PREA AUDIT REPORT ☐ Interim x Final

COMMUNITY CONFINEMENT FACILITIES

Date of report: 04/17/2016

Auditor Information			
Auditor name: Glynn Maddox			
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Email: Glynn.Maddox@nakamotogroup.com			
Telephone number: 478-278-8022			
Date of facility visit: March 21-22, 2016			
Facility Information			
Facility name: North Lawndale Adult Transitional Center			
Facility physical address: 2839 West Fillmore Street, Chicago, Illinois 60612			
Facility mailing address: *(if different from above)* Click here to enter text.			
Facility telephone number: 773-638-8480			
The facility is:	☐ Federal	☐ State	☐ County
	☐ Military	☐ Municipal	☐ Private for profit
	x Private not for profit		
Facility type:	Community treatment center ☐ Halfway house ☐ Alcohol or drug rehabilitation center	x Community-based confinement facility ☐ Mental health facility ☐ Other	
Name of facility's Chief Executive Officer: Yvonne Johnson			
Number of staff assigned to the facility in the last 12 months: 59			
Designed facility capacity: 200			
Current population of facility: 121			
Facility security levels/inmate custody levels: Minimum			
Age range of the population: 19-59 years old			
Name of PREA Compliance Manager: Sakita Adams		**Title:** Program Manager	
Email address: sakita.adams@saferfoundation.org		**Telephone number:** 773-638-8480	
Agency Information			
Name of agency: The Safer Foundation			
Governing authority or parent agency: *(if applicable)* Illinois Department of Corrections			
Physical address: 1301 Concordia Court, Springfield IL 62794			
Mailing address: *(if different from above)* PO Box 19277 Springfield IL, 62794			
Telephone number: 217-558-2200			
Agency Chief Executive Officer			
Name: John Baldwin		**Title:** Director	
Email address: John.Baldwin@doc.illinois.gov		**Telephone number:** 217 558-2200	
Agency-Wide PREA Coordinator			
Name: Mike Funk		**Title:** Agency PREA Coordinator	
Email address: Mike.Funk@doc.illinois.gov		**Telephone number:** 217 557-6010 x5011	

AUDIT FINDINGS

NARRATIVE

The on-site visit to conduct a Prison Rape Elimination Act (PREA) compliance audit of North Lawndale Adult Transitional Center (NLATC) was conducted March 21-22, 2016. This facility is operated by the Safer Foundation, under contract to the Illinois Department of Corrections (IDOC). The standards used for this audit became effective August 20, 2012. The Director, IDOC Contract Administrator and the IDOC PREA Coordinator had been interviewed previously. As part of the audit, a review of all PREA policy and a tour of the facility was completed. At the time of this audit the facility employed 59 staff. The resident population was 121 adult males. An entrance meeting was held with the Center Supervisor, PREA Compliance Manager, the Assistant PREA Coordinator and several other administrative staff, to discuss the audit and schedule of activities. The audit also consisted of a review of supporting documentation and interviews with staff and residents. The staff were questioned regarding PREA training, the NLATC zero-tolerance policy and first responder responsibilities, to include victim/assailant separation, reporting mechanisms and requirements, available interventions, conducting interviews, evidence collection, retaliation monitoring and follow up. There are no on-site medical providers on staff at the center. Twelve (12) random resident interviews were conducted. At the time of the audit, the population did not include residents who were disabled, limited English proficient or who self-identified as Transgender, Intersex, Gay or Bisexual. No resident refused to be interviewed. Additional interviews were completed with six (6) random and eight (8) specialized staff, and one (1) contractor. Through the interviews, the auditor found the residents and staff to be very aware of the PREA. The Agency's policy prohibiting cross-gender viewing and cross-gender pat searches were in practice. Resident interviews support staff's compliance with the facility's prohibition of cross-gender viewing and pat searches. Staff receive PREA related training as part of their initial training at the Academy and annually in cycle training. Residents receive information regarding the program during intake screening. Arriving residents are provided a facility specific PREA information handout. The residents are provided information with reporting mechanisms, to include anonymous third-party resources for reporting. PREA information is also posted in the housing areas and bulletin boards throughout the center. During the past 12 months, the facility had no allegations of sexual assault/sexual harassment. Any and all allegations would be referred to the IDOC for investigation. The NLATC uses IDOC policy and procedure as its daily operational guidelines. This auditor was provided evidence to ensure compliance to the PREA, as documented in this report.

DESCRIPTION OF FACILITY CHARACTERISTICS

North Lawndale Adult Transition Center, a division of the Safer Foundation, provides a bridge for inmates nearing the completion of their sentences to make a transition from incarceration to society near to home. Through a combination of structure, programming and security, the Center provides opportunities and support for offenders to make a gradual readjustment to social and cultural values, employment, family relationships and the demands of daily life in a community setting.

The goal of the Safer Foundation is to assist ex-offenders in becoming productive, law-abiding members of the community. They prepare residents for the practical realities of living in the community, such as locating a place to live, finding and keeping a job, managing finances and maintaining family relationships.

In March 1998, the Safer Foundation entered in to a contractual relationship with the Illinois Department of Correction to build and operate the second adult transition center in the North Lawndale community, located on the near west side of Chicago, Illinois. The newly constructed center opened its doors in July of 2000, and houses 200 male offenders who are within two years of their release date from prison.

The residents are screened and placed at North Lawndale Adult Transition Center by the Illinois Department of Corrections.

The facility is located in a residential area that has a significant amount of drug use and other illegal activity in the area. The facility has security cameras outside the building to monitor the security of the building and staff work to ensure clients are not engaging in inappropriate activities when leaving or returning to the facility.

The building is a large two story "L" shaped block building with a perimeter fence. The parking lot for staff and visitors is in front of the building and creates a square with the building. The security station is manned by staff 24/7 and the staff control access to the building and all doors that lead into other areas of the building, including the residential area.

There is a single point of entry for all visitors and staff. To the left of the front entry is a conference room and the administration offices, to the right is access to the visitation room, and straight ahead is the central security station. On the other side or behind the central security station is the kitchen and dining room, a large group room, staff restroom, shift supervisors office, storage areas, and cleaning chemical storage.

The second floor of the building has a GED classroom, storage areas, and group rooms. The housing area is divided into the South Wing and the West Wing and each wing has a second level or second floor. Each wing consists of a small secured security center, with staff present 24 hours a day and a multi-purpose day room. Each housing area has four rooms with eight beds and two rooms with ten beds, two bathrooms and shower facilities that meet all accommodation ratios, a laundry room, pay phones, vending machines, janitor's closet, storage areas, and the case manager's offices. The South Wing houses the exercise room for use by the entire facility and the West Wing houses the in-house library for use by the entire facility. The facility has two working elevators and is handicapped accessible, including restroom and shower facilities that are handicapped accessible. The resident rooms are all furnished with bunk beds and large storage lockers. These lockers provide space for hanging items as well as a pull out writing ledge and drawer space on the bottom. These lockers are also equipped with a hasp allowing the client's personal property to be secured with a combination lock, provided by the facility.

During the residents stay at North Lawndale Adult Transition Center, they are required to complete a minimum of 35 hours per week in outside employment, education, life skills and/or community service. Residents of North Lawndale have the opportunity to participate in a variety of programs offered in house by both staff and community volunteers.

SUMMARY OF AUDIT FINDINGS

When the on-site audit was completed, another meeting was held with executive/administrative staff, to discuss audit findings. The facility was found to be fully compliant to the PREA, with three standards not applicable. The auditor had been provided with extensive and lengthy files prior to and during the audit for review to support a conclusion of compliance to the PREA. All staff interviews also supported compliance. The facility staff were found to be courteous, cooperative and professional. Staff morale appeared to be good, and the staff/inmate relationships were observed to be very good. All interviewed inmates stated that they felt safe at the facility. All areas of the prison were observed to be clean and well maintained. At the conclusion of the audit, the auditor thanked the NLATC staff for their hard work and dedication to the PREA compliance process.

Number of standards exceeded: 0

Number of standards met: 36

Number of standards not met: 0

Number of standards not applicable: 3

Standard 115.211 Zero tolerance of sexual abuse and sexual harassment; PREA Coordinator

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The Illinois Department of Corrections (IDOC) Administrative Directive (AD) 04.01.301 and the Safer Foundation corporate policy meet the requirements of this standard. The Agency's zero tolerance against sexual abuse is clearly established and the policy also outlines the agency's approach to preventing, detecting and responding to sexual abuse and sexual harassment allegations. Zero tolerance posters are displayed throughout the facility. Both facility staff and residents are provided with a variety of opportunities to become aware of the PREA. The review of training records and staff interviews confirmed that staff, volunteers, and contractors, who have regular or frequent contact with residents, receive PREA related training during initial orientation and annually. The Assistant PREA Coordinator and Manager were interviewed and advised that they have sufficient time and authority to coordinate efforts to comply with PREA standards.

Standard 115.212 Contracting with other entities for the confinement of residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Not Applicable-The Safer Foundation does not contract with other organizations for the confinement of residents.

Standard 115.213 Supervision and monitoring

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

AD 05.01.101, Staffing Plan meets the requirements of this standard. Policy requires the facility to review the staffing plan on an annual basis and update it as necessary. An interview with the Center Supervisor confirmed compliance with the PREA. Safety and security procedures are the primary focus, when considering staffing patterns and video monitoring. There are 54 cameras at the NLATC, with recording capabilities, and are monitored by staff. Staff are assigned to each floor and provide very good supervision (observed by the auditor). Other staff such as case managers are also assigned to each floor, and provide additional coverage and supervision. Security staff supervisors also monitor activities. The facility's resident population and the prevalence of incidents of sexual abuse are also considered when developing staffing patterns. The facility does not deviate from their established staffing plan and when vacancies occur; the facility uses overtime and endeavors to quickly fill open positions with qualified employees. The Center Supervisor was interviewed concerning this standard.

Standard 115.215 Limits to cross-gender viewing and searches

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

AD 04.01.301 Sexual Abuse and Harassment Prevention and Intervention Program addresses this standard. Under no circumstances does the facility allow cross-gender strip searches or cross-gender visual body cavity searches. The facility has no medical staff on site. Cross-gender pat searches are prohibited by policy. However, all randomly selected staff interviewed reported that they received cross-gender pat search training, during their Pre-Service Orientation Training (PSOT) and annually during in-service training. Randomly selected residents interviewed reported that they were instructed in orientation that female staff may enter the living units at any time. Interviews with both staff and residents confirmed that residents are allowed to shower, dress, and use the toilet privately, without being viewed by staff of the opposite gender. During the tour of the facility, the auditor observed female staff members announcing their presence, verbally, when entering all areas holding residents. This practice was also confirmed by residents and staff, during individual confidential interviews. Staff were aware of NLATC policy prohibited the searching of a Transgender or Intersex resident solely to determine their genital status. PREA notifications provided by the IDOC and others by the Safer Foundation (English and Spanish) are posted in each housing area and throughout the facility.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

AD 04.01.301, Sexual Abuse and Harassment Prevention and Intervention Program addresses the mandates of this standard. The NLATC takes appropriate steps to ensure residents with disabilities and residents with limited English proficiency have an opportunity to participate in and benefit from the facility's efforts to prevent, detect and respond to sexual abuse and harassment. PREA handouts, postings, and resident handbooks are in English and Spanish. The auditor reviewed all mentioned documents. Staff interviewed were aware that under no circumstances are residents permitted to act as interpreters or assistants when dealing with PREA issues. No residents with any disabilities

were housed at the facility during the audit. Interviews with staff, residents and a review of policy confirm compliance to this standard.

Standard 115.217 Hiring and promotion decisions

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

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

A.D. 01.02.107, Background Investigations and the Pre-Employment Self-Report Form address the requirements of this standard. The Human Resources Director for the Safer Foundation was interviewed and stated that all components of this standard have been met. All employees, contractors, and volunteers have had their criminal background check completed. The facility continuously monitors the background of employees through the computer criminal history check using the Law Enforcement Agencies Data System (LEADS). This daily reporting system, along with the employee self-report requirements, allows the facility to consider any incidents of sexual abuse in determining whether to hire, retain or promote anyone, or to enlist the services of any contractor/volunteer who may have contact with residents. The PREA Pre-Employment Self Report Form clearly states that material omissions or false information submitted by applicants shall be grounds for termination. The IDOC recently updated a PREA compliance form (relevant to this standard), which is in use by the NLATC.

Standard 115.218 Upgrades to facilities and technologies

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

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

The NLATC has had a video monitoring system (54 cameras) installed prior to August 20, 2012. This equipment provides coverage throughout most of the facility. PREA compliance was considered when this equipment was installed.

Standard 115.221 Evidence protocol and forensic medical examinations

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

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion

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

AD 01.12.120, Investigations of Unusual Incidents and AD 01.12.112, Preservation of Physical Evidence address the requirements of this standard. Staff interviewed were knowledgeable of procedures to immediately separate the victim and perpetrator; isolate the witnesses; follow the chain of command notifications; make appropriate referrals and secure and obtain usable physical evidence, when an allegation of sexual abuse is made. All allegations of sexual abuse or sexual harassment are referred to the IDOC. If necessary, residents will be transported to a local hospital emergency room which is located two blocks from the NLATC. The auditor talked by telephone with the emergency room nursing supervisor, who indicated the hospital was more than willing to examine and treat residents from the facility and that SANE (Sexual Abuse Nurse Examiner) nurses were available on site. The local rape crisis center was contacted, and the Victim Advocate stated services would be provided if needed (a Memorandum of Understanding had been established). All services will be provided at no cost to the resident. There have been no allegations of sexual abuse in the past 12 months at the facility. Interviews with staff and a review of documentation confirm compliance to this standard

Standard 115.222 Policies to ensure referrals of allegations for investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

AD 01.12.120, Investigations of Unusual Incidents; AD 04.01.301, Sexual Abuse and Harassment Prevention and Intervention Program and Illinois State Police (ISP)/Illinois Department of Corrections Memorandum of Understanding meet the requirements of this standard. All allegations of sexual abuse at the NLATC are referred to investigators with the IDOC. The IDOC has a Memorandum of Understanding with the Illinois State Police (ISP), who follow the requirements of the standard to conduct investigations. The Memorandum of Understanding clearly clarifies the responsibilities of both entities; the IDOC will investigate administrative allegations and the ISP will conduct investigations involving staff-on-staff and staff-on-inmate sexual assaults (criminal). When there is substantial evidence that a criminal act has taken place, the case is referred to the State's Attorney for possible prosecution. IDOC and ISP investigators are trained in conducting sexual assault investigations in confinement settings/prisons. No allegations of sexual abuse or sexual harassment were made during the audit period. Interviews with staff and a review of documentation confirm compliance to this standard.

Standard 115.231 Employee training

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

AD 03.03.102, Employee Training and AD 04.01.301, Sexual Abuse and Harassment Prevention and Intervention Program meet the requirements of this standard. All staff are required to receive training annually in cycle training and the curriculum includes PREA

requirements. The auditor reviewed the training curriculum, training sign-in sheets and other related documentation. Staff are required to acknowledge, in writing, not only that they received PREA training, but that they understood it as well. Interviews with staff and an examination of documentation confirm compliance to this standard. All staff interviewed also stated that they had received PREA training.

Standard 115.232 Volunteer and contractor training

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

AD 04.01.301, Sexual Abuse and Harassment Prevention and Intervention Program; Volunteer Orientation Training Program and Volunteer Service Orientation Checklist meet the requirements of this standard. All facility volunteers and contractors have received PREA training, to include the agency's zero-tolerance policy, reporting and responding requirements. The training is documented and copies of training sign-in sheets and other related documents were reviewed by this auditor. Interviews were conducted with one contractor and one volunteer, who stated they had received PREA training.

Standard 115.233 Resident education

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

AD 04.01.301, Sexual Abuse and Harassment Prevention and Intervention Program; PREA Posters (English and Spanish); and the Orientation Manual (English and Spanish) meet the requirements of this standard. Residents are provided information during the intake process that includes a PREA handout and Resident Handbook, printed in both English and Spanish. Residents also receive information during the intake process that includes PREA verbal orientation and the handbook which is in English and Spanish. The information explains the facilities zero tolerance policy regarding sexual abuse and sexual harassment. Residents are also provided information regarding reporting procedures, their right to be free from retaliation and the availability of advocacy services. During the tour, the auditor observed PREA posters throughout the facility including in resident housing areas. A PREA "Report Line" telephone number which may be called to report sexual abuse or sexual harassment, was also posted on the bulletin boards. Interviews with residents confirmed they not only received the information, but were required to acknowledge in writing they completed PREA education. Interviews with staff, residents and a review of documentation confirm compliance to this standard.

Standard 115.234 Specialized training: Investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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

Not Applicable-NLATC staff do not conduct investigations. All investigations are conducted by either IDOC or ISP staff.

Standard 115.235 Specialized training: Medical and mental health care

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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ADs 03.03.102 Employee Training, 04.01.301 Sexual Abuse and Harassment Prevention and Intervention Program, and 04.04.100 General Provisions partially apply to this standard. The facility does not employ or contract for on-site medical services or mental health services. All staff are trained as first responders to refer victims to a local hospital for medical treatment and the collection of forensic evidence. SANE staff are on site at the hospital at all times. The local rape crisis center is willing and able to provide victim advocacy services (confirmed by contact with the center). Staff are also trained to preserve any evidence for investigative purposes. Staff receive refresher training annually during cycle training and documentation of participation is on file. The auditor reviewed the training lesson plan and training sign-in sheets. Staff interviewed confirmed compliance to this standard.

Standard 115.241 Screening for risk of victimization and abusiveness

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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AD 04.01.301, Sexual Abuse and Harassment Prevention and Intervention Program addresses the requirements of this standard. The program manager reviews all referral packets for inmates being considered for placement for this facility. Upon arrival at the NLATC, all residents are screened and assessed for their risk of being sexually abused or sexually harassed by other residents. Sexual abusers are precluded from being referred to a transition center. Residents are not disciplined for refusing to respond or failing to fully disclose information during screening. Controls are in place to ensure that information received during screening is only available to staff on a

need to know basis. Case Managers review all relevant information from other facilities and continue to immediately reassess when additional information is received. The IDOC recently updated the screening form relevant to this standard, to ensure full compliance to the PREA. This form is being used by the NLATC. Interviews with staff and an examination of documentation confirm compliance to this standard.

Standard 115.242 Use of screening information

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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AD 04.01.301, Sexual Abuse and Harassment Prevention and Intervention Program meets the requirements of this standard. The policy requires the use of a screening instrument to determine proper housing, bed, work, education and program assignments. Known abusers are precluded from referral to a transition center. Housing and program assignments are made on a case by case basis for all residents, with continued monitoring and follow up as necessary. The facility does not have dedicated housing for gay, bisexual, transgender or intersex residents. Youthful offenders are not housed at the facility. Interviews with staff and a review of documentation confirm compliance to this standard.

Standard 115.251 Resident reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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AD 04.01.301, Sexual Abuse and Harassment Prevention and Intervention Program; a PREA poster entitled How to Report; the Resident Orientation document and an agreement between the NLATC and the local rape crisis center address the mandates of this standard. Upon arrival at the NLATC, each resident is provided a document covering sexual assault awareness prevention as part of the orientation process. All written information is provided in both English and Spanish. The pamphlet provides residents with information on examples of sexual abuse, how to prevent sexual abuse, what to do, how to report and where to report. The handout provided outlines the numerous ways to report, to include, but not limited to, telling a staff member, submitting a request or grievance, calling the PREA Report Line, contacting the local rape crisis center or writing a letter to the John Howard Association of Illinois, a private entity that is not associated or otherwise connected to the IDOC. Residents sign a document indicating that they received the information. Staff are required to document all allegations. Posters and other documents were noted on display in all common areas of the facility, the Dining Hall and Visiting Room, which also explain reporting methods. Staff are able to privately report sexual abuse and sexual harassment of residents in writing to the agency. Interviews with staff and residents confirmed an in-depth knowledge of available reporting methods.

Standard 115.252 Exhaustion of administrative remedies

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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AD 04.01.114 Local Grievance Procedures, Title 20 of the Administrative Code and IDOC 0046 addresses the requirements of this standard. Inmates may file a grievance; however, all allegations of sexual abuse/sexual harassment, when received by staff, shall immediately result in an administrative or criminal investigation. Inmates are not required to use the formal grievance process and procedures allow an inmate to submit a grievance alleging sexual abuse without submitting it to the staff member who is the subject of the complaint. Inmates may file a regular or emergency grievance at any time, and may seek assistance from others to file same. All required response/reporting time limits concerning grievance processing are required by policy. There were no grievances filed involving any PREA related issue during the past 12 months. Staff interviews confirmed compliance to this policy. The IDOC recently updated the grievance policy relevant to this standard, and NLATC has informed staff and residents of the changes.

Standard 115.253 Resident access to outside confidential support services

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

AD 04.01.301 Sexual Abuse and Harassment Prevention and Intervention Program; ID 04.01.301 Offender Sexual Assaults-Prevention and Intervention and the Resident Orientation Manual addresses this standard. There is a Memorandum of Understanding (MOU) with the local rape crisis center that serves the Chicago, (North Lawndale section) IL area. The local Victim Advocate of that organization assigned to provide services to the NLATC was interviewed. Residents are allowed to contact the rape crisis center telephonically or by mail. The Victim Advocate stated that their organization would provide all services required under this standard, in a confidential manner. Documentation reviewed by the auditor also supports compliance to this standard. The auditor observed posters, pamphlets and other relevant information displayed and available in all common areas of the facility. Interviews with staff and residents confirmed that they were aware of the access to outside victim advocacy groups and where the telephone numbers and addresses were located.

Standard 115.254 Third-party reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance

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

The Resident Orientation Handbook, PREA posters, the Safer Foundation website and IDOC website meet the mandates of this standard. The websites and posted notices (observed by the auditor) assist third party reporters on how to report allegations of sexual abuse. Interviews with both staff and residents revealed they were aware of the procedures for third party reporting. Upon arrival to the NLATC, each resident receives and signs for a handout that addresses the requirements of this standard. PREA posters were observed in the visiting area, and these items also explain to family and friends the reporting processes.

Standard 115.261 Staff and agency reporting duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

AD 04.01.301, Sexual Abuse and Harassment Prevention and Intervention Program; AD 03.02.108, Standards of Conduct and Title 20 of the Illinois Administrative Code, Rules of Conduct, address the requirements of this standard. Policy requires all staff to immediately report any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in a facility; retaliation against residents or staff who reported such an incident; and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. Policy states that apart from reporting to designated supervisors or officials, staff shall not reveal any information related to a sexual abuse report to anyone other than to the extent necessary, as specified in agency policy, to make treatment, investigation, and other security and management decisions. The facility does not house residents under the age of 18. Staff interviewed were aware of their duty to immediately report all allegations of sexual abuse/sexual harassment and retaliation relevant to PREA standards and appropriate reporting methods. The interviewed contract staff indicated they had received PREA training and were well aware of their duty to report any knowledge, suspicion or information regarding an incident of sexual abuse or sexual harassment.

Standard 115.262 Agency protection duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

AD 04.01.301, Sexual Abuse and Harassment Prevention and Intervention Program addresses the requirements of this standard. All staff interviewed were aware of their duties and responsibilities, as it relates to them having knowledge of a resident being at imminent risk for being sexually abused or sexually harassed. Staff indicated they would act immediately to protect the resident by separating the potential victim and predator. In the past 12 months, there were no instances in which the facility staff determined that a resident was subject to substantial risk of imminent sexual abuse.

Standard 115.263 Reporting to other confinement facilities

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

AD 04.01.301, Sexual Abuse and Harassment Prevention and Intervention addresses the requirements of this standard. Policy requires the reporting of any sexual abuse or sexual harassment allegation by a resident that occurred at another facility. Upon receiving an allegation that a resident was sexually abused while confined at another facility/program, the Center Supervisor must notify the Warden or equivalent staff of where and when the alleged incident took place (within 72 hours). There have been no allegations of sexual abuse/sexual harassment reported to have occurred at another facility within the last year. Interviews with staff and a review of policy confirm compliance to this standard.

Standard 115.264 Staff first responder duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

AD 04.01.301, Sexual Abuse and Harassment Prevention and Intervention Program addresses the requirements of this standard. All staff interviewed were very knowledgeable concerning their first responder duties, upon learning of an allegation of sexual abuse or sexual harassment. Staff indicated they would separate the residents, secure the scene, not allow other residents to destroy any evidence and contact their supervisor and the center supervisor. They would also not allow the victim to bath, smoke, brush their teeth, defecate, urinate, eat, drink or change clothes. There were no allegations of sexual abuse made by residents in the past 12 months.

Standard 115.265 Coordinated response

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These

recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

AD 04.01.301, Sexual Abuse and Harassment Prevention and Intervention Program addresses the requirements of this standard. A review of the facility policies and procedures indicates that there would be a coordinated response plan to resolve sexual abuse and/or sexual harassment incidents that includes first responders, referral to medical and mental health practitioners, investigators and facility leadership. There were no incidents requiring a coordinated response within the past 12 months at this facility.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

There is currently no collective bargaining agreement between the Safer Foundation (NLATC) and employees relative to the Prison Rape Elimination Act. There is no policy that would prohibit the NLATC from removing alleged staff sexual abusers from contact with any resident pending the outcome of an investigation or of a determination of whether and to what extent discipline is warranted.

Standard 115.267 Agency protection against retaliation

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

AD 04.01.301, Sexual Abuse and Harassment Prevention and Intervention Program addresses the requirements of this standard. The Program Manager is the designated to be the Retaliation Monitor. Current policy requires the PREA Retaliation Monitor to monitor retaliation for a minimum of 90 days. There is a procedure that includes periodic status checks for residents or the provision of monitoring beyond 90 days, if a continuing need was indicated through periodic status checks or other indicators.

Standard 115.271 Criminal and administrative agency investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Not Applicable-NLATC staff do not conduct investigations. All investigations are conducted by either IDOC or ISP staff.

Standard 115.272 Evidentiary standard for administrative investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

AD 04.01.301 addresses the requirements of this standard. The evidence standard is a preponderance of the evidence in determining whether administrative allegations of sexual abuse or sexual harassment are substantiated.

Standard 115.273 Reporting to residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

AD 04.01.301, Sexual Abuse and Harassment Prevention and Intervention Program addresses the requirements of this standard. The NLATC has a policy requiring that any resident who makes an allegation that he suffered sexual abuse is informed, verbally or in writing, whether the allegation has been determined to be unsubstantiated, substantiated or unfounded (excluding a staff related allegation determined to be unfounded), at the conclusion of the investigation. There were no investigations during the period which required inmate notification per this standard. The residents will be given notification of the case disposition in accordance with policy. Interviews with staff and an examination of policy confirm compliance to this standard.

Standard 115.276 Disciplinary sanctions for staff

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

AD 04.01.301, Sexual Abuse and Harassment Prevention and Intervention Program; AD 03.01.120, Employee Review Hearing; AD 03.01.310, Sexual Harassment; ID 04.01.301, Offender Sexual Assaults-Prevention and Intervention and AD 01.12.120 Investigations of Unusual Incidents address the requirements of this standard. Employees are subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies. Termination is the presumptive disciplinary sanction for staff who have engaged in sexual abuse. Disciplinary sanctions for violations of NLATC policies relating to sexual abuse or sexual harassment are 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. 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, are reported to law enforcement agencies, unless the activity was clearly not criminal, and to any relevant licensing bodies. The policy requiring reporting to relevant licensing bodies is a recent addition to written policy, however, it has been the long standing practice of the agency. In the past 12 months, there were no staff found to have violated the sexual abuse/ sexual harassment policy.

Standard 115.277 Corrective action for contractors and volunteers

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

AD 03.01.310, Sexual Harassment; AD 01.12.120, Investigations of Unusual Incidents and AD 04.01.122, Volunteer Services address the requirements of this standard. Any contractor or volunteer who engages in sexual abuse or harassment is prohibited from contact with residents and will be reported to law enforcement agencies and to relevant licensing bodies, unless the activity was clearly not criminal. In the past 12 months, there were no volunteers or contractors reported to have engaged in any act of sexual abuse with a resident. The policy requiring reporting to relevant licensing bodies is a recent addition to written policy, however, it has been the long standing practice of the agency. The facility would take appropriate remedial measures, and consider prohibiting further contact with inmates, in the event of any violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer. Interviews with staff and a review of documentation confirm compliance to this standard.

Standard 115.278 Disciplinary sanctions for residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

corrective actions taken by the facility.

AD 04.01.301, Sexual Abuse and Harassment Prevention and Intervention Program; Title 20 of the Illinois Administrative Code, Administration of Discipline and AD 05.12.103, Administration of Discipline for Offenders Identified as Seriously Mentally Ill address the requirements of this standard. The NLATC prohibits all sexual activity between residents and may discipline residents for such activity. There were no cases of this nature in the past 12 months. Disciplinary sanctions would be 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. The disciplinary process considers whether a resident's mental disabilities or mental illness contributed to the inmate's behavior when determining what type of sanction, if any, should be imposed. For the purpose of disciplinary action, a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred does not constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation. Interviews with staff and an examination of documentation confirm compliance to this standard.

Standard 115.282 Access to emergency medical and mental health services

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

ADs 04.01.301 Sexual Abuse and Harassment Prevention and Intervention Program and 04.04.100 General Provisions address the requirements of this standard. The facility does not have on-site medical providers on staff. All staff are trained as first responders to refer victims to a local hospital for medical treatment and the gathering of forensic evidence. Residents who require mental health services would be referred to a local rape crisis center. Staff are also trained to preserve on-site evidence for criminal investigations. Residents are offered information about timely access to emergency medical treatment and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate. The treatment is offered at no financial cost to the residents, regardless of whether the victim names the abuser or cooperates with any investigation arising from the incident. There were no residents in need of emergency medical or mental health treatment, relative to this standard, within the last year. Interviews with staff and a review of documentation confirm compliance to this standard.

Standard 115.283 Ongoing medical and mental health care for sexual abuse victims and abusers

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

AD 04.01.301, Sexual Abuse and Harassment Prevention and Intervention Program addresses the requirements of this standard. Residents will receive continued treatment as needed at a local hospital, from staff, or from a local rape crisis center. Services are consistent with a community level of care without financial cost to the resident. Resident victims of sexual abuse while incarcerated would be offered medically appropriate testing for sexually transmitted diseases. The facility would attempt to conduct a mental health evaluation of all

known resident on resident abusers immediately upon learning of the abuse. During this audit period, there were no residents at NLATC who required medical or mental health evaluation or treatment due to a PREA incident. Staff interviews support the finding that the standard is in compliance at this facility.

Standard 115.286 Sexual abuse incident reviews

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

AD 04.01.301, Sexual Abuse and Harassment Prevention and Intervention Program; the IDOC Director's Implementation of Sexual Abuse Incident Reviews Memo and PREA Reporting Instructions address the requirements of this standard. All allegations of sexual harassment/sexual assault are referred to the IDOC investigators, who determine how the case will be handled (if criminal, would be referred to the ISP). The facility has established a PREA Incident Review Committee which operates in accordance with the required components of the standard. The committee consists of the Center Supervisor, the Office Manager, a Case Manager, and the PREA Compliance Manager/ Program Manager. There were no allegations of sexual abuse or sexual harassment during the audit period; therefore, there was no need to activate the incident review team or to prepare a report.

Standard 115.287 Data collection

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

AD 04.01.301, Sexual Abuse and Harassment Prevention and Intervention Program; PREA FY 2015 Annual Compliance Report; PREA Checklist and PREA After-Action Checklist address the requirements of this standard. The facility collects accurate uniform data for every allegation of sexual abuse/harassment by using a standardized instrument. The incident-based information collected includes data required to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice (DOJ_. The Agency data has been aggregated annually. Upon request, the NLATC would provide all such data from the previous calendar year to the IDOC. The required data would then be forwarded to the Department of Justice no later than June 30, through the IDOC. Interviews with staff and an examination of policy confirm compliance to this standard.

Standard 115.288 Data review for corrective action

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

AD 04.01.301, Sexual Abuse and Harassment Prevention and Intervention Program addresses the requirements of this standard. The Administrative Directive was effective July 1, 2015, which is after the June 30th deadline for reporting. The July 1, 2015 policy requires the Agency to collect and review data from all facilities (including 2 contract facilities, which will include the NLATC) in the state and to assess and improve the effectiveness of its sexual abuse prevention, detection, response policies, practices, and training, to include identifying problem areas, taking corrective action on an ongoing basis and preparing an annual report of its findings and corrective actions for each facility (this information will be provided to the IDOC). The facility reviews and assesses all sexual abuse/harassment data at least annually to improve the effectiveness of its sexual abuse prevention, detection and response policies, and to identify any issues or problematic areas and take corrective action, if needed. Interviews with staff and a review of documentation confirm compliance to this standard.

Standard 115.289 Data storage, publication, and destruction

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

AD 04.01.301 Sexual Abuse and Harassment Prevention and Intervention Program addresses the requirements of this standard. The data is retained in a secure filing system. The final report does not contain any personal identifiers and policy requires that the statistical data be retained for a period of no less than 10 years, unless federal, state or local law requires otherwise. The agency makes the information available on the IDOC website included with IDOC data. The reports cover all data required in the elements of this standard. Interviews with staff and a review of documentation confirm compliance to this standard.

AUDITOR CERTIFICATION

I certify that:

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

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

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

Glynn Maddox April 17, 2016

Auditor Signature Date