

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

Interim       Final

Date of Report    7/8/2019

### 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: 6/24-25/2019

### Agency Information

Name of Agency: Department of Juvenile Justice      Governing Authority or Parent Agency (If Applicable)

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

Mailing Address:      City, State, Zip:

Telephone: 217-557-1030      Is Agency accredited by any organization?     Yes     No

The Agency Is:	<input type="checkbox"/> Military	<input type="checkbox"/> Private for Profit	<input type="checkbox"/> Private not for Profit
<input type="checkbox"/> Municipal	<input type="checkbox"/> County	<input checked="" type="checkbox"/> State	<input type="checkbox"/> Federal

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

Agency Website with PREA Information: <https://djj.portal.illinois.gov/PREA/default.aspx>

### Agency Chief Executive Officer

Name: Heidi Mueller      Title: Director

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

### Agency-Wide PREA Coordinator

Name: Patrick Keane@illinois.gov      Title: DJJ PREA Compliance

<b>Email:</b> Patrick.Keane@illinois.gov	<b>Telephone:</b> 630-581-0506, ext.530
<b>PREA Coordinator Reports to:</b> Director	<b>Number of Compliance Managers who report to the PREA Coordinator</b> 5

### Facility Information

<b>Name of Facility:</b> Illinois Youth Center Harrisburg			
<b>Physical Address:</b> 1201 Poplar Street, Harrisburg, Illinois 62946			
<b>Mailing Address (if different than above):</b>			
<b>Telephone Number:</b> 618-252-8681			
<b>The Facility Is:</b>	<input type="checkbox"/> Military	<input type="checkbox"/> Private for Profit	<input type="checkbox"/> Private not for Profit
<input type="checkbox"/> Municipal	<input type="checkbox"/> County	<input checked="" type="checkbox"/> State	<input type="checkbox"/> Federal
<b>Facility Type:</b>	<input type="checkbox"/> Detention	<input checked="" type="checkbox"/> Correction	<input type="checkbox"/> Intake <input type="checkbox"/> Other

**Facility Mission:**  
The mission of the Illinois Department of Juvenile Justice is to build youth skills and strengthen families to promote community safety and positive youth outcomes.

**Facility Website with PREA Information:** <https://djj.portal.illinois.gov/Pages/Default.aspx>

**Is this facility accredited by any other organization?**  Yes  No

### Facility Administrator/Superintendent

<b>Name:</b> Jeremy Burtis	<b>Title:</b> Superintendent
<b>Email:</b> Jeremy.Burtis@illinois.gov	<b>Telephone:</b> 618-252-8681, ext. 234

### Facility PREA Compliance Manager

<b>Name:</b> Ashley Miller	<b>Title:</b> Social Worker III
<b>Email:</b> Ashley.Miller@illinois.gov	<b>Telephone:</b> 618-252-8681, ext.425

### Facility Health Service Administrator

<b>Name:</b> Sarah Hendrix	<b>Title:</b> Healthcare Unit Administrator
<b>Email:</b> Sarah.Hendrix@illinois.gov	<b>Telephone:</b> 618-252-8681, ext. 294

### Facility Characteristics

<b>Designated Facility Capacity:</b> 257	<b>Current Population of Facility:</b> 71
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Number of residents admitted to facility during the past 12 months		315
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 10 days or more:		314
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 72 hours or more:		315
Number of residents on date of audit who were admitted to facility prior to August 20, 2012:		0
Age Range of Population:	13-20	
Average length of stay or time under supervision:		180 Days
Facility Security Level:		Minimum-Medium
Resident Custody Levels:		Minimum-Medium
Number of staff currently employed by the facility who may have contact with residents:		260
Number of staff hired by the facility during the past 12 months who may have contact with residents:		36
Number of contracts in the past 12 months for services with contractors who may have contact with residents:		3
<b>Physical Plant</b>		
Number of Buildings: 5		Number of Single Cell Housing Units: 11
Number of Multiple Occupancy Cell Housing Units:		0
Number of Open Bay/Dorm Housing Units:		0
Number of Segregation Cells (Administrative and Disciplinary):		0
Description of any video or electronic monitoring technology (including any relevant information about where cameras are placed, where the control room is, retention of video, etc.): Illinois Youth Center Harrisburg (IYCH) utilizes a video camera system for video surveillance. Cameras are placed strategically throughout the Center to ensure the safety and security of both residents and staff.		
<b>Medical</b>		
Type of Medical Facility:		Infirmary
Forensic sexual assault medical exams are conducted at:		Harrisburg Medical Center
<b>Other</b>		
Number of volunteers and individual contractors, who may have contact with residents, currently authorized to enter the facility:		40
Number of investigators the agency currently employs to investigate allegations of sexual abuse:		1

# Audit Findings

## Audit Narrative

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

## Overview

The on-site Prison Rape Elimination Act (PREA) compliance audit of the Illinois Youth Center Harrisburg (IYCH), located in Harrisburg, Illinois was conducted on June 24-25, 2019 by U.S. Department of Justice (DOJ) certified PREA Auditor, James L. Roland Jr. from The Nakamoto Group, Inc. The standards used for this audit became effective August 20, 2012. The Auditor conducted an opening meeting, toured the entire facility, interviewed a randomized sample of staff and residents and reviewed PREA related staff and resident documentation. Upon completion of the audit process, a closing meeting was held with the administrative staff to discuss the audit process, preliminary findings and the post-audit process. Employees at the facility were found to be extremely courteous, cooperative and professional. All areas of the facility were clean and well maintained. During the closing meeting, the Auditor thanked the staff for their hard work and dedication to the PREA process.

## Pre-Audit Phase

On April 15, 2019, 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 prior to the on-site visit.

IYCH staff members were asked to complete the Pre-Audit Questionnaire (PAQ) also provided to the facility on April 30, 2019. The completed PAQ and supporting documentation was received by the Auditor on May 15, 2019. All documentation was reviewed by the Auditor 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 being lesbian, gay, bisexual, transgender or intersex (LGBTI), resident reports of sexual abuse/sexual 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 June 24, 2019 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:

- Superintendent
- Assistant Superintendent of Operations
- Assistant Superintendent of Programs
- PREA Compliance Manager/Social Worker III (PCM)
- PREA Compliance Coordinator (PCC)
- Treatment Unit Administrator
- Dietary Manager
- Chief of Security
- Acting Operations Security Chief
- School Principal

The Auditor was provided a private conference room in which to conduct business and confidential interviews. All requested files and rosters of 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 Auditor was escorted by the PCC and the PCM. During the tour, the Auditor reviewed PREA related documentation and materials located on bulletin boards and other locations. The Auditor assessed camera surveillance, physical supervision and electronic monitoring capabilities. Other areas of focus during the facility tour included, but were not limited to, levels of staff supervision and limits to cross-gender viewing. All signs and postings were in both English and Spanish. Residents can shower, dress and use the toilet facilities without exposing themselves to employees of the opposite gender. Informal and formal conversations with employees and residents regarding the PREA standards were conducted. Postings regarding PREA violation reporting and the agency's zero-tolerance policy for sexual abuse and sexual harassment were prominently displayed in all living units, meeting areas and throughout the facility. Audit notice postings with the PREA Auditor's contact information were posted in the same areas. The Auditor notice postings were posted eight weeks prior to 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 77 male residents housed at IYCH. A total of 16 residents were interviewed. The facility indicated that they had no residents who were Limited English Proficient (LEP), no residents who self-identified as being members of the LGBTI community, 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 the PREA and the reporting mechanisms available to them.

## **Staff Interviews**

IYCH employs a staff of 260 individuals. Twenty-three staff members were interviewed, including nine random staff (from all three shifts) and 14 administrative/specialized staff. The administrative staff included the Superintendent, Assistant Superintendent of Operations, PREA Compliance Coordinator and Healthcare Unit Administrator. The specialized staff interviewed included the Human Resource Representative, Treatment Unit Administrator, Mental Health Professional (x2), Internal Affairs Investigator, Juvenile Justice Youth and Family Specialist, Chief of Security, PREA Compliance Manager 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 regarding the Memorandum of Understanding (MOU) that exists between the Crisis Community Center and the facility. It was confirmed that they will 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 services 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 24/7.

## **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 two facility contractor's files to ensure training mandates and background check requirements were in compliance. Screening and intake procedures were evaluated by reviewing five random resident files which included a vulnerability assessment instrument and resident education verification documentation.

## **Investigations**

During the current auditing period, there were five reported allegations of sexual harassment and/or sexual abuse. Administrative investigations were completed in all five cases and all allegations were determined to be unsubstantiated. This documentation was reviewed by the Auditor.

All administrative investigations are conducted by the Chief Investigator. In the event an investigation reveals potentially criminal evidence, the case is referred to the Illinois State Police (ISP). The Chief 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 by 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 June 26, 2019. Discussions centered on the audit process, preliminary findings and the post-audit process. The Auditor thanked the staff for their hard work and dedication to the PREA process.

## Facility Characteristics

*The auditor's description of the audited facility should include details about the facility type, demographics and size of the resident, 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.*



The Illinois Youth Center 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 80 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 recently partnered with Lakeland Community College to offer Culinary Arts, Custodial Maintenance & Horticulture Certification Programs. Substance abuse treatment, diagnostic and evaluation 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.

IYC Harrisburg provides an on-site physician, dental, & psychiatric care at regularly scheduled intervals. It hosts one of two statewide mental health special treatment programs, in addition to having the only accredited sex offender program in the Juvenile Division. A variety of off-grounds activities, both recreational and educational, are made available to the youth 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 five incidents of sexual abuse/sexual harassment. There is a well-established zero-tolerance culture throughout, with documentation addressing all areas of the PREA. The agency, Illinois Department of Juvenile Justice (IDJJ), maintains a Central Administration set of PREA policies as well as specific, detailed policies for the facility. A random review of 20 personnel file background checks and 25 employee training files established facility 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 the PREA and the zero-tolerance policy. 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 receipt of a good understanding of PREA policies. Staff members were knowledgeable about their roles in prevention, reporting, as well as their responsibilities in the event of a PREA related incident, particularly first responder duties. Staff members were able to verbalize the steps mandated in the event they were a first responder to a PREA related incident. Reporting mechanisms were displayed in a conspicuous manner and residents and staff members were aware of all reporting methods available to them. A review of the IYCH staff training curriculum was completed by the Auditor and records support the finding that all employees have received comprehensive PREA training. Staff appeared truly interested and vested in the residents and expressed a true desire to see them succeed.

### **Resident Interviews**

Interviews with residents revealed a good understanding of the PREA safeguards and the zero-tolerance policy. Comprehensive resident PREA education is provided in written form (i.e. Youth Handbook, entrance packet), personal instruction and posters. Twenty vulnerability assessment instruments reviewed by the Auditor indicated that intake and classification assessments are efficient and seamless in addressing referrals based on victimization or abusiveness screening data. Residents acknowledged 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

understanding that the facility has appropriate medical and victim advocacy networks in place. Residents also affirmed they felt safe in the facility. Staff and resident interactions were observed by the Auditor and appeared to be 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:** 43

- §115.311; §115.312; §115.313; §115.315; §115.316; §115.317; §115.318
- §115.321; §115.322
- §115.331; §115.332; §115.333; §115.334; §115.335
- §115.341; §115.342
- §115.351; §115.352; §115.353; §115.354
- §115.361; §115.362; §115.363; §115.364; §115.365; §115.366; §115.367; §115.368
- §115.371; §115.372; §115.373; §115.376; §115.377; §115.378
- §115.381; §115.382; §115.383; §115.386; §115.387; §115.388; §115.389
- §115.401; §115.403

**Number of Standards Not Met:** 0

**Number of Standards Not Met:** 0

**Summary of Corrective Action (if any)**

<b>PREVENTION PLANNING</b>
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**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. Policy IDJJ 04.01.3020 Sexual Abuse and Harassment – Response Procedures
7. Policy IDJJ 01.02.103 Inspection Tours by Administrative Staff
8. Policy IDJJ MH-004 Mandated Abuse and Neglect Reporting
9. Memo: Designation of Agency Wide PREA Coordinator
10. PREA Response Plan
11. Facility Organizational Chart
12. Mental Health Department Organizational Chart
13. IDJJ Organizational Chart
14. Resident Handbook
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 the Center. Agency and facility directives outline a zero-tolerance policy for all forms of sexual abuse and sexual harassment. Residents are informed orally about the zero-tolerance policy and the PREA program during in-processing and are required to view a video during admission and orientation presentations. Additional program information is contained in the Resident Handbook and is posted throughout the facility, as observed 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 informed of PREA policies and procedures. All employees receive initial training and Annual Refresher Training (ART), as well as updates throughout the year.

**Corrective action:** None required

## **Standard 115.312: 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 OR the response to 115.312(a)-1 is "NO".)  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 agency ensure that each facility has developed a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse?  Yes  No
- Does the agency ensure that each facility has implemented a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against

sexual abuse?  Yes  No

- Does the agency ensure that each facility has documented a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse?  Yes  No
- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: The prevalence of substantiated and unsubstantiated incidents of sexual abuse?  Yes  No
- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Generally accepted juvenile detention and correctional/secure residential practices?  Yes  No
- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any judicial findings of inadequacy?  Yes  No
- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any findings of inadequacy from Federal investigative agencies?  Yes  No
- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any findings of inadequacy from internal or external oversight bodies?  Yes  No
- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: All components of the facility's physical plant (including "blind-spots" or areas where staff or residents may be isolated)?  Yes  No
- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: The composition of the resident population?  Yes  No
- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: The number and placement of supervisory staff?  Yes  No
- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Institution programs occurring on a particular shift?  Yes  No
- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any applicable State or local laws, regulations, or standards?  Yes  No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: 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 only until October 1, 2017.)  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 only until October 1, 2017.)  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 only until October 1, 2017.)  Yes  No  NA
- Does the facility ensure only security staff are included when calculating these ratios? (N/A only until October 1, 2017.)  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 MH-004 Mandated Abuse and Neglect Reporting
7. IDJJ Facility Vulnerability Assessment Review
8. Staffing Plan Assessment IYCH 2019
9. Staffing Plan Assessment IYCH 2018
10. Interviews with the following:
  - a. Specialized and Random Staff

Agency policy requires each facility to review the staffing plans on an annual basis. Interviews with the Superintendent revealed 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 an examination of 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 on a weekly basis, with no warning to employees. The IYCH utilizes a number of 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 where there are 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 implement policies and 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
3. Policy IDJJ 05.01.302 Prohibited Cross-Gender Searches
4. Policy IDJJ 05.01.113 Routine Searches of Youth
5. PREA PowerPoint Training Slides
6. IYCH PREA Response Plan
7. Interviews with the following:
  - a. Specialized and Random Staff

Policies and documentation address this standard. Cross-gender strip or cross-gender body cavity searches are prohibited, except in emergency situations or when performed and documented by a medical practitioner. Staff interviews indicated they received cross-gender pat search training during initial and annual training. The Auditor observed that each unit has multiple head 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 prior to entering the unit to allow residents the opportunity to prepare themselves from a privacy perspective. The residents interviewed acknowledged they can shower, dress and use the toilet privately, without being viewed by staff of the opposite gender. Staff, along with a majority 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 their genital status. During the past 12 months, there were no exigent circumstances that required cross-gender viewing of a resident by a staff member at the 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 05.05.101 ADA Accommodations
4. LanguageLine Solutions
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:  
Specialized and Random Staff

IYCH takes appropriate steps to ensure residents with disabilities and residents with Limited English Proficiency (LEP) have an opportunity to participate in and benefit from the facility's efforts to prevent, detect and respond to sexual abuse and sexual harassment. PREA handouts, bulletin board postings and resident handbooks are in both English and Spanish. The above-mentioned documents were submitted to and reviewed by the Auditor. Interviewed staff members were aware of the policy that, under no circumstances, is any resident interpreter or assistant to be used 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 and staff and resident interviews support a finding that the facility is in compliance 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, or 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)

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

Policies and interviews confirm compliance with this standard. Twenty employee files were randomly selected to review the components of this standard. A Human Resource Representative was interviewed, stating that all components 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 successfully passed

before an individual's hiring/promotion status will be approved. A tracking system is in place to ensure that updated background checks are conducted every five years. Policy clearly states the submission of false information by any applicant is grounds for termination. The agency makes its best efforts to contact all prior institution employers for information 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 allegations of sexual abuse/sexual harassment. Documentation on file supports a finding that the facility is in compliance with this standard.

**Corrective action:** None required

## Standard 115.318: Upgrades to facilities and technologies

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

### 115.318 (a)

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

### 115.318 (b)

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

### Auditor Overall Compliance Determination

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

## Instructions for Overall Compliance Determination Narrative

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

### **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 during the auditing period. IYCH utilizes a video camera system for video surveillance. Cameras are placed strategically throughout the Center 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?  Yes  No
- 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 entity 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? (Check N/A if agency attempts to make a victim advocate from a rape crisis center available to victims per 115.321(d) above.)  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. Memorandum of Understanding (MOU) with Women's Center 2019-2021
5. Compliance Review Instrument
6. PREA Response Plan IYC Harrisburg
7. Interviews with the following:
  - a. Specialized and Random Staff

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

**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 such publication 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. PREA Response Plan
11. Report of Investigative Outcome Form
12. Report of Investigative Outcome (examples)
13. Interviews with the following:
  - a. Random and Specialized Staff

Correctional 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 also aware that either the Chief Investigator or the Illinois State Police (ISP) investigates all sexual abuse allegations. All forensic medical examinations are conducted by SANE staff at the Harrisburg Medical Center (HMC). A telephonic interview with the SANE representative at HMC was conducted and the contract 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 Rape, Abuse and Incest National Network (RAINN) and Justice Detention International (JDI), both national victim advocacy agencies, were contacted by this Auditor. Neither had information related to IYCH. The Women's Center was contacted regarding advocacy services for residents at IYCH. 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: Week: 1-4 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 responsibilities in the event of a reported PREA concern. All staff members are mandated to receive training annually and the curriculum includes an extensive review of PREA requirements. Training curriculum, training sign-in sheets and other related training documentation were reviewed by the Auditor. 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. YCH Pre-Audit Questionnaire
2. Policy IDJJ 04.01.122 Contract Personnel Training
3. Policy IDJJ 04.01.1220 Volunteer Services
4. Policy IDJJ 0042
5. YCH Volunteer Notice of Zero Tolerance Policy
6. Volunteer Manual 021
7. Volunteer Manual 023
8. Current and Active Volunteer Roster
9. Contract Personnel Pre-Screen Questionnaire
10. PREA Volunteer and Contractor Sign-off Sheet
11. PREA Volunteer and Contractor Sign-off Sheet (examples)
12. PREA Training Sign-in Sheets
13. IDJJ PowerPoint Presentation
14. Interviews with the following:
  - a. Specialized and Random Staff

Policies, Annual Training 2019 Lesson Plan and Annual Training 2019 Agenda/Presentation address the mandates of this standard. All contractors and volunteers received the PREA training, including the zero-tolerance policy, reporting and responding requirements. The training is documented and maintained on file. Copies of training sign-in sheets and other related documents were reviewed by the Auditor at the facility. At the time of the audit there were no volunteers or contractors available to be 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 such education?  Yes  No
- Do residents receive education upon transfer to a different facility to the extent that the policies and procedures of the resident's new facility differ from those of the previous facility?  Yes  No

**115.333 (d)**

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

### 115.333 (e)

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

### 115.333 (f)

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

### Auditor Overall Compliance Determination

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

### Instructions for Overall Compliance Determination Narrative

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

### 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's
10. End Silence - PREA Comic Training Tool for Youth
11. Reception and Classification Youth Receipt of PREA Information
12. Orientation Checklist/Signature Sheets
13. Youth Orientation Manual
14. Attachment to Youth Orientation

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 acknowledgements, 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 Resident Handbook, printed in English and Spanish. A staff member conducts an education program regarding the PREA for all residents within 30 days of their arrival at the facility. 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 Resident Handbook and posted in each housing unit for resident correspondence concerning any sexual abuse or sexual harassment allegation. There is also a translation language line available to LEP residents. The Auditor was provided a random sampling of PREA 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, completion of PREA education. During the interview process, randomly selected residents indicated they received information about the facility's rules against sexual abuse/sexual harassment, when they arrived at the facility. They further indicated they were advised about their right not to be sexually abused/sexually harassed, how to report sexual abuse/sexual harassment and their right not be punished for reporting sexual abuse/sexual harassment. Residents were aware of available services outside of the facility for dealing with sexual abuse.

**Corrective action:** None required

## Standard 115.334: 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

Preliminary gathering of information in suspected PREA related incidents is conducted by the Chief Investigator. Criminal investigations are conducted outside of the facility by the ISP. There were five allegations of sexual harassment in the past twelve months. A comprehensive review of documentation, in all five cases, was conducted by the Auditor. The comprehensive document review revealed that all allegations were unsubstantiated. Investigative documentation indicates that the facility took appropriate action based on policies and procedures outlined by the IDJJ.

### **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?  Yes  No
- 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?  Yes  No
- 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?  Yes  No
- 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?  Yes  No

### 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.)  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?  Yes  No

### 115.335 (d)

- Do medical and mental health care practitioners employed by the agency also receive training mandated for employees by §115.331?  Yes  No
- Do medical and mental health care practitioners contracted by and volunteering for the agency also receive training mandated for contractors and volunteers by §115.332?  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 MH-004 Mandated Abuse and Neglect Reporting
3. Training Verification Report
4. Risk of Screening Victimization Tool
5. Interviews with the following:
  - a. Specialized and Random Staff

Policies, Annual Training Lesson Plan and PowerPoint Presentation address the mandates of this standard. Other training includes online specialized training for psychologists and victim

advocacy training. The agency ensures all full and part-time medical and mental health practitioners, who work regularly in its facilities, have been trained according to the practitioner's status in the organization. All mental health and medical staff have received the required 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 Harrisburg Medical Center where a SANE is available at all times (a SANE at HMC was interviewed and confirmed access to these services). A review of the training documentation and policy confirm compliance to 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: Prior sexual victimization or abusiveness?  Yes  No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: 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: Current charges and offense history?  Yes  No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Age?  Yes  No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Level of emotional and cognitive development?  Yes  No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Physical size and stature?  Yes  No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Mental illness or mental disabilities?  Yes  No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Intellectual or developmental disabilities?  Yes  No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Physical disabilities?  Yes  No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: The resident's own perception of vulnerability?  Yes  No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: 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 2018 Annual Refresher Training
13. Training Logs/Records for Medical and Mental Health Practitioners
14. Interviews with the following:
  - a. Specialized and Random Staff

Policy addresses 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, with the goal of keeping residents at a high risk of being sexually abused/sexually harassed separate from those residents who are at a high risk of being sexually abusive. Facility policy also requires all residents 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 for not disclosing complete information in response to questions regarding their mental/physical health,

developmental disability, sexual preferences, sexual victimization history and perception of vulnerability. Housing and program assignments are made on a case-by-case basis and residents are not placed in housing units based solely on their sexual identification or status. Interviews with risk management staff and a random review of risk screening assessments support the finding that the facility is in compliance 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  Yes  No
- During any period of isolation, does the agency always refrain from denying residents daily large-muscle exercise?  Yes  No
- During any period of isolation, does the agency always refrain from denying residents any legally required educational programming or special education services?  Yes  No

- Do residents in isolation receive daily visits from a medical or mental health care clinician?  
 Yes  No
- Do residents also have access to other programs and work opportunities to the extent possible?  
 Yes  No

#### 115.342 (c)

- Does the agency always refrain from placing: Lesbian, gay, and bisexual 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 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 paragraph (b) of this section, does the facility clearly document: The basis for the facility's concern for the resident's safety? (N/A for h and i if facility doesn't use isolation?)  Yes  No  NA
- If a resident is isolated pursuant to paragraph (b) of this section, does the facility clearly document: The reason why no alternative means of separation can be arranged? (N/A for h and i if facility doesn't use isolation?)  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?  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-IYC Harrisburg
3. PREA Screening Tool
4. Policy IDJJ 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 04.01.135 Reporting of Child Abuse and Neglect

8. Policy IDJJ 04.01.301 Sexual Abuse and Harassment and Intervention Program
9. Policy IDJJ 04.01.302 Sexual Abuse and Harassment - Response Procedures
10. Staff Training Agenda 2018 Annual Refresher Training
11. Policy IDJJ 03.02.108 Standards of Conduct
12. Interviews with the following:
  - a. Specialized and Random Staff

Policy, 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, with the goal of keeping inmates at a high risk of being sexually abused/sexually harassed separate from those inmates who are at a high risk of being sexually abusive. Housing and program assignments are made on a case-by-case basis and residents are not placed in housing units based solely on their sexual identification or status. From the information provided by the facility, there were zero residents who self-identified as being bi-sexual, gay, transgender or intersex. Additionally, zero residents indicated sexual victimization or abusiveness during risk screening. No residents could be interviewed in those categories in support of this standard. During the audit, risk management staff indicated transgender and intersex residents are reassessed monthly and their own views with respect to their own safety are given serious consideration. Additionally, they are given the opportunity to shower separately from other residents. Seclusion is only used in an emergency, when the resident, due to his current behavior, poses an imminent risk of harm to himself and/or others. Seclusion is not used as a means of punishment, discipline, coercion, convenience or retaliation, nor is it used to supplement the lack of staff presence or competency. The Superintendent shall ensure that seclusion is implemented only as authorized and in accordance with the provisions set forth in IDJJ. The Superintendent is responsible for ensuring that abusive and arbitrary use of seclusion does not occur in the program. The Superintendent ensures that program staff members are sufficiently trained in the proper implementation and subsequent documentation. 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 anytime before the 60 minutes expires, if they demonstrate control of their emotional state. Staff and resident interviews, the review of supporting documentation and the Auditor's observations support the facility being in compliance with the standard.

**Corrective action:** None required

## REPORTING

### Standard 115.351: 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?  Yes  No

#### 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 Handbook
6. Interviews with the following:
  - a. Specialized and Random Staff
  - d. Residents

Policies, the PREA Notices and Resident Handbook 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 inmates to report sexual abuse/sexual harassment. The facility has procedures in place for staff to document all allegations. There are posters and other documents on display throughout the facility which also explain reporting methods. Staff members promptly accept and document all verbal, written, anonymous, private and third-party reports of 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 personnel. All interviewed residents confirmed awareness of the multiple methods of reporting sexual abuse/assault allegations. Interviews with staff and residents, observations of posters addressing reporting methods and an examination of policy/documentation confirm the IYCH's compliance 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  NA

### 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 Handbook
4. Interviews with the following:
  - a. Specialized and Random Staff
  - b. Residents

Policies and interviews address the requirements 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 without submitting it to the staff member who is the subject of the complaint. Additionally, policy prohibits the investigation of the allegation by either staff alleged to be involved in the incident or any staff who may be under their supervision. Policy states that there is no time frame for filing a grievance relating to sexual abuse or sexual harassment. Allegations of physical abuse by staff shall be referred to the ISP, in accordance with procedures established for such referrals. Policy addresses the filing of emergency grievance requests. If a resident file 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. There is no prohibition that limits third parties, including fellow residents, staff members, family members, attorneys and outside victim advocates in assisting residents in filing requests for grievances relating to allegations of sexual abuse or filing such requests on behalf of residents. There were no grievances filed involving PREA related issues during the past 12 months. There were no grievances alleging sexual abuse that involved an extension due to the final decision not being reached within 90 days. Additionally, there were no grievances alleging sexual abuse filed by residents in which the resident declined third-party assistance. Residents are held accountable for manipulative behavior and false allegations. Generally, disciplinary action would be taken if a grievance was filed in bad faith.

**Corrective action:** None required

## **Standard 115.353: 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?  Yes  No
- Does the facility enable reasonable communication between residents and these organizations and agencies, in as confidential a manner as possible?  Yes  No

### **115.353 (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 04.01.302 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. Institution Directive (ID) 20.525.003 Youth Telephone Privileges
- 8. Risk of Victimization Screening Tool (SA 0002)
- 8. Interviews with the following:
  - a. Specialized and Random Staff
  - b. Residents

Policies and the Resident Handbook address the requirements of this standard. The facility has a MOU with Women's Center, a local victim advocacy group. The Auditor reviewed the signed MOU documents. The Resident Handbook provides the contact information for alternate services and the information is also posted in the housing units. 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 Handbook
11. Interviews with the following:
  - a. Specialized and Random Staff
  - b. Residents

Policies, Youth Handbook, PREA Posters, PREA Brochure, and Child Abuse Hotline number meet the mandates of this standard. The posters, telephone numbers and the Website <https://www2.illinois.gov/idjj/Pages/default.aspx> assist third party reporters to report allegations of sexual abuse/sexual harassment. The residents interviewed indicated they were aware of third-party reporting and would probably feel more comfortable reporting an incident of sexual abuse to someone 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 the 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? (N/A if the alleged victim is not under the guardianship of the child welfare system.)  Yes  No  NA
- 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 01.12.120 Investigation of Unusual Incidents
9. Policy IDJJ 03.02.108 Standards of Conduct
10. Policy IDJJ 04.01.301 Sexual Abuse and Harassment and Intervention Program
11. Policy IDJJ 04.01.302 Sexual Abuse and Harassment - Response Procedures
12. Policy IDJJ MH-004 Mandated Abuse and Neglect Reporting
13. Risk of Victimization Screening Tool (SA 0002)
14. Interviews with the following:
  - a. Specialized and Random Staff
  - c. Residents

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. Interviewed staff members were aware of their duty to immediately report all allegations of sexual abuse, sexual harassment and retaliation relevant to the PREA standards. The reporting is ordinarily made to a Shift Supervisor but could be made privately or to a third party. Policy requires the information concerning the identity of the alleged resident victim and the specific facts of the case 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. 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 twelve months. This was verified through interviews with random staff. Safety plans would be established to ensure that the resident was safe. A review of policy and interviews with staff support the finding that the facility is in compliance with this standard.

**Corrective action:** None required

## Standard 115.362: 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 04.01.302 Sexual Abuse and Harassment - Response Procedures
6. Policy IDJJ 04.01.304 Discrimination and Harassment of Youth
7. Policy IDJJ MH-004 Mandated Abuse and Neglect Reporting
8. Interviews with the following:
  - a. Specialized and Random Staff

Policy and interviews address the requirements of this standard. Interviewed staff members were aware of their duties and responsibilities when they become aware or suspect that a resident is being sexually abused or sexually harassed. All staff indicated they would act immediately to protect the resident, including separating the victim/predator, securing the scene to protect possible evidence, preventing the destruction of potential evidence and contacting the operations lieutenant 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 twelve months. This was also verified through interviews with random staff. Safety plans would be 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 Check-list
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

Policy addresses the requirements of this standard. Policy requires that any resident allegation of sexual abuse occurring while confined at another facility be reported to the 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. Interviews with the following:
  - a. Specialized and Random Staff

Policies and interviews address the requirements of this standard. All interviewed staff members were extremely knowledgeable concerning their first responder duties and responsibilities upon learning of an allegation of sexual abuse/sexual harassment. Staff indicated they would separate the residents, secure the scene, prevent the destruction of any evidence and contact their supervisor and medical staff. The supervisor would continue to 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, and a first responder was required to separate the victim and the abuser.

**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

Policy and the IYCH Harrisburg PREA RESPONSE PLAN document address the requirements of this standard. The policies were reviewed by the Auditor. The local policy specifies the guidelines and procedures that prevent sexual abuse/sexual assault and provides for prompt and effective intervention, in the event abuse or an assault occurs. Local policy also includes procedures for the investigation, discipline and prosecution of the assailant or abuser. The IYCH PREA RESPONSE PLAN 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 allegations of prohibited and/or illegal sexually abusive behavior.

**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 of a determination of whether and to what extent discipline is warranted. Staff interviews confirmed compliance to 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 for residents or staff who fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations, 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?  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 04.01.304 Discrimination and Harassment of Youth
9. Interviews with the following:
  - a. Specialized Staff

Policy addresses the requirements of this standard. The policy prohibits any type of retaliation against any staff person 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 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 Procedures
4. Policy IDJJ 05.01.303 Youth Confinement
4. Interviews with the following:
  - a. Specialized Staff

Policy addresses the requirements of the standard. 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 an alternative after an allegation has been reported. 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, as well as 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 entity investigates sexual abuse, does the facility cooperate with outside investigators and endeavor to remain informed about the progress of the investigation? (N/A if an outside agency does not conduct administrative or criminal sexual abuse investigations. See 115.321(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. Attorney Notification (examples)
12. Illinois Administrative Code: Title 20, Chapter IX, Subchapter a, Part 2220 Rules of Conduct
13. 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, as well as access to the resident. The credibility of an alleged victim, suspect or witness is assessed on an individual basis and is not determined by the person's status as resident or staff. The agency does not require a resident who alleges sexual abuse to submit to a polygraph examination or other truth assessment device as a condition for proceeding with the investigation. During the last 12 months there were five allegations of sexual harassment and/or sexual abuse. All were found to be unsubstantiated. The Illinois State Police conducts all criminal investigations. Internal investigations are initiated by the Superintendent, and then forwarded to the Chief Investigator for additional investigation, if it is so warranted. Samples of Attorney Notifications were reviewed by the Auditor. 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:

Policy and interviews address the requirement of this standard. The evidence standard is a preponderance of the evidence in determining whether allegations of sexual abuse/sexual harassment are substantiated. When interviewed, the Chief Investigator confirmed that he 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 an agency 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 Procedures
11. Policy IDJJ 04.01.304 Discrimination and Harassment of Youth
12. Youth Grievance (Form 0046)
13. Youth Response to Grievance (Form 0047)
14. Interviews with the following:
  - a. Specialized and Random Staff

Policy and interviews address the components of this standard. During the last 12 months there were five allegations of sexual harassment and/or sexual 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 the youth and/or family member. Copies of all investigative decisions are maintained. Decisions are available to the victim's family, the administration and the Illinois Department of Children's Services.

**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

Policy 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 to 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 03.02.107 Personnel Files
5. Policy IDJJ 03.02.108 Standards of Conduct
6. Policy AD 04.01.302 Sexual Abuse and Harassment Response Procedures
7. Policy IDJJ 03.01.310 Sexual Harassment
8. Interviews with the following:
  - a. Specialized and Random Staff

Policy 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 would be 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, the IYCH would take appropriate remedial measures and consider whether to prohibit further contact with inmates. 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 and volunteer/contractor and staff interviews. At the time of the audit, no contractors or volunteers were available for interview.

**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)

- 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

Policy 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 packet addresses all disciplinary sanctions for juvenile residents. The facility does not use seclusion in cases of alleged sexual abuse or sexual harassment. Consensual sex of any nature is prohibited. Residents that sexually abuse or harass staff (not consensual) 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 Procedures
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. Policy 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

Policy and interviews address the requirements of this standard. Interviews with health and psychology services staff confirm the institution has a very thorough system for collecting medical and mental health information which allows 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, 100% of the residents who have previously perpetrated sexual abuse, as indicated during the screening, were offered a follow up meeting with a mental health practitioner. Treatment services are offered without financial cost to the inmate, 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 in-processing procedures. In-processing procedures also include screening for previous sexually abusive behavior in an institutional setting or in 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 for the purpose of determining 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 is in compliance 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 04.01.302 Sexual Abuse and Harassment - Response Procedures

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. Policy IDJJ MH-004 Mandated Abuse and Neglect Reporting
12. PREA Investigative Checklist
13. MOU with Women's Center
14. Interviews with the following:
  - a. Specialized and Random Staff

Policy 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 the Harrisburg Medical Center and the Women's Center.

**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.)  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.)  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
16. PREA Investigation Check-list
17. Interviews with the following:
  - a. Specialized and Random Staff

Policies and interviews address the requirements of this standard. The facility medical and mental health personnel provide services to the entire IYCH resident population. Medical personnel are available for consultation or call-back on off-duty hours. Mental health providers are also available for call-back during off-duty hours. Information and access to care is offered to all resident victims, as clinically indicated. Victim advocacy services are offered through trained staff members and the Women's Center. Agency policy prohibits 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, information regarding 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 a review of 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. Policy IDJJ 04.01.301 Sexual Abuse and Harassment and Intervention Program
6. Policy IDJJ 04.01.302 Sexual Abuse and Harassment - Response Procedures
4. Interviews with the following:
  - a. Superintendent

Policy addresses the requirements of this standard. Administrative and criminal investigations are completed on all allegations of sexual abuse/sexual harassment. The Illinois State Police conducts all criminal investigations. The IYCH conducts a sexual abuse incident review at the conclusion of every sexual abuse investigation, unless the allegation was proven to be 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 makes a determination as to whether additional monitoring technology should be added to enhance staff supervision. The review team is comprised of upper-level management officials, including the Superintendent, Health Care Administrator and the Treatment 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 Procedures
4. Interviews with the following:
  - a. Superintendent
  - b. Incident Review Team Member

Policy and interviews address the components of this standard. The data collected is captured with a computer program entitled Youth 360; it 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. IDJJ aggregates and reviews all incident-based sexual abuse data annually. Upon request, IDJJ provides all data from the previous calendar year to the Department of Justice.

**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

Policy addresses 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 data from previous 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

Policy 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 the information is posted.

**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, residents, and detainees?  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 second PREA audit of this facility. The Auditor was allowed access to all areas of the facility and had access to all required supporting documentation. The Auditor was able to conduct private interviews with both residents and staff. 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 prior to the audit. No confidential correspondence was received by the Auditor 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 within 90 days of issuance by auditor. The review period is for prior audits completed during the past three years PRECEDING THIS AGENCY AUDIT. In the case of single facility agencies, the auditor shall ensure that the facility's last audit report was published. 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 in the intake and allegations of sexual abuse processes. Medical networks for the residents are established in the community. The public has access to reporting mechanisms and 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.<sup>1</sup> Auditors are not permitted to submit audit reports that have been scanned.<sup>2</sup> See the PREA Auditor Handbook for a full discussion of audit report formatting requirements.



July 8, 2019

**Auditor Signature**

**Date**

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

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

