ 04.01.135 Reporting of Child Abuse and Neglect
9. Policy: IDJJ 04.01.301 Sexual Abuse and Harassment and Intervention Program
10. Policy: IDJJ 04.01.302 Sexual Abuse and Harassment - Response Procedures
11. Policy: IDJJ 04.01.3020 Sexual Abuse and Harassment - Response Procedures

- 12. Policy: IDJJ 04.01.303 Lesbian, Gay, Bi-sexual, Transgender and Intersex Youth
- 13. Staff Training Agenda 2021 Annual Refresher Training
- 14. Policy: IDJJ 03.02.108 Standards of Conduct
- 15. Interviews with the following:
 - a. Specialized and Random Staff
 - b. Residents

Policies, documentation, and interviews support compliance with this standard. Agency and facility policy require the use of a screening instrument to determine proper housing, bed assignment, work assignment, education, and other program assignments, to keep residents at a high risk of being sexually abused/sexually harassed separate from those residents who are at a high risk of being sexually abusive. Housing and program assignments are made case-by-case, and residents are not placed in housing units based solely on their sexual identification or status. From the information provided by the facility, zero residents self-identified as bisexual, gay, transsexual, or intersex. Additionally, zero residents indicated sexual victimization or abusiveness during risk screening. During the audit, risk management staff indicated that transgender and intersex residents are reassessed monthly, and their views concerning their safety are given serious consideration. Additionally, they are allowed to shower separately from other residents. Staff and resident interviews, the review of supporting documentation, and the Auditor’s observations support the facility complying with the standard. Seclusion is only used in an emergency when the resident poses an imminent risk of harm to himself and/or others due to his current behavior. Seclusion is not used as a means of punishment, discipline, coercion, convenience, retaliation, nor a supplement for lack of staff presence or competency. The Superintendent shall ensure that seclusion is implemented only as authorized and in accordance with the provisions outlined in IDJJ. The Superintendent is responsible for ensuring that abusive and arbitrary use of seclusion does not occur at IYCH. The Superintendent ensures that program staff members are sufficiently trained in proper implementation and subsequent documentation regarding PREA. Per an interview with the Superintendent, residents cannot be kept in seclusion longer than 60 minutes. During that time, the resident is monitored every ten minutes. Residents may be released from seclusion any time before the 60 minutes if they demonstrate control of their emotional state.

Corrective action: None required

REPORTING

Standard 115.351: Resident reporting

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

115.351 (a)

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

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

115.351 (b)

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

115.351 (c)

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

115.351 (d)

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

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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

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

1. IYCH Pre-Audit Questionnaire
2. Policy: IDJJ 01.12.105 Reporting of Unusual Incidents
3. Policy: IDJJ 01.12.120 Investigation of Unusual Incidents
4. Policy: IDJJ 01.12.135 Reporting of Child Abuse and Neglect
5. Policy: IDJJ 04.01.114 Local Youth Grievance Procedures
6. Policy: IDJJ 04.01.301 Sexual Abuse and Harassment and Intervention Program
7. Policy: IDJJ 04.01.302 Sexual Abuse and Harassment - Response Procedures
8. IYCH PREA Response Plan
9. Signage: Sexual Abuse Hotline Number
10. Signage: John Howard Hotline Number
11. Risk of Victimization Screening Tool (SA 0002)
12. Youth Orientation Manual
13. Speak Up or Speak Out (Pamphlet)
14. Reporting Options (Document)
15. Interviews with the following:
 - a. Specialized and Random Staff
 - d. Residents

Policies, the PREA Notices, and Youth Orientation Manual address the requirements of the standard. A review of supporting documentation and staff/resident interviews indicate that there are multiple ways (verbally, in writing, anonymously, privately, and from a third party) for residents to report sexual abuse/sexual harassment. The facility has procedures in place for staff to document all allegations. There are posters and other documents on display throughout the facility that also explain reporting methods. Staff members promptly accept and document all verbal, written, anonymous, private, and third-party reports of the alleged abuse. Family and friends of residents may report sexual abuse/sexual harassment by contacting facility staff, calling the PREA Hotline, or other third-party. All interviewed residents confirmed their awareness of the multiple methods of reporting sexual abuse/harassment allegations. Interviews with staff and residents, observations of posters addressing reporting methods, and an examination of policy/documentation confirm that IYCH complies with this standard.

Corrective action: None required

Standard 115.352: Exhaustion of administrative remedies

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

115.352 (a)

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

115.352 (b)

- Does the agency permit residents to submit a grievance regarding an allegation of sexual abuse without any type of time limits? (The agency may apply otherwise-applicable time limits to any portion of a grievance that does not allege an incident of sexual abuse.) (N/A if agency is exempt from this standard.) Yes No NA
- Does the agency always refrain from requiring a resident to use any informal grievance process, or to otherwise attempt to resolve with staff, an alleged incident of sexual abuse? (N/A if agency is exempt from this standard.) Yes No NA

115.352 (c)

- Does the agency ensure that: A resident who alleges sexual abuse may submit a grievance without submitting it to a staff member who is the subject of the complaint? (N/A if agency is exempt from this standard.) Yes No NA
- Does the agency ensure that: Such grievance is not referred to a staff member who is the subject of the complaint? (N/A if agency is exempt from this standard.) Yes No NA

115.352 (d)

- Does the agency issue a final agency decision on the merits of any portion of a grievance alleging sexual abuse within 90 days of the initial filing of the grievance? (Computation of the 90-day time period does not include time consumed by residents in preparing any administrative appeal.) (N/A if agency is exempt from this standard.) Yes No NA
- If the agency determines that the 90-day timeframe is insufficient to make an appropriate decision and claims an extension of time [the maximum allowable extension of time to respond is 70 days per 115.352(d)(3)], does the agency notify the resident in writing of any such extension and provide a date by which a decision will be made? (N/A if agency is exempt from this standard.) Yes No NA
- At any level of the administrative process, including the final level, if the resident does not receive a response within the time allotted for reply, including any properly noticed extension, may a resident consider the absence of a response to be a denial at that level? (N/A if agency is exempt from this standard.) Yes No NA

115.352 (e)

- Are third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, permitted to assist residents in filing requests for administrative remedies relating to allegations of sexual abuse? (N/A if agency is exempt from this standard.)
 Yes No NA
- Are those third parties also permitted to file such requests on behalf of residents? (If a third party, other than a parent or legal guardian, files such a request on behalf of a resident, the facility may require as a condition of processing the request that the alleged victim agree to have the request filed on his or her behalf, and may also require the alleged victim to personally pursue any subsequent steps in the administrative remedy process.) (N/A if agency is exempt from this standard.) Yes No NA
- If the resident declines to have the request processed on his or her behalf, does the agency document the resident's decision? (N/A if agency is exempt from this standard.)
 Yes No NA
- Is a parent or legal guardian of a juvenile allowed to file a grievance regarding allegations of sexual abuse, including appeals, on behalf of such juvenile? (N/A if agency is exempt from this standard.) Yes No NA
- If a parent or legal guardian of a juvenile files a grievance (or an appeal) on behalf of a juvenile regarding allegations of sexual abuse, is it the case that those grievances are not conditioned upon the juvenile agreeing to have the request filed on his or her behalf? (N/A if agency is exempt from this standard.) Yes No NA

115.352 (f)

- Has the agency established procedures for the filing of an emergency grievance alleging that a resident is subject to a substantial risk of imminent sexual abuse? (N/A if agency is exempt from this standard.) Yes No NA
- After receiving an emergency grievance alleging a resident is subject to a substantial risk of imminent sexual abuse, does the agency immediately forward the grievance (or any portion thereof that alleges the substantial risk of imminent sexual abuse) to a level of review at which immediate corrective action may be taken? (N/A if agency is exempt from this standard.)
 Yes No NA
- After receiving an emergency grievance described above, does the agency provide an initial response within 48 hours? (N/A if agency is exempt from this standard.) Yes No NA
- After receiving an emergency grievance described above, does the agency issue a final agency decision within 5 calendar days? (N/A if agency is exempt from this standard.)
 Yes No NA

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

115.352 (g)

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

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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

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

1. IYCH Pre-Audit Questionnaire
2. Policy: IDJJ 04.01.114 Local Youth Grievance Procedures
3. Policy: IDJJ 04.01.301 Sexual Abuse and Harassment and Intervention Program
4. Policy: IDJJ 04.01.302 Sexual Abuse and Harassment - Response Procedures
5. Policy: IDJJ 04.01.304 Discrimination and Harassment of Youth
6. Policy: IDJJ 04.01.135 Reporting of Child Abuse and Neglect
7. Illinois Administrative Code: Title 20, Chapter IX, SubChapter d, Part 2504 Discipline and Grievances
8. IDJJ Youth Grievance Form (DJJ0046)
9. IDJJ Youth Grievance Response Form (DJJ0047)
10. Youth Orientation Manual
11. PREA Third Party Reporting Guide

12. Interviews with the following:
- a. Specialized and Random Staff
 - b. Residents

Policies and interviews address the requirement of this standard. The policy requires that all PREA grievances be processed in accordance with 115.52a-f. Residents may file a grievance; however, all allegations of sexual abuse/sexual harassment, when received by staff, will immediately be referred for investigation. Residents are not required to use an informal grievance process, and procedures also allow a resident to submit a grievance alleging sexual abuse/harassment without submitting it to the staff member who is the subject of the allegation. Additionally, the policy prohibits the allegation investigation by either staff alleged to be involved in the incident or any staff who may be under their supervision. The policy states that there is no time frame for filing a grievance related to sexual abuse or sexual harassment. Allegations of sexual abuse/harassment by staff shall be referred to the Agency Investigator in accordance with procedures established for such referrals. The policy addresses the filing of emergency administrative remedy requests. If a resident files the emergency grievance with the institution and believes he is under a substantial risk of imminent sexual abuse, an expedited response is required to be provided within 48 hours. No prohibition limits third parties, including fellow residents, staff members, family members, attorneys, and outside victim advocates, in assisting residents with filing requests for grievances related to allegations of sexual abuse or filing such requests on behalf of residents. There were no grievances filed involving PREA related issues during the past 12 months. No grievances were alleging sexual abuse/harassment that involved an extension due to the final decision not being reached within 90 days. Additionally, no grievances were alleging sexual abuse filed by residents in which the resident declined third-party assistance. Residents are held accountable for manipulative behavior and false allegations. Generally, disciplinary action would be taken if a grievance was filed in bad faith.

Corrective action: None required

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

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

115.353 (a)

- Does the facility provide residents with access to outside victim advocates for emotional support services related to sexual abuse by providing, posting, or otherwise making assessable mailing addresses and telephone numbers, including toll-free hotline numbers where available, of local, State, or national victim advocacy or rape crisis organizations? Yes No
- Does the facility provide persons detained solely for civil immigration purposes mailing addresses and telephone numbers, including toll-free hotline numbers where available of local, State, or national immigrant services agencies? (N/A if the facility *never* has persons detained solely for civil immigration purposes.) Yes No NA

- Does the facility enable reasonable communication between residents and these organizations and agencies, in as confidential a manner as possible? Yes No

115.353 (b)

- Does the facility inform residents, prior to giving them access, of the extent to which such communications will be monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws? Yes No

115.353 (c)

- Does the agency maintain or attempt to enter into memoranda of understanding or other agreements with community service providers that are able to provide residents with confidential emotional support services related to sexual abuse? Yes No
- Does the agency maintain copies of agreements or documentation showing attempts to enter into such agreements? Yes No

115.353 (d)

- Does the facility provide residents with reasonable and confidential access to their attorneys or other legal representation? Yes No
- Does the facility provide residents with reasonable access to parents or legal guardians? Yes No

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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

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

1. IYCH Pre-Audit Questionnaire

2. Youth Orientation Manual
3. Policy: IDJJ 04.01.301 Sexual Abuse and Harassment and Intervention Program
4. Policy: IDJJ 04.01.3010 Sexual Abuse and Harassment and Intervention
5. Policy: IDJJ 04.01.302 Sexual Abuse and Harassment - Response Procedures
6. Policy: IDJJ 04.01.303 Lesbian, Gay, Bisexual, Transgender, Questioning, and Intersex (LGBTQI) Youth
7. Policy: IDJJ 04.01.304 Discrimination and Harassment of Youth
8. Institutional Directive (ID) 20.525.003 Youth Telephone Privileges
9. Institutional Directive 20.525.001 Youth Rights and Privileges
10. Risk of Victimization Screening Tool (SA 0002)
11. Locating Sexual Assault Advocate Pamphlet
12. Interviews with the following:
 - a. Specialized and Random Staff
 - b. Residents

Policies and the Youth Orientation Manual address the requirements of this standard. The facility has an MOU with Women's Center, a local victim advocacy group. The Auditor reviewed the signed MOU document. The Youth Orientation Manual provides the contact information for advocacy services, and the information is also posted in the housing units. During the interview process, residents acknowledged awareness of these services and how to access them. Psychology Services staff members have all received victim advocacy support training.

Corrective action: None required

Standard 115.354: Third-party reporting

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

115.354 (a)

- Has the agency established a method to receive third-party reports of sexual abuse and sexual harassment? Yes No
- Has the agency distributed publicly information on how to report sexual abuse and sexual harassment on behalf of a resident? Yes No

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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

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

1. IYCH Pre-Audit Questionnaire
2. Three Options to Reporting Sexual Abuse or Sexual Misconduct Flowchart
3. Policy: IDJJ 04.01.301 Sexual Abuse and Harassment and Intervention Program
4. Policy: IDJJ 04.01.302 Sexual Abuse and Harassment - Response Procedures
5. Policy: IDJJ 04.01.303 Lesbian, Gay, Bisexual, Transgender, Questioning, and Intersex (LGBTQI) Youth
6. Policy: IDJJ 04.01.304 Discrimination and Harassment of Youth
7. Risk of Victimization Screening Tool (SA 0002)
8. Illinois Administrative Code: Title 20, Chapter IX, Subchapter d, Part 2525 Rights and Privileges
9. IDJJ Prevention of Sexual Victimization & Prison Rape Elimination Act: How to Report
10. Youth Orientation Manual
11. Interviews with the following:
 - a. Specialized and Random Staff
 - b. Residents

Policies, Youth Orientation Manual, PREA Posters, PREA Brochure, and Child Abuse Hotline number meet the mandates of this standard. The posters and telephone numbers and the Website <https://www2.illinois.gov/idjj/Pages/default.aspx> assist third parties in reporting sexual abuse/sexual harassment allegations. The residents interviewed indicated they were aware of third-party reporting and would feel more comfortable reporting an incident of sexual abuse/harassment to someone inside the facility. Calls to toll-free telephone numbers must be coordinated with a member of the unit team. IYCH maintains two hotline reporting numbers for residents and staff.

Corrective action: None required

OFFICIAL RESPONSE FOLLOWING A RESIDENT REPORT

Standard 115.361: Staff and agency reporting duties

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

115.361 (a)

- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency? Yes No
- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding retaliation against residents or staff who reported an incident of sexual abuse or sexual harassment? Yes No
- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding any staff neglect or violation of responsibilities that may have contributed to an incident of sexual abuse or sexual harassment or retaliation? Yes No

115.361 (b)

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

115.361 (c)

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

115.361 (d)

- Are medical and mental health practitioners required to report sexual abuse to designated supervisors and officials pursuant to paragraph (a) of this section as well as to the designated State or local services agency where required by mandatory reporting laws? Yes No
- Are medical and mental health practitioners required to inform residents of their duty to report, and the limitations of confidentiality, at the initiation of services? Yes No

115.361 (e)

- Upon receiving any allegation of sexual abuse, does the facility head or his or her designee promptly report the allegation to the appropriate office? Yes No
- Upon receiving any allegation of sexual abuse, does the facility head or his or her designee promptly report the allegation to the alleged victim's parents or legal guardians unless the facility has official documentation showing the parents or legal guardians should not be notified? Yes No
- If an alleged victim is under the guardianship of the child welfare system, does the facility head or his or her designee promptly report the allegation to the alleged victim's caseworker instead of the parents or legal guardians? Yes No

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

115.361 (f)

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

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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

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

1. IYCH Pre-Audit Questionnaire
2. Illinois Administrative code: Title 20, Chapter IX, Subchapter a, Part 2220 Rules of Conduct
3. Administrative Directive (AD) 01.12.105 Reporting of Unusual Incidents
4. Administrative Directive (AD) 04.01.301 Sexual Abuse and Harassment Prevention Program
5. Administrative Directive (AD) 04.01.302 Sexual Abuse and Harassment Response Procedures
6. Administrative Directive (AD) 01.12.135 Reporting of Child Abuse and Neglect
7. PREA Response Plan
8. Policy: IDJJ AD 01.105 Reporting of Unusual Incidents
9. Policy: IDJJ 01.12.120 Investigation of Unusual Incidents
10. Policy: IDJJ 03.02.108 Standards of Conduct
11. Policy: IDJJ 04.01.301 Sexual Abuse and Harassment and Intervention Program
12. Policy: IDJJ 04.01.302 Sexual Abuse and Harassment - Response Procedures
13. Policy: IDJJ MH-004 Mandated Abuse and Neglect Reporting
14. Risk of Victimization Screening Tool (SA 0002)

15. Interviews with the following:
a. Specialized and Random Staff

Policies and interviews address the requirements of this standard. Staff, contractors, and volunteers must report and respond to allegations of sexually abusive behavior, regardless of the source of the report. Staff members interviewed were aware of their duty to immediately report all allegations of sexual abuse, sexual harassment, and retaliation relevant to the PREA standards. The reporting is ordinarily made to a shift supervisor but could be made privately or by a third party. The policy requires the information concerning the identity of the alleged resident victim and the specific facts of the case to be shared with staff on a need-to-know basis due to their involvement with the victim's welfare and/or the investigation of the incident. A review of policy and interviews with staff support the finding that the facility complies with this standard. If a resident was at risk of sexual victimization, staff could temporarily place him in another unit. There have been no residents placed in another unit due to a risk of sexual victimization during the past 12 months. This was verified through interviews with random staff. Safety plans would be established to ensure that the resident was safe.

Corrective action: None required

Standard 115.362: Agency protection duties

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

115.362 (a)

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

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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

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

1. IYCH Pre-Audit Questionnaire
2. IYCH PREA Response Plan
3. Policy: IDJJ 04.01.135 Reporting of Child Abuse and Neglect
4. Policy: IDJJ 04.01.301 Sexual Abuse and Harassment and Intervention Program
5. Policy: IDJJ 04.01.3020 Sexual Abuse and Harassment - Response Procedures
6. Policy: IDJJ 04.01.3020 Sexual Abuse and Harassment - Response Procedures
7. Policy: IDJJ 04.01.304 Discrimination and Harassment of Youth
8. Policy: IDJJ MH-004 Mandated Abuse and Neglect Reporting
9. Interviews with the following:
 - a. Specialized and Random Staff

Policies and interviews address the requirements of this standard. Staff members interviewed were aware of their duties and responsibilities when they suspect that a resident is sexually abused or sexually harassed. All staff indicated they would act immediately to protect the resident, including separating the alleged victim/perpetrator, securing the scene to protect possible evidence, preventing the destruction of potential evidence, and contacting the shift supervisor and medical staff. In the past 12 months, there were no instances in which IYCH staff determined that a resident was subject to a substantial risk of imminent sexual abuse. There have been no residents placed in this status in the past 12 months. This was verified through interviews with random staff. Safety plans have been established to ensure that the resident was safe.

Corrective action: None required

Standard 115.363: Reporting to other confinement facilities

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

115.363 (a)

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

115.363 (b)

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

115.363 (c)

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

115.363 (d)

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

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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

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

1. IYCH Pre-Audit Questionnaire
2. PREA Investigation Checklist
3. Intake Screening Form (HRB0024)
4. Policy: IDJJ 04.01.301 Sexual Abuse and Harassment and Intervention Program
5. Policy: AD 04.01.302 Sexual Abuse and Harassment - Response Procedures
6. Policy: IDJJ MH-004 Mandated Abuse and Neglect Reporting
7. Interviews with the following:
 - a. Specialized and Random Staff

Policies address the requirements of this standard. The policy requires that any resident allegation of sexual abuse occurring while confined at another facility be reported to the Superintendent, where the alleged abuse occurred within 72 hours of receipt of the allegation. Established procedures require the Superintendent to immediately notify the other confinement facility, in writing, of the nature of the sexual abuse allegation.

Corrective action: None required

Standard 115.364: Staff first responder duties

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

115.364 (a)

- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Separate the alleged victim and abuser?
 Yes No
- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Preserve and protect any crime scene until appropriate steps can be taken to collect any evidence? Yes No
- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Request that the alleged victim not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating, if the abuse occurred within a time period that still allows for the collection of physical evidence? Yes No
- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Ensure that the alleged abuser does not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating, if the abuse occurred within a time period that still allows for the collection of physical evidence? Yes No

115.364 (b)

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

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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

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

1. IYCH Pre-Audit Questionnaire

2. PowerPoint training slides
3. IYCH PREA Response Plan
4. Policy: IDJJ 04.01.301 Sexual Abuse and Harassment and Intervention Program
5. Policy: IDJJ 04.01.302 Sexual Abuse and Harassment - Response Procedures
6. Policy: IDJJ 04.01.3020 Sexual Abuse and Harassment - Response Procedures
7. Interviews with the following:
 - a. Specialized and Random Staff

Policies and interviews address the requirements of this standard. All staff members interviewed were extremely knowledgeable concerning their first responder duties and responsibilities upon learning of an allegation of sexual abuse/sexual harassment. Staff indicated they would separate the residents, secure the scene, prevent the destruction of any evidence, and contact their supervisor and medical staff. The supervisor would protect the resident and notify medical, mental health, and administrative/executive staff. In the past 12 months, there were no allegations that a resident was sexually abused or harassed, and a first responder was required to separate the alleged victim and the perpetrator.

Corrective action: None required

Standard 115.365: Coordinated response

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

115.365 (a)

- Has the facility developed a written institutional plan to coordinate actions among staff first responders, medical and mental health practitioners, investigators, and facility leadership taken in response to an incident of sexual abuse? Yes No

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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

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

1. IYCH Pre-Audit Questionnaire
2. IYCH PREA Response Plan
3. PowerPoint Training Slides
4. Policy: IDJJ 04.01.301 Sexual Abuse and Harassment and Intervention Program
5. Policy: IDJJ 04.01.302 Sexual Abuse and Harassment - Response Procedures
6. Policy: IDJJ 01.12.120 Investigation of Unusual Incidents
7. Policy: IDJJ 04.01.135 Reporting of Child Abuse and Neglect
8. Policy: IDJJ 01.02.103 Inspection Tours by Administrative Staff
9. Policy: IDJJ 01.12.105 Reporting of Unusual Incidents
10. Policy: IDJJ 03.02.108 Standards of Conduct
11. Interviews with the following:
 - a. Specialized and Random Staff

The policies and the IYCH PREA Response Plan document address the requirements of this standard. The Auditor reviewed the policies. The local policy specifies the guidelines and procedures that prevent sexual abuse/sexual harassment and provides prompt and effective intervention if abuse or harassment occurs. The local policy also includes procedures for the investigation, discipline, and prosecution of the alleged perpetrator. The IYCH PREA Response Plan document details first responder duties, reporting procedures, physical evidence collection/preservation, and medical/mental health care responsibilities. The plan was developed to assist staff in responding to prohibited and/or illegal sexually abusive behavior allegations.

Corrective action: None required

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

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

115.366 (a)

- Are both the agency and any other governmental entities responsible for collective bargaining on the agency's behalf prohibited from entering into or renewing any collective bargaining agreement or other agreement that limits the agency's ability to remove alleged staff sexual abusers from contact with any residents pending the outcome of an investigation or of a determination of whether and to what extent discipline is warranted? Yes No

115.366 (b)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

Exceeds Standard (*Substantially exceeds requirement of standards*)

- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

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

The facility has a collective bargaining agreement with the State of Illinois and the American Federation of State, County, and Municipal Employees Council 31. The collective bargaining agreement does not prohibit the facility from removing alleged staff sexual abusers from contact with any residents pending the outcome of an investigation or determining whether and to what extent discipline is warranted. Staff interviews confirmed compliance with this standard.

Corrective action: None required

Standard 115.367: Agency protection against retaliation

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

115.367 (a)

- Has the agency established a policy to protect all residents and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other residents or staff? Yes No
- Has the agency designated which staff members or departments are charged with monitoring retaliation? Yes No

115.367 (b)

- Does the agency employ multiple protection measures, such as housing changes or transfers for resident victims or abusers, removal of alleged staff or resident abusers from contact with victims, and emotional support services, for residents or staff who fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations,? Yes No

115.367 (c)

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency monitor: The conduct and treatment of residents or staff who reported the sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff? Yes No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency monitor: The conduct and treatment of residents who were reported to have suffered sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff? Yes No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Act promptly to remedy any such retaliation? Yes No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency monitor: Any resident disciplinary reports? Yes No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency monitor: Resident housing changes? Yes No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency monitor: Resident program changes? Yes No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency monitor: Negative performance reviews of staff? Yes No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency monitor: Reassignments of staff? Yes No
- Does the agency continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need? Yes No

115.367 (d)

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

115.367 (e)

- If any other individual who cooperates with an investigation expresses a fear of retaliation, does the agency take appropriate measures to protect that individual against retaliation?
 Yes No

115.367 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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

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

1. IYCH Pre-Audit Questionnaire
2. IDJJ PREA Retaliation Monitor - Youth (Form DJJ 0498)
3. IDJJ PREA Retaliation Monitor - Staff (Form DJJ 0499)
4. IDJJ PREA Retaliation Monitor (Examples)
5. Policy: IDJJ 04.01.135 Reporting of Child Abuse and Neglect
6. Policy: IDJJ 04.01.301 Sexual Abuse and Harassment and Intervention Program
7. Policy: IDJJ 04.01.302 Sexual Abuse and Harassment - Response Procedures
8. Policy: IDJJ 04.01.3020 Sexual Abuse and Harassment - Response Procedures
9. Policy: IDJJ 04.01.304 Discrimination and Harassment of Youth
10. Interviews with the following:
 - a. Specialized Staff

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

Corrective action: None required

Standard 115.368: Post-allegation protective custody

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

115.368 (a)

- Is any and all use of segregated housing to protect a resident who is alleged to have suffered sexual abuse subject to the requirements of § 115.342? Yes No

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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

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

1. IYCH Pre-Audit Questionnaire
2. Policy: IDJJ 04.01.301 Sexual Abuse and Harassment and Intervention Program
3. Policy: IDJJ 04.01.302 Sexual Abuse and Harassment - Response Procedure
4. Policy: IDJJ 04.01.3020 Sexual Abuse and Harassment - Response Procedure
5. Policy: IDJJ 05.01.303 Youth Confinement
4. Interviews with the following:
 - a. Specialized Staff

Policies address the requirements of the standard. The policy requires staff to assess and consider all appropriate alternatives for safeguarding alleged resident victims of sexual abuse/sexual harassment. The facility does not use seclusion as a result of a PREA allegation. Residents or staff may be re-assigned to another unit or building pending the outcome of the investigation. Compliance with this standard was determined by a review of policy and a tour of the facility and staff interviews.

Corrective action: None required

INVESTIGATIONS

Standard 115.371: Criminal and administrative agency investigations

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

115.371 (a)

- When the agency conducts its own investigations into allegations of sexual abuse and sexual harassment, does it do so promptly, thoroughly, and objectively? [N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations. See 115.321(a).] Yes No NA
- Does the agency conduct such investigations for all allegations, including third party and anonymous reports? [N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations. See 115.321(a).] Yes No NA

115.371 (b)

- Where sexual abuse is alleged, does the agency use investigators who have received specialized training in sexual abuse investigations involving juvenile victims as required by 115.334? Yes No

115.371 (c)

- Do investigators gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data? Yes No
- Do investigators interview alleged victims, suspected perpetrators, and witnesses? Yes No
- Do investigators review prior reports and complaints of sexual abuse involving the suspected perpetrator? Yes No

115.371 (d)

- Does the agency always refrain from terminating an investigation solely because the source of the allegation recants the allegation? Yes No

115.371 (e)

- When the quality of evidence appears to support criminal prosecution, does the agency conduct compelled interviews only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution? Yes No

115.371 (f)

- Do agency investigators assess the credibility of an alleged victim, suspect, or witness on an individual basis and not on the basis of that individual's status as resident or staff?
 Yes No
- Does the agency investigate allegations of sexual abuse without requiring a resident who alleges sexual abuse to submit to a polygraph examination or other truth-telling device as a condition for proceeding? Yes No

115.371 (g)

- Do administrative investigations include an effort to determine whether staff actions or failures to act contributed to the abuse? Yes No
- Are administrative investigations documented in written reports that include a description of the physical evidence and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings? Yes No

115.371 (h)

- Are criminal investigations documented in a written report that contains a thorough description of the physical, testimonial, and documentary evidence and attaches copies of all documentary evidence where feasible? Yes No

115.371 (i)

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

115.371 (j)

- Does the agency retain all written reports referenced in 115.371(g) and (h) for as long as the alleged abuser is incarcerated or employed by the agency, plus five years unless the abuse was committed by a juvenile resident and applicable law requires a shorter period of retention?
 Yes No

115.371 (k)

- Does the agency ensure that the departure of an alleged abuser or victim from the employment or control of the agency does not provide a basis for terminating an investigation?
 Yes No

115.371 (l)

- Auditor is not required to audit this provision.

115.371 (m)

- When an outside agency investigates sexual abuse, does the facility cooperate with outside investigators and endeavor to remain informed about the progress of the investigation? (N/A if an outside agency does not conduct administrative or criminal sexual abuse investigations. See 115.321(a).) Yes No NA

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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

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

1. IYCH Pre-Audit Questionnaire
2. Policy: IDJJ 01.12.101 Employee Criminal Misconduct
3. Policy: IDJJ 01.12.105 Reporting of Unusual Incident
4. Policy: IDJJ 01.02.108 Standards of Conduct
5. Policy: IDJJ 04.01.302 Sexual Abuse and Harassment-Response Procedures
6. Policy: IDJJ 04.01.304 Discrimination and Harassment of Youth
7. Policy: IDJJ 01.12.112 Preservation of Physical Evidence
8. Policy: IDJJ 01.12.115 Institutional Investigation Assignment
9. Policy: IDJJ 01.12.120 Investigations of Unusual Incidents
10. Policy: IDJJ 01.12.135 Reporting of Child Abuse and Neglect
11. Illinois Administrative Code: Title 20, Chapter IX, SubChapter a, Part 2220 Rules of Conduct
12. Interviews with the following:
 - a. Specialized and Random Staff

Policies and interviews address the components of this standard. According to the Superintendent, the facility fully cooperates with any outside agency that initiates an investigation. The Superintendent serves as the facility liaison and provides requested information to outside investigative agencies and access to the resident(s). The credibility of an alleged victim, suspect, or witness is assessed individually and is not determined by the person's status as a resident or staff. The agency does not require a resident who alleges

sexual abuse/harassment to submit to a polygraph examination or other truth assessment device as a condition for proceeding with the investigation. During the last 12 months, there were three allegations of sexual harassment and/or abuse. All were unfounded. The Illinois State Police conduct all criminal investigations. The Superintendent initiates administration Investigations and then forwarded them to the Agency Investigator for additional investigation. The Auditor reviewed examples of Attorney Notifications. Compliance with this standard was determined by a review of policy/documentation and staff interviews.

Corrective action: None required

Standard 115.372: Evidentiary standard for administrative investigations

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

115.372 (a)

- Is it true that the agency does not impose a standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated? Yes No

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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

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

1. IYCH Pre-Audit Questionnaire
2. Policy: IDJJ 01.12.101 Employee Criminal Misconduct
3. Policy: IDJJ 01.12.105 Reporting of Unusual Incident
4. Policy: IDJJ 01.02.108 Standards of Conduct
5. Policy: IDJJ 04.01.302 Sexual Abuse and Harassment-Response Procedures
6. Policy: IDJJ 04.01.304 Discrimination and Harassment of Youth
7. Policy: IDJJ 01.12.112 Preservation of Physical Evidence

8. Policy: IDJJ 01.12.115 Institutional Investigation Assignment
9. Policy: IDJJ 01.12.120 Investigations of Unusual Incidents
10. Policy: IDJJ 01.12.135 Reporting of Child Abuse and Neglect
11. Illinois Administrative Code: Title 20, Chapter IX, SubChapter a, Part 2220 Rules of Conduct
12. Interviews with the following:
 - a. Specialized and Random Staff

Policies and interviews address the requirement of this standard. The evidence standard is a preponderance of the evidence in determining whether allegations of sexual abuse/sexual harassment are substantiated. When interviewed, the Agency Investigator confirmed and was aware of the evidence standard.

Standard 115.373: Reporting to residents

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

115.373 (a)

- Following an investigation into a resident's allegation that he or she suffered sexual abuse in an agency facility, does the agency inform the resident as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded? Yes No

115.373 (b)

- If the agency did not conduct the investigation into a resident's allegation of sexual abuse in the agency's facility, does the agency request the relevant information from the investigative agency in order to inform the resident? (N/A if the agency/facility is responsible for conducting administrative and criminal investigations.) Yes No NA

115.373 (c)

- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The staff member is no longer posted within the resident's unit? Yes No
- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The staff member is no longer employed at the facility? Yes No
- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The agency learns that the staff member has been indicted on a charge related to sexual abuse in the facility? Yes No

- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility? Yes No

115.373 (d)

- Following a resident's allegation that he or she has been sexually abused by another resident, does the agency subsequently inform the alleged victim whenever: The agency learns that the alleged abuser has been indicted on a charge related to sexual abuse within the facility?
 Yes No
- Following a resident's allegation that he or she has been sexually abused by another resident, does the agency subsequently inform the alleged victim whenever: The agency learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility?
 Yes No

115.373 (e)

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

115.373 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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

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

1. IYCH Pre-Audit Questionnaire
2. Investigation Case Review

3. Notification of Completed Investigation
4. Notification of Completed Investigation (Examples)
5. Investigation Report (Examples)
6. Administrative Outcome (Examples)
7. Policy: IDJJ 04.01.105 Youth Center Orientation
8. Policy: IDJJ 04.01.114 Local Youth Grievance Procedures
9. Policy: IDJJ 04.01.301 Sexual Abuse and Harassment and Intervention Program
10. Policy: IDJJ 04.01.302 Sexual Abuse and Harassment - Response Procedure
11. Policy: IDJJ 04.01.3020 Sexual Abuse and Harassment - Response Procedure
12. Policy: IDJJ 04.01.304 Discrimination and Harassment of Youth
13. Youth Grievance (Form 0046)
14. Youth Response to Grievance (Form 0047)
15. Interviews with the following:
 - a. Specialized and Random Staff

Policies and interviews address the components of this standard. During the last 12 months, there were three allegations of sexual harassment and/or abuse. The facility uses the ISP for all criminal investigative services. Residents are informed of the investigative process. All investigative decisions require a written response, including the rationale for the decision. This written documentation is made available to youth and/or family members. Copies of all investigative decisions are maintained. Decisions are available to the victim's family, administration, and the Illinois Department of Child and Family Services (DCFS).

Corrective action: None required

DISCIPLINE

Standard 115.376: Disciplinary sanctions for staff

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

115.376 (a)

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

115.376 (b)

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

115.376 (c)

- Are disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) commensurate with the nature and circumstances of the acts committed, the staff member's disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories? Yes No

115.376 (d)

- Are all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, reported to: Law enforcement agencies (unless the activity was clearly not criminal)? Yes No
- Are all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, reported to: Relevant licensing bodies? Yes No

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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

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

1. IYCH Pre-Audit Questionnaire
2. Illinois Administrative Code: Title 20, Chapter IX, SubChapter a, Part 2220 Rules of Conduct
3. Policy: AD 01.12.101 Employee Criminal Misconduct
4. Policy: AD 03.01.307 Sexual Harassment, Unlawful Discrimination, and Harassment
5. Policy: IDJJ 03.03.102 Employee Training
6. Policy: IDJJ 03.02.107 Personnel Files
7. Policy: IDJJ 03.02.108 Standards of Conduct
8. Policy: IDJJ 03.01.310 Sexual Harassment
9. Interviews with the following:
 - a. Specialized and Random Staff

Policies and interviews address the requirements of this standard. Employees are subject to disciplinary sanctions for violating agency sexual abuse or sexual harassment policies. There

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

Corrective action: None required

Standard 115.377: Corrective action for contractors and volunteers

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

115.377 (a)

- Is any contractor or volunteer who engages in sexual abuse prohibited from contact with residents? Yes No
- Is any contractor or volunteer who engages in sexual abuse reported to: Law enforcement agencies (unless the activity was clearly not criminal)? Yes No
- Is any contractor or volunteer who engages in sexual abuse reported to: Relevant licensing bodies? Yes No

115.377 (b)

- In the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer, does the facility take appropriate remedial measures, and consider whether to prohibit further contact with residents? Yes No

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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

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

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

1. IYCH Pre-Audit Questionnaire
2. Illinois Administrative Code: Title 20, Chapter IX, SubChapter a, Part 2220 Rules of Conduct
3. Policy: IDJJ 03.03.102 Employee Training
4. Policy: IDJJ 01.12.101 Employee Misconduct
5. Policy: IDJJ 03.02.107 Personnel Files
6. Policy: IDJJ 03.02.108 Standards of Conduct
7. Policy: IDJJ 04.01.122 Volunteer Services
8. Policy: IDJJ 03.01.307 Sexual Harassment, Unlawful Discrimination and Harassment
9. Policy: AD 04.01.3020 Sexual Abuse and Harassment Response Procedures
10. Policy: IDJJ 03.01.310 Sexual Harassment
11. Policy: IDJJ 05.01.303 Youth Confinement
12. Training Sign-in Sheets
13. Interviews with the following:
 - a. Specialized and Random Staff

Policies and interviews address the requirements of the standard. Any contractor or volunteer who engages in sexual abuse/sexual harassment would be prohibited from contact with residents and reported to the appropriate investigating agency, law enforcement, or relevant professional/licensing/certifying bodies unless the activity was clearly not criminal in nature. In non-criminal cases, IYCH would take appropriate remedial measures and consider whether to prohibit further contact with residents. During the past 12 months, there were no incidents where a contractor or volunteer was accused or found guilty of sexual abuse or sexual harassment. Compliance with this standard was determined by a review of policy and volunteer/contractor training files, as well as contractor and staff interviews.

Corrective action: None required

Standard 115.378: Interventions and disciplinary sanctions for residents

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

115.378 (a)

- Following an administrative finding that a resident engaged in resident-on-resident sexual abuse, or following a criminal finding of guilt for resident-on-resident sexual abuse, may residents be subject to disciplinary sanctions only pursuant to a formal disciplinary process?
 Yes No

115.378 (b)

- Are disciplinary sanctions commensurate with the nature and circumstances of the abuse committed, the resident's disciplinary history, and the sanctions imposed for comparable offenses by other residents with similar histories? Yes No
- In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident is not denied daily large-muscle exercise? Yes No
- In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident is not denied access to any legally required educational programming or special education services? Yes No
- In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident receives daily visits from a medical or mental health care clinician? Yes No
- In the event a disciplinary sanction results in the isolation of a resident, does the resident also have access to other programs and work opportunities to the extent possible? Yes No

115.378 (c)

- When determining what types of sanction, if any, should be imposed, does the disciplinary process consider whether a resident's mental disabilities or mental illness contributed to his or her behavior? Yes No

115.378 (d)

- If the facility offers therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse, does the facility consider whether to offer the offending resident participation in such interventions? Yes No
- If the agency requires participation in such interventions as a condition of access to any rewards-based behavior management system or other behavior-based incentives, does it always refrain from requiring such participation as a condition to accessing general programming or education? Yes No

115.378 (e)

- Does the agency discipline a resident for sexual contact with staff only upon a finding that the staff member did not consent to such contact? Yes No

115.378 (f)

- For the purpose of disciplinary action does a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred NOT constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation? Yes No

115.378 (g)

- If the agency prohibits all sexual activity between residents, does the agency always refrain from considering non-coercive sexual activity between residents to be sexual abuse? (N/A if the agency does not prohibit all sexual activity between residents.) Yes No NA

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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

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

1. IYCH Pre-Audit Questionnaire
2. Youth Orientation Handbook
3. Policy: IDJJ 04.01.115 Administrative Review Board Hearings
4. Policy: IDJJ 04.01.135 Youth Intervention
5. Policy: IDJJ 04.01.140 Youth Discipline
6. Policy: IDJJ 04.01.301 Sexual Abuse and Harassment and Intervention Program
7. Policy: IDJJ 04.01.302 Sexual Abuse and Harassment - Response Procedure
8. Policy: AD 04.01.302 Sexual Abuse and Harassment Response Procedures
9. Illinois Administrative Code: Title 20, Chapter IX, SubChapter d, Part 2504 Discipline and Grievances
10. Interviews with the following:
 - a. Specialized and Random Staff

Policies and interviews address the components of this standard. Appropriate measures must be taken to protect the due process rights of residents who are, or who may be, subject to discipline. This policy ensures residents are treated fairly under a consistent system of discipline that teaches and encourages appropriate behaviors and discourages inappropriate behaviors. The Resident Orientation Handbook addresses all disciplinary sanctions for juvenile residents. The facility does not use seclusion in cases of alleged sexual abuse or harassment. Consensual sex of any nature is prohibited. Residents that sexually abuse or harass staff will be disciplined. The IYCH program does not discipline residents who make an allegation in good faith, even if an investigation does not establish evidence sufficient to substantiate the allegation.

Corrective action: None required

MEDICAL AND MENTAL CARE

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

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

115.381 (a)

- If the screening pursuant to § 115.341 indicates that a resident has experienced prior sexual victimization, whether it occurred in an institutional setting or in the community, do staff ensure that the resident is offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening? Yes No

115.381 (b)

- If the screening pursuant to § 115.341 indicates that a resident has previously perpetrated sexual abuse, whether it occurred in an institutional setting or in the community, do staff ensure that the resident is offered a follow-up meeting with a mental health practitioner within 14 days of the intake screening? Yes No

115.381 (c)

- Is any information related to sexual victimization or abusiveness that occurred in an institutional setting strictly limited to medical and mental health practitioners and other staff as necessary to inform treatment plans and security management decisions, including housing, bed, work, education, and program assignments, or as otherwise required by Federal, State, or local law? Yes No

115.381 (d)

- Do medical and mental health practitioners obtain informed consent from residents before reporting information about prior sexual victimization that did not occur in an institutional setting, unless the resident is under the age of 18? Yes No

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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

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

1. IYCH Pre-Audit Questionnaire
2. Mental Health Intake Screening Form
3. Policy: IDJJ 04.01.301 Sexual Abuse and Harassment and Intervention Program
4. Policy: IDJJ 04.01.302 Sexual Abuse and Harassment - Response Procedure
5. Policy: IDJJ 04.01.303 Lesbian, Gay, Bisexual, Transgender, Questioning, Intersex (LGBTQI) Youth
6. Policy: IDJJ 04.01.101 Non-Emergency Mental Health Services
7. Policy: IDJJ 04.01.102 Emergency Mental Health Services
8. Policy: IDJJ 04.01.103 Youth Health Care Services
9. Policy: IDJJ 04.01.104 Evaluations of Youth with Gender Dysphoria
10. Policy: IDJJ 04.01.105 Youth Center Orientation
11. Policy: AD 05.05.101 Youth Reception and Classification Process
12. IDJJ 0284 Mental Health Treatment Plan
13. IDJJ 0282 Mental Health Diagnostic Treatment Note
14. IDJJ 0283 Youth Clinical Mental Health Evaluation
15. IDJJ 0429 Screening Tool - Risk of Victimization
16. IDJJ MH-004 Mandated Abuse and Neglect Reporting
17. IDJJ Risk of Victimization Screening Tool (SA0002)
18. Interviews with the following:
 - a. Specialized and Random Staff
 - b. Residents

Policies and interviews address the requirements of this standard. Interviews with health and psychology services staff confirm the institution has a very comprehensive system for collecting medical and mental health information, allowing the staff to provide continued re-assessment and follow-up services to the residents. In the past 12 months, 100% of residents who disclosed prior victimization during screening were offered a follow-up meeting with a medical or mental health practitioner. Additionally, as indicated during the screening, 100% of the residents who have previously perpetrated sexual abuse were offered a follow-up meeting with a mental health practitioner. Treatment services are offered without financial cost to the resident, as confirmed by observation and a review of intake screening documents. Screening for prior sexual victimization in any setting is conducted by unit team staff during intake procedures. Intake procedures also include screening for previous sexually abusive behavior in an institutional setting or the community. When indicated, staff members ensure that the

resident is offered a follow-up meeting with a mental health practitioner within 14 days of the intake screening. Information related to sexual victimization or abusiveness is limited to medical and mental health practitioners and other staff with a need-to-know to determine treatment plans, security, housing, work, program assignments, and other management decisions. Signed and dated informed consents are obtained from residents before reporting prior sexual victimization, which did not occur in an institutional setting. All information is handled confidentially. Interviews with the intake screening staff support a finding that the facility complies with this standard.

Corrective action: None required

Standard 115.382: Access to emergency medical and mental health services

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

115.382 (a)

- Do resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services, the nature and scope of which are determined by medical and mental health practitioners according to their professional judgment? Yes No

115.382 (b)

- If no qualified medical or mental health practitioners are on duty at the time a report of recent sexual abuse is made, do staff first responders take preliminary steps to protect the victim pursuant to § 115.362? Yes No
- Do staff first responders immediately notify the appropriate medical and mental health practitioners? Yes No

115.382 (c)

- Are resident victims of sexual abuse offered timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate? Yes No

115.382 (d)

- Are treatment services provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident? Yes No

Auditor Overall Compliance Determination

Exceeds Standard (*Substantially exceeds requirement of standards*)

- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

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

1. IYCH Pre-Audit Questionnaire
2. Policy: IDJJ 04.01.301 Sexual Abuse and Harassment and Intervention Program
3. Policy: IDJJ 04.01.3020 Sexual Abuse and Harassment - Response Procedure
4. Policy: IDJJ 04.01.303 Lesbian, Gay, Bisexual, Transgender, Questioning, Intersex (LGBTQI) Youth
5. Policy: IDJJ 04.01.101 Non-Emergency Mental Health Services
6. Policy: IDJJ 04.01.102 Emergency Mental Health Services
7. Policy: IDJJ 04.01.103 Youth Health Care Services
8. Policy: IDJJ 04.01.104 Evaluations of Youth with Gender Dysphoria
9. IDJJ 0429 Screening Tool - Risk of Victimization
10. IDJJ Risk of Victimization Screening Tool (SA0002)
11. IDJJ 0282 Mental Health Diagnostic and Treatment Note
12. Policy: IDJJ MH-004 Mandated Abuse and Neglect Reporting
13. PREA Investigative Checklist
14. MOU with Women's Center, Inc.
15. Interviews with the following:
 - a. Specialized and Random Staff

Policies and interviews address the requirements of this standard. All services are provided to residents at no cost. The facility provides timely, unimpeded access to free emergency medical and crisis intervention providers. Referrals are made to Harrisburg Medical Center and the Women's Center Inc.

Corrective action: None required

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

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

115.383 (a)

- Does the facility offer medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility? Yes No

115.383 (b)

- Does the evaluation and treatment of such victims include, as appropriate, follow-up services, treatment plans, and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody? Yes No

115.383 (c)

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

115.383 (d)

- Are resident victims of sexually abusive vaginal penetration while incarcerated offered pregnancy tests? (N/A if “all-male” facility. *Note: in “all-male” facilities, there may be residents who identify as transgender men who may have female genitalia. Auditors should be sure to know whether such individuals may be in the population and whether this provision may apply in specific circumstances.*) Yes No NA

115.383 (e)

- If pregnancy results from the conduct described in paragraph § 115.383(d), do such victims receive timely and comprehensive information about and timely access to all lawful pregnancy-related medical services? (N/A if “all-male” facility. *Note: in “all-male” facilities, there may be residents who identify as transgender men who may have female genitalia. Auditors should be sure to know whether such individuals may be in the population and whether this provision may apply in specific circumstances.*) Yes No NA

115.383 (f)

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

115.383 (g)

- Are treatment services provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident? Yes No

115.383 (h)

- Does the facility attempt to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners? Yes No

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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

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

1. IYCH Pre-Audit Questionnaire
2. Sexual Assault Prevention and Intervention Program Questionnaire
3. Policy: IDJJ 04.01.301 Sexual Abuse and Harassment and Intervention Program
4. Policy: IDJJ 04.01.302 Sexual Abuse and Harassment - Response Procedure
5. Policy: IDJJ 04.01.303 Lesbian, Gay, Bisexual, Transgender, Questioning, Intersex (LGBTQI) Youth
6. Policy: IDJJ 04.01.101 Non-Emergency Mental Health Services
7. Policy: IDJJ 04.01.102 Emergency Mental Health Services
8. Policy: IDJJ 04.01.103 Youth Health Care Services
9. Policy: IDJJ 04.01.104 Evaluations of Youth with Gender Dysphoria
10. IDJJ 0282 Mental Health Diagnostic Treatment Note
11. IDJJ 0283 Youth Clinical Mental Health Evaluation
12. IDJJ 0284 Mental Health Treatment Plan
13. IDJJ Risk of Victimization Screening Tool (SA0002)
14. Policy: IDJJ MH-004 Mandated Abuse and Neglect Reporting
15. MOU with Women's Center Inc.
16. PREA Investigation Checklist
17. Interviews with the following:
 - a. Specialized and Random Staff

Policies and interviews address the requirements of this standard. The facility's medical and mental health personnel provide services to the entire IYCH resident population. Medical personnel are available for consultation or call-back during off-duty hours. Mental health

providers are also available for call-back during off-duty hours. Information and access to care are offered to all resident victims, as clinically indicated. Victim advocacy services are offered through trained staff members, and the Women's Center Inc. Agency policies prohibit resident co-pays for medical treatment in cases of sexual abuse. All treatment is offered at no financial cost to the resident. Resident victims of sexual abuse are offered information about and timely access to sexually transmitted infection prophylaxis. This information is provided in accordance with professionally accepted standards of care when medically appropriate. There were no allegations of sexual abuse that required referral for forensic evidence collection by a SANE provider in the past year. Compliance with this standard was determined by reviewing policy/documentation and interviews with a SANE and facility medical staff. Secondary materials documenting compliance are on file.

Corrective action: None required

DATA COLLECTION AND REVIEW

Standard 115.386: Sexual abuse incident reviews

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

115.386 (a)

- Does the facility conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation, including where the allegation has not been substantiated, unless the allegation has been determined to be unfounded? Yes No

115.386 (b)

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

115.386 (c)

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

115.386 (d)

- Does the review team: Consider whether the allegation or investigation indicates a need to change policy; or practice to better prevent, detect, or respond to sexual abuse? Yes No
- Does the review team: Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; gang affiliation; or other group dynamics at the facility? Yes No

- Does the review team: Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse? Yes No
- Does the review team: Assess the adequacy of staffing levels in that area during different shifts? Yes No
- Does the review team: Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff? Yes No
- Does the review team: Prepare a report of its findings, including but not necessarily limited to determinations made pursuant to §§ 115.386(d)(1) - (d)(5), and any recommendations for improvement and submit such report to the facility head and PREA compliance manager? Yes No

115.386 (e)

- Does the facility implement the recommendations for improvement, or document its reasons for not doing so? Yes No

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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

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

1. IYCH Pre-Audit Questionnaire
2. PREA Retaliation Monitor - Youth (Form DJJ 0498)
3. PREA Retaliation Monitor - Youth (Examples)
4. PREA Sexual Abuse Incident Review (Examples)
5. Appointment Memo – June 21, 2021
6. PREA Incident Review (Document)
7. Policy: IDJJ 04.01.301 Sexual Abuse and Harassment and Intervention Program
8. Policy: IDJJ 04.01.302 Sexual Abuse and Harassment - Response Procedure

4. Interviews with the following:
 - a. Superintendent

The policies address the requirements of this standard. Administrative and criminal investigations are completed on all allegations of sexual abuse/sexual harassment. The Illinois State Police conduct all criminal investigations. The IYCH would conduct a sexual abuse incident review after every sexual abuse investigation unless the allegation were unfounded. Based on interviews with members of the facility incident review team, the review is conducted within 30 days of the conclusion of the investigation, and consideration is given as to whether the incident was motivated by race, ethnicity, gender identity, status, perceived status, or gang affiliation. The team also decides if additional monitoring technology should be added to enhance staff supervision. The review team comprises upper-level management officials, including the Superintendent, Mental Health Treatment Unit Administrator, and the Healthcare Unit Administrator. Per policy, all required reviews by the team are completed within 30 days of the conclusion of all investigations. Per policy, the findings are thoroughly documented. An annual review of all incidents is also completed. The review team seeks additional information from other staff, as needed, to ensure a thorough review has been completed.

Corrective action: None required

Standard 115.387: Data collection

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

115.387 (a)

- Does the agency collect accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions? Yes No

115.387 (b)

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

115.387 (c)

- Does the incident-based data include, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice? Yes No

115.387 (d)

- Does the agency maintain, review, and collect data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews? Yes No

115.387 (e)

- Does the agency also obtain incident-based and aggregated data from every private facility with which it contracts for the confinement of its residents? (N/A if agency does not contract for the confinement of its residents.) Yes No NA

115.387 (f)

- Does the agency, upon request, provide all such data from the previous calendar year to the Department of Justice no later than June 30? (N/A if DOJ has not requested agency data.)
 Yes No NA

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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

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

1. IYCH Pre-Audit Questionnaire
2. Policy: IDJJ 04.01.301 Sexual Abuse and Harassment and Intervention Program
3. Policy: IDJJ 04.01.302 Sexual Abuse and Harassment - Response Procedure
4. Interviews with the following:
 - a. Superintendent
 - b. Incident Review Team Member

Policies and interviews address the components of this standard. The data collected is captured with a computer program entitled Youth 360. The Youth 360 system software provides information necessary to answer all questions from the most recent version of the Survey of Sexual Violence, conducted by the Department of Justice. IDJJ aggregates incident-based sexual abuse data annually. Upon request, IDJJ provides all data from the previous calendar year to the Department of Justice. The agency aggregates and reviews all data annually.

Corrective action: None required

Standard 115.388: Data review for corrective action

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

115.388 (a)

- Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Identifying problem areas? Yes No
- Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Taking corrective action on an ongoing basis? Yes No
- Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Preparing an annual report of its findings and corrective actions for each facility, as well as the agency as a whole? Yes No

115.388 (b)

- Does the agency's annual report include a comparison of the current year's data and corrective actions with those from prior years and provide an assessment of the agency's progress in addressing sexual abuse? Yes No

115.388 (c)

- Is the agency's annual report approved by the agency head and made readily available to the public through its website or, if it does not have one, through other means? Yes No

115.388 (d)

- Does the agency indicate the nature of the material redacted where it redacts specific material from the reports when publication would present a clear and specific threat to the safety and security of a facility? Yes No

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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

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

1. IYCH Pre-Audit Questionnaire
2. Policy: IDJJ 04.01.301 Sexual Abuse and Harassment and Intervention Program
3. 2017 Illinois Department of Juvenile Justice PREA Report
4. Interviews with the following:
 - a. Superintendent

Policies address the requirements of this standard. As confirmed by a review of supporting documentation, the IDJJ collects accurate, uniform data for every allegation of sexual abuse/sexual harassment by using a standardized instrument. The agency tracks information concerning sexual abuse via Youth 360. The data collected includes the information necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice. The report includes a comparison of the current year's data and corrective actions with those prior years and provides an assessment of the agency's progress. The agency aggregates and reviews all data annually.

Corrective action: None required

Standard 115.389: Data storage, publication, and destruction

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

115.389 (a)

- Does the agency ensure that data collected pursuant to § 115.387 are securely retained?
 Yes No

115.389 (b)

- Does the agency make all aggregated sexual abuse data, from facilities under its direct control and private facilities with which it contracts, readily available to the public at least annually through its website or, if it does not have one, through other means? Yes No

115.389 (c)

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

115.389 (d)

- Does the agency maintain sexual abuse data collected pursuant to § 115.387 for at least 10 years after the date of the initial collection, unless Federal, State, or local law requires otherwise? Yes No

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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

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

1. IYCH Pre-Audit Questionnaire
2. Policy: IDJJ 04.01.301 Sexual Abuse and Harassment and Intervention Program
3. Policy: IDJJ 01.05.105 Use of Computers
4. Illinois Juvenile Justice Website: <https://www2.illinois.gov/idjj/Pages/default.aspx>
5. Interviews with the following:
 - a. Superintendent
 - b. PCC

Policies and interviews address the components of this standard. IDJJ maintains sexual abuse data collected for at least ten years after the date of its initial collection. IDJJ monitors and makes available aggregated sexual abuse data from its' facilities and contracted agency facilities on its' website. That data can be found at <https://www2.illinois.gov/idjj/Pages/default.aspx>. All personal identifiers are removed before posting information.

Corrective action: None required

AUDITING AND CORRECTIVE ACTION

Standard 115.401: Frequency and scope of audits

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

115.401 (a)

- During the prior three-year audit period, did the agency ensure that each facility operated by the agency, or by a private organization on behalf of the agency, was audited at least once? (*Note: The response here is purely informational. A "no" response does not impact overall compliance with this standard.*) Yes No

115.401 (b)

- Is this the first year of the current audit cycle? (*Note: a "no" response does not impact overall compliance with this standard.*) Yes No
- If this is the second year of the current audit cycle, did the agency ensure that at least one-third of each facility type operated by the agency, or by a private organization on behalf of the agency, was audited during the first year of the current audit cycle? (N/A if this is **not** the *second* year of the current audit cycle.) Yes No NA
- If this is the third year of the current audit cycle, did the agency ensure that at least two-thirds of each facility type operated by the agency, or by a private organization on behalf of the agency, were audited during the first two years of the current audit cycle? (N/A if this is **not** the *third* year of the current audit cycle.) Yes No NA

115.401 (h)

- Did the auditor have access to, and the ability to observe, all areas of the audited facility? Yes No

115.401 (i)

- Was the auditor permitted to request and receive copies of any relevant documents (including electronically stored information)? Yes No

115.401 (m)

- Was the auditor permitted to conduct private interviews with residents? Yes No

115.401 (n)

- Were residents permitted to send confidential information or correspondence to the auditor in the same manner as if they were communicating with legal counsel? Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

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

Instructions for Overall Compliance Determination Narrative

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

This was the third PREA audit of this facility. The Auditor was given access to all facility areas and had access to all required supporting documentation. The Auditor was able to conduct private interviews with both residents and staff. All IDJJ facilities have received at least one PREA audit since August 20, 2012. At least one-third of all agency facilities were audited during the one-year period after August 20, 2012. The Auditor was provided supporting documentation before and during the audit. Notifications of the audit posted throughout the IYCH allowed residents to correspond confidentially with the Auditor before the audit. The Auditor received no confidential correspondence as a result of the audit postings at the facility.

Corrective action: None required

Standard 115.403: Audit contents and findings

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

115.403 (f)

- The agency has published on its agency website, if it has one, or has otherwise made publicly available, all Final Audit Reports. The review period is for prior audits completed during the past three years PRECEDING THIS AGENCY AUDIT. The pendency of any agency appeal pursuant to 28 C.F.R. § 115.405 does not excuse noncompliance with this provision. (N/A if there have been no Final Audit Reports issued in the past three years, or in the case of single facility agencies that there has never been a Final Audit Report issued.) Yes No NA

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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

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

Corrective action: None required

AUDITOR CERTIFICATION

I certify that:

- The contents of this report are accurate to the best of my knowledge.
- No conflict of interest exists with respect to my ability to conduct an audit of the agency under review, and
- I have not included in the final report any personally identifiable information (PII) about any resident or staff member, except where the names of administrative personnel are specifically requested in the report template.

Auditor Instructions:

Type your full name in the text box below for Auditor Signature. This will function as your official electronic signature. Auditors must deliver their final report to the PREA Resource Center as a searchable PDF format to ensure accessibility to people with disabilities. Save this report document into a PDF format prior to submission.¹ Auditors are not permitted to submit audit reports that have been scanned.² See the PREA Auditor Handbook for a full discussion of audit report formatting requirements.

James L. Roland Jr.

8-29-2021

Auditor Signature

Date

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

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