PREA Facility Audit Report: Final

Name of Facility: North Lawndale Adult Transition Center
Facility Type: Community Confinement
Date Interim Report Submitted: 02/16/2024
Date Final Report Submitted: 08/12/2024

Auditor Certification	
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.	☑
I have not included in the final report any personally identifiable information (PII) about any inmate/resident/detainee or staff member, except where the names of administrative personnel are specifically requested in the report template.	☑
Auditor Full Name as Signed: Kendra Prisk	**Date of Signature:** 08/12/2024

AUDITOR INFORMATION	
Auditor name:	Prisk, Kendra
Email:	2kconsultingllc@gmail.com
Start Date of On-Site Audit:	01/25/2024
End Date of On-Site Audit:	01/26/2024

FACILITY INFORMATION	
Facility name:	North Lawndale Adult Transition Center
Facility physical address:	2839 West Fillmore, Chicago , Illinois - 60612
Facility mailing address:	

Primary Contact

Name:	
Email Address:	
Telephone Number:	

Facility Director	
Name:	Bobby Moore
Email Address:	Bobby.Moore@saferfoundation.org
Telephone Number:	773-638-8480

Facility PREA Compliance Manager

Facility Characteristics	
Designed facility capacity:	208
Current population of facility:	149
Average daily population for the past 12 months:	150
Has the facility been over capacity at any point in the past 12 months?	No
Which population(s) does the facility hold?	Males
Age range of population:	21-75
Facility security levels/resident custody levels:	Minimum
Number of staff currently employed at the facility who may have contact with residents:	37
Number of individual contractors who have contact with residents, currently authorized to enter the facility:	0

Number of volunteers who have contact with residents, currently authorized to enter the facility:	0

AGENCY INFORMATION	
Name of agency:	Safer Foundation
Governing authority or parent agency (if applicable):	
Physical Address:	571 West Jackson Boulevard , Chicago , Illinois - 60661
Mailing Address:	
Telephone number:	

Agency Chief Executive Officer Information:	
Name:	
Email Address:	
Telephone Number:	

Agency-Wide PREA Coordinator Information			
Name:	Ryan Nottingham	**Email Address:**	ryan.nottingham@illinois.gov

Facility AUDIT FINDINGS

Summary of Audit Findings

The OAS automatically populates the number and list of Standards exceeded, the number of Standards met, and the number and list of Standards not met.

Auditor Note: In general, no standards should be found to be "Not Applicable" or "NA." A compliance determination must be made for each standard. In rare instances where an auditor determines that a standard is not applicable, the auditor should select "Meets Standard" and include a comprehensive discussion as to why the standard is not applicable to the facility being audited.

Number of standards exceeded:	
0	
Number of standards met:	
41	
Number of standards not met:	
0	

POST-AUDIT REPORTING INFORMATION	
GENERAL AUDIT INFORMATION	
On-site Audit Dates	
1. Start date of the onsite portion of the audit:	2024-01-25
2. End date of the onsite portion of the audit:	2024-01-26
Outreach	
10. Did you attempt to communicate with community-based organization(s) or victim advocates who provide services to this facility and/or who may have insight into relevant conditions in the facility?	(●) Yes ( ) No
a. Identify the community-based organization(s) or victim advocates with whom you communicated:	JDI, YWCA and Our Resilience
AUDITED FACILITY INFORMATION	
14. Designated facility capacity:	208
15. Average daily population for the past 12 months:	150
16. Number of inmate/resident/detainee housing units:	4
17. Does the facility ever hold youthful inmates or youthful/juvenile detainees?	( ) Yes ( ) No (●) Not Applicable for the facility type audited (i.e., Community Confinement Facility or Juvenile Facility)

Audited Facility Population Characteristics on Day One of the Onsite Portion of the Audit	
Inmates/Residents/Detainees Population Characteristics on Day One of the Onsite Portion of the Audit	
36. Enter the total number of inmates/ residents/detainees in the facility as of the first day of onsite portion of the audit:	136
38. Enter the total number of inmates/ residents/detainees with a physical disability in the facility as of the first day of the onsite portion of the audit:	1
39. Enter the total number of inmates/ residents/detainees with a cognitive or functional disability (including intellectual disability, psychiatric disability, or speech disability) in the facility as of the first day of the onsite portion of the audit:	2
40. Enter the total number of inmates/ residents/detainees who are Blind or have low vision (visually impaired) in the facility as of the first day of the onsite portion of the audit:	0
41. Enter the total number of inmates/ residents/detainees who are Deaf or hard-of-hearing in the facility as of the first day of the onsite portion of the audit:	1
42. Enter the total number of inmates/ residents/detainees who are Limited English Proficient (LEP) in the facility as of the first day of the onsite portion of the audit:	6
43. Enter the total number of inmates/ residents/detainees who identify as lesbian, gay, or bisexual in the facility as of the first day of the onsite portion of the audit:	1

44. Enter the total number of inmates/ residents/detainees who identify as transgender or intersex in the facility as of the first day of the onsite portion of the audit:	0
45. Enter the total number of inmates/ residents/detainees who reported sexual abuse in the facility as of the first day of the onsite portion of the audit:	0
46. Enter the total number of inmates/ residents/detainees who disclosed prior sexual victimization during risk screening in the facility as of the first day of the onsite portion of the audit:	0
47. Enter the total number of inmates/ residents/detainees who were ever placed in segregated housing/isolation for risk of sexual victimization in the facility as of the first day of the onsite portion of the audit:	0
48. Provide any additional comments regarding the population characteristics of inmates/residents/detainees in the facility as of the first day of the onsite portion of the audit (e.g., groups not tracked, issues with identifying certain populations):	No text provided.
Staff, Volunteers, and Contractors Population Characteristics on Day One of the Onsite Portion of the Audit	
49. Enter the total number of STAFF, including both full- and part-time staff, employed by the facility as of the first day of the onsite portion of the audit:	37
50. Enter the total number of VOLUNTEERS assigned to the facility as of the first day of the onsite portion of the audit who have contact with inmates/residents/detainees:	2

51. Enter the total number of CONTRACTORS assigned to the facility as of the first day of the onsite portion of the audit who have contact with inmates/residents/detainees:	6
52. Provide any additional comments regarding the population characteristics of staff, volunteers, and contractors who were in the facility as of the first day of the onsite portion of the audit:	No text provided.

INTERVIEWS

Inmate/Resident/Detainee Interviews

Random Inmate/Resident/Detainee Interviews

53. Enter the total number of RANDOM INMATES/RESIDENTS/DETAINEES who were interviewed:	10
54. Select which characteristics you considered when you selected RANDOM INMATE/RESIDENT/DETAINEE interviewees: (select all that apply)	☑ Age ☑ Race ☑ Ethnicity (e.g., Hispanic, Non-Hispanic) ☐ Length of time in the facility ☑ Housing assignment ☑ Gender ☐ Other ☐ None
55. How did you ensure your sample of RANDOM INMATE/RESIDENT/DETAINEE interviewees was geographically diverse?	Four residents were interviewed from 1S, five from 1W, six from 2S and five from 2W.
56. Were you able to conduct the minimum number of random inmate/ resident/detainee interviews?	◉ Yes ○ No

57. Provide any additional comments regarding selecting or interviewing random inmates/residents/detainees (e.g., any populations you oversampled, barriers to completing interviews, barriers to ensuring representation):	All 20 residents interviewed were male. Eight were black, four were white, seven were Hispanic and one was another race. All 20 were at the facility a year or less.
Targeted Inmate/Resident/Detainee Interviews	
58. Enter the total number of TARGETED INMATES/RESIDENTS/DETAINEES who were interviewed:	10
As stated in the PREA Auditor Handbook, the breakdown of targeted interviews is intended to guide auditors in interviewing the appropriate cross-section of inmates/residents/detainees who are the most vulnerable to sexual abuse and sexual harassment. When completing questions regarding targeted inmate/resident/detainee interviews below, remember that an interview with one inmate/resident/detainee may satisfy multiple targeted interview requirements. These questions are asking about the number of interviews conducted using the targeted inmate/resident/detainee protocols. For example, if an auditor interviews an inmate who has a physical disability, is being held in segregated housing due to risk of sexual victimization, and disclosed prior sexual victimization, that interview would be included in the totals for each of those questions. Therefore, in most cases, the sum of all the following responses to the targeted inmate/resident/detainee interview categories will exceed the total number of targeted inmates/residents/detainees who were interviewed. If a particular targeted population is not applicable in the audited facility, enter "0".	
60. Enter the total number of interviews conducted with inmates/residents/detainees with a physical disability using the "Disabled and Limited English Proficient Inmates" protocol:	1
61. Enter the total number of interviews conducted with inmates/residents/detainees with a cognitive or functional disability (including intellectual disability, psychiatric disability, or speech disability) using the "Disabled and Limited English Proficient Inmates" protocol:	2
62. Enter the total number of interviews conducted with inmates/residents/detainees who are Blind or have low vision (i.e., visually impaired) using the "Disabled and Limited English Proficient Inmates" protocol:	0

a. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/ detainees in this category:	■ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.
b. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/ residents/detainees).	The auditor spoke with medical staff and reviewed risk screening documents.
63. Enter the total number of interviews conducted with inmates/residents/ detainees who are Deaf or hard-of-hearing using the "Disabled and Limited English Proficient Inmates" protocol:	1
64. Enter the total number of interviews conducted with inmates/residents/ detainees who are Limited English Proficient (LEP) using the "Disabled and Limited English Proficient Inmates" protocol:	4
65. Enter the total number of interviews conducted with inmates/residents/ detainees who identify as lesbian, gay, or bisexual using the "Transgender and Intersex Inmates; Gay, Lesbian, and Bisexual Inmates" protocol:	1
66. Enter the total number of interviews conducted with inmates/residents/ detainees who identify as transgender or intersex using the "Transgender and Intersex Inmates; Gay, Lesbian, and Bisexual Inmates" protocol:	0

a. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/ detainees in this category:	■ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.
b. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/ residents/detainees).	The auditor spoke with medical and reviewed risk screening documents.
67. Enter the total number of interviews conducted with inmates/residents/ detainees who reported sexual abuse in this facility using the "Inmates who Reported a Sexual Abuse" protocol:	0
a. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/ detainees in this category:	■ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.
b. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/ residents/detainees).	The auditor reviewed the investigative log.
68. Enter the total number of interviews conducted with inmates/residents/ detainees who disclosed prior sexual victimization during risk screening using the "Inmates who Disclosed Sexual Victimization during Risk Screening" protocol:	2

69. Enter the total number of interviews conducted with inmates/residents/ detainees who are or were ever placed in segregated housing/isolation for risk of sexual victimization using the "Inmates Placed in Segregated Housing (for Risk of Sexual Victimization/Who Allege to have Suffered Sexual Abuse)" protocol:	0
a. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/ detainees in this category:	■ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.
b. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/ residents/detainees).	The facility does not have a segregated housing unit.
70. Provide any additional comments regarding selecting or interviewing targeted inmates/residents/detainees (e.g., any populations you oversampled, barriers to completing interviews):	No text provided.
Staff, Volunteer, and Contractor Interviews	
Random Staff Interviews	
71. Enter the total number of RANDOM STAFF who were interviewed:	12

72. Select which characteristics you considered when you selected RANDOM STAFF interviewees: (select all that apply)	☐ Length of tenure in the facility ☑ Shift assignment ☑ Work assignment ☑ Rank (or equivalent) ☑ Other (e.g., gender, race, ethnicity, languages spoken) ☐ None
If "Other," describe:	Race, gender and ethnicity.
73. Were you able to conduct the minimum number of RANDOM STAFF interviews?	◉ Yes ○ No
74. Provide any additional comments regarding selecting or interviewing random staff (e.g., any populations you oversampled, barriers to completing interviews, barriers to ensuring representation):	Eight staff were interviewed from day shift and four were interviewed from night shift. With regard to the demographics of the random staff interviewed; four were male and eight were female. Eleven staff were black and one was another race/ethnicity. Eight of the staff interviewed were CRC I, two were CRC II, and two were program staff.
Specialized Staff, Volunteers, and Contractor Interviews	
Staff in some facilities may be responsible for more than one of the specialized staff duties. Therefore, more than one interview protocol may apply to an interview with a single staff member and that information would satisfy multiple specialized staff interview requirements.	
75. Enter the total number of staff in a SPECIALIZED STAFF role who were interviewed (excluding volunteers and contractors):	15
76. Were you able to interview the Agency Head?	◉ Yes ○ No

77. Were you able to interview the Warden/Facility Director/Superintendent or their designee?	(●) Yes ( ) No
78. Were you able to interview the PREA Coordinator?	(●) Yes ( ) No
79. Were you able to interview the PREA Compliance Manager?	( ) Yes ( ) No (●) NA (NA if the agency is a single facility agency or is otherwise not required to have a PREA Compliance Manager per the Standards)

80. Select which SPECIALIZED STAFF roles were interviewed as part of this audit from the list below: (select all that apply)	☑ Agency contract administrator ☐ Intermediate or higher-level facility staff responsible for conducting and documenting unannounced rounds to identify and deter staff sexual abuse and sexual harassment ☐ Line staff who supervise youthful inmates (if applicable) ☐ Education and program staff who work with youthful inmates (if applicable) ☐ Medical staff ☐ Mental health staff ☐ Non-medical staff involved in cross-gender strip or visual searches ☑ Administrative (human resources) staff ☑ Sexual Assault Forensic Examiner (SAFE) or Sexual Assault Nurse Examiner (SANE) staff ☑ Investigative staff responsible for conducting administrative investigations ☑ Investigative staff responsible for conducting criminal investigations ☑ Staff who perform screening for risk of victimization and abusiveness ☐ Staff who supervise inmates in segregated housing/residents in isolation ☑ Staff on the sexual abuse incident review team ☑ Designated staff member charged with monitoring retaliation ☑ First responders, both security and non-security staff ☑ Intake staff

	☑ Other
If "Other," provide additional specialized staff roles interviewed:	Mailroom
81. Did you interview VOLUNTEERS who may have contact with inmates/ residents/detainees in this facility?	○ Yes ◉ No
82. Did you interview CONTRACTORS who may have contact with inmates/ residents/detainees in this facility?	◉ Yes ○ No
a. Enter the total number of CONTRACTORS who were interviewed:	1
b. Select which specialized CONTRACTOR role(s) were interviewed as part of this audit from the list below: (select all that apply)	☐ Security/detention ☐ Education/programming ☐ Medical/dental ☑ Food service ☐ Maintenance/construction ☐ Other

83. Provide any additional comments regarding selecting or interviewing specialized staff.	It should be noted that the auditor interviewed the PREA Coordinator, Agency Head, Human Resource staff and Investigative staff from the Illinois Department of Corrections. While Safer Foundations is the agency that operates the community confinement facility, all PREA related activities are dictated and monitored by the Illinois Department of Corrections. Safer Foundations does not have their own policy and procedures related to PREA, rather they follow all IDOC policies and procedures. Additionally, they utilize all IDOC documents and forms. The IDOC PREA Coordinator monitors PREA compliance for Safer Foundations and is actively involved in ensuring the facility meets all PREA standards.

SITE REVIEW AND DOCUMENTATION SAMPLING

Site Review

PREA Standard 115.401 (h) states, "The auditor shall have access to, and shall observe, all areas of the audited facilities." In order to meet the requirements in this Standard, the site review portion of the onsite audit must include a thorough examination of the entire facility. The site review is not a casual tour of the facility. It is an active, inquiring process that includes talking with staff and inmates to determine whether, and the extent to which, the audited facility's practices demonstrate compliance with the Standards. Note: As you are conducting the site review, you must document your tests of critical functions, important information gathered through observations, and any issues identified with facility practices. The information you collect through the site review is a crucial part of the evidence you will analyze as part of your compliance determinations and will be needed to complete your audit report, including the Post-Audit Reporting Information.

84. Did you have access to all areas of the facility?	(●) Yes ( ) No
Was the site review an active, inquiring process that included the following:	
85. Observations of all facility practices in accordance with the site review component of the audit instrument (e.g., signage, supervision practices, cross-gender viewing and searches)?	(●) Yes ( ) No

86. Tests of all critical functions in the facility in accordance with the site review component of the audit instrument (e.g., risk screening process, access to outside emotional support services, interpretation services)?	(●) Yes ( ) No
87. Informal conversations with inmates/ residents/detainees during the site review (encouraged, not required)?	(●) Yes ( ) No
88. Informal conversations with staff during the site review (encouraged, not required)?	(●) Yes ( ) No

89. Provide any additional comments regarding the site review (e.g., access to areas in the facility, observations, tests of critical functions, or informal conversations).	The on-site portion of the audit was conducted on January 25-26, 2024. The auditor had an initial briefing with facility leadership and discussed the audit logistics. After the initial briefing, the auditor selected residents and staff for interview as well as documentation to review. The auditor conducted a tour of the facility on January 25, 2024. The tour included all areas associated with the facility to include; housing units, intake, visitation, education, food service, recreation, and administration. During the tour the auditor was cognizant of staffing levels, video monitoring placement, blind spots, posted PREA information, privacy for residents in housing units and other factors as indicated in the appropriate standard findings. The auditor observed PREA information posted throughout the facility via PREA Posters and PREA Reporting Posters. PREA Posters were observed on legal size paper in English and Spanish in each resident room, in the laundry rooms near the phones, in the dayrooms and across numerous common areas. The PREA Posters included information on reporting mechanisms and the zero tolerance policy. The PREA Reporting Posters were observed on letter size paper in English and Spanish on housing unit doors, in the laundry rooms near the phones, in the dayrooms and across numerous common areas. The PREA Reporting Posters included information on the zero tolerance policy, reporting mechanism (to include the external reporting entity – John Howard Association) and contact information for Just Detention International (national victim advocacy organization). It should be noted the PREA Reporting Posters were put up at the facility the day before/day of the on-site portion of the audit. Third party reporting information was observed in visitation and the front entrance via the PREA Posters. The PREA Posters were

	in English and Spanish on legal size paper. The auditor observed the Spanish PREA Poster in visitation was blocked by a vending machine. During the interim report period the facility relocated the Spanish PREA Poster and provided photos confirming it was visible. During the tour the auditor confirmed the facility follows the staffing plan. There were numerous staff for the building, including at least one staff in each housing area and numerous staff throughout other areas of the facility. Staff conduct formal and informal rounds every few hours. The auditor confirmed that the staffing was adequate to protect residents from sexual abuse. The auditor did not observe overcrowding and confirmed that rooms housed two residents. The line of sight for staff was adequate on the living unit hallways when conducting rounds and reviewing video monitoring technology. The auditor did not observe any blind spot. Informal conversation with residents indicated staff make rounds every half hour or so and they see supervisors at least once a day. They confirmed the rooms are not overcrowded. During the tour the auditor observed a plethora of cameras around the facility, including in the housing area hallways and housing unit common areas as well as in most facility common areas. Cameras are viewed by the staff in main control and the two housing unit control areas. Administrative level staff are also able to remotely access the cameras. With regard to cross gender viewing, the auditor did not identify any issues. Housing areas had shared restrooms with a solid entrance door. Showers were shared with a curtain at the entrance and toilets were public style with enclosed walls and a door. The auditor observed that all strip searches (only completed “for cause”) are done in a room with a small window. The window had tint to provide adequate privacy. A review of video

	monitoring technology confirmed no cross gender viewing issues. With regard to the opposite gender announcement, the auditor did not hear a general announcement but did observe that prior to entering any resident room or the shared bathroom the staff would knock and announce “female”. Resident risk assessments are electronic and paper. Investigative files are electronic and paper and are maintained by IDOC Internal Affairs (not at the facility). The facility does not maintain medical and mental health files. Paper risk assessments are maintained in the residents record in each corresponding Case Manager’s locked office. Electronic risk assessments are completed and located in the Offender 360 program. During the tour the auditor had a staff member illustrate how to access Offender 360 and the resident’s risk assessment. The staff member was unable to pull up the risk assessment and could not view responses confirming the information is only accessible to those with a need to know. During the tour the auditor observed the resident mail process. Residents can place outgoing mail in any of the U.S. mailboxes when outside the facility or they can place it in the outgoing mailbox within the facility. Outgoing mail placed in the facility mailbox is unsealed and staff review the outgoing mail for unauthorized information/documents. Outgoing legal mail is placed in the outgoing mailbox sealed and staff do not open or review legal mail. Legal mail is given to the counselor who ensures there is not any contraband in it prior to sealing it. The counselor does not read or scan the legal mail. Incoming mail is received by facility staff who open it, scan it and search it. The original is provided to the resident. Legal mail is provided to the counselor. Residents open legal mail in front of the counselor to ensure there is not any contraband. The mail room staff member stated that mail to the John Howard Association and mail to the victim

	advocacy organization is treated like regular mail. The auditor observed the intake/education process through a demonstration. All residents come from an IDOC facility (prison). Residents are provided a Handbook and a PREA Brochure in English or Spanish. The Handbook contains information on the zero tolerance policy, definitions and examples of sexual abuse and sexual harassment, way to prevent sexual abuse, what to do if sexually abused and reporting mechanisms. Residents sign that they received the Handbook. Staff do not conduct any additional education with residents related to PREA. Staff advised for LEP residents they have two bilingual staff, but if the resident spoke a language other than Spanish they were unsure what would be done as they never experienced that situation. Additionally, staff stated they have never experienced a disabled resident who needed accommodations for PREA information either. The auditor was provided a demonstration of the initial risk assessment. The initial risk assessment is completed in the visiting room where residents are pulled to the side and are asked risk screening questions. The auditor observed that this process did not provide adequate privacy. Staff complete the initial risk screening on paper utilizing the DOC form and then enter the responses into Offender 360. Staff obtain certain information from the resident’s file, including age, height and weight. Other information is obtained by asking the questions that are on the DOC form. Staff indicated they receive the residents file before they arrive so they look at information prior to the risk screening. If the file differs from the response provided by the resident, staff advise the resident of the file information and ask them to clarify their response. The paper DOC form is provide to the Case Manager to store and file. The 30 day reassessment is completed a couple of

	days prior to 30 days and is done via a file review. The reassessment is directly entered into Offender 360. Staff confirmed that they do not meet with the resident and ask any additional questions for the reassessment. The auditor attempted to tested the internal reporting mechanism during the tour. The auditor called the hotline through the payphones in the housing units but received a busy signal. Calls to the PREA hotline from the payphones are not monitored or recorded, are free and do not require a pin/ID. Residents also all have access to cell phones when outside the facility. The auditor also tested the written internal reporting mechanism during the tour. The auditor submitted a grievance form on January 26, 2024 via the locked grievance box in the common area. At the issuance of the interim report the auditor had not received confirmation that the grievance was received. The auditor also tested the outside reporting mechanism via a letter to the John Howard Association at a prior IDOC audit. Because the process is the same for letters to JHA, the auditor did not complete another test. The auditor obtained an envelope and sent a letter to the John Howard Association on January 10, 2023. The auditor obtained assistance from a resident to utilize his name and number on the return address. The letter was placed in the outgoing US mail box by the resident. While a return name and number is required, mail to JHA is to be treated as privileged and as such mailroom staff should not open the letter. Residents are able to remain anonymous within the letter. The John Howard Association is utilized for numerous services and they are not just an organization to report sexual abuse. The auditor received confirmation on January 20, 2023 that the letter was received by the John Howard Association. A copy of the letter that was mailed was forwarded back to the auditor as well as the confirmation from John Howard

	Association staff that the resident can remain anonymous. Additionally during the tour, the auditor asked staff to demonstrate how they submit a written report. Staff indicated all verbal reports would be documented in an incident report. The staff illustrated that paper incident reports were available in the housing unit control area. Staff advised they would fill the information out by hand on the form and they also have the ability to fill the form out electronically. The incident report is signed and given to the supervisor on duty and the Chief. Staff confirmed that if they wanted to privately report they can bypass supervisors and give the incident report to the Director. The auditor was unable to test the process for emotional support services. The facility had only recently (day of audit) posted information on an organization to contact related to emotional support services (Just Detention International). It should be noted that when information is provided, residents have access to cellphones to contact the organizations. Additionally, they would be able to mail any correspondence outside the facility. The auditor tested the third party reporting mechanism on January 22, 2023. The auditor called the PREA hotline as outlined on the agency website. The hotline is the same hotline utilized for the resident population. The auditor received confirmation from the PREA Coordinator on January 23, 2023 that the message was received and forwarded to him to handle. He indicated he would provide the information to the facility for investigation if it was a report of sexual abuse or sexual harassment. The auditor utilized a staff translator for LEP residents interviews. A bilingual staff member assisted with translation for the interview questions. Additionally, the facility has access

	to utilizes Propio. The auditor confirmed that the facility had the information, including contact number and pin to utilize the services. The auditor tested Propio services at prior IDOC audits. The auditor was provided the call in number and the PREA Coordinator entered the client information for access. The services require a pin number and is only accessible through staff. Propio provides over the phone interpretation for LEP residents. Additionally during a prior IDOC audit, the auditor utilized the American Sign Language video translation service. This service is set up through the Americans with Disabilities Act Coordinator via a computer. It should be noted that staff were unaware of these resources and how to utilize them.

Documentation Sampling

Where there is a collection of records to review-such as staff, contractor, and volunteer training records; background check records; supervisory rounds logs; risk screening and intake processing records; inmate education records; medical files; and investigative files-auditors must self-select for review a representative sample of each type of record.

90. In addition to the proof documentation selected by the agency or facility and provided to you, did you also conduct an auditor-selected sampling of documentation?	(●) Yes ( ) No

91. Provide any additional comments regarding selecting additional documentation (e.g., any documentation you oversampled, barriers to selecting additional documentation, etc.).	During the audit the auditor requested personnel and training files of staff, resident files, medical and mental health records, grievances, incident reports and investigative files for review. A more detailed description of the documentation review is as follows: Personnel and Training Files. The auditor reviewed a total of 20 files. The review included four staff hired in the previous twelve months, two contractors hired in the previous twelve months and one contractor hired more than five years prior. The files included three total contractors and two volunteers. Resident Files. A total of 23 resident files were reviewed. All 23 resident files were of those that arrived within the previous twelve months, four were disabled residents, five were LEP residents and three disclosed prior sexual victimization during the risk screening. It should be noted that disclosure of victimization during the risk screening is not a standard in the community confinement tool, however the PREA Auditor Handbook and the Online Audit System require this and as such the auditor selected two residents to review and interview. Medical and Mental Health Records. The facility does not maintain medical and mental health records. Secondary records related to transportation to and from the hospital or doctor’s office would be maintained. There were zero residents who reported sexual abuse or sexual harassment and as such no secondary documentation was available for review. Grievances. There were zero sexual abuse grievances. The auditor reviewed the grievance log and all available 2023 grievances. Hotline Calls. The facility has an internal hotline. Zero sexual abuse allegations were

	reported via the hotline. Incident Reports. The auditor reviewed a sample of random incident reports as there were zero reported sexual abuse or sexual harassment allegations. Investigation Files. There were zero allegations reported during the previous twelve months. The auditor reviewed one investigation prior to the previous twelve months that was initially deemed PREA but was subsequently determined not to meet the definition of sexual abuse or sexual harassment.

SEXUAL ABUSE AND SEXUAL HARASSMENT ALLEGATIONS AND INVESTIGATIONS IN THIS FACILITY

Sexual Abuse and Sexual Harassment Allegations and Investigations Overview

Remember the number of allegations should be based on a review of all sources of allegations (e.g., hotline, third-party, grievances) and should not be based solely on the number of investigations conducted. Note: For question brevity, we use the term “inmate” in the following questions. Auditors should provide information on inmate, resident, or detainee sexual abuse allegations and investigations, as applicable to the facility type being audited.

92. Total number of SEXUAL ABUSE allegations and investigations overview during the 12 months preceding the audit, by incident type:

	# of sexual abuse allegations	# of criminal investigations	# of administrative investigations	# of allegations that had both criminal and administrative investigations
Inmate-on-inmate sexual abuse	0	0	0	0
Staff-on-inmate sexual abuse	0	0	0	0
Total	0	0	0	0

93. Total number of SEXUAL HARASSMENT allegations and investigations overview during the 12 months preceding the audit, by incident type:

	# of sexual harassment allegations	# of criminal investigations	# of administrative investigations	# of allegations that had both criminal and administrative investigations
Inmate-on-inmate sexual harassment	0	0	0	0
Staff-on-inmate sexual harassment	0	0	0	0
Total	0	0	0	0

Sexual Abuse and Sexual Harassment Investigation Outcomes

Sexual Abuse Investigation Outcomes

Note: these counts should reflect where the investigation is currently (i.e., if a criminal investigation was referred for prosecution and resulted in a conviction, that investigation outcome should only appear in the count for “convicted.”) Do not double count. Additionally, for question brevity, we use the term “inmate” in the following questions. Auditors should provide information on inmate, resident, and detainee sexual abuse investigation files, as applicable to the facility type being audited.

94. Criminal SEXUAL ABUSE investigation outcomes during the 12 months preceding the audit:

	Ongoing	Referred for Prosecution	Indicted/ Court Case Filed	Convicted/ Adjudicated	Acquitted
Inmate-on-inmate sexual abuse	0	0	0	0	0
Staff-on-inmate sexual abuse	0	0	0	0	0
Total	0	0	0	0	0

95. Administrative SEXUAL ABUSE investigation outcomes during the 12 months preceding the audit:

	Ongoing	Unfounded	Unsubstantiated	Substantiated
Inmate-on-inmate sexual abuse	0	0	0	0
Staff-on-inmate sexual abuse	0	0	0	0
Total	0	0	0	0

Sexual Harassment Investigation Outcomes

Note: these counts should reflect where the investigation is currently. Do not double count. Additionally, for question brevity, we use the term “inmate” in the following questions. Auditors should provide information on inmate, resident, and detainee sexual harassment investigation files, as applicable to the facility type being audited.

96. Criminal SEXUAL HARASSMENT investigation outcomes during the 12 months preceding the audit:

	Ongoing	Referred for Prosecution	Indicted/ Court Case Filed	Convicted/ Adjudicated	Acquitted
Inmate-on-inmate sexual harassment	0	0	0	0	0
Staff-on-inmate sexual harassment	0	0	0	0	0
Total	0	0	0	0	0

97. Administrative SEXUAL HARASSMENT investigation outcomes during the 12 months preceding the audit:

	Ongoing	Unfounded	Unsubstantiated	Substantiated
Inmate-on-inmate sexual harassment	0	0	0	0
Staff-on-inmate sexual harassment	0	0	0	0
Total	0	0	0	0

Sexual Abuse and Sexual Harassment Investigation Files Selected for Review

Sexual Abuse Investigation Files Selected for Review

98. Enter the total number of SEXUAL ABUSE investigation files reviewed/ sampled:	0
a. Explain why you were unable to review any sexual abuse investigation files:	There were zero sexual abuse and sexual harassment allegations at the facility.

99. Did your selection of SEXUAL ABUSE investigation files include a cross-section of criminal and/or administrative investigations by findings/outcomes?	○ Yes ○ No ◉ NA (NA if you were unable to review any sexual abuse investigation files)
Inmate-on-inmate sexual abuse investigation files	
100. Enter the total number of INMATE-ON-INMATE SEXUAL ABUSE investigation files reviewed/sampled:	0
101. Did your sample of INMATE-ON-INMATE SEXUAL ABUSE investigation files include criminal investigations?	○ Yes ○ No ◉ NA (NA if you were unable to review any inmate-on-inmate sexual abuse investigation files)
102. Did your sample of INMATE-ON-INMATE SEXUAL ABUSE investigation files include administrative investigations?	○ Yes ○ No ◉ NA (NA if you were unable to review any inmate-on-inmate sexual abuse investigation files)
Staff-on-inmate sexual abuse investigation files	
103. Enter the total number of STAFF-ON-INMATE SEXUAL ABUSE investigation files reviewed/sampled:	0
104. Did your sample of STAFF-ON-INMATE SEXUAL ABUSE investigation files include criminal investigations?	○ Yes ○ No ◉ NA (NA if you were unable to review any staff-on-inmate sexual abuse investigation files)

105. Did your sample of STAFF-ON-INMATE SEXUAL ABUSE investigation files include administrative investigations?	○ Yes ○ No ◉ NA (NA if you were unable to review any staff-on-inmate sexual abuse investigation files)
Sexual Harassment Investigation Files Selected for Review	
106. Enter the total number of SEXUAL HARASSMENT investigation files reviewed/sampled:	0
a. Explain why you were unable to review any sexual harassment investigation files:	There were zero sexual abuse and sexual harassment allegations at the facility.
107. Did your selection of SEXUAL HARASSMENT investigation files include a cross-section of criminal and/or administrative investigations by findings/outcomes?	○ Yes ○ No ◉ NA (NA if you were unable to review any sexual harassment investigation files)
Inmate-on-inmate sexual harassment investigation files	
108. Enter the total number of INMATE-ON-INMATE SEXUAL HARASSMENT investigation files reviewed/sampled:	0
109. Did your sample of INMATE-ON-INMATE SEXUAL HARASSMENT files include criminal investigations?	○ Yes ○ No ◉ NA (NA if you were unable to review any inmate-on-inmate sexual harassment investigation files)

110. Did your sample of INMATE-ON-INMATE SEXUAL HARASSMENT investigation files include administrative investigations?	○ Yes ○ No ◉ NA (NA if you were unable to review any inmate-on-inmate sexual harassment investigation files)
Staff-on-inmate sexual harassment investigation files	
111. Enter the total number of STAFF-ON-INMATE SEXUAL HARASSMENT investigation files reviewed/sampled:	0
112. Did your sample of STAFF-ON-INMATE SEXUAL HARASSMENT investigation files include criminal investigations?	○ Yes ○ No ◉ NA (NA if you were unable to review any staff-on-inmate sexual harassment investigation files)
113. Did your sample of STAFF-ON-INMATE SEXUAL HARASSMENT investigation files include administrative investigations?	○ Yes ○ No ◉ NA (NA if you were unable to review any staff-on-inmate sexual harassment investigation files)
114. Provide any additional comments regarding selecting and reviewing sexual abuse and sexual harassment investigation files.	No text provided.

SUPPORT STAFF INFORMATION

DOJ-certified PREA Auditors Support Staff

115. Did you receive assistance from any DOJ-CERTIFIED PREA AUDITORS at any point during this audit? REMEMBER: the audit includes all activities from the pre-onsite through the post-onsite phases to the submission of the final report. Make sure you respond accordingly.	○ Yes ◉ No

Non-certified Support Staff

116. Did you receive assistance from any NON-CERTIFIED SUPPORT STAFF at any point during this audit? REMEMBER: the audit includes all activities from the pre-onsite through the post-onsite phases to the submission of the final report. Make sure you respond accordingly.	○ Yes ◉ No

AUDITING ARRANGEMENTS AND COMPENSATION

121. Who paid you to conduct this audit?	◉ The audited facility or its parent agency ○ My state/territory or county government employer (if you audit as part of a consortium or circular auditing arrangement, select this option) ○ A third-party auditing entity (e.g., accreditation body, consulting firm) ○ Other

Standards
Auditor Overall Determination Definitions
• Exceeds Standard (Substantially exceeds requirement of standard) • Meets Standard (substantial compliance; complies in all material ways with the stand for the relevant review period) • Does Not Meet Standard (requires corrective actions)
Auditor Discussion Instructions
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.

115.211	Zero tolerance of sexual abuse and sexual harassment; PREA coordinator
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. Pre-Audit Questionnaire 2. Administrative Directive (AD) 04.01.301 Sexual Abuse and Harassment Prevention and Intervention Program 3. North Lawndale Adult Transition Center Institutional Directive (ID) 04.01.301 Sexual Abuse and Harassment Prevention and Intervention Program 4. Administrative Directive 04.01.302 Screening for Risk of Victimization and Abusiveness 5. Administrative Directive 01.02.103 Duty Administrative Officer, Back-up Duty Administrative Officer and Required Inspection Tours 6. Administrative Directive 04.03.104 Evaluation, Treatment and Correctional

	Management of Transgender Offenders 7. Administrative Directive 05.01.113 Searches of Offenders 8. Administrative Directive 04.01.105 Facility Orientation 9. Administrative Directive 04.01.111 ADA Accommodations 10. Administrative Directive 05.07.101 Reception and Classification Process 11. Administrative Directive 01.12.120 Investigations of Unusual Incidents 12. Administrative Directive 01.12.112 Preservation of Physical Evidence 13. Administrative Directive 01.12.101 Employee Criminal Misconduct 14. Administrative Directive 01.12.125 Uniform Investigative Reporting System 15. Administrative Directive 01.12.115 Institutional Investigative Assignment 16. Administrative Directives 01.01.101 Administrative Directives 17. Administrative Directive 01.02.101 Staff Meeting 18. Administrative Directive 04.01.122 Volunteer Services 19. Administrative Directive 03.03.102 Employee Training 20. Administrative Directive 05.15.100 Restrictive Housing 21. Administrative Directive 04.01.114 Local Offender Grievance Procedures 22. Administrative Directive 03.01.120 Employee Review Hearing 23. Standard Operating Procedural (SOP) Manual for Mental Health 24. Illinois Administrative Code 20.504 25. PREA Sexual Abuse and Harassment Prevention and Intervention Program Manual (PREA Manual) 26. Agency Organizational Chart Interviews: 1. Interview with the PREA Coordinator Findings (By Provision):

	115.211 (a): The PAQ indicated that the agency has a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment in facilities it operates directly or under contract. The PAQ also stated that the facility has a policy outlining how it will implement the agency's approach to preventing, detecting and responding to sexual abuse and sexual harassment and that the policy includes definitions on prohibited behaviors regarding sexual abuse and sexual harassment and sanctions for those found to have participated in prohibited behaviors. The PAQ further stated that the policy includes a description of agency strategies and response to reduce and prevent sexual abuse and sexual harassment of residents. The agency policy, AD 04.01.301 outlines the agency's strategies on preventing, detecting and responding to sexual abuse and include definitions of prohibited behavior. Page 1 states that the agency has a zero tolerance policy. In addition ID 04.01.301, outlines the facility specific policies on preventing, detecting and responding to sexual abuse and sexual harassment. Page 2 (both policies) provide the definitions of prohibited behaviors and page 12 outlines sanctions for those who have participated in prohibited behaviors. In addition to AD and ID 04.01.301, the agency has numerous other policies that address portions of the sexual abuse prevention, detection and response strategies. The policies include: 04.01.302, 01.02.103, 04.03.104, 05.01.113, 04.01.105, 04.01.111, 05.07.101, 01.12.120, 01.12.112, 01.12.101, 01.12.115, 01.01.101, 01.02.101, 04.01.122, 03.03.102, 05.15.100, 04.01.114, 03.01.120, SOP Manual for Mental Health and Illinois Administrative Code 20.504. The policies address "preventing" sexual abuse and sexual harassment through the designation of a PC, training (staff, volunteers and contractors), staffing, intake/risk screening, resident education and posting of signage (PREA posters, etc.). The policies address "detecting" sexual abuse and sexual harassment through training (staff, volunteers, and contractors) and intake/ risk screening. The policies address "responding" to allegations of sexual abuse and sexual harassment through reporting, victim services, medical and mental health services, employee and resident discipline, incident reviews and data collection. The policies are consistent with the PREA standards and outlines the agency's approach to sexual safety. Additionally, the agency has the PREA Manual which addresses each provision of each standard and has corresponding direction, if applicable, related to the provision/standard. The PREA Manual is utilized by agency staff as a road map for PREA compliance. 115.211 (b): The PAQ indicated that the agency employs or designates an upper-level, agency-wide PREA Coordinator (PC) with sufficient time and authority to develop, implement and oversee agency efforts to comply with the PREA standards. Further communication indicates the agency (Safer Foundations) utilizes the IDOC PC and has a PCM at the facility to ensure facility compliance. The facility follows all IDOC policies and procedures and the IDOC PC is responsible for monitoring and ensuring facility compliance. AD 04.01.301, page 3 states that the Director shall designate an Agency PREA Coordinator who shall develop, implement and oversee the Department's Sexual Abuse and Harassment Prevention and Intervention Program. The agency's organizational chart reflects that the PC position is an upper-

	level, agency-wide position. The position is the Senior Public Service Administrator who reports to the Chief Compliance Officer who reports to the Director. The interview with the PC indicated that the work gets done, but often requires that he work long hours. He stated the Department is currently in the process of restructuring the PREA Unit to incorporate additional staff. To date, two Administrative Assistants IIs have been hired and one Internal Security Investigator II. The PC stated he coordinates the agency's efforts to comply with the PREA standards through the use of SharePoint and an email distribution list. He stated that he also makes site visits to each facility, holds regional and statewide meetings and trainings and he is always available via email or phone. The interview with the PC indicated that if he identifies an issue complying with a PREA standard he would contact the specific Department Head and notify them of a concern and develop corrective action collectively. He indicated if the issue requires a policy change, the Department's Policy and Directive Unit as well as the Legal Department are utilized. Additionally, he stated that he can also utilize the National PREA Resource Center and networking with other states if necessary. It should be noted that while not required, the facility also has a PREA Compliance Manager (Safer Foundations staff) that assists the facility with PREA Compliance. Based on a review of the PAQ, AD 04.01.301, ID 04.01.301, 04.01.302, 01.02.103, 04.03.104, 05.01.113, 04.01.105, 04.01.111, 05.07.101, 01.12.120, 01.12.112, 01.12.101, 01.12.115, 01.01.101, 01.02.101, 04.01.122, 03.03.102, 05.15.100, 04.01.114, 03.01.120, SOP Manual for Mental Health, Illinois Administrative Code 20.504, the PREA Manual, the agency organizational chart and information from interview with the PC, this standard appears to meet this standard.

115.212	**Contracting with other entities for the confinement of residents**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. Pre-Audit Questionnaire 2. North Lawndale Adult Transition Center Contract Findings (By Provision): 115.212 (a): The PAQ indicated that the agency has entered into or renewed two contracts for the confinement of residents since the last PREA audit and both

	contracts require the contractor to adopt and comply with PREA standards. Further communication with the PC indicated that the agency (Safer Foundations) contracts with the IDOC for the confinement of residents and as such the agency being audited (Safer Foundations) does not contract for the confinement of their residents. Therefore, this provision does not apply. It should be noted that the contract with IDOC does contain the following language “vendor shall comply with all applicable fiscal, operational and program policies of the IDOC contained in Administrative Directives, Administrative Rules and applicable memoranda. IDOC shall provide at least one complete set to the Center”. It also states that the “vendor shall grant open access, at all times, to the IDOC for inspection, audits, routine IDOC business and any other purposes relating to this program as determined by the IDOC”. 115.212 (b): The PAQ indicated that the two contracts require the agency to monitor the contractor’s compliance with PREA standards. Further communication with the PC indicated that the agency (Safer Foundations) contracts with the IDOC for the confinement of residents and as such the agency being audited (Safer Foundations) does not contract for the confinement of their residents. Therefore, this provision does not apply. It should be noted the IDOC coordinates the audits for the contracted facilities and pays for the audits, ensuring that they follow PREA standards and are PREA compliant. 115.212 (c): The PAQ indicated that since August 20, 2012, the agency has not entered into one or more contracts with a private agency or other entity that failed to comply with the PREA standards. Further communication with the PC indicated that the agency (Safer Foundations) contracts with the IDOC for the confinement of residents and as such the agency being audited (Safer Foundations) does not contract for the confinement of their residents. Therefore, this provision does not apply. Based on the review of the PAQ and the contract this standard appears to be not applicable and as such compliant.

115.213	**Supervision and monitoring**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. Pre-Audit Questionnaire

2. Administrative Directive 04.01.301 Sexual Abuse and Harassment Prevention and Intervention Program

3. Staffing Plan

4. Staffing Plan Reviews

5. Deviations from the Staffing Plan

Interviews:

1. Interview with the Director

2. Interview with the PREA Coordinator

Site Review Observations:

1. Staffing Levels

2. Video Monitoring Technology or Other Monitoring Devices

Findings (By Provision):

115.213 (a): The PAQ indicated that for each facility, the agency develops and documents a staffing plan that provides for adequate levels of staffing, and, where applicable, video monitoring to protect residents against sexual abuse. 04.01.301 pages 4-5 addresses the agency's staffing plan development. Specifically, it states that the Chief Administrative Officer of each correctional facility shall ensure the facility develops, documents and makes its best efforts to comply on a regular basis with a staffing plan that provides for adequate levels of staffing, and where applicable, video monitoring, to protect residents against sexual abuse and sexual harassment. In calculating adequate staffing levels and determining the need for video monitoring, facilities shall take into consideration: generally accepted correctional practices, any judicial findings of inadequacy, any finding of inadequacy from Federal investigative agencies, any finding of inadequacy from internal or external oversight bodies, all components of the facility's physical plant including blind-spots or areas where staff or offenders may be isolated, the composition of the offender population, the number and placement of supervisory staff, institutional programs occurring on a particular shift, any applicable State or local laws, the prevalence of substantiated and unsubstantiated incidents of abuse and any other relevant factors. The PAQ indicated that the current staffing is based on of 150 residents and the average daily population over the previous twelve months was 61. The 2023 staffing plan indicates the facility employs 56 staff, 37 which are

	considered security staff. The staffing plan outlines the elements under this provision as well as other elements as they relate to staffing levels. The auditor reviewed the staffing plan and the roster and noted that numerous staff work Monday through Friday at the facility. Security mainly work 7am-7pm or 7pm-7am while program and administrative staff have varying hours. Additionally, there were many security staff who work varying schedules to ensure adequate staff on Saturdays and Sundays. During the tour the auditor confirmed the facility follows the staffing plan. There were numerous staff for the building, including at least one staff in each housing area and numerous staff throughout other areas of the facility. Staff conduct formal and informal rounds every few hours. The auditor confirmed that the staffing was adequate to protect residents from sexual abuse. The auditor did not observe overcrowding and confirmed that rooms housed two residents. The line of sight for staff was adequate on the living unit hallways when conducting rounds and reviewing video monitoring technology. The auditor did not observe any blind spot. Informal conversation with residents indicated staff make rounds every half hour or so and they see supervisors at least once a day. They confirmed the rooms are not overcrowded. The interview with the Director confirmed the facility has a staffing plan that provides adequate levels to protect residents from sexual abuse. He stated they follow the contract which requires a minimum of three staff per shift. He stated they typically have additional staff and that they have staff presence everywhere. The Director confirmed the elements under this provision are included in the development and review of the staffing plan. He stated there are numerous non-security staff that served in security before that are utilized to assist with staffing. The Director stated video monitoring is part of the staffing plan and the staffing plan is documented. The Director further advised that he monitors the staffing plan through the daily shift report and communication with the Shift Supervisor and Chief. He indicated they are a small facility so he always knows what is going on. The PC stated that community confinement facilities go through the annual staffing plan review just like the prisons. He indicated that blind spots or problematic areas are always considered and, if appropriate, or feasible, mirrors and cameras are provided. He also stated that staff make frequent rounds to ensure safety. The PC stated that the facility is the lowest security level and does not house individuals designated as predators. He confirmed that the required components under this provision are included in the development and review of the staffing plan. 115.213 (b): The PAQ indicated that each time the staffing plan is not complied with, the facility documents and justifies all deviations from the staffing plan. 04.01.301, page 5 states that if circumstances arise where the staffing plan is not complied with, the facility shall document and justify all deviation from the plan on the Daily Roster review, DOC 0531, in accordance with 05.01.101. A review of documentation indicated the shift schedule outlines the staffing plan and any deviations are documented on the shift schedule. The documentation confirmed that there were no deviations related to minimum staffing levels. The interview with the Director confirmed that any deviations from the staffing plan would be documented. He

	stated deviations are documented on the shift report, which notes what areas are open and closed and what posts are filled or not filled. He further stated that they always have the required minimum number of staff per the staffing plan. 115.213 (c): The PAQ indicated that at least once every year the facility reviews the staffing plan to see whether adjustments are needed in: the staffing plan, prevailing staffing patterns, the deployment of video monitoring systems and other monitoring technologies, or the allocation of facility/agency resources to commit to the staffing plan to ensure compliance with the staffing plan. 04.01.301, page 5 states that whenever necessary, but no less frequent than once per year, the facility, in consultation with the Agency PREA Coordinator, shall assess, determine and document whether adjustments are needed to the staffing plan established herein, the facility's deployment of video monitoring systems and other monitoring technologies, and the resources the facility has available to ensure adherence to staffing plan. The staffing plan was most recently reviewed on February 16, 2024. The plan was reviewed to assess, determine and document whether any adjustments were needed to the staffing plan, the deployment of video monitoring technologies and/or the resources available to commit to ensuring adherence to the staffing plan. The staffing plan was previously reviewed on September 21, 2022. The PC confirmed that he is consulted regarding each facility's staffing plan. Based on a review of the PAQ, 04.01.301, the staffing plan, annual staffing plan reviews, deviations from the staffing plan, observations from the tour and information from the interviews with the PC and the Director indicate that this standard appears to be compliant.

115.215	**Limits to cross-gender viewing and searches**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. Pre-Audit Questionnaire 2. Administrative Directive 04.01.301 Sexual Abuse and Harassment Prevention and Intervention Program 3. Administrative Directive 04.03.104 Evaluation, Treatment and Correctional Management of Transgender Offenders 4. Administrative Directive 05.01.113 Searches of Offenders

	5. Rehabilitation, Safety Management and Care for Transgender People in Correctional Settings Curriculum 6. Personal Searches Curriculum 7. Personal Search Card 8. Staff Training Records Interviews: 1. Interview with Random Staff 2. Interview with Random Residents Site Review Observations: 1. Observations of Privacy in Housing Units and Restrooms 2. Observation of Opposite Gender Announcement Findings (By Provision): 115.215 (a): The PAQ indicated that the facility does not conduct cross gender strip and cross gender visual body cavity searches of residents and that there have been zero searches of this kind in the previous twelve months. The PAQ stated zero searches of this kind were conducted at the facility over the past twelve months. 05.01.113, page 2 states that cross-gender strip searches shall be prohibited. A review of the Personal Searches Curriculum confirmed that page 4 discusses the prohibition under 05.01.113. 115.215 (b): The PAQ indicated that the facility does not permit cross-gender pat-down searches of female residents, absent exigent circumstances and the facility does not restrict female residents' access to regularly available programming or other out-of-cell opportunities in order to comply with this provision. The PAQ stated there have been zero pat-down searches of female residents by male staff. The Personal Searches Curriculum, page 4 indicates that staff are trained that only female correctional employees, who are properly trained, are authorized to conduct pat down or clothed body searches of female offenders. There were zero female or transgender female residents at the facility and as such no interviews were conducted. Staff advised they do not house female residents and have not housed transgender female residents and as such this provision does not apply.

115.215 (c): The PAQ indicated that facility policy requires all cross gender strip searches, all cross gender visual body cavity searches and all cross gender pat searches of female residents be documented. The PAQ stated that the facility does not house female residents and as such that part of the provision does not apply. 01.12.105, page 3 states that notification of serious and significant unusual incidents shall be in accordance with the provisions of this directive. Page 3 states that following initial notification of the respective Deputy Director or Chief, the Chief Administrative Officer shall ensure electronic notification of the incident is provided and the notification includes the date and time, offenders involved, staff involved and narrative of the incident. The Personal Search Manual, page 4 states that in exigent or emergency circumstances, a male correctional employee, who is properly trained, may conduct a search if a properly trained, female correctional employee is not available. An exigent or emergency or situation is one in which a reasonable suspicion exists that a weapon, or another item of serious contraband, is present and it presents an immediate danger to the offender(s), facility security, or the public which cannot be safety averted either by securing, escorting or isolating the offender.

115.215 (d): The PAQ indicated that the facility has implemented policies and procedures that enable residents to shower, perform bodily functions, and change clothing without non-medical 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. The PAQ further indicated that policies and procedures require staff of the opposite gender to announce their presence when entering a resident housing unit. 04.01.301, page 7 indicates that offenders shall be able to shower, perform bodily functions and change clothing without non-medical staff of the opposite gender viewing their breasts, buttocks or genitalia, except when such viewing is incidental to routine cell checks. Page 7 further notates that staff of the opposite gender, whether assigned to the unit or not, shall make the following verbal announcement upon their arrival in a housing unit “Male/Female in the housing unit”. With regard to cross gender viewing, the auditor did not identify any issues. With regard to cross gender viewing, the auditor did not identify any issues. Housing area had shared restrooms with a solid entrance door. Showers were shared with a curtain at the entrance and toilets were public style with enclosed walls and a door. The auditor observed that all strip searches (only completed “for cause”) are done in a room with a small window. The window had tint to provide adequate privacy. A review of video monitoring technology confirmed no cross gender viewing issues. With regard to the opposite gender announcement, the auditor did not hear a general announcement but did observe that prior to entering any resident room or the shared bathroom the staff would knock and announce “female”. All twelve random staff interviewed stated that residents have privacy when showering, using the restroom and changing clothes and all twelve indicated that staff of the opposite gender announce prior to entering resident living areas. Interviews with 20 residents indicated they have privacy when showering, using the

	restroom and changing their clothes. Further seventeen of the residents stated that staff of the opposite gender announce when they enter resident living areas. 115.215 (e): The PAQ indicated that the facility has a policy prohibiting staff from searching or physically examining a transgender or intersex resident for the sole purpose of determining the resident's genital status and that no searches of this nature have occurred within the previous twelve months. 05.01.113, page 2 states that staff shall not search or physically examine a transgender or intersex offender for the sole purpose of determining the offender's genital status. If the offender's genital status is unknown, it may be determined during conversation with the offender, reviewing medical records, or, if necessary, by learning that information as part of a broader medical examination conducted in private by a medical practitioner. Interviews with twelve random staff indicated four were aware of an agency policy that prohibits strip searching a transgender or intersex resident for the sole purpose of determining the residents' genital status. There were zero transgender residents at the facility and as such no interviews were conducted. 115.215 (f): 05.01.113, page 2 states that the Office of Staff Development and Training shall ensure security staff are trained in conducting searches of offenders in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs. Page 11 further states that offenders designated as transgender non-conforming shall be designated as such in Offender 360 and provided an offender identification card specifying the gender of staff that will perform strip searches of that offender as determined by the Transgender Administrative Committee in consultation with the offender. If a strip search is to be performed, the transgender or gender non-conforming offender shall be searched by the gender of the staff designated on tehri offender identification card. 04.03.104, pages 8-9 also outline the same information described in 05.01.113. The Personal Search Curriculum pages 3-4 outline the basic guidelines for conducting searches including being systematic, thorough, objective and consistent. Page 5 states that when conducting searches of a transgender or intersex offender, the searches should be conducted in a professional and respectful manner, consistent with the type of search being conducted, and security needs. Searches should be complete in accordance with applicable Administrative Directives or Institutional Directives based on the gender of the facility, unless otherwise directed by the CAO. The training further states that if an offender has been confirmed and identified in Offender 360 or on their identification badge to be transgender or gender non-conforming, the offender may express preferences to be searched by a male or female staff of their gender identify rather than the gender staff above, that request will be considered and if possible, honored, if staff are available to do so. Staff are also provided training titled Rehabilitation, Safety Management and Care for Transgender People in Correctional Settings. A review of the training confirmed that staff are provided information on definitions and terminology, appropriate language, bias, gender informed professional skills including appropriate language and

	misgendering, statistics and policy and procedure related to transgender care. Staff are also provided a Personal Search Card that outlines the steps for offender pat-searches and offender strip searches. The PAQ indicated that 100% of staff had received training on conducting cross gender pat down searches and searches of transgender and intersex residents. Interviews with twelve staff indicated all twelve had received training on how to conduct cross-gender pat down searches and searches of transgender and intersex residents. The auditor requested training documents for twelve staff. At the issuance of the interim report, three documents were provided indicating these staff completed day four of cycle training which included the cross gender searches and transgender and intersex resident searches training. Based on a review of the PAQ, 04.01.301, 04.03.104, 05.01.113, staff training records, observations made during the tour, as well as information from interviews with random staff and random residents indicates this standard appears to require corrective action. Interviews with twelve random staff indicated four were aware of an agency policy that prohibits strip searching a transgender or intersex resident for the sole purpose of determining the residents' genital status. The auditor requested training documents for twelve staff. At the issuance of the interim report, three documents were provided indicating these staff completed day four of cycle training which included the cross gender searches and transgender and intersex resident searches training. Corrective Action The facility will need to train staff on cross gender pat-down searches and searches of transgender and intersex residents. Additionally, the training should include the prohibition of searching transgender and intersex residents for the sole purpose of determining genital status. Confirmation of the training will need to be provided to the auditor. The facility will need to provide the originally requested documentation. If the documentation is not available, the facility will need to ensure all current staff receive the search training. Confirmation of the training will need to be provided. Verification of Corrective Action Since the Interim Audit Report The auditor gathered and analyzed the following additional evidence provided by the facility during the corrective action period relevant to the requirements in this standard.

	Additional Documents: 1. Staff Training The facility provided training documents confirming all previously requested staff completed the search training. Additionally, documentation was provided for all facility staff confirming they received search training through cycle training (Day 4) or viewing the PREA Resource Center's video on cross gender searches and searches of transgender and intersex individuals. Further the facility provided documentation confirming staff were provided training on the prohibition of strip searching transgender and intersex residents for the sole purpose of determining their genital status. The training was completed via roll call for five consecutive days. Signatures were provided confirming staff completed and understood each training. Based on the documentation provided the facility has corrected this standard and as such appears to be compliant.

115.216	**Residents with disabilities and residents who are limited English proficient**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. Pre-Audit Questionnaire 2. Administrative Directive 04.01.301 Sexual Abuse and Harassment Prevention and Intervention Program 3. Administrative Directive 04.01.105 Facility Orientation 4. Administrative Directive 04.01.111 ADA Accommodations 5. Administrative Directive 05.07.101 Reception and Classification Process 6. PREA Sexual Abuse and Harassment Prevention and Intervention Program Manual (PREA Manual) 7. Video Remote Interpreting Information 8. Language Interpretation Procedure – Propio Language Services, LLC.

9. Individuals In Custody Handbook (Handbook)

10. PREA Posters

11. PREA Reporting Posters

Interviews:

1. Interview with the Agency Head

2. Interview with Random Staff

3. Interview with Disabled and LEP Residents

Site Review Observations:

1. Observations of PREA Posters

Findings (By Provision):

115.216 (a): The PAQ stated that the agency has established procedures to provide disabled residents 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. 04.01.301, pages 7-8 state that the Department shall provide offender education in formats accessible to all offenders, including those who are limited English proficient, deaf, visually impaired or otherwise disabled, as well as to offender who have limited reading skills. 04.01.111, pages 3-4 indicate that the CAO shall ensure offenders are provide with information regarding ADA disability accommodations and shall establish procedures for offender access to teletypewriter (TTY) and Video Remote Interpreting (VRS) equipment. The policy also indicates that the CAO shall find alternative notification methods for auditory announcements (tactile paging system). 05.07.101, page 2 states that all videos used during orientation shall include closed captioning subtitles and closed captioning utilizing American Sign Language which has been reviewed for accuracy of the interpretation by the Illinois Deaf and Hard of Hearing Commissioner or a qualified interpreter. The policy further states that the department shall reserve the first row of seats during orientation for offenders who are disabled. A review of PREA Posters, Handbook and distributed information confirmed that information can be provided in large font and bright colors and can be read to residents in terminology that they understand. Additionally, pages 34-36 of the Handbook provide information on Americans with Disabilities (ADA) including requesting accommodations, telecommunication equipment and sign language information. The interview with the Agency Head confirmed that the agency has an

	Administrative Directive, 04.01.111 ADA Accommodations and Propio Language Service Contact that establishes procedures to provide residents with disabilities and residents who are limited English Proficient 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. The Agency Head stated that orientation/ educational materials are available in Spanish and that orientation is also available via video with the use of American Sign Language and Spanish translation. The interview further indicated that offenders have the ability to participate in interactive dialogue with staff if further clarification is warranted. The facility has access to utilizes Propio. The auditor confirmed that the facility had the information, including contact number and pin to utilize the services. During a prior IDOC audit, the auditor utilized the American Sign Language video translation service. This service is set up through the Americans with Disabilities Act Coordinator via a computer. It should be noted that staff were unaware of these resources and how to utilize them. The auditor observed PREA information posted throughout the facility via PREA Posters and PREA Reporting Posters. PREA Posters were observed on legal size paper in English and Spanish in each resident room, in the laundry rooms near the phones, in the dayrooms and across numerous common areas. The PREA Posters included information on reporting mechanisms and the zero tolerance policy. The PREA Reporting Posters were observed on letter size paper in English and Spanish on housing unit doors, in the laundry rooms near the phones, in the dayrooms and across numerous common areas. The PREA Reporting Posters included information on the zero tolerance policy, reporting mechanism (to include the external reporting entity – John Howard Association) and contact information for Just Detention International (national victim advocacy organization). It should be noted the PREA Reporting Posters were put up at the facility the day before/day of the on-site portion of the audit. Interviews with four disabled residents and four LEP resident indicated five were provided information in a format that they could understand. 115.216 (b): The PAQ indicates that the agency has established procedures to provide residents with limited English proficiency 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. 04.01.301, pages 7-8 state that the Department shall provide offender education in formats accessible to all offenders, including those who are limited English proficient, deaf, visually impaired or otherwise disabled, as well as to offender who have limited reading skills. 04.01.105, page 2 states that for a non-English speaking offender, reasonable efforts shall be made for the orientation to be explained to him or her in a language her or she understands. It further states that offenders shall receive written orientation material and/or translation in their own language and when a literacy problem exists, a staff member shall assist the offender in understanding the materials. The facility also has a contract with Propio Language Services, LLC. This company provides the facility a phone number that they can call that connects the staff member with a translator who can will translate information between the staff

	member and LEP resident. The company has interpretation services for over 600 languages. A review of PREA Posters, Handbook and distributed information confirmed that information is available in both English and Spanish and can be translated into other languages, as needed. The auditor utilized a staff translator for LEP residents interviews. A bilingual staff member assisted with translation for the interview questions. Additionally, the facility has access to utilizes Propio. The auditor confirmed that the facility had the information, including contact number and pin to utilize the services. The auditor tested Propio services at prior IDOC audits. The auditor was provided the call in number and the PREA Coordinator entered the client information for access. The services require a pin number and is only accessible through staff. Propio provides over the phone interpretation for LEP residents. It should be noted that staff were unaware of these resources and how to utilize them. The auditor observed PREA information posted throughout the facility via PREA Posters and PREA Reporting Posters. PREA Posters were observed on legal size paper in English and Spanish in each resident room, in the laundry rooms near the phones, in the dayrooms and across numerous common areas. The PREA Posters included information on reporting mechanisms and the zero tolerance policy. The PREA Reporting Posters were observed on letter size paper in English and Spanish on housing unit doors, in the laundry rooms near the phones, in the dayrooms and across numerous common areas. The PREA Reporting Posters included information on the zero tolerance policy, reporting mechanism (to include the external reporting entity – John Howard Association) and contact information for Just Detention International (national victim advocacy organization). It should be noted the PREA Reporting Posters were put up at the facility the day before/day of the on-site portion of the audit. Interviews with four disabled residents and four LEP resident indicated five were provided information in a format that they could understand. 115.216 (c): The PAQ indicated that agency policy prohibits use of resident interpreters, resident readers, or other type 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 responder duties, or the investigation of the resident’s allegation. The PAQ further stated the agency/facility documents the limited circumstances and that there were zero instances where a resident was utilized to interpret, read or provide other types of assistance. 04.01.301, page 9 states staff shall not rely on individuals in custody to act as interpreters when reporting or investigating allegations of sexual abuse or sexual harassment for other individuals in custody who do not speak English, or who may speak very limited English; except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the safety of the individual. Use of such interpreters shall be documented. Interviews with twelve random staff indicated three were aware of a policy that prohibits utilizing resident interpreters, readers or other types of resident assistants for sexual abuse allegations. Interviews with four disabled residents and four LEP resident indicated five were provided information in a format that they could understand. None

	indicated they had another resident interpret, translate or provide assistance. Based on a review of the PAQ, PAQ, 04.01.301, 04.01.105, 04.01.111, 05.07.101, the PREA Manual, VRS/TTY information, Propio Language Services LLC information, the Handbook, PREA Posters, observations made during the tour as well as interviews with the Agency Head, random staff, LEP residents and residents with a disability indicate that this standard appears to require corrective action. The facility has access to utilizes Propio. The auditor confirmed that the facility had the information, including contact number and pin to utilize the services. During a prior IDOC audit, the auditor utilized the American Sign Language video translation service. This service is set up through the Americans with Disabilities Act Coordinator via a computer. The auditor utilized a staff translator for LEP residents interviews. A bilingual staff member assisted with translation for the interview questions. Additionally, the facility has access to utilizes Propio. The auditor confirmed that the facility had the information, including contact number and pin to utilize the services. The auditor tested Propio services at prior IDOC audits. The auditor was provided the call in number and the PREA Coordinator entered the client information for access. The services require a pin number and is only accessible through staff. Propio provides over the phone interpretation for LEP residents. It should be noted that staff were unaware of these resources and how to utilize them. The auditor observed PREA information posted throughout the facility via PREA Posters and PREA Reporting Posters. It should be noted the PREA Reporting Posters were put up at the facility the day before/day of the on-site portion of the audit. Interviews with twelve random staff indicated three were aware of a policy that prohibits utilizing resident interpreters, readers or other types of resident assistants for sexual abuse allegations. Interviews with four disabled residents and four LEP resident indicated five were provided information in a format that they could understand. Corrective Action The facility will need to train staff on the prohibition of utilizing other residents as interpreters, readers and other types of assistants as well as the resources available for LEP and disabled residents. The training should include information on when and how to utilize the resources and a demonstration on how to use them (video for ASL and phone call for language translation). A copy of the training will need to be provided to the auditor. Additionally, the facility will need to ensure the PREA Reporting Posters remain posted throughout the facility in English and Spanish in adequate font. Photos will need to be provided during the corrective action period confirming the PREA Reporting Posters are still up. Verification of Corrective Action Since the Interim Audit Report

	The auditor gathered and analyzed the following additional evidence provided by the facility during the corrective action period relevant to the requirements in this standard. Additional Documents: 1. Staff Training 2. Photos of Posted Information The facility provided documentation confirming staff were trained on the prohibition of resident interpreters, readers and assistants as well as the resources available to provide accommodations for LEP and disabled residents. Staff signatures confirmed the training was provided during roll call for five consecutive days. The facility provided numerous photos confirming the PREA Reporting Posters and PREA Posters were still up around the facility. Based on the documentation provided the facility has corrected this standard and as such appears to be compliant.

115.217	**Hiring and promotion decisions**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. Pre-Audit Questionnaire 2. Administrative Directive 01.02.107 Background Investigations 3. Administrative Directive 03.02.100 Administrative Review of Personnel or Service Issues 4. Administrative Directive 03.02.108 Standards of Conduct 5. PREA Preemployment Self Report DOC 0450

6. PREA Questionnaire for Institutional Employers DOC 0589

7. Arrest Tracking Process Memorandum

8. Personnel Files of Staff

9. Personnel Files for Contractors

Interviews:

1. Interview with Human Resource Staff

Findings (By Provision):

115.217 (a): The PAQ indicated that agency policy prohibits hiring or promoting anyone who may come in contact with residents, and shall not enlist the services of any contractor who may have contact with residents if they have: engaged in sexual abuse in prison, jail, lockup or any other institution; been convicted of engaging or attempting to engage in sexual activity in the community or has been civilly or administratively adjudicated to have engaged in sexual abuse by force, overt or implied threats of force or coercion. 03.02.100, page 3 states that the Department shall not hire, promote or enlist the services of any employee, contractual or otherwise, who may have contact with offenders and: has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility or other institution a defined in 42 U.S.C. 1997; has been convicted of engaging in or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats or force, or coercion, or inf the victim did not consent or was unable to consent or refuse; or has been civilly or administratively adjudicated to have engaged in the activity described above. A review of four staff hired in the previous twelve months indicated two had a criminal background records check, however both were completed by IDOC after the hire date with Safer Foundations. The auditor requested documentation for two newly hired contractors, however the documentation had not been received at the issuance of the interim report. During documentation review it was determined that the agency (Safer Foundations) initially completes a criminal background records check via Accurate. This third party services conducts criminal background record checks via a search of public records in locations that the applicant reported they lived/worked. The auditor determined this is not an adequate method for criminal background record checks. The contracting agency (IDOC) conducts criminal background record checks on staff at the facility, however the auditor observed these were done well after hire. The IDOC conducts criminal history record checks through the federal NCIC system. Further, the auditor observed that the IDOC does not conduct criminal background record checks on contractors, rather these criminal background record checks are completed by Safer Foundations via Accurate.

	115.217 (b): The PAQ indicated that the agency considers any incidents of sexual harassment in determining whether to hire or promote any staff or enlist the services of any contractor who may have contact with a resident. 03.02.100, page 3 states that the Department shall consider any incident of sexual harassment in determining whether to hire or promote anyone, or enlist the services of any contractual employee, who may have contact with offenders. The interview with Human Resource staff indicated that the Background Investigation Unit (BIU) reports any incidents that are uncovered while conducting the background check relating to sexual harassment and include these incidents in an Administrative Review (AR) that is forwarded on to the IDOC Executive Staff for their review. This also include contractual employees. 115.217 (c): The PAQ indicated that agency policy requires that before it hires any new employees who may have contact with residents, it (a) conducts criminal background record checks, and (b) consistent with federal, state, and local law, makes 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. 01.02.107, pages 2-3 state that background investigations shall be completed on person prior to employment or prior to placement in safety sensitive position and on person who provide services for the Department. There shall be two levels of background investigations: a computer criminal history check which include a check of an individual's criminal history through the Law Enforcement Agencies Data System (LEADS) and a complete background investigation which includes a check of LEADS and nine other database queries. Policy indicates a complete background investigation is required for all applicants prior to employment, employees, contractual employees and interns. The policy also indicates that the DOC 0450 is also required for the background investigation. A review of the DOC 0589 confirms that the PREA Questionnaire for Institutional Employers is sent to all prior institutional employers and contains four questions including if the individual was involved in a substantiated sexual abuse allegation and/or a sexual harassment allegation and/or if the individual resigned during a pending investigation of sexual abuse and/or a pending investigation of sexual harassment. The PAQ indicated that eighteen individual were hired in the past twelve months that may have contact with residents. A review of four staff hired in the previous twelve months indicated two had a criminal background records check, however both were completed by IDOC after the hire date with Safer Foundations. Appropriate documentation was not provided to determine if prior institutional checks were needed for the staff hired in the previous twelve months. It should be noted that the auditor did confirm that IDOC and Accurate both have a process for contacting prior institutional employers. The interview with Human Resource staff confirmed that the Background Investigation Unit (BIU) performs a background check on all request for background investigations sent by facilities. In addition, the BIU performs a check of IDOC Intel, work discipline and any PREA related incidents for all employees promoting to Shift

	Supervisor or a promotion in a Merit Compensation position. The Human Resource staff also stated that they check IDOC Intel and work discipline for employees that have answered “Yes” on the DOC 0450 (PREA self-disclosure). During documentation review it was determined that the agency (Safer Foundations) initially completes a criminal background records check via Accurate. This third party services conducts criminal background record checks via a search of public records in locations that the applicant reported they lived/worked. The auditor determined this is not an adequate method for criminal background record checks. The contracting agency (IDOC) conducts criminal background record checks on staff at the facility, however the auditor observed these were done well after hire. The IDOC conducts criminal history record checks through the federal NCIC system. Further, the auditor observed that the IDOC does not conduct criminal background record checks on contractors, rather these criminal background record checks are completed by Safer Foundations via Accurate. 115.217 (d): The PAQ stated that agency policy requires that a criminal background record check be completed before enlisting the services of any contractor who may have contact with residents. The PAQ indicated that there have been zero contracts at the facility within the past twelve months. 01.02.107, pages 2-3 state that background investigations shall be completed on person prior to employment or prior to placement in safety sensitive position and on person who provide services for the Department. There shall be two levels of background investigations: a computer criminal history check which include a check of an individual’s criminal history through the Law Enforcement Agencies Data System (LEADS) and a complete background investigation which includes a check of LEADS and nine other database queries. Policy indicates a complete background investigation is required for all applicants prior to employment, employees, contractual employees and interns. The policy also indicates that the DOC 0450 is also required for the background investigation. The auditor requested documentation for two newly hired contractors, however the documentation had not been received at the issuance of the interim report. The Human Resource staff confirmed that all contractors who have routine access to individuals in custody go through the background process. During documentation review it was determined that the agency (Safer Foundations) initially completes a criminal history records check via Accurate. This third party services conducts criminal background record checks via a search of public records in locations that the applicant reported they lived/worked. The auditor determined this is not an adequate method for criminal background record checks. The contracting agency (IDOC) conducts criminal background record checks on staff at the facility, however the auditor observed these were done well after hire. The IDOC conducts criminal history record checks through the federal NCIC system. Further, the auditor observed that the IDOC does not conduct criminal background record checks on contractors, rather these criminal background record checks are completed by Safer Foundations via Accurate. During the interim report the PC provided an email that was sent to the Human Resources Supervisor of the agency that advised that the contractors for Safer Foundations will require a

	criminal background records check through IDOC prior to enlisting their services at Safer Foundation as well as a criminal background records check every five years. The email indicates this should be documented via the DOC 0032 form that is utilized throughout IDOC. 115.217 (e): The PAQ indicated that agency policy requires that either criminal background record checks be conducted at least every five years for current employees and contractors who may have contact with residents, or that a system is in place for otherwise capturing such information for current employees. 03.02.108, page 2 states that employees are required to verbally report as soon as possible but within five working days a written report and final disposition to the Background Investigations Unit any arrest, indictment or conviction for a felony or misdemeanor, other than minor traffic offenses such as a parking ticket. The memo from the Background Investigations Unit staff indicated that every applicant processed by the IDOC had fingerprints submitted through the Illinois State Police LEADS/NCIC system. When fingerprints are submitted, a permanent marker is indicated on the entry which enables arrest tracking. If the individual is ever arrested, the nationwide system generates a direct response to the IDOC Background Investigations Unit which is immediately notified of the arrest. The BIU then contacts the CAO of the facility or program site where the employee/contractor is assigned. The facility provided the auditor examples of employee fingerprint submissions and employee arrest notifications, confirming that the IDOC is notified of any arrests. Safer Foundations contractors are not fingerprinted through IDOC and as such the auditor requested documentation for one contractor that was employed over five years. The facility was only able to provide one criminal background records check completed through Accurate in February 2024. The interview with Human Resource staff indicated that every applicant processed by the Illinois Department of Corrections Background Investigations Unit has, as part of the background investigations process and as a condition of their employment, fingerprints submitted through the Illinois State Police LEADS/NCIC system. When fingerprints are submitted, a permanent marker is indicated on the entry which enables Arrest Tracking. If the individual is ever arrested, the nationwide system generates a direct response to the Illinois Department of Corrections Background Investigations Unit which is immediately notified of the arrest. The notification includes the individual’s name, date or birth, and other pertinent identifying information, as well as the Agency which effected the arrest and the charge(s). During documentation review it was determined that the agency (Safer Foundations) initially completes a criminal history records check via Accurate. This third party services conducts criminal background record checks via a search of public records in locations that the applicant reported they lived/worked. The auditor determined this is not an adequate method for criminal background record checks. The contracting agency (IDOC) conducts criminal background record checks on staff at the facility, however the auditor observed these were done well after hire. The IDOC conducts criminal history record checks through the federal NCIC system. Further, the auditor observed that the IDOC does not conduct criminal

	background record checks on contractors, rather these criminal background record checks are completed by Safer Foundations via Accurate During the interim report the PC provided an email that was sent to the Human Resources Supervisor of the agency that advised that the contractors for Safer Foundations will require a criminal background records check through IDOC prior to enlisting their services at Safer Foundation as well as a criminal background records check every five years. The email indicates this should be documented via the DOC 0032 form that is utilized throughout IDOC. 115.217 (f): A review of the DOC 0450 Prison Rape Elimination Act Pre-Employment Self-Report confirms that all staff (new applicant and promotion) are required to fill out the form which contains the following questions: have you engaged in sexual abuse in a prison, jail, lockup, community confinement facility, or other correctional facility, a pretrial detention facility, a juvenile facility, a facility for persons who are mentally ill or disabled or have intellectual disabilities or are chronically ill or handicapped, a facility providing skilled nursing intermediate or long-term care custodial or residential care or other institution as defined in the Civil Rights Institutionalized Persons Act (42 U.S.C. 1997)?; have you been convicted of engaging or attempting to engage in sexual activity in the community that was 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?; and have you been civilly or administratively adjudicated to have engaged 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; and has there ever been any allegation, complaint or finding made against you regarding any incidents of sexual harassment? A review of documentation for four newly hired staff indicated all four had answered PREA questions utilizing the DOC 0450 prior to hire. The facility did not have any staff promoted during the previous twelve months and as such no documentation was reviewed related to PREA questions prior to promotion The Human Resource staff stated that when an individual applies for employment with IDOC they are required to fill out the DOC 0031, Applicant Information Sheet (AIS). There are numerous questions within the AIS that asks about visiting, corresponding with and living with IDOC offenders. Additionally, the applicant is asked about any contact with Law Enforcement. Applicants and promoting employees are also required to complete the DOC 0450 (PREA self-report). The Human Resource staff member confirmed that staff have a continuing affirmative duty to disclose any previous misconduct. The staff indicated that policy of Standards of Conduct require the employee to disclose misconduct. 115.217 (g): The PAQ indicates that material omissions regarding sexual misconduct or the provision of materially false information is grounds for termination. 03.02.108, page 7 states that any employee who knowingly provides false information, including, but not limited to, false information provided in statements, incident reports, correspondence or an interview shall be subject to disciplinary

	action, including termination. Additionally, DOC 0450 has a section indicating that material omissions regarding such misconduct, or the provision of materially false information, shall be grounds for ineligibility or termination from employment. 115.217 (h): The interview with the Human Resource staff indicated that IDOC routinely provides this information upon request with a signed release of information. Based on a review of the PAQ, 01.02.107, 03.02.100, 03.02.108, DOC 0450, DOC 0589, the Arrest Tracking Process Memorandum, a review of personnel files for staff and contractors and information obtained from the Human Resource staff interview indicates that this standard appears to require corrective action. A review of four staff hired in the previous twelve months indicated two had a criminal background records check, however both were completed by IDOC after the hire date with Safer Foundations. Appropriate documentation was not provided to determine if prior institutional checks were needed for the staff hired in the previous twelve months. The auditor requested documentation for two newly hired contractors, however the documentation had not been received at the issuance of the interim report. Safer Foundations contractors are not fingerprinted through IDOC and as such the auditor requested documentation for one contractor that was employed over five years. The facility was only able to provide one criminal background records check completed through Accurate in February 2024. During documentation review it was determined that the agency (Safer Foundations) initially completes a criminal background records check via Accurate. This third party services conducts criminal background record checks via a search of public records in locations that the applicant reported they lived/worked. The auditor determined this is not an adequate method for criminal background record checks. The contracting agency (IDOC) conducts criminal background record checks on staff at the facility, however the auditor observed these were done well after hire. The IDOC conducts criminal history record checks through the federal NCIC system. Further, the auditor observed that the IDOC does not conduct criminal background record checks on contractors, rather these criminal background record checks are completed by Safer Foundations via Accurate. Corrective Action The agency will need to work with IDOC to develop a process for criminal background record checks for staff and contractors. All criminal background record checks will need to be completed prior to hire (staff), prior to enlisting services (contractor) and at least every five years. Additionally, these criminal background record checks will need to be completed via an appropriate law enforcement

	database query (i.e. NCIC). A process memo will need to be provided to the auditor once confirmed. The facility will need to provide a list of newly hired staff and contractors during the corrective action period and associated criminal background record checks. Additionally, the facility will need to provide confirmation that all staff and contractors that have been at the facility over five years have had an updated criminal background records check or have been entered into another applicable system that captures such information. A list of staff hired during the corrective action period and contractors hired during the corrective action period will need to be provided as well as associated documentation for this standard. Verification of Corrective Action Since the Interim Audit Report The auditor gathered and analyzed the following additional evidence provided by the facility during the corrective action period relevant to the requirements in this standard. Additional Documents: 1. Updated Administrative Directive 01.02.107 Background Investigations 2. Staff Training 3. Assurance Memorandum 4. Criminal Background Record Checks A training memorandum from the IDOC PREA Coordinator was provided that outlined all staff and contractors at the facility are required to have a criminal background records check through IDOC prior to hire as outlined in 01.02.107. Staff electronically signed the training memorandum confirming they read and understood the information. 01.02.107 was updated to include language (page 3) that requires subcontractors at the Adult Transition Centers to have an IDOC criminal background records check prior to hire. It also was updated to state that subcontractors are required to have a criminal background records check completed at least every five years. Staff were trained on these two requirements and electronic signatures were provided confirming their understanding.

	A training memo was also provided that outlined staff are required to be asked the questions under this standard prior to hire and promotion via the DOC 0450, as outlined in 03.02.106. Staff signatures were provided confirming they understood the information. The facility provided documentation for all staff and contractors originally requested during the on-site confirming they all had an IDOC criminal background records check completed during the corrective action plan. Additionally, assurance memos were provided advising that all staff and contractors at the facility had an IDOC criminal background records check. An assurance memo was also provided noting that all current staff and contractors had an updated five year criminal background records check completed. The facility provided documentation indicating there have been zero contractors hired during the corrective action period and zero staff promoted during the corrective action period. There were four staff hired during the corrective action period. The documentation provided was inadequate and showed IDOC criminal background record checks completed after hire. As such, the auditor spoke with the IDOC PC related to noncompliance with this standard as the agency (Safer Foundations) was not following the policy and procedure they were trained on. The IDOC PC took immediate action related to the issue. The IDOC PREA Coordinator, IDOC Agency Head, the IDOC Manager of the Background Investigations, numerous other IDOC staff and numerous Safer Foundation staff, including the Vice President of Human Resources and Recruitment Specialists had a conference call on July 30, 2024 related the criminal background records check process. The conference call outlined that all criminal background records checks, including contractors under Safer Foundations are required to have a DOC 0032 completed prior to hire/enlisting services. The IDOC Background Investigations Unit will conduct the required background records checks and complete all prior institutional checks. Upon completion of the DOC 0032 Safer Foundations will be advised if the individual is “Eligible for Hire” or “Not Eligible for Hire”. The conference call discussed that staff and contractors are prohibited from providing services and prohibited access to residents until an approved DOC 0032 is provided by the IDOC Background Investigation Unit. The conference call further advised that staff and contractor access to residents may not be provided on a provisional basis while waiting on a response from IDOC. Electronic signatures were provided by all in attendance of the call confirming their understanding of this policy and procedure. Safer Foundations had one staff hired after the conference call. Documentation was

	provided from August 3, 2024 confirming that the Safer Foundations staff had a criminal background records check completed via IDOC prior to hire. Based on the documentation provided the facility has corrected this standard and as such appears to be compliant.

115.218	**Upgrades to facilities and technology**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. Pre-Audit Questionnaire Interviews: 1. Interview with the Agency Head 2. Interview with the Director Site Review Observations: 1. Observations of Absence of Modification to the Physical Plant 2. Observations of Absence of Video Monitoring Technology Findings (By Provision): 115.218 (a): The PAQ indicated that the agency/facility has not acquired a new facility or made substantial expansion or modifications to existing facilities the last PREA audit. During the tour the auditor confirmed there were no expansions or modifications. The interview with the Agency Head indicated that the agency has a zero tolerance and that PREA is taken seriously. He stated that they take safety into consideration when planning or making any substantial modifications. The Agency Head indicated they utilize a multi-facet approach to ensure that everyone at the table is able to discuss any issues or items related to building and modification. He further stated they the agency looks at housing for vulnerable populations to ensure safety. The interview with the Director confirmed there were no substantial

	expansions or modifications to the existing facility since the last PREA audit. 115.218 (b): The PAQ indicated that the agency/facility has not installed or updated a video monitoring system, electronic surveillance system or other monitoring technology since the last PREA audit. During the tour the auditor observed a plethora of cameras around the facility, including in the housing area hallways and housing unit common areas as well as in most facility common areas. Cameras are viewed by the staff in main control and the two housing unit control areas. Administrative level staff are also able to remotely access the cameras. The interview with the Agency Head confirmed that any use of newly updated or installed monitoring technology would be utilized to assist in enhancing the agency's ability to protect residents from sexual abuse. He stated that the agency has increased their video monitoring technology and has updated older technology. He indicated that video monitoring is utilized to review and investigate and also to assist with monitoring. He further stated that they review video after an allegation but they also use video monitoring in a proactive approach. The Director confirmed that when installing or updating video monitoring technology they consider how that technology will protect residents from sexual abuse. He stated physical presence is always the best but that video monitoring is an asset. He indicated video monitoring is utilized secondary to staffing and that it covers blind spots of the facility. The Director advised that they have built up the video monitoring technology over the years and are currently moving toward high definition technology. Based on a review of the PAQ, observations made during the tour and information from interviews with the Agency Head and Director indicates that this standard appears to be compliant.

115.221	**Evidence protocol and forensic medical examinations**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. Pre-Audit Questionnaire 2. Administrative Directive 04.01.301 Sexual Abuse and Harassment Prevention and Intervention Program 3. Administrative Directive 01.12.120 Investigations of Unusual Incidents 4. Administrative Directive 01.12.112 Preservation of Physical Evidence

5. Victim Advocacy Attempts

6. Memorandum of Understanding with the Illinois State Police

7. Correspondence with the Illinois State Police

Interviews:

1. Interviews with Random Staff

2. Interview with the PREA Coordinator

3. Interview with SAFE/SANE

Findings (By Provision):

115.221 (a): The PAQ indicated that the agency is responsible for conducting administrative and criminal investigations. Additionally, the PAQ stated that the Illinois State Police is also responsible for conducting criminal investigations. The PAQ indicated that when conducting a sexual abuse investigation, the agency investigators follow a uniform evidence protocol. 04.01.301, page 10 states that all allegations of sexual abuse or harassment shall be investigated by trained investigators in accordance with 01.12.120. The initial investigative report shall be provided to the Chief Administrative Officer within 24 hours of the onset of the investigation. Policy further states that upon conclusion of the investigation the results shall be forwarded to the Chief of Operations who shall report the incident to the Illinois State Police, where appropriate. 01.12.120, pages 1-2 state that The CAO shall ensure that an internal investigation is conducted by facility staff, or by staff assigned by the Chief of Investigations and Intelligence, on each unusual incident report, if it is determined that further facts are required. The Director or the respective Deputy Director or Chief may request that the Chief of Operations initiate a Department investigation of any other major incident. Department investigations shall be conducted by the Investigations and Intelligence Unit. 01.12.112 pages 1-2 describe the uniform evidence protocol including preservation and collection. Interviews with twelve random staff indicated four were aware of and understood the protocol for obtaining usable physical evidence. Additionally, six of the twelve staff stated they knew who was responsible for conducting sexual abuse investigations.

115.221 (b): The PAQ indicated that the evidence protocol is not developmentally appropriate for youth as the agency does not house youthful residents. It further stated that the protocol was adapted from or otherwise based on the most recent edition of the DOJ’s Office of Violence Against Women publication “A National

	Protocol for Sexual Assault Medical Forensic Examinations, Adult/Adolescents". Further clarification with the PCM indicated that it was not developed for youth as they do not house youth, however it was developed based on the most recent edition of the DOJ's publication. 01.12.112 indicates that prior to evidence collection the scene shall be secured; evidence shall be collected subsequent of searches, sketches and photographs; evidence shall be handled as little as possible and evidence shall be marked and tagged. The memo from the Chief of Investigations and Intelligence also indicated that all Sexual Assault Evidence Kits will be completed by an outside hospital or outside hospital emergency room with trained medical staff and the hospital completing the kit will be responsible for submitting the kit to the Illinois State Police Division of Forensic Services. 115.221 (c): The PAQ indicated that the facility offers all residents who experience sexual abuse access to forensic medical examinations at an outside medical facility. The PAQ stated that forensic medical examinations are offered without financial cost to the victim. It further indicated forensic medical examinations are conducted by SAFE or SANE, and when SAFE or SANE are not available examinations are conducted by a qualified medical practitioner. The PAQ confirmed that state statue (Illinois Compiled Statutes ILCS) requires forensic medical examination to be performed by SANE/SAFE. 04.01.301, page 9 states individuals in custody shall not be charged a co-payment for medical treatment, including a forensic medical examination, obtained for alleged sexual abuse. Where evidentiary or medically appropriate, treatment for a forensic medical exam shall be performed by a certified Sexual Assault Forensic Examiner (SAFE) or a certified Sexual Assault Nurse Examiner (SANE) at a local emergency room as determined by the local or medical facility. If a forensic medical examination is conducted, and to ensure a secure chain of custody, the local emergency room or medical facility shall only release the evidence collection kit to a member of the facility's Internal Affairs Unit or a member of the Investigations and Intelligence Unit. The evidence collection kit shall not be returned to the facility by the medical furlough security staff. The auditor contacted John H. Stroger, Jr. Hospital of Cook County related to forensic medical examinations. Hospital staff confirmed that they provide forensic medical examinations through SANE. The staff stated a SANE is available during the day and is on call in the evenings. The auditor also contacted Provident Hospital of Cook County related to forensic medical examinations. Hospital staff advised they do not provide forensic medical examinations because they do not have a SANE. There were zero allegations reported during the previous two years confirming there have been zero forensic medical examinations. There were zero allegations reported during the previous two years confirming there have been zero forensic medical examinations. 115.221 (d): The PAQ indicated that the facility attempts to make available to the victim a victim advocate from a rape crisis center and the efforts are documented. The PAQ further indicated that if a rape crisis center is not available a qualified staff

	member from a community-based organization or a qualified agency staff member, however a rape crisis center advocate is always provided. 04.01.301, page 5 states that the PCM shall identify community agencies, including advocacy and crisis organizations, where reports can be made or that provide assistance or support services to staff or offenders in the prevention or intervention of sexual abuse and harassment. Page 8 further states that all response efforts, including efforts to secure advocacy services from a rape crisis center, shall be documented. The facility provided documentation indicating that they have worked with the Illinois Coalition Against Sexual Assault (ICASA) to reach out to the local rape crisis centers to provide services under this provision. The Director and PC both reached out to the organization identified by ICASA (YWCA Chicago). Documentation was providing confirming they sent written correspondence to the contact person provided by ICASA, as well as called the numbers listed on the website, including the hotline. The attempts did not yield return communication. The facility did not provide further documentation indicating the qualified staff member or qualified community-based organization identified to provide these services. The interview with the PC indicated that if requested by the victim, a victim advocate, qualified agency staff member or qualified community based organization staff member accompanies ad provides emotional support, crisis intervention, information and referrals during forensic medical examinations and investigatory interviews. He further stated that all forensic medical examinations are conducted at hospitals with SAFE/SANE and that the hospitals have MOUs in place to ensure a victim advocate is available. Additionally, he indicated that IDOC facilities have MOUs with rape crisis centers to ensure advocates are available and that contact information to these organizations is provided in facility handbooks as well as multiple posting throughout facilities. There were zero residents who reported sexual abuse during the on-site portion of the audit and as such no interviews were conducted. There were zero allegations reported during the previous two years and as such no documentation was available for review. 115.221 (e): The PAQ indicated that as requested by the victim, the victim advocate, qualified agency staff member or qualified community-based organization staff member shall accompany and support the victim through the forensic medical examination process and investigatory interviews. 04.01.301, page 5 states that the PCM shall identify community agencies, including advocacy and crisis organizations, where reports can be made or that provide assistance or support services to staff or offenders in the prevention or intervention of sexual abuse and harassment. Page 8 further states that all response efforts, including efforts to secure advocacy services from a rape crisis center, shall be documented. The facility provided documentation indicating that they have worked with the Illinois Coalition Against Sexual Assault (ICASA) to reach out to the local rape crisis centers to provide services under this provision. The Director and PC both reached out to the organization identified by ICASA (YWCA Chicago). Documentation was providing confirming they sent written correspondence to the contact person provided by ICASA, as well as called the numbers listed on the website, including the hotline. The attempts did not yield

	return communication. The facility did not provide further documentation indicating the qualified staff member or qualified community-based organization identified to provide these services. It should be noted that under state law a victim advocate is provided at all hospitals that offer forensic medical examination via SAFE/SANE. As such, part of this provision is compliant through state law. The interview with the PC indicated that if requested by the victim, a victim advocate, qualified agency staff member or qualified community based organization staff member accompanies ad provides emotional support, crisis intervention, information and referrals during forensic medical examinations and investigatory interviews. He further stated that all forensic medical examinations are conducted at hospitals with SAFE/SANE and that the hospitals have MOUs in place to ensure a victim advocate is available. Additionally, he indicated that IDOC facilities have MOUs with rape crisis centers to ensure advocates are available and that contact information to these organizations is provided in facility handbooks as well as multiple posting throughout facilities. He confirmed that all rape crisis centers comply with requirements set forth by the Illinois Coalition Against Sexual Assault. There were zero residents who reported sexual abuse during the on-site portion of the audit and as such no interviews were conducted. There were zero allegations reported during the previous two years and as such no documentation was available for review. 115.221 (f): The PAQ indicated that the agency/facility is not responsible for investigating administrative or criminal investigations of sexual abuse. The agency/ facility does conduct sexual abuse investigations, however there are certain criminal investigations that are conducted by the Illinois State Police. The MOU with the Illinois State Police (signed in 2019) indicates that they conduct investigations related to sexual assault involving staff on staff or staff on resident. A review of documentation confirmed that the PC has annual correspondence with the Illinois State Police related to the Survey of Sexual Victimization. During that correspondence the Illinois State Police confirm that they follow a uniform evidence protocol and the requirements under this standard. 115.221 (g): The auditor is not required to audit this provision. 115.221 (h): The facility provided documentation indicating that they have worked with the Illinois Coalition Against Sexual Assault (ICASA) to reach out to the local rape crisis centers to provide services under this provision. The Director and PC both reached out to the organization identified by ICASA (YWCA Chicago). Documentation was providing confirming they sent written correspondence to the contact person provided by ICASA, as well as called the numbers listed on the website, including the hotline. The attempts did not yield return communication. The facility did not provide further documentation indicating the qualified staff member or qualified community-based organization identified to provide these services.

Based on a review of the PAQ, 04.01.301, 01.12.120, 01.12.112, the MOU with the Illinois State Police, the correspondence with the Illinois State Police and information from interviews with random staff and the PREA Coordinator indicates that this standard appears to require corrective action. The facility provided documentation indicating that they have worked with the Illinois Coalition Against Sexual Assault (ICASA) to reach out to the local rape crisis centers to provide services under this provision. The Director and PC both reached out to the organization identified by ICASA (YWCA Chicago). Documentation was providing confirming they sent written correspondence to the contact person provided by ICASA, as well as called the numbers listed on the website, including the hotline. The attempts did not yield return communication. The facility did not provide further documentation indicating the qualified staff member or qualified community-based organization identified to provide these services. Additionally, interviews with twelve random staff indicated four were aware of and understood the protocol for obtaining usable physical evidence and six of the twelve staff stated they knew who was responsible for conducting sexual abuse investigations.

Corrective Action

The facility will need to identify the staff or organization that is utilized to provide victim advocacy services under this standard. Information related to the staff and/or organization will need to be provided, including the screening to ensure appropriateness. Training will need to be provided with appropriate staff related to the process of utilizing the staff/organization for residents who report sexual abuse. Confirmation of the training will need to be provided. Further, staff will need to be trained on the evidence protocol and responsibility of IDOC for conducting sexual abuse investigations. Confirmation of the training will need to be provided.

Verification of Corrective Action Since the Interim Audit Report

The auditor gathered and analyzed the following additional evidence provided by the facility during the corrective action period relevant to the requirements in this standard.

Additional Documents:

1. Staff Training
2. Victim Advocacy Information

	The facility provided training documentation confirming staff were trained on the uniform evidence protocol and the process for affording residents who report sexual abuse access to victim advocates. The training memo outlined contacting the rape crisis center and that if the rape crisis center is unable to provide services to contact Stateville Correctional Center for a qualified agency staff member. The training memo also directed staff to provide contact information for Just Detention International to the victims as well. The training memo further advised to document all efforts to afford victim advocates. Staff signatures were provided confirming staff received and understood the training. The facility confirmed that Stateville Correctional Center medical and mental health staff serve as the qualified agency staff members for victim advocacy. Staff have received appropriate training and have agreed to serve in the role. The facility has zero allegations of sexual abuse during the corrective action period. Based on the documentation provided the facility has corrected this standard and as such appears to be compliant.

115.222	**Policies to ensure referrals of allegations for investigations**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. Pre-Audit Questionnaire 2. Administrative Directive 04.01.301 Sexual Abuse and Harassment Prevention and Intervention Program 3. Administrative Directive 01.12.120 Investigations of Unusual Incidents 4. Memorandum of Understanding with the Illinois State Police/Office of Executive Inspector General 5. Incident Reports

Interviews:

1. Interview with the Agency Head

2. Interviews with Investigative Staff

Findings (By Provision):

115.222 (a): The PAQ indicated that the agency ensures an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment. 04.01.301, page 10 states that all allegations of sexual abuse or harassment shall be investigated by trained investigators in accordance with 01.12.120. The initial investigative report shall be provided to the Chief Administrative Officer within 24 hours of the onset of the investigation. Policy further states that upon conclusion of the investigation the results shall be forwarded to the Chief of Operations who shall report the incident to the Illinois State Police, where appropriate. 01.12.120, pages 1-2 state that The CAO shall ensure that an internal investigation is conducted by facility staff, or by staff assigned by the Chief of Investigations and Intelligence, on each unusual incident report, if it is determined that further facts are required. The Director or the respective Deputy Director or Chief may request that the Chief of Operations initiate a Department investigation of any other major incident. Department investigations shall be conducted by the Investigations and Intelligence Unit. The PAQ noted there were zero allegations reported within the previous twelve month. There were zero allegations reported during the previous two years and as such no documentation was available for review. The interview with the Agency Head confirmed that the agency ensures an administrative or criminal investigation is completed for all allegations of sexual abuse or sexual harassment. He stated the agency has a policy/manual and that all allegation are investigated. He indicated that when an allegation is reported though any of the available channels it is reported to the PCM who then reports it to intel staff. Intel staff complete an investigation and if deemed substantiated it is forwarded for criminal charges. The Agency Head stated that the agency takes all allegations seriously and they prosecute to the fullest extent.

115.222 (b): The PAQ indicated that the agency has a policy that requires that allegations of sexual abuse or sexual harassment be referred for investigation to an agency with the legal authority to conduct criminal investigations, including the agency if it conducts its own investigations, unless the allegation does not involve potentially criminal behavior. The PAQ further stated that the policy is published on the agency’s website and all referrals for criminal investigations are documented. 04.01.301, page 10 states that all allegations of sexual abuse or harassment shall

	be investigated by trained investigators in accordance with 01.12.120. The initial investigative report shall be provided to the Chief Administrative Officer within 24 hours of the onset of the investigation. Policy further states that upon conclusion of the investigation the results shall be forwarded to the Chief of Operations who shall report the incident to the Illinois State Police, where appropriate. Additionally, the MOU with the Illinois State Police (signed in 2019) indicates that they conduct investigations related to sexual assault involving staff on staff or staff on resident. A review of the agency website indicates that it states that IDOC investigates all allegations of offender on offender sexual abuse and staff sexual misconduct. It further states that investigations are initiated by the Investigations Unit at IDOC Headquarters. The interview with the investigators confirmed that all allegations are referred to an investigative agency with the authority to conduct criminal investigations. All allegations are investigated by IDOC investigators. There were zero allegations reported during the previous two years and as such no documentation was available for review. 115.222 (c): The agency/facility has the authority to conduct both administrative and criminal investigations. The Illinois State Police also have the authority to conduct criminal investigations. 04.01.301 states that upon conclusion of the investigation the results shall be forwarded to the Chief of Operations who shall report the incident to the Illinois State Police, where appropriate. Additionally, the MOU with the Illinois State Police (signed in 2019) indicates that they conduct investigations related to sexual assault involving staff-on-staff or staff-on-resident. 115.222 (d): The PAQ stated that if the agency is not responsible for conducting administrative or criminal investigations of alleged sexual abuse, and another state entity has that responsibility, this other entity has a policy governing how such investigations are conducted. The agency/facility has the authority to conduct both administrative and criminal investigations. The Illinois State Police also has the authority to conduct criminal investigations. 04.01.301 states that upon conclusion of the investigation the results shall be forwarded to the Chief of Operations who shall report the incident to the Illinois State Police, where appropriate. Additionally, the MOU with the Illinois State Police (signed in 2019) indicates that they conduct investigations related to sexual assault involving staff on staff or staff on resident. 115.222 (e): The auditor is not required to audit this provision. Based on a review of the PAQ, 04.01.301, 01.12.120, the MOU with the Illinois State Police, the agency’s website and information obtained via interviews with the Agency Head and the investigators indicate that this standard appears to be compliant.

115.231	Employee training
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. Pre-Audit Questionnaire 2. Administrative Directive 04.01.301 Sexual Abuse and Harassment Prevention and Intervention Program 3. Administrative Directive 03.03.102 Employee Training 4. Administrative Directives 01.01.101 Administrative Directives 5. Administrative Directive 01.02.101 Staff Meeting 6. PREA Pre-Service Orientation Training Curriculum 7. PREA – Individual in Custody Sexual Assault Prevention and Intervention Curriculum 8. Transgender and Non-Binary Individuals in Custody Setting – A Guide to Rehabilitation, Safety Management and Care 9. Supervising Individuals in Custody in the IDOC Women's Division 10. Staff Training Records Interviews: 1. Interviews with Random Staff Findings (By Provision): 115.231 (a): The PAQ indicated that the agency trains all employees who may have contact with residents on the requirements under this provision. 04.01.301, pages 3-4 state that the PC shall develop or approve standardized modules for training staff. Training shall include, but may not be limited to: the Department's zero tolerance policy; the Department's Sexual Abuse and Harassment Prevention and Intervention Policy; an offender's right to be free from sexual abuse and harassment and to be free from retaliation for reporting sexual abuse and harassment; common signs of sexually abusive or harassing behavior; common signs of being a victim of sexual abuse or harassment; protocol for initial response,

	including identification and separation of offenders; reporting procedures and preservation of physical evidence of sexual abuse. 03.03.102, page 1 states that the Department shall ensure all new employees receive orientation and pre-service training and all employees receive in-service training on a fiscal year basis. A review of the PREA Pre-Service Orientation Training Curriculum and the PREA –Individual in Custody Sexual Assault Prevention and Intervention Curriculum confirm that both trainings includes information on: the agency's zero-tolerance policy, how to fulfill their responsibilities under the agency's sexual abuse and sexual harassment policies and procedures, the residents' right to be free from sexual abuse and sexual harassment, the right of the resident to be free from retaliation for reporting sexual abuse or sexual harassment, the dynamics of sexual abuse and sexual harassment in a confinement setting, the common reactions of sexual abuse and sexual harassment victims, how to detect and respond to signs of threatened and actual sexual abuse how to avoid inappropriate relationship with residents and how to comply with relevant laws related to mandatory reporting. With regard to how to communicate effectively and professionally with lesbian, gay, bisexual, transgender and intersex residents, staff are required to complete the Transgender and Non-Binary Individuals in Custody Setting – A Guide to Rehabilitation, Safety Management and Care video. A review of twelve staff training records indicated that three had received PREA training. Interviews with twelve random staff indicated eight had received PREA training and the training included the required elements under this provision. Most of the staff were unfamiliar with numerous topics that were to be covered under this provision. 115.231 (b): The PAQ indicated that training is tailored to the gender of resident at the facility and that employees who are reassigned to facilities with opposite gender are given additional training. 03.03.102, page 4 states that all employees employed at a women's facility shall receive an additional 40 hours of gender responsive and trauma informed training onsite upon hire. Each employee shall then be provided a gender responsive and trauma informed refresher each subsequent year of employment. A review of the Supervising Individuals in Custody in the IDOC Women's Division training curriculum confirms the training includes 83 slides related to trauma informed practices, gender specific programs and services, different level of value of communication for women and health boundaries and professional distance. Additionally, the agency has the Gender Responsibility and Supervising the Female Offender training. North Lawndale Adult Transition Center houses male residents only, no additional training is required. 115.231 (c): The PAQ indicated that between trainings the agency provides employees who may have contact with residents with refresher information about current policies regarding sexual abuse and sexual harassment and that staff are provided training annually. 03.03.102, page 4 states that employees shall receive an additional 40 hours of training each subsequent year of employment. 01.01.101, page 7 states that the Policy and Directives Unit shall provide monthly notice of, and

	make available via the Department Intranet any new or revised directives, rescission notices, or provide a notice of no change. Additionally, 01.02.101 states that administrative and supervisory staff meeting shall be held at least once a month to ensure that lines of two-way communication are established between all levels of supervision and that the meeting will be used for discussing policy and program changes and topics which are of general interest to the group. A review of thirteen staff training records indicated none had completed PREA training at least every two years. 115.231 (d): The PAQ indicated that the agency documents that employees who may have contact with residents understand the training they have received through employee signatures or electronic verification. 03.03.102, page 6 states that certificates or other verification of training received shall be provided to the Training Coordinator. The certificates or verification of training shall include all information required on the DOC 0200. Additionally, all newly hired staff are required to complete the Acknowledgement of Participation which indicates that the staff has read and understood 04.01.301. The auditor requested training documents for thirteen staff, at the issuance of the interim report three training records were provided confirming staff signed the DOC 0200 that they received and understood training. Based on a review of the PAQ, PAQ, 04.01.301, 03.03.102, 01.01.101, 01.02.101, PREA Pre-Service Orientation Training Curriculum, PREA – Individual in Custody Sexual Assault Prevention and Intervention Curriculum, Transgender and Non-Binary Individuals in Custody Setting – A Guide to Rehabilitation, Safety Management and Care training, Supervising Individuals in Custody in the IDOC Women's Division, staff training records and information from interviews with random staff indicate that this standard appears to require corrective action. A review of twelve staff training records indicated that three had received PREA training. Interviews with twelve random staff indicated eight had received PREA training and the training included the required elements under this provision. Most of the staff were unfamiliar with numerous topics that were to be covered under this provision. Corrective Action The facility will need to ensure all current staff have completed PREA training. This should be dated after the on-site portion of the audit for all staff. A copy of the training will need to be provided to the auditor. Further, the facility will need to ensure all staff receive training as outlined in policy, with a minimum of PREA training every two years. A process memorandum as well as an assurance from the Director will need to be provided indicating the process, how it will be followed and

	that it will be followed. Verification of Corrective Action Since the Interim Audit Report The auditor gathered and analyzed the following additional evidence provided by the facility during the corrective action period relevant to the requirements in this standard. Additional Documents: 1. Staff Training 2. Staff Training Memorandum A facility documented that staff will receive PREA training annually through IDOC Day 2 cycle training. The facility provided a memo advising all staff at the facility had completed PREA training via Day 2 cycle training. The facility provided documentation for all previously requested staff (with the exception of one staff who terminated employment), confirming they received PREA training during the corrective action period. Based on the documentation provided the facility has corrected this standard and as such appears to be compliant.

115.232	**Volunteer and contractor training**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. Pre-Audit Questionnaire 2. Administrative Directive 04.01.301 Sexual Abuse and Harassment Prevention and Intervention Program 3. Administrative Directive 04.01.122 Volunteer Services 4. Administrative Directive 03.03.102 Employee Training

5. Volunteer Services Handbook

6. PREA Pre-Service Orientation Training Curriculum

7. PREA – Individual in Custody Sexual Assault Prevention and Intervention Curriculum

8. Contractor and Volunteer Training Records

Interviews:

1. Interview with Contractors and/or Volunteers

Findings (By Provision):

115.232 (a): The PAQ indicated that all volunteers and contractors who have contact with residents have been trained on their responsibilities under the agency's policies and procedures regarding sexual abuse and sexual harassment prevention, detection and response. 04.01.301, pages 3-4 state that the PC shall develop or approve standardized modules for training staff. Training shall include, but may not be limited to: the Department's zero tolerance policy; the Department's Sexual Abuse and Harassment Prevention and Intervention Policy; an offender's right to be free from sexual abuse and harassment and to be free from retaliation for reporting sexual abuse and harassment; common signs of sexually abusive or harassing behavior; common signs of being a victim of sexual abuse or harassment; protocol for initial response, including identification and separation of offenders; reporting procedures and preservation of physical evidence of sexual abuse. Page 2 states that the term staff for the purpose of this directive shall mean any Department employee, contracted employee, employee of a vendor or volunteer. 04.01.122, page 3 states that the Facility Volunteer Coordinator shall ensure volunteers receive orientation and training appropriate to the type of volunteer assignment at the facility or program site prior to service. Training shall include, but not be limited to, preparation of an incident report, volunteer rules of conduct and the Department's zero tolerance policy toward all forms of sexual abuse and sexual harassment. The PAQ indicated that six volunteers and contractors had received PREA training. Further communication with the PC indicated different numbers from the facility, however it was determined the numbers were incorrect. At the date of the on-site portion of the audit the facility had six contractors and two volunteers. A review of the PREA Pre-Service Orientation Training Curriculum and the PREA - Individual in Custody Sexual Assault Prevention and Intervention Curriculum confirms that the trainings discuss responsibilities under the agency's sexual abuse and sexual harassment policy. A review of the Volunteer Handbook confirms that it includes information on the zero tolerance, how to report and red flags. The auditor requested training for three contractors and two volunteers. At the issuance of the

	interim report the auditor received documentation indicating one contractor had received training on PREA. The interview with the contractor confirmed that he was provided information on the agency's sexual abuse and sexual harassment policies and their responsibilities under those policies and procedures. 115.232 (b): The PAQ indicated that the level and type of training provided to volunteers and contractors is based on the services they provide and level of contact they have with residents. Additionally, the PAQ stated that all volunteers and contractors who have contact with residents have been notified of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and informed on how to report such incidents. 04.01.301, pages 3-4 state that the PC shall develop or approve standardized modules for training staff. Training shall include, but may not be limited to: the Department's zero tolerance policy; the Department's Sexual Abuse and Harassment Prevention and Intervention Policy; an offender's right to be free from sexual abuse and harassment and to be free from retaliation for reporting sexual abuse and harassment; common signs of sexually abusive or harassing behavior; common signs of being a victim of sexual abuse or harassment; protocol for initial response, including identification and separation of offenders; reporting procedures and preservation of physical evidence of sexual abuse. Page 2 states that the term staff for the purpose of this directive shall mean any Department employee, contracted employee, employee of a vendor or volunteer. 04.01.122, page 3 states that the Facility Volunteer Coordinator shall ensure volunteers receive orientation and training appropriate to the type of volunteer assignment at the facility or program site prior to service. Training shall include, but not be limited to, preparation of an incident report, volunteer rules of conduct and the Department's zero tolerance policy toward all forms of sexual abuse and sexual harassment. A review of the PREA Pre-Service Orientation Training Curriculum and the PREA - Individual in Custody Sexual Assault Prevention and Intervention Curriculum confirms that the trainings discuss responsibilities under the agency's sexual abuse and sexual harassment policy. A review of the Volunteer Services Handbook confirms that it includes information on the zero tolerance, how to report and red flags. The auditor requested training for three contractors and two volunteers. At the issuance of the interim report the auditor received documentation indicating one contractor had received training on PREA. The interview with the contractor indicated that he completed training online and he also completed a course in a group setting. He further stated he received paperwork during the training. The contractor confirmed the training included information on the zero tolerance policy and that they should report any information to the security supervisor. 115.232 (c): The PAQ indicated that the agency maintains documentation confirming that volunteers and contractors understand the training they have received. 03.03.102, page 6 states that certificates or other verification of training received shall be provided to the Training Coordinator. The certificates or verification

	of training shall include all information required on the DOC 0200. Additionally, all newly hired staff are required to complete the Acknowledgement of Participation which indicates that the staff has read and understood 04.01.301. Additionally, 04.01.122, page 3 states that individual volunteer files shall include training documentation including documented orientation and any additional training. Training documentation shall be signed and dated by the volunteer along with the Volunteer Coordinator. A review of the one completed contractor training confirmed the contractor signed that they received and understood the training. Based on a review of the PAQ, 04.01.301, 04.01.122, 03.03.102, the Volunteer Services Handbook, PREA Pre-Service Orientation Training Curriculum. the PREA – Individual in Custody Sexual Assault Prevention and Intervention Curriculum and the volunteer training record indicates that this standard appears to require corrective action. The auditor requested training for three contractors and two volunteers. At the issuance of the interim report the auditor received documentation indicating one contractor had received training on PREA. Corrective Action The facility will need to provide the requested documentation. If documentation is not available, the facility will need to ensure all contractors and volunteers have received PREA training. Confirmation of the training will need to be provided. Additionally, the facility will need to develop a process to ensure all contractors and volunteers receive training prior to contact with residents. A process memorandum will need to be provided as well as training with applicable staff on the process. Verification of Corrective Action Since the Interim Audit Report The auditor gathered and analyzed the following additional evidence provided by the facility during the corrective action period relevant to the requirements in this standard. Additional Documents: 1. Contractor and Volunteer Training 2. Process Memorandum

	The facility provided the originally requested documentation. The volunteer training was completed in 2016 and a refresher was completed in 2024. The contractors had training completed in February 2024. A training/process memo was provided that outlined that all volunteers and contractors will be provided education prior to providing services and the training will be documented. The facility provided a training curriculum that will be utilized for training, which covers the zero tolerance policy, reporting, detection, etc. Staff signatures were provided confirming they received and understood the training. Based on the documentation provided the facility has corrected this standard and as such appears to be compliant.

115.233	**Resident education**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. Pre-Audit Questionnaire 2. Administrative Directive 04.01.301 Sexual Abuse and Harassment Prevention and Intervention Program 3. Administrative Directive 04.01.105 Facility Orientation 4. Administrative Directive Administrative Directive 04.01.111 ADA Accommodations 5. Administrative Directive 05.07.101 Reception and Classification Process 6. Video Remote Interpreting Information 7. Language Interpretation Procedure – Propio Language Services, LLC. 8. Individuals In Custody Handbook (Handbook) 9. PREA Brochure 10. PREA Posters 11. PREA Reporting Posters 12. Resident Education Records

Documentation Received During the Interim Report Period

1. Updated LEP Resident Education

Interviews:

1. Interview with Intake Staff
2. Interview with Random Residents

Site Review Observations:

1. Observations of Intake Area
2. Observations of PREA Posters

Findings (By Provision):

115.233 (a): The PAQ stated that during the intake process, residents shall receive information explaining the zero-tolerance policy regarding sexual abuse and sexual harassment, how to report incidents or suspicions of sexual abuse or sexual harassment, their rights to be free from sexual abuse and sexual harassment and to be free from retaliation for reporting such incidents, and regarding agency policies and procedures for responding to such incidents. 4.01.301, page 7 states that during the admission and orientation process, individuals in custody shall be provided with a presentation explaining the Department’s zero tolerance policy regarding sexual abuse and sexual harassment, including reporting procedures and available services. Individuals in custody shall be informed that victims need not name their attacker to receive medical and mental health services. The policy further states that the facility orientation handbook shall include an explanation of reporting procedures and programs and services available to victims or predators of sexual abuse and harassment to include mailing addresses and telephone numbers of local, state or national victim advocacy or rape crisis organizations. The PAQ indicated that 172 residents received PREA information at intake during the previous twelve months. A review of the Handbook (pages 80-89) confirms that residents are provided information about the zero-tolerance policy, their right to be free from sexual abuse and sexual harassment, their right to be free from retaliation from reporting such incidents, examples of sexual abuse and sexual harassment, how to prevent sexual abuse and sexual harassment and how to report sexual abuse and sexual harassment. A review of 23 resident files indicated 22 received PREA education, however the documentation indicated they had only received a

	Handbook. The auditor observed the intake/education process through a demonstration. All residents come from an IDOC facility (prison). Residents are provided a Handbook and a PREA Brochure in English or Spanish. The Handbook contains information on the zero tolerance policy, definitions and examples of sexual abuse and sexual harassment, way to prevent sexual abuse, what to do if sexually abused and reporting mechanisms. Residents sign that they received the Handbook. Staff do not conduct any additional education with residents related to PREA. Staff advised for LEP residents they have two bilingual staff, but if the resident spoke a language other than Spanish they were unsure what would be done as they never experienced that situation. Additionally, staff stated they have never experienced a disabled resident who needed accommodations for PREA information either. The interview with the intake staff confirmed that residents receive information on the agency's sexual abuse and sexual harassment policies during intake. The staff advised that the residents get a Handbook and Brochure on the date they arrive and they also ask the PREA risk screening questions. Interviews with 20 total residents indicated four were provided information on the sexual abuse and sexual harassment policies and twelve were provided information about the agency's zero tolerance policy, their rights under PREA, how to report and the facility's response to an allegation of sexual abuse or sexual harassment upon arrival. It should be noted that all residents entering the facility are being transferred from an IDOC facility where they were provided PREA education upon intake and comprehensive PREA education within 30 days. 115.233 (b): The PAQ indicated that the facility provides residents who are transferred from a different community confinement facility with refresher information referenced in provision (a). The PAQ further stated that there were zero residents transferred from another community confinement facility who was provided the refresher information over the previous twelve months. 4.01.301, page 7 states that during the admission and orientation process, individuals in custody shall be provided with a presentation explaining the Department's zero tolerance policy regarding sexual abuse and sexual harassment, including reporting procedures and available services. Individuals in custody shall be informed that victims need not name their attacker to receive medical and mental health services. The policy further states that the facility orientation handbook shall include an explanation of reporting procedures and programs and services available to victims or predators of sexual abuse and harassment to include mailing addresses and telephone numbers of local, state or national victim advocacy or rape crisis organizations. A review of the Handbook (page 80-89) confirms that residents are provided information about the zero-tolerance policy, their right to be free from sexual abuse and sexual harassment, their right to be free from retaliation from reporting such incidents, examples of sexual abuse and sexual harassment, how to prevent sexual abuse and sexual harassment and how to report sexual abuse and sexual harassment. The interview with the intake staff confirmed that residents receive information on the agency's sexual abuse and sexual harassment policies during intake. The staff advised that the residents get a Handbook and Brochure on

	the date they arrive and they also ask the PREA risk screening questions. Interviews with 20 total residents indicated four were provided information on the sexual abuse and sexual harassment policies and twelve were provided information about the agency's zero tolerance policy, their rights under PREA, how to report and the facility's response to an allegation of sexual abuse or sexual harassment upon arrival. 115.233 (c): The PAQ indicated that resident PREA education is available in formats accessible to all s, including those who are disabled or limited English proficient. 04.01.301, pages 7-8 state that the Department shall provide offender education in formats accessible to all offenders, including those who are limited English proficient, deaf, visually impaired or otherwise disabled, as well as to offender who have limited reading skills. 04.01.111, pages 3-4 indicate that the CAO shall ensure offenders are provide with information regarding ADA disability accommodations and shall establish procedures for offender access to teletypewriter (TTY) and Video Remote Interpreting (VRS) equipment. The policy also indicates that the CAO shall find alternative notification methods for auditory announcements (tactile paging system). 05.07.101, page 2 states that all videos used during orientation shall include closed captioning subtitles and closed captioning utilizing American Sign Language which has been reviewed for accuracy of the interpretation by the Illinois Deaf and Hard of Hearing Commissioner or a qualified interpreter. The policy further states that he department shall reserve the first row of seats during orientation for offenders who are disabled. 04.01.105, page 2 states that for a non-English speaking offender, reasonable efforts shall be made for the orientation to be explained to him or her in a language her or she understands. It further states that offenders shall receive written orientation material and/or translation in their own language and when a literacy problem exists, a staff member shall assist the offender in understanding the materials. The facility also has a contract with Propio Language Services, LLC. This company provides the facility a phone number that they can call that connects the staff member with a translator who can will translate information between the staff member and LEP resident. The company has interpretation services for over 600 languages. A review of PREA Posters, the Handbook and distributed information confirmed that information can be provided in large font, bright colors, can be read to residents in terminology that they understand and is available in Spanish. Additionally, pages 35-36 of the Handbook provide information on Americans with Disabilities (ADA) including requesting accommodations, telecommunication equipment and sign language information. A review of four disabled resident files and four LEP resident file indicated all eight had signed indicating they received education via the Handbook. It should be noted that the LEP residents had signed English acknowledgment forms. During the interim report period the facility provided updated PREA education with LEP residents. All four LEP residents were documented with being provided information on PREA via a Spanish acknowledgment form.

	115.233 (d): The PAQ indicated that the agency maintains documentation of resident participation in PREA education sessions. 04.01.301, page 7 states the individual in custody's participation in the orientation process shall be documented on the Orientation Receipt, DOC 0291. A review of 23 resident files indicated all 23 received signed that they received PREA education, however the documentation indicated they had only received a Handbook. 115.233 (e): The PAQ indicated that the agency ensures that key information about the agency's PREA policies is continuously and readily available or visible through posters, resident handbooks or other written formats. 04.01.301, page 7 states the individual in custody's participation in the orientation process shall be documented on the Orientation Receipt, DOC 0291. A review of the Handbook and PREA Posters confirmed information is accessible to residents through these avenues. The auditor observed PREA information posted throughout the facility via PREA Posters and PREA Reporting Posters. PREA Posters were observed on legal size paper in English and Spanish in each resident room, in the laundry rooms near the phones, in the dayrooms and across numerous common areas. The PREA Posters included information on reporting mechanisms and the zero tolerance policy. The PREA Reporting Posters were observed on letter size paper in English and Spanish on housing unit doors, in the laundry rooms near the phones, in the dayrooms and across numerous common areas. The PREA Reporting Posters included information on the zero tolerance policy, reporting mechanism (to include the external reporting entity – John Howard Association) and contact information for Just Detention International (national victim advocacy organization). It should be noted the PREA Reporting Posters were put up at the facility the day before/day of the on-site portion of the audit. Based on a review of the PAQ, 04.01.301, 04.01.105, 04.01.111, 05.07.101, Propio Language Services, LLC. information, Video Remote Interpreting information, the Handbook, PREA Posters, observations made during the tour as well as information obtained during interviews with intake staff and random residents indicate that this standard appears to require corrective action. A review of 23 resident files indicated 22 received PREA education, however the documentation indicated they had only received a Handbook. Staff do not conduct any additional education with residents related to PREA other than providing the Handbook and Brochure. Staff advised for LEP residents they have two bilingual staff, but if the resident spoke a language other than Spanish they were unsure what would be done as they never experienced that situation. Additionally, staff stated they have never experienced a disabled resident who needed accommodations for PREA information either. The interview with the intake staff confirmed that residents receive information on the agency's sexual abuse and sexual harassment policies during intake. The staff advised that the residents get a Handbook and Brochure on the date they arrive and they also ask the PREA risk screening questions. A review of four disabled resident files and four LEP resident file indicated all eight had signed indicated they received

	education via the Handbook. It should be noted that the LEP residents had signed English acknowledgment forms. During the interim report period the facility provided updated PREA education with LEP residents. All four LEP residents were documented with being provided information on PREA via a Spanish acknowledgment form. The auditor observed PREA information posted throughout the facility via PREA Posters and PREA Reporting Posters. It should be noted the PREA Reporting Posters were put up at the facility the day before/day of the on-site portion of the audit. Corrective Action The facility will need to develop a process for resident education that includes going over the right to be free from sexual abuse and sexual harassment, the right to be free from retaliation and the facility's policies and procedures in response to an allegation of sexual abuse or sexual harassment. This will need to be completed in person or via video. A process memorandum will need to be provided outlining the education process. All appropriate staff will need to be trained on the process. A copy of the training will need to be provided. Confirmation of the new education process being implemented will need to be provided (video). Further, the facility will need to develop methods for LEP and disabled residents to participate in education. A process memorandum describing this will also need to be provided as well as training with applicable staff. Confirmation of this process will also need to be provided to the auditor (video). All current residents will need to receive PREA education. The missing resident document will need to be provided as well as confirmation of updated education with current residents. The facility will also need to provide photos of the PREA Reporting Posters around the facility confirming they are still posted. Additional interviews of residents via video may be required as well. Verification of Corrective Action Since the Interim Audit Report The auditor gathered and analyzed the following additional evidence provided by the facility during the corrective action period relevant to the requirements in this standard. Additional Documents: 1. Process Memorandum 2. Staff Training 3. Individual In Custody Education Documents

	4. Assurance Memorandum 5. Photos of Posted Information The facility provided a process memo outlining that education will be completed via the PREA video and the IDOC script that accompanies the video. The video is in English, Spanish and ASL and also has subtitles. The Handbook will also be provided, which is in English and Spanish. Staff received training on this process and signed that they understood the process. The facility provided an assurance memo indicating all residents had received updated education as well as thirteen education records as confirmation of completion. Additionally, the facility provided photos confirming the PREA Reporting Poster and PREA Poster were still up around the facility. Based on the documentation provided the facility has corrected this standard and as such appears to be compliant.

115.234	**Specialized training: Investigations**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. Pre-Audit Questionnaire 2. Administrative Directive 04.01.301 Sexual Abuse and Harassment Prevention and Intervention Program 3. Administrative Directive 01.12.115 Institutional Investigative Assignments 4. Prison Rape Elimination Act (PREA) for Investigators Training Curriculum 5. Investigator Training Records Interviews:

	1. Interviews with Investigative Staff Findings (By Provision): 115.234 (a): The PAQ indicates that agency policy requires that investigators are trained in conducting sexual abuse investigations in confinement settings. 04.01.301, page 10 states that all allegations of sexual abuse or harassment shall be investigated by trained investigators in accordance with 01.12.120. 01.12.115, page 2 states that the CAO shall ensure that each individual appointed as an investigator be registered for the next available investigator training program within ten days of temporary or permanent assignment as an investigator. Training topics include but are not limited to: investigative techniques, including interviewing sexual abuse victims; crime scene preservation; collection and preservation of evidence, including sexual abuse evidence collection in a confinement setting; proper use of Miranda and Garrity warnings; criteria and evidence required to substantiate a case for administrative action or prosecution referral; and investigative reporting. The agency utilizes their own training for this standard; PREA for Investigators. A review of documentation indicated that the facility utilizes IDOC agency investigators, as there are no facility investigators. Interviews with the investigators confirmed they received specialized training regarding conducting sexual abuse and sexual harassment investigations in a confinement setting. Both staff stated the training was the 40 hour institutional investigator training as well as additional online trainings. 115.234 (b): 01.12.115, page 2 states that the CAO shall ensure that each individual appointed as an investigator be registered for the next available investigator training program within ten days of temporary or permanent assignment as an investigator. Training topics include but are not limited to: investigative techniques, including interviewing sexual abuse victims; crime scene preservation; collection and preservation of evidence, including sexual abuse evidence collection in a confinement setting; proper use of Miranda and Garrity warnings; criteria and evidence required to substantiate a case for administrative action or prosecution referral; and investigative reporting. The agency utilizes their own training for this standard; PREA for Investigators. A review of the training curriculum confirmed slides 67-118 include the following: techniques for interviewing sexual abuse victims, proper use of Miranda and Garrity warnings, sexual abuse evidence collection in confinement settings and the criteria and evidence required to substantiate an administrative investigation. A review of documentation indicated that the facility utilizes IDOC agency investigators, as there are no facility investigators. Interviews with the investigators confirmed that the specialized investigator training included the topics required under this provision: techniques for interviewing sexual abuse victims, proper use of Miranda and Garrity warnings, sexual abuse evidence collection in confinement settings and the criteria and

	evidence required to substantiate an administrative case. 115.234 (c): The PAQ indicated that the agency maintains documentation showing that investigators have completed the required training and that two agency investigators have completed the specialized training. A review of documentation indicated that the facility utilizes IDOC agency investigators and both had the specialized investigator training. 115.234 (d): The auditor is not required to audit this provision. Based on a review of the PAQ, 04.01.301, 01.12.115, PREA for Investigators Training Curriculum, a review of investigator training records, as well as the interviews with the investigators, indicate that this standard appears to be compliant.

115.235	**Specialized training: Medical and mental health care**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. Pre-Audit Questionnaire 2. Administrative Directive 04.01.301 Sexual Abuse and Harassment Prevention and Intervention Program 3. Administrative Directive 03.03.102 Employee Training 4. PREA Sexual Abuse and Harassment Prevention and Intervention Program Manual (PREA Manual) 5. Prison Rape Elimination Act: What Healthcare and Mental Health Providers Need to Know Training Curriculum 6. Wexford Health Prison Rape Elimination Act (PREA) and Implementation Training Curriculum Findings (By Provision):

	115.235 (a): The PAQ indicated that the agency has a policy related to the training of medical and mental health practitioners who work regularly in its facilities. 04.01.301, page 4 states that PC shall develop or approve specialized training modules for all full and part-time medical and mental health care practitioners who work regularly in the facilities. Training shall include: detecting and assessing signs of sexual abuse and sexual harassment; preserving physical evidence of sexual abuse; responding effectively and professionally to victims of sexual abuse and sexual harassment; and how and whom to report allegations or suspicions of sexual abuse and sexual harassment. The training is conducted via the Prison Rape Elimination Act: What Healthcare and Mental Health Providers Need to Know and the Wexford Health Overview of the 2003 Prison Rape Elimination Act (PREA) and Implementation. A review of the training curriculums confirmed that they include the following topics: how to detect and assess signs of sexual abuse and sexual harassment, how to preserve physical evidence of sexual abuse, how to respond effectively and professionally to victims of sexual abuse and sexual harassment and how and whom to report allegations or suspicion of sexual abuse and sexual harassment. The PAQ indicated that the facility has zero medical and mental health staff and that residents are transported to the local hospital for all services. The facility does not employ medical or mental health care staff. All services are provided in the community and as such no training is required. No files were reviewed and no interviews were conducted. 115.235 (b): The PAQ indicated that this provision does not apply as agency medical and mental health care staff do not perform forensic medical examinations. The facility does not employ medical or mental health staff and as such no interviews were conducted. 115.235 (c): The PAQ indicated that documentation showing the completion of the training is maintained by the agency. The facility does not employ medical or mental health care staff. All services are provided in the community and as such no training is required. 115.235 (d): 04.01.301, pages 3-4 state that the PC shall develop or approve standardized modules for training staff. Training shall include, but may not be limited to: the Department’s zero tolerance policy; the Department’s Sexual Abuse and Harassment Prevention and Intervention Policy; an offender’s right to be free from sexual abuse and harassment and to be free from retaliation for reporting sexual abuse and harassment; common signs of sexually abusive or harassing behavior; common signs of being a victim of sexual abuse or harassment; protocol for initial response, including identification and separation of offenders; reporting procedures and preservation of physical evidence of sexual abuse. 03.03.102, page 1 states that the Department shall ensure all new employees receive orientation and pre-service training and all employees receive in-service training on a fiscal

	year basis. A review of the PREA Pre-Service Orientation Training Curriculum and the PREA –Individual in Custody Sexual Assault Prevention and Intervention Curriculum confirm that both trainings includes information on responsibilities in prevention, detection and response as well as the zero tolerance policy and how to report allegations of sexual abuse. The facility does not employ medical or mental health care staff. All services are provided in the community and as such no training is required. Based on a review of the PAQ, 04.01.301, 03.03.102, Prison Rape Elimination Act: What Healthcare and Mental Health Providers Need to Know training curriculum and the Wexford Health Overview of the 2003 Prison Rape Elimination Act (PREA) and Implementation training curriculum indicate that this standard appears to be compliant.

115.241	**Screening for risk of victimization and abusiveness**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. Pre-Audit Questionnaire 2. Administrative Directive 04.01.302 Screening for Risk of Victimization and Abusiveness 3. PREA Sexual Abuse and Harassment Prevention and Intervention Program Manual (PREA Manual) 4. Screening for Potential Sexual Victimization or Sexual Abuse (DOC 0494) 5. Assessment and Reassessment Documents Interviews: 1. Interview with Staff Responsible for Risk Screening 2. Interview with Random Residents 3. Interview with the PREA Coordinator Site Review Observations:

1. Observations of Risk Screening Area

2. Observations of Where Resident Files are Located

Findings (By Provision):

115.241 (a): The PAQ indicated that the agency has a policy that requires screening (upon admission to a facility or transfer to another facility) for risk of sexual abuse victimization or sexual abusiveness toward other residents. 04.01.302, page 2 states screening and assessment shall be documented on the Screening for Potential Sexual Victimization or Sexual Abuse, DOC 0494, or Offender 360 (O360) equivalent, and shall occur: within 24 hours of admission or transfer to any facility and by staff, designated by the CAO, who shall screen each individual in custody for sexually abusive behavior or victimization. It further states that within 72 hours of admission or transfer to any facility and require: clinical Services staff, or other staff designated by the CAO, to supplement the initial screening by considering prior acts of sexual abuse, prior convictions for violent offenses, and history of prior institutional violence of sexual abuse by reviewing documents such as, but not limited to, pre-sentence reports, statement of facts, and other material in the master file or O360. Any supplemental findings or concerns be documented on the DOC 0494 completed in accordance with II.G.1.a. A separate DOC 0494 shall not be required. The auditor was provided a demonstration of the initial risk assessment. The initial risk assessment is completed in the visiting room where residents are pulled to the side and are asked risk screening questions. The auditor observed that this process did not provide adequate privacy. Staff complete the initial risk screening on paper utilizing the DOC form and then enter the responses into Offender 360. Staff obtain certain information from the resident's file, including age, height and weight. Other information is obtained by asking the questions that are on the DOC form. Staff indicated they receive the residents file before they arrive so they look at information prior to the risk screening. If the file differs from the response provided by the resident, staff advise the resident of the file information and ask them to clarify their response. The paper DOC form is provide to the Case Manager to store and file. The interview with the staff responsible for the risk screening confirmed that residents are screened for their risk of victimization and abusiveness upon intake. Interviews with nineteen residents that arrived within the previous twelve months indicated nine were asked questions related to risk of victimization and abusiveness.

115.241 (b): The PAQ indicated that the policy requires that residents be screened for risk of sexual victimization or risk of sexually abusing other residents within 72 hours of their intake. 04.01.302, page 2 states screening and assessment shall be documented on the Screening for Potential Sexual Victimization or Sexual Abuse, DOC 0494, or Offender 360 (O360) equivalent, and shall occur: within 24 hours of

	admission or transfer to any facility and by staff, designated by the CAO, who shall screen each individual in custody for sexually abusive behavior or victimization. It further states that within 72 hours of admission or transfer to any facility and require: clinical Services staff, or other staff designated by the CAO, to supplement the initial screening by considering prior acts of sexual abuse, prior convictions for violent offenses, and history of prior institutional violence of sexual abuse by reviewing documents such as, but not limited to, pre-sentence reports, statement of facts, and other material in the master file or O360. Any supplemental findings or concerns be documented on the DOC 0494 completed in accordance with II.G.1.a. A separate DOC 0494 shall not be required. The PAQ indicated that 171 residents were screened within 72 hours over the previous twelve months. This indicates that 100% of those whose length of stay was for 72 hours or more received a risk screening within 72 hours. A review of 22 resident files of those that arrived within the previous twelve months indicated all 22 had an initial risk screening. Nineteen of the 22 were within 72 hours. The interview with the staff responsible for the risk screening confirmed that residents are screened for their risk of victimization and abusiveness within 72 hours. Interviews with nineteen residents that arrived within the previous twelve months indicate nine were asked the questions related to risk of victimization and abusiveness when they first arrived. 115.241 (c): The PAQ indicated that the risk screening is conducted using an objective screening instrument. A review of the Screening for Potential Sexual Victimization or Sexual Abuse (DOC 0494) indicates that residents are asked about identified or perceived sexual orientation, gender identity and history or sexual victimization. Additionally, the Screening for Potential Sexual Victimization or Sexual Abuse (DOC 0494) indicates that general information such as age, height, weight, number of incarcerations, non-violent or violent criminal history, disabilities, education level, socioeconomic status, immigrant status/language, history or sexual abusive behavior, criminal history of sexual abuse in the community, history of domestic violence, security threat group affiliation and history or institutional assaultive/violent behavior are factored into the risk screening assessment tool. Each question has appropriate responses that correspond to a number. The numbers are added up at the end of the victimization section and predatory section and the total number determines where the resident falls on the continuum. The continuum ranges from not likely, likely, moderately likely to highly likely for both vulnerable and predatory. The residents who fall in the highly likely or moderately likely range are then reviewed for the official vulnerable or predatory designation. The DOC 0949 also states that the evaluator may refer an individual in custody on the continuum, but if the individual falls into the likely or not likely range, a rational for the referral should be documented. 115.241 (d): A review of the Screening for Potential Sexual Victimization or Sexual Abuse (DOC 0494) indicates that the tool has two sections; vulnerability and predatory. The vulnerability section includes general information such as age,

	height, weight, number of incarcerations, non-violent or violent criminal history, disabilities (developmental, mental illness and physical), education level, socioeconomic status and immigrant status/language. residents are also asked about identified or perceived sexual orientation, gender identity and history or sexual victimization. The is also asked about his/her own perception of their safety at the time of the screening. Each question has appropriate responses that correspond to a number. The numbers are added up at the end of the victimization section and the total number determines where the resident falls on the continuum. The continuum ranges from not likely, likely, moderately likely to highly likely for vulnerability. The residents who fall in the highly likely or moderately likely range are then reviewed for the official vulnerable designation. The staff responsible for the risk screening stated that the initial risk screening is completed through the DOC form. The staff advised the initial risk screening considers: number of incarcerations, violent or non-violent offenses, disabilities, age, height, weight, sexual orientation, education level and history of sexual abuse/sexual harassment. The staff indicated they ask the questions on the form and also review the file for information. The staff further confirmed through probe that all required elements under this provision are included in the risk screening. The auditor reviewed the DOC 0494 and confirmed all element, with the exception of whether the individual has a sex offense committed against an adult or child, are on the form and asked by staff. 115.241 (e): A review of the Screening for Potential Sexual Victimization or Sexual Abuse (DOC 0494) indicates information including, history or sexual abusive behavior, criminal history of sexual abuse in the community, history of domestic violence, security threat group affiliation and history or institutional assaultive/ violent behavior are factored into the risk screening assessment tool. Each question has appropriate responses that correspond to a number. The numbers are added up at the end of the predatory section and the total number determines where the resident falls on the continuum. The continuum ranges from not likely, likely, moderately likely to highly likely for predatory. The residents who fall in the highly likely or moderately likely range are then reviewed for the official predatory designation. The staff responsible for the risk screening stated that the initial risk screening is completed through the DOC form. The staff advised the initial risk screening considers: number of incarcerations, violent or non-violent offenses, disabilities, age, height, weight, sexual orientation, education level and history of sexual abuse/sexual harassment. The staff indicated they ask the questions on the form and also review the file for information. The staff further confirmed through probe that all required elements under this provision are included in the risk screening. The auditor reviewed the DOC 0494 and confirmed all elements under this standards are on the form and are asked by the staff. 115.241 (f): The PAQ did not indicate that the policy requires that the facility reassess each resident’s risk of victimization or abusiveness within a set time

	period, not to exceed 30 days after the resident's arrival at the facility, based upon any additional, relevant information received by the facility since the intake screening. However, communication with the Director indicated this should have been marked yes and that they do reassess each resident's risk level. 04.01.302, page 2 states screening and assessment shall be documented on the Screening for Potential Sexual Victimization or Sexual Abuse, DOC 0494, or Offender 360 (O360) equivalent, and shall occur no sooner than 15 calendar days, but no later than 30 calendar days of admission or transfer to the facility, each individual in custody, including any individual returned to a Reception and Classification Center as a parole or mandatory supervised release violator, shall be screened again for sexually abusive behavior or victimization based upon any additional, relevant information received by the facility since the initial intake screening. The PAQ indicated that 142 residents were reassessed within 30 days, which is equivalent to 100% of the residents who arrived and stayed longer than 30 days. During the tour the auditor was provided a demonstration of the 30 day risk reassessment. The 30 day reassessment is completed a couple of days prior to 30 days and is done via a file review. The reassessment is directly entered into Offender 360. Staff confirmed that they do not meet with the resident and ask any additional questions for the reassessment. Interviews with nineteen residents that arrived within the previous twelve months indicated none had been asked questions related to their risk of victimization and abusiveness more than once. The interview with the staff responsible for the risk screening confirmed that residents are reassessed within 30 days, but that it is done through a file review. A review of 22 resident files of those that arrived in the previous twelve months indicated 20 had a reassessment. Eighteen of the 20 were within 30 days of arrival. One of the risk assessment not completed was not yet due. 115.241 (g): The PAQ indicated that the policy requires that an resident's risk level be reassessed when warranted due to a referral, request, incident of sexual abuse, or receipt of additional information that bears on the resident's risk of sexual victimization or abusiveness. 04.01.302, page 2 states screening and assessment shall be documented on the Screening for Potential Sexual Victimization or Sexual Abuse, DOC 0494, or Offender 360 (O360) equivalent, and shall occur for all alleged victims and alleged perpetrators at the conclusion of any sexual abuse investigation determined to be substantiated or unsubstantiated. Additionally it states screening and assessment shall be documented on the Screening for Potential Sexual Victimization or Sexual Abuse, DOC 0494, or Offender 360 (O360) equivalent, and shall occur when warranted due to a referral, request, or receipt of additional information that bears on the individual in custody's risk of sexual victimization or abusiveness. The interview with staff responsible for the risk screening confirmed that residents are reassessed when warranted due to referral, request, incident of sexual abuse or receipt of additional information. Interviews with nineteen residents that arrived within the previous twelve months indicated none had been asked questions related to their risk of victimization and abusiveness more than once. A review of 22 resident files of those that arrived in the previous twelve months

	indicated 20 had a reassessment. Eighteen of the 20 were within 30 days of arrival. One of the risk assessment not completed was not yet due. There were zero sexual abuse investigations completed during the previous twelve months and as such no reassessments due to incident of sexual abuse were completed. 115.241 (h): The PAQ indicated that policy prohibits disciplining residents for refusing to answer (or for not disclosing complete information related to) questions regarding: (a) whether or not the resident has a mental, physical, or developmental disability; (b) whether or not the resident is or is perceived to be gay, lesbian, bisexual, transgender, intersex, or gender non-conforming; (c) whether or not the resident has previously experienced sexual victimization; and (d) the residents' own perception of vulnerability. 04.01.302, page 2 states individuals in custody shall not be disciplined for refusing to answer, or not disclosing complete information in response to, questions asked during the screening for potential sexual victimization or sexual abuse. The interview with the staff responsible for risk screening confirmed that residents are not disciplined for refusing to respond or not disclose information related to the risk screening. 115.241 (i): 04.01.302, page 2 states the CAO shall ensure staff conducting the risk screenings are provided with an area to conduct the risk screenings which provides a reasonable level of confidentiality while considering the safety and security of the staff conducting the screenings. Further policy states access to information related to sexual abuse occurring in a correctional setting shall be treated as confidential and limited to staff directly related to the assessment, treatment, placement or investigation of the individual in custody to the extent possible while ensuring the safety and security of individuals in custody and staff. Electronic risk assessments are completed and located in the Offender 360 program. During the tour the auditor had a staff member illustrate how to access Offender 360 and the resident's risk assessment. The staff member was unable to pull up the risk assessment and could not view responses confirming the information is only accessible to those with a need to know. The interview with the PREA Coordinator indicated that the agency has outlined who should have access to a resident's risk assessment within the facility in order to protect sensitive information from exploitation. The staff responsible for risk screening confirmed that the agency has outlined who should have access to the risk screening information so that it is not exploited. The staff indicated only Case Managers have access to the information. Based on a review of the PAQ, 04.01.302, the PREA Manual, DOC 0494, resident risk assessments and the information from interviews with the PREA Coordinator, staff responsible for conducting the risk screenings and random residents indicate that this standard requires corrective action. The auditor was provided a demonstration of the initial risk assessment. The initial risk assessment is completed in the visiting room where residents are pulled to the side and are asked risk screening questions.

	The auditor observed that this process did not provide adequate privacy. Interviews with nineteen residents that arrived within the previous twelve months indicated nine were asked questions related to risk of victimization and abusiveness. The auditor reviewed the DOC 0494 and confirmed all element, with the exception of whether the individual has a sex offense committed against an adult or child, are on the form and asked by staff. The 30 day reassessment is completed a couple of days prior to 30 days and is done via a file review. The reassessment is directly entered into Offender 360. Staff confirmed that they do not meet with the resident and ask any additional questions for the reassessment. Interviews with nineteen residents that arrived within the previous twelve months indicated none had been asked questions related to their risk of victimization and abusiveness more than once. The interview with the staff responsible for the risk screening confirmed that residents are reassessed within 30 days, but that it is done through a file review. A review of 22 resident files of those that arrived in the previous twelve months indicated 20 had a reassessment. Eighteen of the 20 were within 30 days of arrival. One of the risk assessment not completed was not yet due. Corrective Action The facility will need to identify a private area to conduct risk assessments. Photos of the identified area will need to be provided to confirm the space is confidential. The risk screening tool will need to be updated to include prior sexual offense against a child or adult in the victimization section. A copy of the updated risk screening tool will need to be provided. All current residents will need to be screened using the updated risk assessment tool (it should be noted that this does not require an in-person as this is information that can be obtained from the file). A sample of the updated risk assessments will need to be provided. The facility will need to re-evaluate their risk screening process, specifically the 30 day reassessments. These are required to be completed in person. A process memorandum will need to be provided outlining how risk assessments will be completed. Appropriate staff will need to be trained on the process. A copy of the training will need to be provided. Confirmation of utilization of the process (video) will need to be provided or five resident video interviews will need to be provided to confirm the process is being completed. Verification of Corrective Action Since the Interim Audit Report The auditor gathered and analyzed the following additional evidence provided by the facility during the corrective action period relevant to the requirements in this standard.

	Additional Documents: 1. Staff Training 2. Photo of Risk Screening Location 3. Updated Risk Screening Tool 4. Individuals in Custody Risk Screenings Additional Interviews: 1. Interview with Staff Responsible for Risk Screening The facility provided training documents that outlined the IDOC PREA Coordinator conducted training with staff on the process for risk assessments. This training included direction of risk screening to be conducted in a private setting and that reassessments are to be conducted in person. Staff signatures were provided confirming they received and understood the training. A photo was provided of the updated location for risk assessments. The auditor confirmed it was a private office setting. The auditor conducted a phone interview with the staff responsible for the risk screening. She outlined the updated process for the risk screening, including the file review process and that reassessments are completed in person. The interview confirmed the updated process and location were adequate. The facility provided the updated risk screening tool that included prior sexual convictions against an adult or child in the victimization section. Confirmation was provided that the element was added on both the paper form and the electronic form. The facility did not have any residents with a prior sexual offense and as such zero risk screenings were required to be updated. Based on the documentation provided the facility has corrected this standard and as such appears to be compliant.

115.242	Use of screening information
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. Pre-Audit Questionnaire 2. Administrative Directive 04.01.302 Screening for Risk of Victimization and Abusiveness 3. Administrative Directive 04.03.104 Evaluation, Treatment and Correctional Management of Transgender Offenders 4. PREA Sexual Abuse and Harassment Prevention and Intervention Program Manual (PREA Manual) 5. Transgender/Intersex Housing Determination Documents 6. LGBTI Resident Housing Assignments Interviews: 1. Interview with Staff Responsible for Risk Screening 2. Interview with PREA Coordinator Site Review Observations: 1. Shower Area in Housing Units Findings (By Provision): 115.242 (a): The PAQ indicated that the agency/facility uses information from the risk screening required by §115.41 to inform housing, bed, work, education, and program assignments with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive. 04.01.302, page 4 states prior to housing an individual in custody identified as a predator with another individual, the proposed housing assignment shall be reviewed and approved by the CAO in consultation with the facility PREA Compliance Manager. Prior to housing an individual in custody identified as vulnerable with another individual, the proposed housing assignment shall be

	reviewed and approved by the CAO in consultation with the facility PREA Compliance Manager. Housing an individual in custody identified as vulnerable with an individual in custody identified as a predator shall be prohibited. The interview with the PREA Coordinator indicated that the information from the risk screening to determine risk of victimization and perpetration and whether the individual in custody is provided a designation of predator and/or vulnerable. He stated those designated as predator cannot be housed in minimum security or community confinement level facilities. The interview with the staff responsible for the risk screening indicated that information from the risk screening is utilized to follow-up with residents. The staff stated if they answer certain questions that stand out they follow up with them more and help the resident build confidence. The staff advised that another staff member was responsible for housing so she was unsure if that information was used for housing. A review of housing documentation confirmed there were zero residents at high risk of abusiveness and zero residents at high risk of victimization. It should be noted that residents at high risk of abusiveness are not housed at community confinement facilities and as such the staff do not have to consider that element when determining housing. Additionally, residents work outside the facility in the community. 115.242 (b): The PAQ indicated that the agency/facility makes individualized determinations about how to ensure the safety of each resident. 04.01.302, page 4 states prior to housing an individual in custody identified as a predator with another individual, the proposed housing assignment shall be reviewed and approved by the CAO in consultation with the facility PREA Compliance Manager. Prior to housing an individual in custody identified as vulnerable with another individual, the proposed housing assignment shall be reviewed and approved by the CAO in consultation with the facility PREA Compliance Manager. Housing an individual in custody identified as vulnerable with an individual in custody identified as a predator shall be prohibited. The interview with the staff responsible for the risk screening indicated that information from the risk screening is utilized to follow-up with residents. The staff stated if they answer certain questions that stand out they follow up with them more and help the resident build confidence. The staff advised that another staff member was responsible for housing so she was unsure if that information was used for housing. 115.242 (c): The PAQ indicated that the agency/facility makes housing and program assignments for transgender or intersex residents in the facility on a case-by-case basis. 04.03.104, page 7 indicates that transgender, intersex and gender incongruent offenders shall not be assigned to gender-specific facilities based solely on their external genital anatomy. The Transgender Administrative Committee (TAC) shall make individualized determinations about how to ensure the safety of each offender including considering transfer from one gender-specific facility to an opposite gender facility and specifically the gender of staff which will perform searches of the offender. The determination shall consider, on a case-by-case basis,

	whether specific placement ensure the offender's health and safety, and whether the placement would present management or security concerns. The agency as a whole houses approximately 150 transgender individuals. Currently the agency houses nine transgender female individuals at female facilities and zero transgender male individuals at male facilities. The review of meeting minutes for four TAC meetings confirms that housing is reviewed on a case-by-case basis for each individual. The PC stated that transgender and intersex resident's housing and programming assignments are determined by the multidisciplinary Transgender Administrative Committee (TAC) and guided by Administrative Directive 04.03.104. He confirmed the TAC considers whether the placement will ensure the resident's safety and whether the placement would present any management or security problems. 115.242 (d): 04.03.104, page 7 states that decisions shall be made by the TAC on a case-by-case basis with serious consideration given to circumstances including, but not limited to, the following: the offender's perception of whether a male or female facility is safest for him or her, as well as the preferred gender of staff to perform searches. The interviews with the PC confirmed that the residents' views with respect to his/her safety would be given serious consideration. The interview with the staff responsible for the risk screening indicated she was not sure if their views with respect to their safety were given serious consideration. There were zero transgender or intersex residents at the facility during the on-site portion of the audit and as such no interviews were completed. 115.242 (e): 04.03.104, page 9 states that transgender, intersex and gender incongruent offenders shall be allowed the same frequency of showers in accordance with his or her classification. Showers shall be separated and private from other offenders. Interviews with the PC and the staff responsible for risk screening confirmed that transgender and intersex residents are afforded the opportunity to shower separately. The PC stated that transgender and intersex residents are able to shower alone with adequate shower coverings when dayrooms/ showers are closed to other individuals in custody. During the tour the auditor observed that resident restrooms had a solid entrance door. The showers inside the restroom also had a curtain at the entrance. Residents can shower anytime during the day. There were zero transgender or intersex residents at the facility during the on-site portion of the audit and as such no interviews were completed. 115.242 (f): 04.03.104, page 7 states that transgender, intersex and gender incongruent offenders shall not be assigned to gender specific facilities based solely on their external genital anatomy. Additionally, the PREA Manual, pages 27-28 indicate that the agency shall not place lesbian, gay, bisexual, transgender, or intersex inmates in dedicated facilities, units, or wings solely on the basis of such identification or status, unless such placement is in a dedicated facility, unit, or wing

	established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting such inmates. The interview with the PC confirmed that the agency is not subject to a consent decree and that there is not a dedicated facility for LGBTI residents. He further stated facility placement officers ensure this practice does not take place. The interview with the one LGB resident confirmed he did not feel LGBTI residents were placed in one wing, housing unit or facility based on gender identity and/or sexual preference. There was only one LGB resident identified at the facility and as such it was determined that LGBTI residents are not placed in one housing area solely due to their gender identity and/or sexual preference. Based on a review of the PAQ, 04.01.302, 04.03.104, the PREA Manual, transgender housing determinations (agency wide – not facility specific), observations made during the tour and information from interviews with the PC and staff responsible for conducting the risk screening, indicates that this standard appears to require corrective action. The interview with the staff responsible for the risk screening indicated that information from the risk screening is utilized to follow-up with residents. The staff stated if they answer certain questions that stand out they follow up with them more and help the resident build confidence. The staff advised that another staff member was responsible for housing so she was unsure if that information was used for housing. The interview with the staff responsible for the risk screening indicated she was not sure if their views with respect to their safety were given serious consideration. Corrective Action The facility will need to train appropriate staff on how information for the risk screening is utilized (i.e. housing, program and job assignments). Confirmation of the training will need to be provided. Further a process memorandum will need to be provided on how staff will handle those identified as predator or victim if received by the facility. Additionally, staff will need to be trained on how transgender and intersex residents are handled under this standard. Confirmation of the training will need to be provided. Verification of Corrective Action Since the Interim Audit Report The auditor gathered and analyzed the following additional evidence provided by the facility during the corrective action period relevant to the requirements in this standard.

	Additional Documents: 1. Staff Training The facility provided documentation confirming staff received training on the use of screening information as well as requirements under this standard for transgender and intersex residents. Training outlined housing high risk residents, transgender and intersex resident views on safety and shower procedures. Staff signatures confirmed staff received and understood the training. The facility did not have any high risk abusers and based on facility type would never house high risk abusers. Based on the documentation provided the facility has corrected this standard and as such appears to be compliant.

115.251	**Resident reporting**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. Pre-Audit Questionnaire 2. PREA Sexual Abuse and Harassment Prevention and Intervention Program Manual (PREA Manual) 3. Memorandum of Understanding with the John Howard Association 4. TRUST Act Memorandum 5. Individuals In Custody Orientation Manual (Handbook) 6. PREA Posters 7. PREA Reporting Posters Interviews:

1. Interview with the PREA Coordinator
2. Interview with Random Staff
3. Interview with Random Residents

Site Review Observations:

1. Observation of PREA Reporting Information
2. Testing of Internal Reporting Hotline
3. Testing of the External Reporting Entity

Findings (By Provision):

115.251 (a): The PAQ indicated that the agency has established procedures allowing for multiple internal ways for residents to report privately to agency officials about: (a) sexual abuse or sexual harassment; (b) retaliation by other resident or staff for reporting sexual abuse and sexual harassment; and (c) staff neglect or violation of responsibilities that may have contributed to such incidents. The PREA Manual, page 29 states that offenders shall be encouraged to report allegations to staff at all levels. Offenders shall be provided with avenues of internal reporting, including, but not limited to, a telephone hotline maintained by the Investigations and Intelligence Unit, or by mail to an outside entity (e.g. John Howard Association). Offenders shall be provided information on reporting mechanisms as noted in section 115.233. A review of additional documentation to include the Handbook and PREA Posters indicated that they outline methods for reporting. These methods include: telling any staff member; calling the hotline, writing to the PC, to the John Howard Association (outside reporting entity) and/or sending a note, grievance or request slip. The auditor observed PREA information posted throughout the facility via PREA Posters and PREA Reporting Posters. PREA Posters were observed on legal size paper in English and Spanish in each resident room, in the laundry rooms near the phones, in the dayrooms and across numerous common areas. The PREA Posters included information on reporting mechanisms and the zero tolerance policy. The PREA Reporting Posters were observed on letter size paper in English and Spanish on housing unit doors, in the laundry rooms near the phones, in the dayrooms and across numerous common areas. The PREA Reporting Posters included information on the zero tolerance policy, reporting mechanism (to include the external reporting entity – John Howard Association) and contact information for Just Detention International (national victim advocacy organization). It should be noted the PREA Reporting Posters were put up at the facility the day before/day of the on-site portion of the audit. The auditor attempted to tested the internal reporting mechanism during the tour. The auditor called the hotline through the payphones in

	the housing units but received a busy signal. Calls to the PREA hotline from the payphones are not monitored or recorded, are free and do not require a pin/ID. Residents also all have access to cell phones when outside the facility. The auditor also tested the written internal reporting mechanism during the tour. The auditor submitted a grievance form on January 26, 2024 via the locked grievance box in the common area. At the issuance of the interim report the auditor had not received confirmation that the grievance was received. Interviews with 20 residents confirm that all 20 were aware of at least one method to report sexual abuse and sexual harassment. Most residents indicated that they would report through staff or the hotline. Interviews with twelve random staff indicated residents can report to verbally to staff, through the hotline, via a grievance or a kite and through John Howard Association. 115.251 (b): The PAQ stated that the agency provides at least one way for residents to report sexual abuse to a public or private entity or office that is not part of the agency. Additionally, the PAQ states that the facility does not house residents solely for civil immigration purposes. The agency has an MOU with the John Howard Association. The MOU states John Howard Association will allow IDOC to identify JHA within inmate orientation materials and prison posting as one way for inmates to report sexual abuse or sexual harassment to an entity that is not part of the agency, and that is able to receive and forward inmate reports of sexual abuse or harassment to Agency official for investigation, allowing the inmate to remain anonymous, upon request. The MOU further provides additional responsibilities for JHA and IDOC. The PREA Manual, page 29 indicates that offenders shall be provided contact information to the John Howard Association to make such reports. This information shall be available in Handbook. A review of the Handbook and PREA Posters confirmed that inmates can report externally to the John Howard Association. The Handbook (page 83) provides the address to JHA. The PREA Reporting Poster states that inmates can report via privileged mail to the John Howard Association through the PO Box in Chicago, Illinois. The auditor observed PREA information posted throughout the facility via PREA Posters and PREA Reporting Posters. PREA Posters were observed on legal size paper in English and Spanish in each resident room, in the laundry rooms near the phones, in the dayrooms and across numerous common areas. The PREA Posters included information on reporting mechanisms and the zero tolerance policy. The PREA Reporting Posters were observed on letter size paper in English and Spanish on housing unit doors, in the laundry rooms near the phones, in the dayrooms and across numerous common areas. The PREA Reporting Posters included information on the zero tolerance policy, reporting mechanism (to include the external reporting entity – John Howard Association) and contact information for Just Detention International (national victim advocacy organization). It should be noted the PREA Reporting Posters were put up at the facility the day before/day of the on-site portion of the audit. The auditor also tested the outside reporting mechanism via a letter to the John Howard Association at a prior IDOC audit. Because the process is the same for letters to JHA, the auditor did not complete another test. The auditor

	obtained an envelope and sent a letter to the John Howard Association on January 10, 2023. The auditor obtained assistance from a resident to utilize his name and number on the return address. The letter was placed in the outgoing US mail box by the resident. While a return name and number is required, mail to JHA is to be treated as privileged and as such mailroom staff should not open the letter. Residents are able to remain anonymous within the letter. The John Howard Association is utilized for numerous services and they are not just an organization to report sexual abuse. The auditor received confirmation on January 20, 2023 that the letter was received by the John Howard Association. A copy of the letter that was mailed was forwarded back to the auditor as well as the confirmation from John Howard Association staff that the resident can remain anonymous. During the tour the auditor observed the resident mail process. Residents can place outgoing mail in any of the U.S. mailboxes when outside the facility or they can place it in the outgoing mailbox within the facility. Outgoing mail placed in the facility mailbox is unsealed and staff review the outgoing mail for unauthorized information/ documents. Outgoing legal mail is placed in the outgoing mailbox sealed and staff do not open or review legal mail. Legal mail is given to the counselor who ensures there is not any contraband in it prior to sealing it. The counselor does not read or scan the legal mail. Incoming mail is received by facility staff who open it, scan it and search it. The original is provided to the resident. Legal mail is provided to the counselor. Residents open legal mail in front of the counselor to ensure there is not any contraband. The mail room staff member stated that mail to the John Howard Association and mail to the victim advocacy organization is treated like regular mail. The interview with the PC indicated residents are provided information for the John Howard Association, which is the outside reporting entity ad that all correspondence is considered privileged. He stated that upon receipt, the John Howard Association immediately contacts the agency PREA Coordinator. Interviews with 20 residents indicated that nine were aware of the John Howard Association and thirteen were also aware they could anonymously report. 115.251 (c): The PAQ indicated that the agency has a policy mandating that staff accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously, and from third parties. It further indicated that staff are required to document verbal reports immediately. 04.01.301, page 10 states that any alleged sexual abuse or harassment shall be reported through chain of command as an unusual incident in accordance with 01.12.105. The PREA Manual, page 29 further states that staff shall accept reports made verbally, in writing, anonymously, and from third parties and shall promptly document any verbal reports. Interviews with 20 residents indicated all 20 knew they could report verbally and/or in writing to staff and eighteen knew they could report through a third party. Interviews with twelve random staff indicated that all ten were aware that residents could report verbally, in writing, anonymously and through a third party. Two stated they were unsure about reporting through a third party. The staff stated that verbal reports are typically documented immediately. There were zero allegations reported during the previous two years and as such no documentation was available for review.

	Additionally during the tour, the auditor asked staff to demonstrate how they submit a written report. Staff indicated all verbal reports would be documented in an incident report. The staff illustrated that paper incident reports were available in the housing unit control area. Staff advised they would fill the information out by hand on the form and they also have the ability to fill the form out electronically. The incident report is signed and given to the supervisor on duty and the Chief. Staff confirmed that if they wanted to privately report they can bypass supervisors and give the incident report to the Director. 115.251 (d): The PAQ indicates the agency has established procedures for staff to privately report sexual abuse and sexual harassment of residents. It further states that staff can report through any of the reporting mechanisms offered to individuals in custody. The PAQ indicated that staff are informed of this method through PREA refresher trainings and postings around the facility. The PREA Manual, page 29 states that the agency shall provide a method for staff to privately report sexual abuse and sexual harassment of inmates. Interviews with twelve random staff indicated eleven were aware that they could privately report sexual abuse of a resident. Based on a review of the PAQ, PREA Manual, MOU with John Howard Association, the TRUST Act memo, the Handbook, PREA Posters, observations during the tour and information from interviews with the PC, random residents and random staff indicates this standard appears to require corrective action. The auditor observed PREA information posted throughout the facility via PREA Posters and PREA Reporting Posters. It should be noted the PREA Reporting Posters were put up at the facility the day before/day of the on-site portion of the audit. The auditor attempted to tested the internal reporting mechanism during the tour. The auditor called the hotline through the payphones in the housing units but received a busy signal. Calls to the PREA hotline from the payphones are not monitored or recorded, are free and do not require a pin/ID. Residents also all have access to cell phones when outside the facility. The auditor also tested the written internal reporting mechanism during the tour. The auditor submitted a grievance form on January 26, 2024 via the locked grievance box in the common area. At the issuance of the interim report the auditor had not received confirmation that the grievance was received. The mail room staff member stated that mail to the John Howard Association and mail to the victim advocacy organization is treated like regular mail. Interviews with 20 residents indicated that nine were aware of the John Howard Association and thirteen were also aware they could anonymously report. Corrective Action

	The facility will need to alleviate the issue with the PREA hotline number. Once the problem is alleviated, the facility will need to test the PREA hotline number through the payphones via a resident. The resident will need to provide a signed document indicating the date and time he called on the payphone and whether it went through. The resident will need to leave a test message, which will need to be forwarded to the auditor as confirmation of the call and functionality. The facility will also need to provide confirmation the submitted grievance was received. If it was not received in a timely manner the facility will need to re-evaluate their grievance reporting process. A process memorandum will need to be provided to outline how the facility will ensure the grievance box is checked regularly. A test grievance will need to be submitted by a resident and confirmation that the grievance was received will need to be provided. Further the mailroom staff will need to be provided training on how mail to JHA and the victim advocacy organization is treated (like privileged mail). Confirmation of the training will need to be provided. Lastly, the facility will need to provide photos of the PREA Reporting Posters around the facility to confirm they are still up. Recommendation The auditor highly recommends that information related to JHA and the ability to remain anonymous be discussed during resident education under 115.233. Verification of Corrective Action Since the Interim Audit Report The auditor gathered and analyzed the following additional evidence provided by the facility during the corrective action period relevant to the requirements in this standard. Additional Documents: 1. Test Grievance Response 2. Hotline Test 3. Grievance Test 4. Staff Training 5. Photos of Posted Information

	The facility provided documentation indicating the grievance submitted by the auditor was received on January 30, 2024. A response was provided to the test grievance on February 2, 2024. The facility also conducted a second test of the grievance process on February 29, 2024. A response via memo was provided on March 1, 2024 confirming the written reporting mechanism is functionable. The facility conducted a test of the hotline on February 29, 2024. The Director completed the call. Confirmation was provided through the IDOC that the call was received, confirming the hotline is functionable. The mailroom staff signed a training memo outlining how mail to and from JHA is treated (privileged). Additionally, photos were provided confirming the PREA Poster and PREA Reporting Poster were still up around the facility. Based on the documentation provided the facility has corrected this standard and as such appears to be compliant.

115.252	**Exhaustion of administrative remedies**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. Pre-Audit Questionnaire 2. Administrative Directive 04.01.114 Local Offender Grievance Procedures 3. Individuals In Custody Orientation Manual (Handbook) 4. Grievance Log 5. Sample Grievances Findings (By Provision):

	115.252 (a): 04.01.114 is the policy related to grievance procedures for residents. The PAQ indicated that the agency is not exempt from this standard. 115.252 (b): The PAQ indicated that agency policy or procedure allows a residents to submit a grievance regarding an allegation of sexual abuse at any time, regardless of when the incident is alleged to have occurred. The PAQ further indicated that residents are required to use an informal grievance process, or otherwise to attempt to resolve with staff, an alleged incident of sexual abuse. Further communication with the PC indicated that this was an error and that resident are not required to use the informal grievance process. 04.01.114, page 2 states that offender grievances related to allegations of sexual abuse shall not be subject to any filing time frame. Policy further states that offender grievances involving alleged incidents of sexual abuse shall be exempt from any informal grievance process. A review of the Handbook indicated there was no information on sexual abuse grievances. 115.252 (c): The PAQ stated that agency policy and procedure allow a resident to submit a grievance alleging sexual abuse without submitting it to the staff member who is the subject of the complaint. It further stated that agency policy and procedure requires that a resident grievance alleging sexual abuse not be referred to the staff member who is the subject of the complaint. 04.01.114, page 6 indicates an offender may submit the grievance without submitting it to any staff member who is the subject of the compliant. Policy further states that no grievance shall be referred to any staff member who is the subject of the complaint. A review of the Handbook indicated there was no information on sexual abuse grievances. 115.252 (d): The PAQ stated that agency policy and procedure requires that a decision on the merits of any grievance or portion of a grievance alleging sexual abuse be made within 90 days of the filing of the grievance. The PAQ indicated there were zero sexual abuse grievances filed in the previous twelve months The PAQ further indicates that the agency always notifies a resident in writing when the agency files for an extension, including notice of the date by which a decision will be made. 04.01.114, page 6 states that the Department shall issue a final 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 shall not include time consumed by the offender in preparing any administrative appeal. Policy further states that the Department may claim an extension of time to respond, of up to 70 days, if the normal time period for response is insufficient to. make an appropriate decision. The offender shall be notified, in writing, of such extension and provided with a date by which a decision will be made. Page 6 also states that at any level of the grievance process, if the offender does not receive a response within the time allotted for reply, including any properly noticed extension, the offender may consider the absence of a response to be a denial at that level. A review of the grievance log indicated there were 25 total grievances in 2023. The

	facility advised none were sexual abuse, however they were only able to produce fourteen of the 25 grievances, none of which were sexual abuse allegations. There were zero residents who reported sexual abuse at the facility during the on-site portion of the audit and as such no interviews were completed. 115.252 (e): The PAQ indicated that agency policy and procedure permits third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, to assist residents in filing requests for administrative remedies relating to allegations of sexual abuse and to file such requests on behalf of residents. It further indicated that agency policy and procedure requires that if a resident declines to have third-party assistance in filing a grievance alleging sexual abuse, the agency documents the residents' decision to decline. 04.01.114, page 6 states that third parties, including other offenders, staff members, family members, attorneys, etc., shall be permitted to assist offenders in filing grievances relating to allegations of sexual abuse, and shall also be permitted to file such requests on behalf of the offender. Policy further states that the Department shall require, as a condition of processing the grievance, the alleged victim to agree to have the grievance filed on his or her behalf. If the alleged victim declines, the decision shall be documented. The PAQ indicated there were zero third-party grievances filed in the previous twelve months where the resident declined assistance and which contained the residents decision to decline. A review of the grievance log indicated there were 25 total grievances in 2023. The facility advised none were sexual abuse, however they were only able to produce fourteen of the 25 grievances, none of which were sexual abuse allegations. There were zero residents who reported sexual abuse at the facility during the on-site portion of the audit and as such no interviews were completed. 115.252 (f): The PAQ indicated that the agency has a policy and established procedures for filing an emergency grievance alleging that a resident is subject to a substantial risk of imminent sexual abuse. It further indicated that the agency's policy and procedure for emergency grievances alleging substantial risk of imminent sexual abuse requires an initial response within 48 hours. The PAQ also indicated that the agency's policy and procedure for emergency grievances alleging substantial risk of imminent sexual abuse requires that a final agency decision be issued within five days. 04.01.114, page 7 states that for emergency grievances alleging an offender is subject to a substantial risk of imminent sexual abuse, the Department shall provide an initial response within 48 hours, and shall have a final decision provided within five calendar days. The initial response and the final decision shall document the Department's determination whether the offender is in substantial risk of imminent sexual abuse and the action taken in response to the emergency grievance. The PAQ indicated there were zero emergency grievances alleging substantial risk of imminent sexual abuse filed in the previous twelve months. A review of the grievance log indicated there were 25 total grievances in 2023. The facility advised none were sexual abuse, however they were only able to

	produce fourteen of the 25 grievances, none of which were sexual abuse allegations. There were zero residents who reported sexual abuse at the facility during the on-site portion of the audit and as such no interviews were completed. 115.252 (g): The PAQ indicated that the agency has a written policy that limits its ability to discipline a resident for filing a grievance alleging sexual abuse to occasions where the agency demonstrates that the resident filed the grievance in bad faith. 04.01.114, page 2 stats that staff shall be prohibited from imposing discipline due to use of the grievance process. The PAQ indicated that zero residents have been disciplined for filing a grievance in bad faith in the previous twelve months. Based on a review of the PAQ, 04.01.114, the Handbook, the grievance log and sample grievances, this standard appears to require corrective action. A review of the Handbook indicated there was no information on sexual abuse grievances. The facility advised none were sexual abuse, however they were only able to produce fourteen of the 25 grievances, none of which were sexual abuse allegations. Corrective Action The facility will need to update the Handbook to include information specific to sexual abuse grievances. Further the facility will need to re-evaluate their current grievance process. A process memorandum on the updated process, including who will check the grievance box, how often they will check the grievance box, how grievances will be process, how grievances will be stored/filed and how grievances will be responded to, will need to be provided. Appropriate staff will need to be trained on the process and confirmation of the training will need to be provided. The facility will need to provide the grievance log during the corrective action period and corresponding grievances with responses. Verification of Corrective Action Since the Interim Audit Report The auditor gathered and analyzed the following additional evidence provided by the facility during the corrective action period relevant to the requirements in this standard. Additional Documents:

	1. Updated Handbook 2. Process Memorandum 3. Grievance Log and Grievances The facility provided the updated Handbook which included information on sexual abuse grievances on page 60. A process memo was provided that advised staff would provide a memo to the resident confirming receipt of a grievance. A response to the grievance would then be provided on the grievance. Grievances will be tracked via a Microsoft Word document. The grievance log was provided as well as the four grievances received during the corrective action period. Zero of the grievances were sexual abuse, however all four confirmed the grievance process from the memo was followed. All had a memo advising the grievance was received and all had a response provided on the grievance. Based on the documentation provided the facility has corrected this standard and as such appears to be compliant.

115.253	**Resident access to outside confidential support services**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. Pre-Audit Questionnaire 2. Administrative Directive 04.01.301 Sexual Abuse and Harassment Prevention and Intervention Program 3. Victim Advocacy Attempts 4. Individuals in Custody Orientation Manual (Handbook) 5. PREA Posters 6. PREA Reporting Posters

Interviews:

1. Interview with Random Residents

Site Review Observations:

1. Observation of Victim Advocacy Information

Findings (By Provision):

115.253 (a): The PAQ indicated that the facility provides residents with access to outside victim advocates for emotional support services related to sexual abuse. The PAQ also stated that the facility provides residents with mailing addresses and phone numbers to local, state or national victim advocacy or rape crisis centers and provides residents with access to such services by enabling reasonable communication. The facility provided documentation indicating that they have worked with the Illinois Coalition Against Sexual Assault (ICASA) to reach out to the local rape crisis centers to provide services under this provision. The Director and PC both reached out to the organization identified by ICASA (YWCA Chicago). Documentation was providing confirming they sent written correspondence to the contact person provided by ICASA, as well as called the numbers listed on the website, including the hotline. The attempts did not yield return communication. It should be noted the auditor also attempted to contact this organization as well as a second organization related to the services under this provision. YWCA had not responded at the issuance of the interim report. Resilience provided feedback related to questions about the MOU, but did not respond related to whether they would provide services for the organization if requested (i.e. entering into an MOU). A review of the PREA Reporting Poster confirmed that residents are provided the telephone number and mailing address to Just Detention International. The PREA Poster advises residents that they can contact victim advocates for emotional support services by writing to JDI or contacting specific staff for additional information. The Handbook (page 82) includes the address and phone number for Prairie Center Against Sexual Assault and advises that individuals may contact victim advocates for emotional support services and additional information on the services can be obtained through the Counselor, Mental Health and PCM. The auditor observed PREA information posted throughout the facility via PREA Posters and PREA Reporting Posters. PREA Posters were observed on legal size paper in English and Spanish in each resident room, in the laundry rooms near the phones, in the dayrooms and across numerous common areas. The PREA Reporting Posters included information on the zero tolerance policy, reporting mechanism (to include the external reporting entity – John Howard Association) and contact information for Just Detention International (national victim advocacy organization). It should be noted the PREA Reporting Posters were put up at the facility the day before/day of

	the on-site portion of the audit. Additionally, the information for victim advocacy services observed (JDI) differed from the information provided in the Handbook (Prairie Center Against Sexual Assault). The auditor was unable to test the process for emotional support services. The facility had only recently (day of audit) posted information on an organization to contact related to emotional support services (Just Detention International). It should be noted that when information is provided, residents have access to cellphones to contact the organizations. Additionally, they would be able to mail any correspondence outside the facility. Interviews with 20 residents indicated that one was aware of outside victim advocacy services and six were provided a telephone number and mailing address to a local, state and/or national rape crisis center. None of the residents were aware of specific information related to the victim advocacy organization. 115.253 (b): The PAQ indicated that the facility informs residents, prior to giving them access to outside support services, the extent to which such communications will be monitored. It further stated that the facility informs residents, prior to giving them access to outside support services, of the mandatory reporting rules governing privacy, confidentiality, and/or privilege that apply to disclosures of sexual abuse made to outside victim advocates, including any limits to confidentiality under relevant federal, state, or local law. The facility provided documentation indicating that they have worked with the Illinois Coalition Against Sexual Assault (ICASA) to reach out to the local rape crisis centers to provide services under this provision. The Director and PC both reached out to the organization identified by ICASA (YWCA Chicago). Documentation was providing confirming they sent written correspondence to the contact person provided by ICASA, as well as called the numbers listed on the website, including the hotline. The attempts did not yield return communication. It should be noted the auditor also attempted to contact this organization as well as a second organization related to the services under this provision. YWCA had not responded at the issuance of the interim report. Resilience provided feedback related to questions about the MOU, but did not respond related to whether they would provide services for the organization if requested (i.e. entering into an MOU). A review of the PREA Reporting Poster confirmed that residents are provided the telephone number and mailing address to Just Detention International. The PREA Poster advises residents that they can contact victim advocates for emotional support services by writing to JDI or contacting specific staff for additional information. The PREA Reporting Poster further states that calls from the resident phone may be monitored or recorded and that allegations provided to victim advocates may be forwarded to authorities in accordance with mandatory reporting laws. The Handbook (page 82) includes the address and phone number for Prairie Center Against Sexual Assault and advises that individuals may contact victim advocates for emotional support services and additional information on the services can be obtained through the Counselor, Mental Health and PCM. The Handbook did not outline how calls and mail to the victim advocacy organization are treated. The auditor observed PREA information posted throughout the facility via PREA Posters and PREA Reporting Posters. PREA

	Posters were observed on legal size paper in English and Spanish in each resident room, in the laundry rooms near the phones, in the dayrooms and across numerous common areas. The PREA Reporting Posters included information on the zero tolerance policy, reporting mechanism (to include the external reporting entity – John Howard Association) and contact information for Just Detention International (national victim advocacy organization). It should be noted the PREA Reporting Posters were put up at the facility the day before/day of the on-site portion of the audit. Additionally, the information for victim advocacy services observed (JDI) differed from the information provided in the Handbook (Prairie Center Against Sexual Assault). During the tour the auditor observed the resident mail process. Residents can place outgoing mail in any of the U.S. mailboxes when outside the facility or they can place it in the outgoing mailbox within the facility. Outgoing mail placed in the facility mailbox is unsealed and staff review the outgoing mail for unauthorized information/documents. Outgoing legal mail is placed in the outgoing mailbox sealed and staff do not open or review legal mail. Legal mail is given to the counselor who ensures there is not any contraband in it prior to sealing it. The counselor does not read or scan the legal mail. Incoming mail is received by facility staff who open it, scan it and search it. The original is provided to the resident. Legal mail is provided to the counselor. Residents open legal mail in front of the counselor to ensure there is not any contraband. The mail room staff member stated that mail to the victim advocacy organization is treated like regular mail. Interviews with 20 residents indicated that one was aware of outside victim advocacy services and six were provided a telephone number and mailing address to a local, state and/or national rape crisis center. None of the residents were aware of specific information related to the victim advocacy organization. 115.253 (c): The PAQ indicated that the facility does not maintain a memorandum of understanding or other agreement with a community service provider that is able to provide residents with emotional support services related to sexual abuse. The PAQ indicated the facility maintains documentation of their attempts to enter into an MOU. The facility provided documentation indicating that they have worked with the Illinois Coalition Against Sexual Assault (ICASA) to reach out to the local rape crisis centers to provide services under this provision. The Director and PC both reached out to the organization identified by ICASA (YWCA Chicago). Documentation was providing confirming they sent written correspondence to the contact person provided by ICASA, as well as called the numbers listed on the website, including the hotline. The attempts did not yield return communication. It should be noted the auditor also attempted to contact this organization as well as a second organization related to the services under this provision. YWCA had not responded at the issuance of the interim report. Resilience provided feedback related to questions about the MOU, but did not respond related to whether they would provide services for the organization if requested (i.e. entering into an MOU). Based on a review of the PAQ, victim advocacy attempts, the PREA Poster, the

	Handbook, observations made during the tour and interviews with random residents, this standard appears to require corrective action. The contact information provided on the PREA Reporting Poster and in the Handbook were not consistent. Two different organizations were noted. It should be noted the PREA Reporting Posters were put up at the facility the day before/day of the on-site portion of the audit. Interviews with 20 residents indicated that one was aware of outside victim advocacy services and six were provided a telephone number and mailing address to a local, state and/or national rape crisis center. None of the residents were aware of specific information related to the victim advocacy organization. The Handbook and the PREA Reporting Posters did not outline how mail to the victim advocacy organization is treated. The mail room staff member stated that mail to the victim advocacy organization is treated like regular mail. Corrective Action The facility will need to update their Handbook with consistent victim advocacy contact information (JDI). The Handbook should also include how mail to this organization is treated. A copy of the updated Handbook will need to be provided. This information will also need to be provided to the residents. Confirmation of this will need to be provided to the auditor. The facility will need to train mailroom staff on how mail to and from the victim advocacy organization is treated. Confirmation of the training will need to be provided. Further, the facility will need to provide photos during the corrective action period confirming that PREA Reporting Posters are still posted throughout the facility. Verification of Corrective Action Since the Interim Audit Report The auditor gathered and analyzed the following additional evidence provided by the facility during the corrective action period relevant to the requirements in this standard. Additional Documents: 1. Training Memorandum 2. Updated Handbook 3. Photos of Posted Information

	A training memo was provided that outlined how mail to and from JDI is treated (like privileged mail). Mailroom staff signed the training memo confirming they understood the information. The facility provided the updated Handbook which included contact information for JDI, how to contact them and level of confidentiality of contact. Photos of the training memo posted around the facility were provided to confirm the residents were advised of how mail to and from JDI would be treated. Additionally, photos were provided confirming the PREA Posters and PREA Reporting Posters were up around the facility. Based on the documentation provided the facility has corrected this standard and as such appears to be compliant.

115.254	**Third party reporting**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. Pre-Audit Questionnaire 2. PREA Sexual Abuse and Harassment Prevention and Intervention Program Manual (PREA Manual) 3. PREA Poster 4. Photos of PREA Posters in Visitation Findings (By Provision): 115.254 (a): The PAQ indicated that the agency has a method to receive third-party reports of sexual abuse and sexual harassment and the agency publicly distributes that information on how to report sexual abuse and sexual harassment on behalf of a resident. The PREA Manual, page 32 states that the Department shall post publicly, and maintain, the third-party reporting avenue on its public website. A

	review of the agency's website confirms that there is information on how to report sexual abuse and/or staff sexual misconduct. Individuals can call the IDOC Headquarters number (217-558-4013) and leave a message. Additionally, the PREA Posters state that individuals can write to the IDOC PREA Coordinator and/or to the John Howard Association. Third party reporting information was observed in visitation and the front entrance via the PREA Posters. The PREA Posters were in English and Spanish on legal size paper. The auditor observed the Spanish PREA Poster in visitation was blocked by a vending machine. During the interim report period the facility relocated the Spanish PREA Poster and provided photos confirming it was visible. The auditor tested the third party reporting mechanism on January 22, 2023. The auditor called the PREA hotline as outlined on the agency website. The hotline is the same hotline utilized for the resident population. The auditor received confirmation from the PREA Coordinator on January 23, 2023 that the message was received and forwarded to him to handle. He indicated he would provide the information to the facility for investigation if it was a report of sexual abuse or sexual harassment. Based on a review of the PAQ, the PREA Manual, the PREA Poster, photos of the PREA Posters in visitation, the functional test and the agency's website this standard appears to be compliant.

115.261	**Staff and agency reporting duties**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. Pre-Audit Questionnaire 2. Administrative Directive 04.01.301 Sexual Abuse and Harassment Prevention and Intervention Program 3. Administrative Directive 01.12.105 Reporting of Unusual Incidents 4. PREA Sexual Abuse and Harassment Prevention and Intervention Program Manual (PREA Manual) Interviews: 1. Interviews with Random Staff 2. Interview with the Director

	3. Interview with the PREA Coordinator Findings (By Provision): 115.261 (a): The PAQ indicated that the agency requires all staff to report immediately and according to agency policy any knowledge, suspicion, or information they receive regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency; any retaliation against residents or staff who reported such an incident; and/or any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. 04.01.301, page 8 states that any verbal report or observance of sexual activity shall be treated as possible sexual abuse. Any report or observance of sexual abuse or harassment shall be documented on an Incident Report, DOC 0434, and reported to the facility PCM in accordance with Paragraph II.G.6. All reports shall be investigated accordingly. Page 10 (Paragraph II.G.6) states that any alleged sexual abuse or harassment shall be reported through chain of command as an unusual incident in accordance with 01.12.105. All staff who observe the alleged abuse or harassment or to whom the initial report was made shall complete a DOC 0434 and may be required to be interviewed by an investigator or other staff designated by the Chief Administrative Officer prior to leaving the facility at the end of their shift. Interviews with twelve staff confirmed that policy requires that they report any knowledge, suspicion or information regarding an incident of sexual abuse and sexual harassment, any retaliation related to reporting sexual abuse and/or information related to any staff neglect or violation of responsibilities that contributed to the sexual abuse or retaliation. Staff stated they report the information to the supervisor or the Chief. 115.261 (b): The PAQ indicated that apart from reporting to designated supervisors or officials and designated state or local services agencies, agency policy prohibits staff from revealing any information related to a sexual abuse report to anyone other than to the extent necessary to make treatment, investigation, and other security and management decisions. 04.01.301, page 8 states that any verbal report or observance of sexual activity shall be treated as possible sexual abuse. Any report or observance of sexual abuse or harassment shall be documented on an Incident Report, DOC 0434, and reported to the facility PCM in accordance with Paragraph II.G.6. All reports shall be investigated accordingly. Page 10 (Paragraph II.G.6) states that any alleged sexual abuse or harassment shall be reported through chain of command as an unusual incident in accordance with 01.12.105. All staff who observe the alleged abuse or harassment or to whom the initial report was made shall complete a DOC 0434 and may be required to be interviewed by an investigator or other staff designated by the Chief Administrative Officer prior to leaving the facility at the end of their shift. The PREA Manual, page 32 further states that the information concerning the identity of the alleged offender victim and the

	specific facts of the case shall be limited to staff who need to know because of their involvement with the victim's welfare and the investigation of the incident. This is important to not only preserve the victim's privacy but to preserve maximum flexibility to investigate the allegation. Interviews with twelve staff confirmed that policy requires that they report any knowledge, suspicion or information regarding an incident of sexual abuse and sexual harassment, any retaliation related to reporting sexual abuse and/or information related to any staff neglect or violation of responsibilities that contributed to the sexual abuse or retaliation. Staff stated they report the information to the supervisor or the Chief. 115.261 (c): The facility does not employ medical or mental health care staff and as such no interviews were conducted. 115.261 (d): The interview with the PREA Coordinator indicated that while State law (730 ILCS 5/5-8-6) specifically prohibits anyone under the age of eighteen to be confined to the Illinois Department of Corrections; if an allegation was made regarding a youth (such as a minor child visiting an individual in custody housed at the facility), the Illinois State Police and/or the Department of Children & Family Services, as appropriate, would be contacted to notify the agency of the allegation so they may properly investigate. For allegations made by a vulnerable adult in custody, the agency would ensure access to mental health is available for immediate assessment (per PREA protocol) as well as long-term services. Additionally, access to community confidential support services would be available and offered. The Director stated that the facility does not house anyone under eighteen. He indicated any reports by a vulnerable adult would be handled like any other allegation, which would involve reporting up the chain of command, conducting an investigation, making sure the resident is safe and having a mental health assessment completed. 115.261 (e): 04.01.301, page 8 states that any verbal report or observance of sexual activity shall be treated as possible sexual abuse. Any report or observance of sexual abuse or harassment shall be documented on an Incident Report, DOC 0434, and reported to the facility PCM in accordance with Paragraph II.G.6. All reports shall be investigated accordingly. Page 10 (Paragraph II.G.6) states that any alleged sexual abuse or harassment shall be reported through chain of command as an unusual incident in accordance with 01.12.105. All staff who observe the alleged abuse or harassment or to whom the initial report was made shall complete a DOC 0434 and may be required to be interviewed by an investigator or other staff designated by the Chief Administrative Officer prior to leaving the facility at the end of their shift. The interview with the Director indicated that all allegations of sexual abuse and sexual harassment are reported to the IDOC investigator. There were zero allegations reported during the previous two years and as such no documentation was available for review.

	Based on a review of the PAQ, 04.01.301, 01.12.105, the PREA Manual, and information from interviews with random staff, the PREA Coordinator and the Director indicates that this standard appears to be compliant.

115.262	Agency protection duties
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. Pre-Audit Questionnaire 2. Administrative Directive 04.01.301 Sexual Abuse and Harassment Prevention and Intervention Program 3. PREA Sexual Abuse and Harassment Prevention and Intervention Program Manual (PREA Manual) Interviews: 1. Interview with the Agency Head 2. Interview with the Director 3. Interviews with Random Staff Findings (By Provision): 115.262 (a): The PAQ indicated that when the agency or facility learns that a resident is subject to a substantial risk of imminent sexual abuse, it takes immediate action to protect the resident (i.e., it takes some action to assess and implement appropriate protective measures without unreasonable delay). 04.01.301, page 8 states that any offender who alleges to be a victim of sexual abuse shall be immediately provided protection from the alleged abuser and the incident shall be investigated. The PREA Manual, page 33 states that in cases where the alleged perpetrator is another offender, the Shift Supervisor shall be notified immediately. The Shift Supervisor shall ensure appropriate and immediate safeguards to protect the offender are taken. Depending on the severity, safeguards may include monitoring the situation, changing housing assignments, changing

	work assignments, placing the alleged victim and perpetrator in Special Housing, etc. The PREA Manual further states that if the alleged perpetrator is a staff member, all options for safeguarding the offender shall be considered as described above. Options may include reassignment to another unit or post, or other measures that will effectively separate the staff member from the offender. The PAQ further stated there were zero instances where the facility learned that a resident was an imminent risk of substantial risk of sexual abuse. The Agency Head stated that the agency has many actions, including removing the individual from harm's way, removing the perpetrator and placing the staff member on administrative leave. He further stated that the risk would be investigated and the individual would be provided medical and mental health services. The interview with the Director indicated that if a resident was deemed at imminent risk of sexual abuse the first and most important thing is the safety of the individual. He stated they could change rooms, change wings within the facility and if that is not enough they can contact IDOC to change facilities. Interviews with random staff indicated that residents at imminent risk of sexual abuse would be moved to another area and/or transferred. Staff indicated they would also contact the supervisor for more direction. Based on a review of the PAQ, 04.01.301, PREA Manual and information from interviews with the Agency Head, Director and random staff indicates that this standard appears to be compliant.

115.263	**Reporting to other confinement facilities**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. Pre-Audit Questionnaire 2. Administrative Directive 04.01.301 Sexual Abuse and Harassment Prevention and Intervention Program 3. PREA Sexual Abuse and Harassment Prevention and Intervention Program Manual (PREA Manual) Interviews: 1. Interview with the Agency Head 2. Interview with the Director

Findings (By Provision):

115.263 (a): The PAQ indicated that the agency has a policy requiring that, upon receiving an allegation that a resident was sexually abused while confined at another facility, the head of the facility must notify the head of the facility or appropriate office of the agency or facility where sexual abuse is alleged to have occurred. 04.01.301, page 9 states that reports of sexual abuse or sexual harassment occurring while an offender was housed within a different jurisdiction, such as a municipal lockup, county jail, or correctional center in another state, shall be documented on a DOC 0434 and reported to the Chief Administrative Officer of the facility that received the allegation the allegation to the Chief Administrative Officer of the agency where the alleged abuse occurred within 72 hours. The PAQ indicated there were zero residents that reported that they were abused while confined at another facility. A review of documentation confirmed there were zero residents who reported sexual abuse that occurred at another facility.

115.263 (b): The PAQ indicated that agency policy requires that the facility head provide such notification as soon as possible, but no later than 72 hours after receiving the allegation. 04.01.301, page 9 states that reports of sexual abuse or sexual harassment occurring while an offender was housed within a different jurisdiction, such as a municipal lockup, county jail, or correctional center in another state, shall be documented on a DOC 0434 and reported to the Chief Administrative Officer of the facility that received the allegation the allegation to the Chief Administrative Officer of the agency where the alleged abuse occurred within 72 hours.

115.263 (c): The PAQ indicated that the agency or facility documents that it has provided such notification within 72 hours of receiving the allegation. 04.01.301, page 9 states that reports of sexual abuse or sexual harassment occurring while an offender was housed within a different jurisdiction, such as a municipal lockup, county jail, or correctional center in another state, shall be documented on a DOC 0434 and reported to the Chief Administrative Officer of the facility that received the allegation the allegation to the Chief Administrative Officer of the agency where the alleged abuse occurred within 72 hours.

115.263 (d): The PAQ indicated that the agency or facility policy requires that allegations received from other facilities and agencies are investigated in accordance with the PREA standards. 04.01.301, page 9 states reports of sexual abuse or harassment occurring while an individual in custody was housed at a

	different facility shall be reported to the CAO of the facility where the incident occurred as soon as possible, but not later than 72 hours after the initial report was received. The CAO that receives such notification shall ensure the allegation is investigated in accordance with the procedures herein. The PREA Manual, pages 33-34 state that in cases where there is an allegation that sexual abuse occurred at another Department facility, the Chief Administrative Officer of the victim's current facility shall report the allegation to the Chief Administrative of the identified facility. In cases alleging sexual abuse by staff at another facility, the Chief Administrative Officer of the offender's current facility shall refer the matter directly to Internal Affairs. The PAQ stated there were zero allegations reported to them from another facility in the previous twelve months. The Agency Head stated that when notified by another agency of an allegation within an IDOC facility, the point of contact is the PC. He stated the PC would then forward it to the appropriate facility to investigate. The Agency Head indicated that the agency/facility would reach out to the other agency to obtain any follow-up information. He confirmed that they had a recent example from South Dakota and that it was forwarded from the PC to the facility for investigation. The interview with the Director indicated that if an allegation is received from another facility it would be treated like a fresh incident. An incident report would be completed and it would be sent to the IDOC investigator for investigation. There were zero allegations reported during the previous two years and as such no documentation was available for review. Based on a review of the PAQ, 04.01.301, the PREA Manual, and interviews with the Agency Head and Director, this standard appears to be compliant.

115.264	**Staff first responder duties**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. Pre-Audit Questionnaire 2. Administrative Directive 04.01.301 Sexual Abuse and Harassment Prevention and Intervention Program 3. PREA Checklist Interviews: 1. Interviews with First Responders

	2. Interviews with Random Staff Findings (By Provision): 115.264 (a): The PAQ indicated that the agency has a first responder policy for allegations of sexual abuse and that the policy requires that, upon learning of an allegation that a resident was sexually abused, the first security staff member to respond to the report to separate the alleged victim and abuser. It further states that the policy requires that, upon learning of an allegation that a resident was sexually abused, the first security staff member to respond to the report to preserve and protect any crime scene until appropriate steps can be taken to collect any evidence and if the abuse occurred within a time period that still allows for the collection of physical evidence, the first security staff member to respond to the report request that the alleged victim and ensure that the alleged perpetrator not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating. 04.01.301, page 8 states that any offender who alleges to be a victim of sexual abuse shall be immediately provided protection from the alleged abuser and the incident shall be investigated. The victim shall be referred to health services for examination, treatment and evidence collection in accordance with Paragraph II.G.5 and be evaluated by mental health or a crisis intervention team member within 24 hours to assess the need for counseling services. Policy further states that staff responding to any allegation of sexual abuse shall take steps to ensure preservation of the area in which the alleged abuse occurred, including requesting the alleged victim and abuser not to take any action that. may destroy physical evidence, including changing clothes, bathing, brushing teeth, urinating, defecating drinking or eating, etc. The PREA Checklist also provides staff with a checklist of duties to ensure is completed post sexual abuse allegation. The PREA Checklist includes the required first responder duties. The PAQ indicated there were zero sexual abuse allegations reported and as such no first responder duties were required. The security first responder stated first responder duties include removing the person from the area, reporting the information, generating an incident report, making sure the victim gets medical and mental health attention and ensuring the victim gets whatever else he needs. The non-security first responder stated first responder duties include notifying security staff of the incident/allegation. There were zero residents who reported sexual abuse at the facility during the on-site portion of the audit and as such no interviews were conducted. There were zero allegations reported during the previous two years and as such no documentation was available for review. 115.264 (b): The PAQ indicated that agency policy requires that if the first staff responder is not a security staff member, that responder shall be required to request that the alleged victim not take any actions that could destroy physical

	evidence. It further indicated that agency policy requires that if the first staff responder is not a security staff member, that responder shall be required to notify security staff. 04.01.301, page 8 states that a member of the security staff shall be promptly notified if the staff responding is other than security staff. The PREA Checklist also provides staff with a checklist of duties to ensure is completed post sexual abuse allegation. The PREA Checklist includes the required first responder duties. The PAQ indicated there were zero allegations of sexual abuse reported during the previous twelve months. The security first responder stated first responder duties include removing the person from the area, reporting the information, generating an incident report, making sure the victim gets medical and mental health attention and ensuring the victim gets whatever else he needs. The non-security first responder stated first responder duties include notifying security staff of the incident/allegation. Interviews with random staff indicated they were unaware of first responder duties. Staff advised that they would contact their supervisor to handle the situation and provide direction. There were zero allegations reported during the previous two years and as such no documentation was available for review. Based on a review of the PAQ, 04.01.301, the PREA Checklist and interviews with random staff and first responders, this standard appears to require corrective action. The security first responder stated first responder duties include removing the person from the area, reporting the information, generating an incident report, making sure the victim gets medical and mental health attention and ensuring the victim gets whatever else he needs. The non-security first responder stated first responder duties include notifying security staff of the incident/allegation. Interviews with random staff indicated they were unaware of first responder duties. Staff advised that they would contact their supervisor to handle the situation and provide direction. Corrective Action The facility will need to provide all staff (security and non-security) with training on first responder duties. All staff should be knowledgeable on the steps to take if an allegation is reported or an incident occurs. Confirmation of the training will need to be provided to the auditor. Recommendation The auditor highly recommends that the facility conduct mock sexual abuse drills once a year on all shifts in order to keep staff knowledgeable (due to limited number

	of allegations/incidents at the facility). Verification of Corrective Action Since the Interim Audit Report The auditor gathered and analyzed the following additional evidence provided by the facility during the corrective action period relevant to the requirements in this standard. Additional Documents: 1. Staff Training The facility provided training documentation confirming staff were trained on security and non-security first responder duties. Staff signatures confirmed they received and understood the refresher training. Based on the documentation provided the facility has corrected this standard and as such appears to be compliant.

115.265	**Coordinated response**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. Pre-Audit Questionnaire 2. Administrative Directive 04.01.301 Sexual Abuse and Harassment Prevention and Intervention Program 3. North Lawndale Adult Transition Center Directive (ID) 04.01.301 Sexual Abuse and Harassment Prevention and Intervention Program Interviews: 1. Interview with the Director

	Findings (By Provision): 115.265 (a): The PAQ indicated that the facility has developed a written institutional plan to coordinate actions taken in response to an incident of sexual abuse among staff first responders, medical and mental health practitioners, investigators, and facility leadership. ID 04.01.301, pages 7-13 outline the steps that need to be taken in response to an allegation of sexual abuse. Page 7-8 outlines first responder duties, while pages 9-10 describes medical and mental health duties. Pages 10-12 describe the investigators duties and pages 12-13 discuss facility leadership duties. The Director confirmed that the facility has a plan to coordinate actions among first responder, medical, mental health, investigator and facility leadership in response to a sexual abuse allegation. He stated it is more on paper since they have not had to put it into practice. Based on a review of the PAQ, ID 04.01.301 and information from the interview with the Director, this standard appears to be compliant.

115.266	**Preservation of ability to protect residents from contact with abusers**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. Pre-Audit Questionnaire 2. Collective Bargaining Agreements Interviews: 1. Interview with the Agency Head Findings (By Provision): 115.266 (a): The PAQ indicated that the agency, facility, or any other governmental

	entity responsible for collective bargaining on the agency's behalf has entered into or renewed any collective bargaining agreement or other agreement since August 20, 2012, or since the last PREA audit, whichever is later. Further communication with the PC indicated that IDOC has collective bargaining agreements, however Safer Foundations does not have collective bargaining agreements. A review of a sample of IDOC's collective bargaining agreements confirm that those reviewed allowed for the removal of the alleged staff abuser. Most of the agreements indicated that a written reason for the removal, discipline or termination should be provided to the union. The interview with the Agency Head confirmed that the agency (IDOC) has entered into or renewed any collective bargaining agreements or other agreements since August 20, 2012. He stated that depending on the severity, the agreements allow staff to be removed from contact and/or placed on administrative leave. 115.266 (b): The auditor is not required to audit this provision. Based on a review of the PAQ, a sample of IDOC collective bargaining agreements and the interview with the Agency Head, this standard appears to be compliant.

115.267	**Agency protection against retaliation**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. Pre-Audit Questionnaire 2. Administrative Directive 04.01.301 Sexual Abuse and Harassment Prevention and Intervention Program 3. PREA Retaliation Monitor – Staff (DOC 0499) 4. PREA Retaliation Monitor – Offender (DOC 0498) Interviews: 1. Interview with the Agency Head 2. Interview with the Director 3. Interview with Designated Staff Member Charged with Monitoring Retaliation

	Findings (By Provision): 115.267 (a): The PAQ indicated that the agency has 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. 04.01.301, pages 11-12 state that for a minimum of 90 days following the initial report of sexual abuse or harassment, the Department shall monitor the conduct and treatment of offenders or staff who reported the sexual abuse and of offenders who were reported to have suffered sexual abuse to observe if there are changes that may suggest possible retaliation by offenders or staff. Policy further states that the Department shall act promptly to remedy any such retaliation. The PAQ indicated that the agency designates staff members charged with monitoring for retaliation. 115.267 (b): 04.01.301, pages 11-12 state that for a minimum of 90 days following the initial report of sexual abuse or harassment, the Department shall monitor the conduct and treatment of offenders or staff who reported the sexual abuse and of offenders who were reported to have suffered sexual abuse to observe if there are changes that may suggest possible retaliation by offenders or staff. Offender conduct and treatment shall be documented on the PREA Retaliation Monitor – Offender, DOC 0498. The review shall include, but not be limited to, disciplinary reports, housing or programming changes and facility transfers and include periodic in-person status checks to ensure they display no changes that may suggest retaliation. Staff conduct and treatment shall be documented on the PREA Retaliation Monitor – Staff, DOC 0499. The review shall include, but not be limited to, negative performance reviews and reassignments. Interviews with the Agency Head, Director and staff responsible for monitoring retaliation all indicated that protective measures would be taken if residents or staff members expressed fear of retaliation. The Agency Head stated that the agency has options to protect individual, including transferring an individual to another facility, removing the abuser from contact with the individual and moving staff to another post or facility. The Director stated that the first action they take to protect individuals from retaliation is making sure the resident does not have any more contact with the other individual. He stated they are limited in terms of movement but they can move rooms and wings. He confirmed they can contact IDOC for facility transfers as well. The Director confirmed they can take corrective action with staff, including removal of the staff member. He indicated they advise the individual to report any retaliation so that they can take action. The staff responsible for monitoring stated the role she plays is to make sure the resident or staff is safe and able to report any possible retaliation. She indicated they can take protective actions such as moving staff to a different shift or moving them from contact with all residents, housing changes for residents, transfer to the other Adult Transition Center and offering

	emotional support services. There were no residents who reported sexual abuse during the on-site portion of the audit and as such no interviews were completed. There were zero residents who reported sexual abuse during the on-site portion of the audit and as such no interviews were completed. 115.267 (c): The PAQ indicated that the agency/facility monitors the conduct or treatment of residents or staff who reported sexual abuse and of residents who were reported to have suffered sexual abuse to see if there are any changes that may suggest possible retaliation by residents or staff. The PAQ stated that the agency/ facility monitors the conduct or treatment for 90 days. The PAQ further stated that the agency/facility acts promptly to remedy any relation and that the agency/facility continues such monitoring beyond 90 days if the initial monitoring indicates a continuing need. 04.01.301, pages 11-12 state that for a minimum of 90 days following the initial report of sexual abuse or harassment, the Department shall monitor the conduct and treatment of offenders or staff who reported the sexual abuse and of offenders who were reported to have suffered sexual abuse to observe if there are changes that may suggest possible retaliation by offenders or staff. Offender conduct and treatment shall be documented on the PREA Retaliation Monitor – Offender, DOC 0498. The review shall include, but not be limited to, disciplinary reports, housing or programming changes and facility transfers and include periodic in-person status checks to ensure they display no changes that may suggest retaliation. Policy further states that the Department shall act promptly to remedy any such retaliation. The PAQ indicated there were zero incidents of retaliation reported. The interview with the Director indicated if retaliation is suspected they have two tracks they take. First they contact IDOC to report the retaliation and to have an investigation initiated. For residents they may transfer one of the residents to the other Adult Transition Center. For staff and residents they would follow the disciplinary track for appropriate discipline. He indicated they review all option and make sure the individual being retaliated against is safe and comfortable. The interview with the staff member responsible for monitoring retaliation indicated that she conducts monitoring until the issue is resolved. She stated it is typically three to four days of monitoring from when the issue was reported. She indicated they try to “nip it in the bud” quickly. The staff further stated that when she monitors for retaliation she observes everything to see if there is anything that has changed. She stated she also asks them if there is anything they want to tell her. There were zero residents who reported sexual abuse during the on-site portion of the audit and as such no interviews were completed. 115.267 (d): 04.01.301, pages 11-12 state that for a minimum of 90 days following the initial report of sexual abuse or harassment, the Department shall monitor the conduct and treatment of offenders or staff who reported the sexual abuse and of offenders who were reported to have suffered sexual abuse to observe if there are changes that may suggest possible retaliation by offenders or staff. Offender conduct and treatment shall be documented on the PREA Retaliation Monitor –

	Offender, DOC 0498. The review shall include, but not be limited to, disciplinary reports, housing or programming changes and facility transfers and include periodic in-person status checks to ensure they display no changes that may suggest retaliation. The interview with the staff member responsible for monitoring retaliation confirmed she would conduct periodic status checks. She stated she is at the facility twelve hours a day and the days she is there she checks on them. She advised she also advises other supervisor to check on the individual as well. There were zero residents who reported sexual abuse during the on-site portion of the audit and as such no interviews were completed. 115.267 (e): 04.01.301, page 12 states that if any other individual who cooperates with an investigation expresses a fear of retaliation, the Department shall take appropriate measures to protect the individuals against retaliation. The Agency Head stated that the same protective measures would be offered to those who cooperate with an investigation or express fear for retaliation. The Director stated that the first action they take to protect individuals from retaliation is making sure the resident does not have any more contact with the other individual. He stated they are limited in terms of movement but they can move rooms and wings. He confirmed they can contact IDOC for facility transfers as well. The Director confirmed they can take corrective action with staff, including removal of the staff member. He indicated they advise the individual to report any retaliation so that they can take action. The Director indicated if retaliation is suspected they have two tracks they take. First they contact IDOC to report the retaliation and to have an investigation initiated. For residents they may transfer one of the residents to the other Adult Transition Center. For staff and residents they would follow the disciplinary track for appropriate discipline. He indicated they review all option and make sure the individual being retaliated against is safe and comfortable. 115.267 (f): Auditor not required to audit this provision. Based on a review of the PAQ, 04.01.301, DOC 0498, and interviews with the Agency Head, Director and staff charged with monitoring for retaliation, this standard appears to require corrective action. The interview with the staff member responsible for monitoring retaliation indicated that she conducts monitoring until the issue is resolved. She stated it is typically three to four days of monitoring from when the issue was reported. She indicated they try to “nip it in the bud” quickly. The staff further stated that when she monitors for retaliation she observes everything to see if there is anything that has changed. She stated she also asks them if there is anything they want to tell her. The interview with the staff member responsible for monitoring retaliation confirmed she would conduct periodic status checks. She stated she is at the facility twelve hours a day and the days she is there she checks on them. She advised she also advises other supervisor to check on the individual as well.

	Corrective Action The facility will need to train appropriate staff on the process for monitoring for retaliation, including the required checks under provision (d), how often in-person status checks are to be completed and how long monitoring should be (90 days). Confirmation of the training will need to be provided. Further, the facility will need to complete a mock sexual abuse allegation (if none are reported during the corrective action period) including the completed 90 day monitoring for retaliation via the DOC 0498. A copy of the documentation will need to be provided. Verification of Corrective Action Since the Interim Audit Report The auditor gathered and analyzed the following additional evidence provided by the facility during the corrective action period relevant to the requirements in this standard. Additional Documents: 1. Staff Training The facility provided training documentation confirming staff were trained on the monitoring for retaliation process. Staff signatures confirmed they received and understood the refresher training. A mock sexual abuse allegation was initiated to provide additional training on the monitoring for retaliation process. Documentation was provided confirming the monitoring including the 30, 60 and 90 days in-person status checks and the required discipline, housing, work, program and education checks. Based on the documentation provided the facility has corrected this standard and as such appears to be compliant.

115.271	**Criminal and administrative agency investigations**

	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. Pre-Audit Questionnaire 2. Administrative Directive 04.01.301 Sexual Abuse and Harassment Prevention and Intervention Program 3. Administrative Directive 01.12.120 Investigations of Unusual Incidents 4. Administrative Directive 01.12.101 Employee Criminal Misconduct 5. Administrative Directive 01.12.112 Preservation of Physical Evidence 6. Administrative Directive 01.12.125 Uniform Investigative Reporting System 7. Administrative Directive 01.12.115 Institutional Investigative Assignment 8. Memorandum of Understanding with the Illinois State Police/Office of Executive Inspector General 9. Investigator Training Records Interviews: 1. Interviews with Investigative Staff 2. Interview with the Director 3. Interview with the PREA Coordinator Findings (By Provision): 115.271 (a): The PAQ indicated that the agency/facility has a policy related to criminal and administrative agency investigations. 04.01.301, page 10 states that all allegations of sexual abuse or harassment shall be investigated by trained investigators in accordance with 01.12.120. The initial investigative report shall be provided to the Chief Administrative Officer within 24 hours of the onset of the investigation. Policy further states that upon conclusion of the investigation the results shall be forwarded to the Chief of Operations who shall report the incident to the Illinois State Police, where appropriate. 01.12.120, page 1 states the CAO shall ensure that an internal investigation is conducted by facility staff, or by staff assigned by the Chief of Investigations and Intelligence, on each unusual incident

	reported, if it is determined that further facts are required. Page 2 states that the facility investigation shall include, but not be limited to: obtaining statements from all involved individuals; obtaining statements from all known and any possible witnesses; securing and preserving all weapons; securing and preserving any other evidence; determining if all policies and procedures were followed; determining the quality of offender and staff supervision; conferring with local State Attorney to determine if criminal prosecution is warranted and referring individuals to the prosecuting authority for criminal prosecution, when warranted. 01.12.101, 01.12.105, 01.12.115, 01.12.112 and 01.12.125 all outline different elements to the investigative process for the agency. Interviews with the investigators confirmed that an investigation would be initiated immediately after the allegation was received. Both confirmed that anonymous and third party reports would involve the same investigative process as allegations made via other reporting methods. There were zero allegations reported during the previous two years and as such no documentation was available for review. 115.271 (b): 01.12.115, page 2 states that the CAO shall ensure that each individual appointed as an investigator be registered for the next available investigator training program within ten days of temporary or permanent assignment as an investigator. Training topics include but are not limited to: investigative techniques, including interviewing sexual abuse victims; crime scene preservation; collection and preservation of evidence, including sexual abuse evidence collection in a confinement setting; proper use of Miranda and Garrity warnings; criteria and evidence required to substantiate a case for administrative action or prosecution referral; and investigative reporting. The agency utilizes their own training for this standard; PREA for Investigators. A review of the training curriculum confirmed slides 67-118 include the following: techniques for interviewing sexual abuse victims, proper use of Miranda and Garrity warnings, sexual abuse evidence collection in confinement settings and the criteria and evidence required to substantiate an administrative investigation. A review of documentation indicated that the facility utilizes IDOC agency investigators. Both identified IDOC investigators were documented with specialized training. There were zero allegations reported during the previous two years. 115.271 (c): 04.01.301, page 10 states that for reports of sexual abuse, the crime scene shall always be protected and investigators shall collect and tag evidence from the scene in accordance with established procedures. Evidence collected shall be submitted to the State Police within ten business days of receipt. 01.12.120, page 1 states the CAO shall ensure that an internal investigation is conducted by facility staff, or by staff assigned by the Chief of Investigations and Intelligence, on each unusual incident reported, if it is determined that further facts are required. Page 2 states that the facility investigation shall include, but not be limited to: obtaining statements from all involved individuals; obtaining statements from all known and any possible witnesses; securing and preserving all weapons; securing

	and preserving any other evidence; determining if all policies and procedures were followed; determining the quality of offender and staff supervision; conferring with local State Attorney to determine if criminal prosecution is warranted and referring individuals to the prosecuting authority for criminal prosecution, when warranted. 01.12.101, 01.12.105, 01.12.115, 01.12.112 and 01.12.125 all outline different elements to the investigative process for the agency. Interviews with the investigators indicated his first steps would include gathering and preserving all evidence and starting the PREA checklist. The administrative investigator stated he would ensure residents are separated, conduct interviews, collect proper evidence, complete a credibility assessment and tie things together with a conclusion. The criminal investigator stated investigations into allegations of sexual abuse and sexual harassment, are done promptly, thoroughly, and objectively for all allegations. He indicated that he would gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data; he would interview the alleged victim, suspected perpetrators, and witnesses; and he would review prior complaints and reports of sexual abuse involving the suspected perpetrator. The criminal investigator stated that he would collect direct and circumstantial evidence including those indicated above. The administrative investigator stated he would collect evidence such as physical, video, interviews and credibility assessments. There were zero allegations reported during the previous two years and as such no documentation was available for review. 115.271 (d): The investigators confirmed that when they discovers that a prosecutable crime may have taken place they may consults with prosecutors before conducting any compelled interviews. The administrative investigation advised they are not required to consult with prosecutors. There were zero allegations reported during the previous two years and as such no documentation was available for review. 115.271 (e): 04.01.301, page 10 states that alleged victims of sexual abuse shall not be required to submit to truth telling verification examinations such as voice stress analysis or polygraph exam as part of or as a condition of the investigation. Interviews with the investigators confirmed they would never, under any circumstance, require a resident victim of sexual abuse to submit to a polygraph tests or any other truth-telling devices as a condition for proceeding with the investigation. The administrative investigator stated credibility is based on the credibility assessment. The criminal investigator further stated that credibility of a victim, suspect and/or witness would be assessed on an individual basis and it is not determined based on the person’s status. There were zero residents who reported sexual abuse during the on-site portion of the audit and as such no interviews were completed.

	115.271 (f): 01.12.120, page 3 states that the supervisor of the internal investigation team shall submit an initial report, verbal or written, to the CAO within 48 hours of the incident and shall submit a final written report utilizing the Report of Investigation, DOC 0262, within ten working day from the conclusion of the investigation. Interviews with investigative staff confirmed that all administrative investigations are documented in a written report via the DOC 0262 and would include a description of physical evidence and interview evidence as well as facts and finding ascertained during the investigative process. The administrative investigator stated that staff actions or failure to act are documented in the conclusion of the investigation. They review evidence to ensure staff followed policy and procedure. The criminal investigators further stated that during the investigation he would review logbooks, video and interview statements to determine if staff actions or failure to act contributed to the sexual abuse. There were zero allegations reported during the previous two years and as such no documentation was available for review. 115.271 (g): 01.12.120, page 3 states that the supervisor of the internal investigation team shall submit an initial report, verbal or written, to the CAO within 48 hours of the incident and shall submit a final written report utilizing the Report of Investigation, DOC 0262, within ten working day from the conclusion of the investigation. Interviews with investigative staff confirmed that all criminal investigations are documented in a written report via the DOC 0262 and would include a description of physical evidence and interview evidence as well as facts and finding ascertained during the investigative process. The criminal investigators stated investigations include attachments such as statements, video, audio, physical evidence, tec. There were zero allegations reported during the previous two years and as such no documentation was available for review. 115.271 (h): The PAQ indicated that substantiated allegations of conduct that appear to be criminal are referred for prosecution. 04.01.301, page 11 states that upon conclusion of the investigation, if applicable, the case shall be reviewed with the appropriate State’s Attorney for possible referral for prosecution. The PAQ indicated there were zero allegations referred for prosecution since the last PREA audit. Interviews with investigators indicated that substantiated allegations that appear to be criminal are referred for prosecution. There were zero allegations reported during the previous two years and as such no documentation was available for review. 115.271 (i): The PAQ indicated that the agency retains all written reports pertaining to the administrative or criminal investigation of alleged sexual abuse or sexual harassment for as long as the alleged abuser is incarcerated or employed by the agency, plus five years. A review of a sample of historic investigations confirmed retention is being met.

	115.271 (j): Interviews with the investigators confirmed that the investigation would proceed regardless of whether the staff member terminates employment and/or the resident leaves the facility prior to the completed investigation. Investigators stated the individual leaving has no bearing and the investigation would proceed accordingly. 115.271 (k): The auditor is not required to audit this standard. 115.271 (l): 04.01.301 states that upon conclusion of the investigation the results shall be forwarded to the Chief of Operations who shall report the incident to the Illinois State Police, where appropriate. Additionally, the MOU with the Illinois State Police (signed in 2019) indicates that they conduct investigations related to sexual assault involving staff-on-staff and staff-on-resident. The PREA Coordinator stated that the facility Internal Affairs offices and IDOC's Office of Investigations & Intelligence have a very close relationship with the Illinois State Police and that information is communicated through these avenues. The Director stated that they remained informed of the progress of investigations through IDOC investigators. He stated the IDOC investigator will usually communicate with him or the Chief of Security and they get a final report at the conclusion of the investigation. Interviews with investigative staff indicated that they would serve as a liaison if ISP conducts an investigation. Based on a review of the PAQ, 04.01.310, 01.12.101, 01.12.112, 01.12.115, 01.12.120, 01.12.125, the MOU with the State Police, investigative training records and information from interviews with the PREA Coordinator, Director and investigative staff indicate that this standard appears to be compliant.

115.272	**Evidentiary standard for administrative investigations**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. Pre-Audit Questionnaire 2. Administrative Directive 04.01.301 Sexual Abuse and Harassment Prevention

	and Intervention Program 3. Prison Rape Elimination Act (PREA) for Investigators Training Curriculum Interviews: 1. Interviews with Investigative Staff Findings (By Provision): 115.272 (a): The PAQ indicated that the agency imposes a standard of a preponderance of the evidence or a lower standard of proof when determining whether allegations of sexual abuse or sexual harassment are substantiated. 04.01.301, page 10 states that the Department shall impose no standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated. Additionally, the PREA for Investigators Training Curriculum includes information on the elements to substantiate an investigation (preponderance of evidence). Interviews with investigators indicated that the standard required to substantiate an administrative investigation is a preponderance of the evidence. There were zero allegations reported during the previous two years and as such no documentation was available for review. Based on a review of the PAQ, 04.01.301, PREA Investigators Training Curriculum, and information from the interviews with the investigators, it is determined that this standard appears to be compliant.

115.273	**Reporting to residents**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. Pre-Audit Questionnaire 2. Administrative Directive 04.01.301 Sexual Abuse and Harassment Prevention and Intervention Program 3. PREA Sexual Abuse and Harassment Prevention and Intervention Program

	Manual (PREA Manual) Interviews: 1. Interview with the Director 2. Interviews with Investigative Staff Findings (By Provision): 115.273 (a): The PAQ indicated that the agency has a policy requiring that any resident who makes an allegation that he or she suffered sexual abuse in an agency facility is informed, verbally or in writing, as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded following an investigation by the agency. 04.01.301, page 10 states that the alleged victim will be notified, in writing, of the outcome of the investigation. The PAQ indicated there were zero sexual abuse allegations reported and as such zero notifications were made during the audit period. Interviews with the Director and investigators confirmed that residents are informed of the outcome of the investigation into their allegation. Investigators stated a document is provided to the victim after the investigation is completed. There were zero residents who reported sexual abuse during the on-site portion of the audit and as such no interviews were completed. There were zero allegations reported during the previous two years and as such no documentation was available for review. 115.273 (b): The PAQ indicate that if an outside entity conducts such investigations, the agency requests the relevant information from the investigative entity in order to inform the resident of the outcome of the investigation. The PAQ indicated there were zero sexual abuse allegations reported during the previous twelve months and zero notifications related to outside entity investigations. 04.01.301, page 10 states that the alleged victim will be notified, in writing, of the outcome of the investigation. If an outside law enforcement agency conducts the investigation, relevant information shall be requested from the investigative entity to ensure the alleged victim is informed of the outcome of the investigation. There were zero allegations reported during the previous two years and as such no documentation was available for review. 115.273 (c): The PAQ indicated following an resident's allegation that a staff member has committed sexual abuse against the resident, the agency/facility subsequently informs the resident (unless the agency has determined that the

	allegation is unfounded) whenever: the staff member is no longer posted within the resident's unit; the staff member is no longer employed at the facility; the agency learns that the staff member has been indicted on a charge related to sexual abuse within the facility; or the agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility. Additionally, the PAQ indicated that there has not been a substantiated or unsubstantiated complaint (i.e., not unfounded) of sexual abuse committed by a staff member against a resident in an agency facility in the past 12 months. The PREA Manual, page 40 states that following a resident's allegation that a staff member has committed sexual abuse against the resident, the agency shall subsequently inform the resident (unless the agency has determined that the allegation is unfounded) whenever: the staff member is no longer posted within the resident's unit; the staff member is no longer employed at the facility; the agency learns that the staff member has been indicted on a charge related to sexual abuse within the facility; or the agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility. The PREA Manual further states that an assessment shall be completed to determine if actions described above are warranted in accordance with section 115.65. The actions may not be appropriate in all cases. Offenders shall be notified only if there is a link between the listed actions in this section and an incident of sexual abuse. The timing of such notifications shall not interfere with any pending criminal or administrative investigations. There were zero residents who reported sexual abuse at the facility during the on-site portion of the audit and as such no interviews were completed. There were zero sexual abuse allegations reported against staff in the previous twelve months. 115.273 (d): The PAQ indicated following an resident's allegation that he or she has been sexually abused by another resident in an agency facility, the agency subsequently informs the alleged victim whenever: the agency learns that the alleged abuser has been indicted on a charge related to sexual abuse within the facility; or the agency learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility. The PREA Manual, page 40 states that following a resident's allegation that he or she has been sexually abused by another resident, the agency shall 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; or the agency learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility. There were zero residents who reported sexual abuse at the facility during the on-site portion of the audit and as such no interviews were completed. There were zero resident-on-resident sexual abuse allegation over the previous twelve months and as such no notifications were required under this provision. 115.273 (e): The PAQ indicated the agency has a policy that all notifications to residents described under this standard are documented. 04.01.301, page 10 states that the alleged victim will be notified, in writing, of the outcome of the

	investigation. The PAQ indicated there were zero sexual abuse investigations completed within the previous twelve months and zero notifications. There were zero allegations reported during the previous two years and as such no documentation was available for review. 115.273 (f): This provision is not required to be audited. Based on a review of the PAQ, 04.01.301, the PREA Manual, and information from interviews with the Director and the investigators, this standard appears to be compliant.

115.276	**Disciplinary sanctions for staff**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. Pre-Audit Questionnaire 2. Administrative Directive 04.01.301 Sexual Abuse and Harassment Prevention and Intervention Program 3. Administrative Directive 03.01.120 Employee Review Hearing 4. PREA Sexual Abuse and Harassment Prevention and Intervention Program Manual (PREA Manual) Findings (By Provision): 115.276 (a): The PAQ indicated that staff is subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies04.01.301, page 11 states that all terminations for violating the agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignment, shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and to any relevant licensing bodies. The PREA Manual, page 41 states that staff shall be subject to disciplinary sanctions up to and including termination for violating agency sexual abuse and sexual harassment policies. There were zero allegations reported during the previous two years and as such no documentation was available for review.

	115.276 (b): The PREA Manual, page 41 states termination shall be the presumptive disciplinary sanction for staff who have engaged in sexual abuse. It further states that administrative discipline shall be conducted using the Employee Review Hearing Process and the collective bargaining agreement. Any decision made on the proposal shall be in accordance with all applicable laws, rules and regulations. The PAQ indicated there were zero staff members who violated the sexual abuse or sexual harassment policies in the previous twelve months and zero staff members who was terminated (or resigned prior to termination) for violating the agency's sexual abuse or sexual harassment policies. There were zero allegations reported during the previous two years and as such no documentation was available for review. 115.276 (c): The PAQ indicated that the disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) 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. The PAQ indicated there were zero staff that were disciplined short of termination for violating the sexual abuse or sexual harassment policies. The PREA Manual, page 41 states that disciplinary sanctions for violations of agency policy relating to sexual abuse or sexual harassment shall be 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. 03.01.120 further describes the employee disciplinary review process. There were zero allegations reported during the previous two years and as such no documentation was available for review. 115.276 (d): The PAQ indicated that 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. 04.01.301, page 11 states that all terminations for violating the agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignment, shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and to any relevant licensing bodies. The PAQ indicated there were no staff members who were reported to law enforcement or licensing boards following their termination (or resignation prior to termination) for violating agency sexual or sexual harassment policies. There were zero allegations reported during the previous two years and as such no documentation was available for review. Based on a review of the PAQ, 04.01.301, 03.01.120 and the PREA Manual this

	standard appears to be compliant.

115.277	Corrective action for contractors and volunteers
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. Pre-Audit Questionnaire 2. Administrative Directive 04.01.301 Sexual Abuse and Harassment Prevention and Intervention Program Interviews: 1. Interview with the Director Findings (By Provision): 115.277 (a): The PAQ indicated that agency policy requires that any contractor or volunteer who engages in sexual abuse be reported to law enforcement agencies (unless the activity was clearly not criminal) and to relevant licensing bodies and that any contractor or volunteer who engages in sexual abuse be prohibited from contact with residents04.01.301, page 11 states that any contractor or volunteer who engages in sexual abuse shall be prohibited from contact with offenders and shall be reported to law enforcement agencies unless the activity was clearly not criminal, and to relevant licensing bodies. The PAQ indicated that there have been no contractors or volunteers who violated the sexual abuse or sexual harassment policies within the previous twelve months and as such none were reported to law enforcement or relevant licensing bodies. A review of documentation confirmed there were zero contractors or volunteers who violated the agency’s sexual abuse or sexual harassment policies. 115.277 (b): The PAQ indicated that the facility takes appropriate remedial measures and considers whether to prohibit further contact with residents in the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer. 04.01.301, page 11 states that any contractor or volunteer who engages in sexual abuse shall be prohibited from contact with offenders and shall be reported to law enforcement agencies unless the activity was

	clearly not criminal, and to relevant licensing bodies. The interview with the Director indicated that any violation of the sexual abuse and sexual harassment policies would result in the person being locked out of the facility. He stated further action would be based on the type of allegation. If there was sexual abuse, it would be investigated with possible criminal charges. Based on a review of the PAQ, 04.01.301, and information from the interview with the Director, this standard appears to be compliant.

115.278	**Disciplinary sanctions for residents**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. Pre-Audit Questionnaire 2. Administrative Directive 04.01.301 Sexual Abuse and Harassment Prevention and Intervention Program 3. Illinois Administrative Code 20.504 4. PREA Sexual Abuse and Harassment Prevention and Intervention Program Manual (PREA Manual) Interviews: 1. Interview with the Director Findings (By Provision): 115.278 (a): The PAQ indicated that residents are subject to disciplinary sanctions only pursuant to a formal disciplinary process following an administrative finding and/or a criminal finding that a resident engaged in resident-on-resident sexual abuse. 04.01.301, page 10 states that upon conclusion of the investigation disciplinary reports shall be completed, served and processed, where warranted. 20.504, page 2 states that no offender shall be found guilting of any violation without a hearing before the Adjustment Committee or Program Unit. 20.504 further describes the formal disciplinary process required. The PAQ indicated there were

	zero administrative or criminal finding of guilt for resident-on-resident sexual abuse. A review of documentation confirmed there were zero resident-on-resident sexual abuse allegations reported during the previous twelve months. 115.278 (b): 20.507, pages 2-3 stated that in determining the appropriate sanctions, the Adjustment Committee or Program Unit, the CAO and the Director shall consider, among other matters, mitigating or aggravating factors including; the offenders age, medical and mental health state, if the offender was determined to be mentally ill, the extent and degree of participation in the commission of the offense and the offender's prior disciplinary record. The Director stated that if a resident violates the sexual abuse and sexual harassment policy he would be immediately transferred from the facility. He stated they are a negative three for zero tolerance, meaning they do not tolerate anyone being out of line. All individuals would be sent back to IDOC. The Director confirmed that discipline 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. 115.278 (c): 20.507, pages 2-3 stated that in determining the appropriate sanctions, the Adjustment Committee or Program Unit, the CAO and the Director shall consider, among other matters, mitigating or aggravating factors including; the offenders age, medical and mental health state, if the offender was determined to be mentally ill, the extent and degree of participation in the commission of the offense and the offender's prior disciplinary record. The interview with the Director confirmed that the disciplinary process considers whether the resident's mental disabilities or mental illness contributed to his or her behavior when determining what type of sanction, if any, should be imposed. 115.278 (d): The PAQ indicated the facility offers therapy, counseling, or other interventions designed to address and correct the underlying reasons or motivations for abuse and they consider whether to require the resident to participate in order to gain access to other programs and privileges. Further communication with the PC indicated the facility does not offer therapy, counseling or other interventions designed to address and correct the underlying reasons or motivations for abuse. It further stated that sex offender treatment is only offered at Big Muddy River Correctional Center and Taylorville Correctional Center. The facility does not have medical or mental health care staff. All services are provided in the community. As such, no interviews were conducted. 115.278 (e): The PAQ indicated that the agency disciplines residents for sexual conduct with staff only upon finding that the staff member did not consent to such

	contact. 115.278 (f): The PAQ indicated that the agency prohibits disciplinary action for a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred, even if an investigation does not establish evidence sufficient to substantiate the allegation. 04.01.301, page 12 states disciplinary action for a report of sexual abuse made in good faith, based upon a reasonable belief that the alleged conduct occurred, even if an investigation does not establish evidence sufficient to substantiate the allegation, shall be prohibited. The PREA Manual, page 42 states that the maintenance of an effective sexual abuse prevention policy, and general secure and orderly running of a facility, requires that offenders be held responsible for manipulative behavior and intentionally making false allegations. Allegations of false reports shall be considered by staff in accordance with the procedures and standards founds within Illinois Administrative Code 507, Administration of Discipline. 115.278 (g): The PAQ indicated that the agency prohibits all sexual activity between residents. It further indicated that if the agency prohibits all sexual activity between residents and disciplines residents for such activity, the agency deems such activity to constitute sexual abuse only if it determines that the activity is coerced. Based on a review of the PAQ, 04.01.301, 20.507, the PREA Manual, and information from the interview with the Director, this standard appears to be compliant.

115.282	**Access to emergency medical and mental health services**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. Pre-Audit Questionnaire 2. Administrative Directive 04.01.301 Sexual Abuse and Harassment Prevention and Intervention Program Interviews: 1. Interviews with First Responders

Findings (By Provision):

115.282 (a): The PAQ indicated that resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services and that the nature of scope of services are determined by medical and mental health practitioners according to their professional judgment. The PAQ further indicates that medical and mental health staff maintain secondary materials (e.g., form, log) documenting the timeliness of emergency medical treatment and crisis intervention services that were provided; the appropriate response by non-health staff in the event health staff are not present at the time the incident is reported; and the provision of appropriate and timely information and services concerning contraception and sexually transmitted infection prophylaxis. 04.01.301, page 8 states that any offender who alleges to a be a victim of sexual abuse shall be referred to health services for examination, treatment and evidence collection in accordance with Paragraph II.G.5 and shall be evaluated by mental health services or a crisis intervention team member within 24 hours to assess the. need for counseling services. During the tour the auditor confirmed that the facility did not have a medical or mental health area and did not provide medical or mental health services on-site. The facility does not employ medical or mental health care staff and as such no interviews were conducted. There were zero residents who reported sexual abuse at the facility during the on-site portion of the audit and as such no interviews were completed. There were zero allegations reported during the previous two years and as such no documentation was available for review.

115.282 (b): 04.01.301, page 8 states that any offender who alleges to a be a victim of sexual abuse shall be referred to health services for examination, treatment and evidence collection in accordance with Paragraph II.G.5 and shall be evaluated by mental health services or a crisis intervention team member within 24 hours to assess the need for counseling services. Page 9 (Paragraph II.G.5) further states that treatment shall be provided by a certified SAFE or SANE at a local emergency room and that the medical examination provided by Department facilities shall include a general physical examination for recent sexual abuse. The security first responder stated first responder duties include removing the person from the area, reporting the information, generating an incident report, making sure the victim gets medical and mental health attention and ensuring the victim gets whatever else he needs. The non-security first responder stated first responder duties include notifying security staff of the incident/allegation. There were zero allegations reported during the previous two years and as such no documentation was available for review.

115.282 (c): The PAQ indicated that resident victims of sexual abuse while

	incarcerated are 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. 04.01.301, page 9 states that a general physical examination for recent sexual abuse shall include, but not be limited to: a blood test (RPR for Syphilis); culture smears for seminal fluid, Gonorrhea, Chlamydia and other Sexually Transmitted Diseases (STD) as appropriate; Hepatitis C antibody test and Hepatitis B surface antigen and antibody blood test and an HIV test and counseling shall be offered. There were zero residents who reported sexual abuse at the facility during the on-site portion of the audit and as such no interviews were completed. There were zero allegations reported during the previous two years and as such no documentation was available for review. 115.282 (d): The PAQ indicated that treatment services are provided to every victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. 04.01.301, page 9 states that offenders shall not be charged a co-payment for medical treatment, including forensic medical examinations, obtained for alleged sexual abuse. Based on a review of the PAQ, 04.01.301 and information from interviews with the first responders, this standard appears to be complaint.

115.283	**Ongoing medical and mental health care for sexual abuse victims and abusers**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. Pre-Audit Questionnaire 2. Administrative Directive 04.01.301 Sexual Abuse and Harassment Prevention and Intervention Program 3. PREA Sexual Abuse and Harassment Prevention and Intervention Program Manual (PREA Manual) Findings (By Provision):

	115.283 (a): The PAQ indicated the facility offers 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. 04.01.301, page 8 states that any offender who alleges to a be a victim of sexual abuse shall be referred to health services for examination, treatment and evidence collection in accordance with Paragraph II.G.5 and shall be evaluated by mental health services or a crisis intervention team member within 24 hours to assess the need for counseling services. Additionally, 04.01.301, page 6 states that if it is determined that the offender was previously a victim of sexual abuse, the facility PCM shall notify medical and mental health staff within fourteen days of the screening. During the tour the auditor confirmed that the facility did not have a medical or mental health area and did not provide medical or mental health services on-site. There were zero allegations reported during the previous two years and as such no documentation was available for review. 115.283 (b): 04.01.301, page 8 states that any offender who alleges to a be a victim of sexual abuse shall be referred to health services for examination, treatment and evidence collection in accordance with Paragraph II.G.5 and shall be evaluated by mental health services or a crisis intervention team member within 24 hours to assess the need for counseling services. The facility does not employ medical or mental health care staff and as such no interviews were conducted. There were zero residents who reported sexual abuse at the facility during the on-site portion of the audit and as such no interviews were completed. There were zero allegations reported during the previous two years and as such no documentation was available for review. 115.283 (c): The facility provides access to medical and mental health care off-site through local community providers. The facility does not employ medical or mental health care staff and as such no interviews were conducted. 115.283 (d): The PAQ indicated that this provision is not applicable as the facility does not house female residents. 04.10.301, page 10 states female victims of sexual abusive vaginal penetration while incarcerated shall be offered pregnancy tests. If pregnancy results from the sexual abuse, such victims shall receive timely and comprehensive information about and timely access to all lawfully pregnancy-related medical services 115.283 (e): The PAQ indicated that this provision is not applicable as the facility does not house female residents. 04.10.301, page 10 states female victims of sexual abusive vaginal penetration while incarcerated shall be offered pregnancy tests. If pregnancy results from the sexual abuse, such victims shall receive timely

	and comprehensive information about and timely access to all lawfully pregnancy-related medical services. The PREA Manual, page 45 states that if pregnancy results from the conduct described in paragraph (d) of this section (sexually abusive vaginal penetration), such victims shall receive timely and comprehensive information about and timely access to all lawful pregnancy-related medical services. It further states that Department healthcare providers shall deliver comprehensive prenatal counseling and care for pregnant female offenders. 115.283 (f): The PAQ indicated that resident victims of sexual abuse while incarcerated are offered tests for sexually transmitted infections as medically appropriate. 04.01.301, page 9 states that a general physical examination for recent sexual abuse shall include, but not be limited to: a blood test (RPR for Syphilis); culture smears for seminal fluid, Gonorrhea, Chlamydia and other Sexually Transmitted Diseases (STD) as appropriate; Hepatitis C antibody test and Hepatitis B surface antigen and antibody blood test and an HIV test and counseling shall be offered. There were zero residents who reported sexual abuse at the facility during the on-site portion of the audit and as such no interviews were completed. There were zero allegations reported during the previous two years and as such no documentation was available for review. 115.283 (g): The PAQ indicated that treatment services are provided to every victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. 04.01.301, page 9 states that offenders shall not be charged a co-payment for medical treatment, including forensic medical examinations, obtained for alleged sexual abuse. There were zero residents who reported sexual abuse at the facility during the on-site portion of the audit and as such no interviews were completed. There were zero allegations reported during the previous two years and as such no documentation was available for review. 115.283 (h): The PAQ indicated that the facility attempts to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history and offers treatment when deemed appropriate by mental health practitioners. The PAQ indicated that any abusers would be immediately discharged from the program as it would be a violation of their probation. The PREA Manual, page 46 states that all prisons shall attempt to conduct a mental health evaluation of all known inmate-on-inmate abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners. The facility does not employ medical or mental health care staff and as such no interviews were conducted. There were zero resident-on-resident sexual abuse allegations reported during the audit period and as such there were no resident-on-resident abusers.

	Based on a review of the PAQ, 04.01.301 and the PREA Manual indicates this standard appears to be complaint.

115.286	Sexual abuse incident reviews
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. Pre-Audit Questionnaire 2. Administrative Directive 04.01.301 Sexual Abuse and Harassment Prevention and Intervention Program 3. Sexual Abuse Incident Review Form (DOC 0593) Interviews: 1. Interview with the Director 2. Interview with the PREA Coordinator 3. Interview with Incident Review Team Findings (By Provision): 115.286 (a): The PAQ indicated that the facility conducts a sexual abuse incident review at the conclusion of every criminal or administrative sexual abuse investigation, unless the allegation has been determined to be unfounded. 04.01.301, page 11 states that the facility shall conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation, unless the allegation was determined to be unfounded. Such reviews shall ordinarily occur within 30 days of the conclusion of the investigation. The PAQ indicated that there were zero sexual abuse incident reviews completed within the previous twelve months. There were zero allegations reported during the previous two years and as such no documentation was available for review. 115.286 (b): The PAQ indicated that the facility ordinarily conducts a sexual abuse

	incident review within 30 days of the conclusion of the criminal or administrative sexual abuse investigation. It further stated that in the past 12 months there were zero criminal and/or administrative investigations of alleged sexual abuse completed at the facility that were followed by a sexual abuse incident review within 30 days, excluding only “unfounded” incidents. 04.01.301, page 11 states that the facility shall conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation, unless the allegation was determined to be unfounded. Such reviews shall ordinarily occur within 30 days of the conclusion of the investigation. There were zero allegations reported during the previous two years and as such no documentation was available for review. 115.286 (c): The PAQ indicated that the sexual abuse incident review team includes upper-level management officials and allows for input from line supervisors, investigators, and medical or mental health practitioners. 04.01.301, page 11 states that the review team, at minimum, shall include: Assistant Chief Administrative Officer; Shift Commander or Lieutenant; a representative from Internal Affairs; the PCM, a representative from medical and a representative from mental health. The interview with the Director indicated that the facility had a sexual abuse incident review team and that it consists of the Program Manager, Chief of Security, Facility Review Auditor and himself. He advised they do not have medical or mental health care staff. 115.286 (d): The PAQ indicated that the facility prepares a report of its findings from sexual abuse incident reviews including, but not necessarily limited to, determinations made pursuant to paragraphs (d)(1)-(d)(5) of this section and any recommendations for improvement, and submits such report to the facility head and PREA Compliance Manager. 04.01.301, page 11 states that the review, including any reports of findings or any recommendation for improvement, shall be documented on the DOC 0593, Sexual Abuse Incident Review. Interviews with the Director, PC and incident review team member confirmed sexual abuse incident reviews would include the required elements under this provision. The Director stated they use information from the sexual abuse incident reviews to determine if there needs to be any changes to prevent the incident from happening in the future. The PC stated that all sexual abuse incident reviews are forwarded to him and he has not noticed any trends. He further stated that after the sexual abuse incident review is submitted recommendations are approved and put into place (when possible). 115.286 (e): The PAQ indicated that the facility implements the recommendations for improvement or documents its reasons for not doing so. 04.01.301, page 11 states that the DOC 0593 shall be forwarded to the Chief Administrative Officer so recommendations for improvement may be considered. Any recommendation not implemented shall be documented on the DOC 0593 including justification for not doing so. A review of the form confirmed that a section exists for recommendations.

	Based on a review of the PAQ, 04.01.301, DOC 0593 form, and information from interviews with the Director, the PC and a member of the sexual abuse incident review team, this standard appears to be compliant. Recommendation The auditor highly recommends that facility conduct a mock sexual abuse investigation annually due to the limited number of allegations in order to stay updated on the process.

115.287	**Data collection**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. Pre-Audit Questionnaire 2. Administrative Directive 04.01.301 Sexual Abuse and Harassment Prevention and Intervention Program 3. PREA Checklist 4. Investigative Reports 5. Illinois Department of Corrections (IDOC) Annual PREA Report 6. Survey of Sexual Victimization Findings (By Provision): 115.287 (a): The PAQ indicated that the agency collects accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions. 04.01.301, pages 12-13 state that the Chief Administrative Officer and the facility PCM shall conduct an annual evaluation of the Sexual Abuse and Harassment Prevention and Intervention Program at their respective facility and submit to the PC a written report of the findings. The report should at minimum include: a review of each incident of sexual

	abuse or harassment that occurred during the reporting period; program and procedural changes implemented based on recommendations of the review team; training needs to ensure future safety and security; record of referrals to outside community resources; record of referrals for post-release service and statistical data. Policy further states that upon receipt of the reports from each facility, the agency PC shall assess the overall effectiveness of the Department's Sexual Abuse and Harassment Prevention and Intervention Program and submit a written report to the Director that has at minimum: statistical data and corrective action by facility; aggregated incident based sexual abuse or harassment data for the Department; perceived areas of concern and recommended or implemented improvements; a comparison of the current year's statistical data and corrective action with those of previous reporting periods; and an assessment of the Department's progress in addressing sexual abuse or harassment overall. A review of investigative reports (IDOC) and the PREA Checklist confirm that information/data related to each sexual abuse and sexual harassment allegation is reported and documented. The PREA Checklist is then forwarded to the PC to assist with compiling statistical data to identify trends. It should be noted that Safer Foundations does not collect data, rather IDOC collects data for this facility and the second Safer Foundations facility. The IDOC oversees all PREA compliance for Safer Foundations and as such all data and reports are completed through IDOC. 115.287 (b): The PAQ indicated that the agency aggregates the incident-based sexual abuse data at least annually. 04.01.301, pages 12-13 state that upon receipt of the reports from each facility, the agency PC shall assess the overall effectiveness of the Department's Sexual Abuse and Harassment Prevention and Intervention Program and submit a written report to the Director that has at minimum: statistical data and corrective action by facility; aggregated incident based sexual abuse or harassment data for the Department; perceived areas of concern and recommended or implemented improvements; a comparison of the current year's statistical data and corrective action with those of previous reporting periods; and an assessment of the Department's progress in addressing sexual abuse or harassment overall. A review of the IDOC Annual PREA Report indicates that it includes agency accomplishments, facilities audited during the year, statistical data and corrective actions. The report compares data from 2014 through the current year. It should be noted that Safer Foundations does not collect data, rather IDOC collects data for this facility and the second Safer Foundations facility. The IDOC oversees all PREA compliance for Safer Foundations and as such all data and reports are completed through IDOC. 115.287 (c): The PAQ indicated that the standardized instrument includes, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence (SSV) conducted by the Department of Justice. A review of the agency's most recent Survey of Sexual Victimization (formerly known as Survey of Sexual Violence) confirms that the agency collects appropriate

	information using a standardized instrument and reports the appropriate information via the SSV. 115.287 (d): The PAQ indicated that the agency maintains, reviews, and collects data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews. 04.01.301, pages 12-13 state that the Chief Administrative Officer and the facility PCM shall conduct an annual evaluation of the Sexual Abuse and Harassment Prevention and Intervention Program at their respective facility and submit to the PC a written report of the findings. The report should at minimum include: a review of each incident of sexual abuse or harassment that occurred during the reporting period; program and procedural changes implemented based on recommendations of the review team; training needs to ensure future safety and security; record of referrals to outside community resources; record of referrals for post-release service and statistical data. Policy further states that upon receipt of the reports from each facility, the agency PC shall assess the overall effectiveness of the Department's Sexual Abuse and Harassment Prevention and Intervention Program and submit a written report to the Director that has at minimum: statistical data and corrective action by facility; aggregated incident based sexual abuse or harassment data for the Department; perceived areas of concern and recommended or implemented improvements; a comparison of the current year's statistical data and corrective action with those of previous reporting periods; and an assessment of the Department's progress in addressing sexual abuse or harassment overall. It should be noted that Safer Foundations does not collect data, rather IDOC collects data for this facility and the second Safer Foundations facility. The IDOC oversees all PREA compliance for Safer Foundations and as such all data and reports are completed through IDOC. 115.287 (e): The PAQ indicated that the agency obtains incident-based and aggregated data from every private facility with which it contracts for the confinement of residents and that data from private facilities complies with SSV reporting regarding content. 04.01.301, pages 12-13 state that the Chief Administrative Officer and the facility PCM shall conduct an annual evaluation of the Sexual Abuse and Harassment Prevention and Intervention Program at their respective facility and submit to the PC a written report of the findings. The report should at minimum include: a review of each incident of sexual abuse or harassment that occurred during the reporting period; program and procedural changes implemented based on recommendations of the review team; training needs to ensure future safety and security; record of referrals to outside community resources; record of referrals for post-release service and statistical data. Policy further states that upon receipt of the reports from each facility, the agency PC shall assess the overall effectiveness of the Department's Sexual Abuse and Harassment Prevention and Intervention Program and submit a written report to the Director that has at minimum: statistical data and corrective action by facility; aggregated incident based sexual abuse or harassment data for the Department; perceived

	areas of concern and recommended or implemented improvements; a comparison of the current year's statistical data and corrective action with those of previous reporting periods; and an assessment of the Department's progress in addressing sexual abuse or harassment overall. A review of the IDOC Annual PREA Report indicates that it includes agency accomplishments, facilities audited during the year, statistical data and corrective actions. The report compares data from 2014 through the current year. The data included information from both Safer Foundation facilities, including Crossroads Adult Transition Center. It should be noted that Safer Foundations does not collect data, rather IDOC collects data for this facility and the second Safer Foundations facility. The IDOC oversees all PREA compliance for Safer Foundations and as such all data and reports are completed through IDOC. 115.287 (f): The PAQ indicated that the agency provided the Department of Justice with data from the previous calendar year upon request. 04.01.301, page 13 states that upon request, the report shall be submitted to the Department of Justice. Based on a review of the PAQ, 04.01.301, investigative reports, the PREA Checklist, the Survey of Sexual Victimization and the IDOC Annual PREA Report this standard appears to be compliant.

115.288	**Data review for corrective action**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. Pre-Audit Questionnaire 2. Administrative Directive 04.01.301 Sexual Abuse and Harassment Prevention and Intervention Program 3. Illinois Department of Corrections (IDOC) Annual PREA Report Interviews: 1. Interview with the Agency Head 2. Interview with the PREA Coordinator

	Findings (By Provision): 115.288 (a): The PAQ indicated that the agency reviews data collected and aggregated pursuant to §115.87 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, response policies, and training, including: identifying problem areas; taking corrective action on an ongoing basis; and preparing an annual report of its findings from its data review and any corrective actions for each facility, as well as the agency as a whole. 04.01.301, pages 12-13 state that the Chief Administrative Officer and the facility PCM shall conduct an annual evaluation of the Sexual Abuse and Harassment Prevention and Intervention Program at their respective facility and submit to the PC a written report of the findings. The report should at minimum include: a review of each incident of sexual abuse or harassment that occurred during the reporting period; program and procedural changes implemented based on recommendations of the review team; training needs to ensure future safety and security; record of referrals to outside community resources; record of referrals for post-release service and statistical data. Policy further states that upon receipt of the reports from each facility, the agency PC shall assess the overall effectiveness of the Department's Sexual Abuse and Harassment Prevention and Intervention Program and submit a written report to the Director that has at minimum: statistical data and corrective action by facility; aggregated incident based sexual abuse or harassment data for the Department; perceived areas of concern and recommended or implemented improvements; a comparison of the current year's statistical data and corrective action with those of previous reporting periods; and an assessment of the Department's progress in addressing sexual abuse or harassment overall. A review of the IDOC Annual PREA Report indicates that it includes agency accomplishments, facilities audited during the year, statistical data and corrective actions. The report compares data from 2014 through the current year. The interview with the Agency Head indicated that the agency collects data on a quarterly basis and they do trend analysis on the data. He stated that the data assist with identifying hot spots and other variables and they determine action plans for each facility and agency as whole. He further confirmed they utilize the data to determine measures to put in place to correct any issues. The PC confirmed that the agency reviews data that is collected in order to assess and improve the effectiveness of the sexual abuse prevention, detection and response policies. He stated the Agency Head approves the report and that the information is published on the agency website. He further stated that the report includes data collected from all 31 of the IDOC's facilities and the agency takes corrective action on an ongoing basis based on the data. It should be noted that Safer Foundations does not collect data, rather IDOC collects data for this facility and the second Safer Foundations facility. The IDOC oversees all PREA compliance for Safer Foundations and as such all data and reports are completed through IDOC. 115.288 (b): The PAQ indicated that the annual report includes a comparison of the current year's data and corrective actions with those from prior years and that the

	annual report provides an assessment of the agency's progress in addressing sexual abuse. 04.01.301, pages 12-13 state that the Chief Administrative Officer and the facility PCM shall conduct an annual evaluation of the Sexual Abuse and Harassment Prevention and Intervention Program at their respective facility and submit to the PC a written report of the findings. The report should at minimum include: a review of each incident of sexual abuse or harassment that occurred during the reporting period; program and procedural changes implemented based on recommendations of the review team; training needs to ensure future safety and security; record of referrals to outside community resources; record of referrals for post-release service and statistical data. Policy further states that upon receipt of the reports from each facility, the agency PC shall assess the overall effectiveness of the Department's Sexual Abuse and Harassment Prevention and Intervention Program and submit a written report to the Director that has at minimum: statistical data and corrective action by facility; aggregated incident based sexual abuse or harassment data for the Department; perceived areas of concern and recommended or implemented improvements; a comparison of the current year's statistical data and corrective action with those of previous reporting periods; and an assessment of the Department's progress in addressing sexual abuse or harassment overall. A review of the IDOC Annual PREA Report indicates that it includes agency accomplishments, facilities audited during the year, statistical data and corrective actions. The report compares data from 2014 through the current year. It should be noted that Safer Foundations does not collect data, rather IDOC collects data for this facility and the second Safer Foundations facility. The IDOC oversees all PREA compliance for Safer Foundations and as such all data and reports are completed through IDOC. 115.288 (c): The PAQ indicated that the agency makes its annual report readily available to the public at least annually through its website and that the annual reports are approved by the Agency Head. 04.01.301, page 13 states that the annual report shall be made available on the Department's website no later than June 30th of the year subsequent to the reporting period. The interview with the Agency Head confirmed that he reviews and approvals the annual report. A review of the website confirmed that the current annual report as well as prior annual reports are available for review. 115.288 (d): The PAQ indicated that when the agency redacts material from an annual report for publication, the redactions are limited to specific materials where publication would present a clear and specific threat to the safety and security of the facility and that the agency indicates the nature of material redacted. 04.01.301, page 13 states that the final report shall not contain any personal identifiers. The Department may redact information on the posted report if said information would present a clear and specific threat to the safety and security of a facility or the Department. A review of IDOC Annual PREA Report confirmed there was no personal identifying information included nor any security related information. The report did not contain any redacted information. The interview with

	the PC indicated that identifying information of any alleged victim or alleged perpetrator is not include in the report. Based on a review of the PAQ, 04.01.301, the IDOC Annual PREA Report, the website and information obtained from interviews with the Agency Head and PC, this standard appears to be compliant.

115.289	**Data storage, publication, and destruction**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. Pre-Audit Questionnaire 2. Administrative Directive 04.01.301 Sexual Abuse and Harassment Prevention and Intervention Program 3. PREA Sexual Abuse and Harassment Prevention and Intervention Program Manual (PREA Manual) 4. Illinois Department of Corrections (IDOC) Annual PREA Report Interviews: 1. Interview with the PREA Coordinator Findings (By Provision): 115.289 (a): The PAQ indicated that the agency ensures that incident-based and aggregate data are securely retained. The PREA Manual, page 50 states that the agency shall ensure that data collected pursuant to 115.87 are securely retained. The interview with the PREA Coordinator indicated that all electronic data is located on a secure network drive and all physical files are located in secure offices. 115.289 (b): The PAQ indicated that agency policy requires that aggregated sexual abuse data from facilities under its direct control and private facilities with which it contracts be made readily available to the public at least annually through its

	website. 04.01.301, page 14 states the annual report shall be made available on the Department's website no later than June 30th of the year subsequent that of the reporting period. A review of the website confirmed that the current annual report, which includes aggregated data, as well as prior annual reports are available for review. 115.289 (c): The PAQ indicated that before making aggregated sexual abuse data publicly available, the agency removes all personal identifiers. 04.01.301, page 13 states that the final report shall not contain any personal identifiers. A review of the IDOC Annual PREA Report confirmed there was no personal identifying information included nor any security related information. The report did not contain any redacted information. 115.289 (d): The PAQ indicated that the agency maintains sexual abuse data collected pursuant to Standard 115.287 for at least ten years after the date of initial collection, unless federal, state or local law requires otherwise. 04.01.301, page 13 states that all reports and statistical data shall be retained for a period of no less than ten years. A review of prior IDOC Annual PREA Reports confirmed that data is available from 2014 to current. Based on a review of the PAQ, 04.01.301, the IDOC Annual PREA Report, the agency website and information obtained from the interview with the PREA Coordinator, this standard appears to be compliant.

115.401	**Frequency and scope of audits**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Findings (By Provision): 115.401 (a): The facility is part of Safer Foundations, a private non-profit organization. The agency contracts with Illinois Department of Corrections. Both Safer Foundation facilities as well as all IDOC facilities were audited in the previous three-year audit cycle and audit report are found on the IDOC's website (IDOC coordinates, oversees and pays for Safer Foundation PREA audits).

	115.401 (b): The facility is part of Safer Foundations, a private non-profit organization. The agency contracts with Illinois Department of Corrections. The IDOC has a schedule for all their facilities to be audited within the three-year cycle, with one third being audited in each cycle (both Safer Foundation facilities are audited in the second year of the audit cycle). The facility is being audited in the second year of the three-year cycle. 115.401 (h) – (m): The auditor had access to all areas of the facility; was permitted to review any relevant policies, procedure or documents and was permitted to conduct private interviews. 115.401 (n): The auditor observed the audit announcement on bright blue and yellow letter size paper in both English and Spanish. The audit announcements were posted on the bulletin board in the housing units, in the dayroom of the housing units, in the laundry room of the housing units and in many common areas. The audit announcement advised the residents that correspondence with the auditor would remain confidential unless the resident reported information such as sexual abuse, harm to self or harm to others. The residents were able to send correspondence via special mail. The auditor did not receive any correspondence from residents at the facility.

115.403	**Audit contents and findings**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Findings (By Provision): 115.403 (f): The agency (Safer Foundations) has audit reports published on the IDOC website for all audits completed during the previous three, three year audit cycles. IDOC coordinates, oversees and pays for Safer Foundation PREA audits.

Appendix: Provision Findings		
115.211 (a)	**Zero tolerance of sexual abuse and sexual harassment; PREA coordinator**	
	Does the agency have a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment?	yes
	Does the written policy outline the agency's approach to preventing, detecting, and responding to sexual abuse and sexual harassment?	yes
115.211 (b)	**Zero tolerance of sexual abuse and sexual harassment; PREA coordinator**	
	Has the agency employed or designated an agency-wide PREA Coordinator?	yes
	Is the PREA Coordinator position in the upper-level of the agency hierarchy?	yes
	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 community confinement facilities?	yes
115.212 (a)	**Contracting with other entities for the confinement of residents**	
	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.)	na
115.212 (b)	**Contracting with other entities for the confinement of residents**	
	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.)	na
115.212 (c)	**Contracting with other entities for the confinement of residents**	
	If the agency has entered into a contract with an entity that fails to comply with the PREA standards, did the agency do so only in	na

	emergency circumstances after making all reasonable attempts to find a PREA compliant private agency or other entity to confine residents? (N/A if the agency has not entered into a contract with an entity that fails to comply with the PREA standards.)	
	In such a case, does the agency document its unsuccessful attempts to find an entity in compliance with the standards? (N/A if the agency has not entered into a contract with an entity that fails to comply with the PREA standards.)	na
115.213 (a)	**Supervision and monitoring**	
	Does the facility have a documented staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring to protect residents against sexual abuse?	yes
	In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: The physical layout of each facility?	yes
	In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: The composition of the resident population?	yes
	In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: The prevalence of substantiated and unsubstantiated incidents of sexual abuse?	yes
	In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Any other relevant factors?	yes
115.213 (b)	**Supervision and monitoring**	
	In circumstances where the staffing plan is not complied with, does the facility document and justify all deviations from the plan? (NA if no deviations from staffing plan.)	yes
115.213 (c)	**Supervision and monitoring**	
	In the past 12 months, has the facility assessed, determined, and documented whether adjustments are needed to the staffing plan established pursuant to paragraph (a) of this section?	yes
	In the past 12 months, has the facility assessed, determined, and documented whether adjustments are needed to prevailing	yes

	staffing patterns?	
	In the past 12 months, has the facility assessed, determined, and documented whether adjustments are needed to the facility's deployment of video monitoring systems and other monitoring technologies?	yes
	In the past 12 months, has the facility assessed, determined, and documented whether adjustments are needed to the resources the facility has available to commit to ensure adequate staffing levels?	yes
115.215 (a)	**Limits to cross-gender viewing and searches**	
	Does the facility always refrain from conducting any cross-gender strip searches or cross-gender visual body cavity searches, except in exigent circumstances or by medical practitioners?	yes
115.215 (b)	**Limits to cross-gender viewing and searches**	
	Does the facility always refrain from conducting cross-gender pat-down searches of female residents, except in exigent circumstances? (N/A if the facility does not have female inmates.)	yes
	Does the facility always refrain from restricting female residents' access to regularly available programming or other outside opportunities in order to comply with this provision? (N/A if the facility does not have female inmates.)	yes
115.215 (c)	**Limits to cross-gender viewing and searches**	
	Does the facility document all cross-gender strip searches and cross-gender visual body cavity searches?	yes
	Does the facility document all cross-gender pat-down searches of female residents?	yes
115.215 (d)	**Limits to cross-gender viewing and searches**	
	Does the facility have policies that enable residents to shower, perform bodily functions, and change clothing without non-medical 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
	Does the facility have procedures that enable residents to shower,	yes

	perform bodily functions, and change clothing without non-medical 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?	
	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?	yes
115.215 (e)	**Limits to cross-gender viewing and searches**	
	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
	If the 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
115.215 (f)	**Limits to cross-gender viewing and searches**	
	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
	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
115.216 (a)	**Residents with disabilities and residents who are limited English proficient**	
	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
	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

	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
	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
	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
	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
	Do such steps include, when necessary, ensuring effective communication with residents who are deaf or hard of hearing?	yes
	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
	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
	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
	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: Who are blind or have low vision?	yes
115.216 (b)	**Residents with disabilities and residents who are limited English proficient**	

	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
	Do these steps include providing interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary?	yes
115.216 (c)	**Residents with disabilities and residents who are limited English proficient**	
	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 §115.264, or the investigation of the resident's allegations?	yes
115.217 (a)	**Hiring and promotion decisions**	
	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
	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
	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 two questions immediately above ?	yes
	Does the agency prohibit the enlistment of the 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
	Does the agency prohibit the enlistment of the 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	yes

	force, or coercion, or if the victim did not consent or was unable to consent or refuse?	
	Does the agency prohibit the enlistment of the 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 two questions immediately above ?	yes
115.217 (b)	**Hiring and promotion decisions**	
	Does the agency consider any incidents of sexual harassment in determining whether to hire or promote anyone who may have contact with residents?	yes
	Does the agency consider any incidents of sexual harassment in determining to enlist the services of any contractor who may have contact with residents?	yes
115.217 (c)	**Hiring and promotion decisions**	
	Before hiring new employees who may have contact with residents, does the agency: Perform a criminal background records check?	yes
	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
115.217 (d)	**Hiring and promotion decisions**	
	Does the agency perform a criminal background records check before enlisting the services of any contractor who may have contact with residents?	yes
115.217 (e)	**Hiring and promotion decisions**	
	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
115.217	**Hiring and promotion decisions**	

(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
	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
	Does the agency impose upon employees a continuing affirmative duty to disclose any such misconduct?	yes
115.217 (g)	**Hiring and promotion decisions**	
	Does the agency consider material omissions regarding such misconduct, or the provision of materially false information, grounds for termination?	yes
115.217 (h)	**Hiring and promotion decisions**	
	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
115.218 (a)	**Upgrades to facilities and technology**	
	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.)	na
115.218 (b)	**Upgrades to facilities and technology**	
	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	na

	agency’s ability to protect residents from sexual abuse? (N/A if agency/facility has not installed or updated any video monitoring system, electronic surveillance system, or other monitoring technology since August 20, 2012 or since the last PREA audit, whichever is later.)	
115.221 (a)	**Evidence protocol and forensic medical examinations**	
	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
115.221 (b)	**Evidence protocol and forensic medical examinations**	
	Is this protocol developmentally appropriate for youth where applicable? (NA if the agency/facility is not responsible for conducting any form of criminal or administrative sexual abuse investigations.)	yes
	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? (NA if the agency/facility is not responsible for conducting any form of criminal or administrative sexual abuse investigations.)	yes
115.221 (c)	**Evidence protocol and forensic medical examinations**	
	Does the agency offer all victims of sexual abuse access to forensic medical examinations, whether on-site or at an outside facility, without financial cost, where evidentiarily or medically appropriate?	yes
	Are such examinations performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) where possible?	yes
	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

	Has the agency documented its efforts to provide SAFEs or SANEs?	yes
115.221 (d)	**Evidence protocol and forensic medical examinations**	
	Does the agency attempt to make available to the victim a victim advocate from a rape crisis center?	yes
	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
	Has the agency documented its efforts to secure services from rape crisis centers?	yes
115.221 (e)	**Evidence protocol and forensic medical examinations**	
	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
	As requested by the victim, does this person provide emotional support, crisis intervention, information, and referrals?	yes
115.221 (f)	**Evidence protocol and forensic medical examinations**	
	If the agency itself is not responsible for investigating allegations of sexual abuse, has the agency requested that the investigating agency follow the requirements of paragraphs (a) through (e) of this section? (N/A if the agency/facility is responsible for conducting criminal AND administrative sexual abuse investigations.)	yes
115.221 (h)	**Evidence protocol and forensic medical examinations**	
	If the agency uses a qualified agency staff member or a qualified community-based staff member for the purposes of this section, has the individual been screened for appropriateness to serve in this role and received education concerning sexual assault and forensic examination issues in general? (N/A if agency attempts to make a victim advocate from a rape crisis center available to victims per 115.221(d) above).	yes

115.222 (a)	**Policies to ensure referrals of allegations for investigations**	
	Does the agency ensure an administrative or criminal investigation is completed for all allegations of sexual abuse?	yes
	Does the agency ensure an administrative or criminal investigation is completed for all allegations of sexual harassment?	yes
115.222 (b)	**Policies to ensure referrals of allegations for investigations**	
	Does the agency have a policy 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
	Has the agency published such policy on its website or, if it does not have one, made the policy available through other means?	yes
	Does the agency document all such referrals?	yes
115.222 (c)	**Policies to ensure referrals of allegations for investigations**	
	If a separate entity is responsible for conducting criminal investigations, does the policy describe the responsibilities of both the agency and the investigating entity? (N/A if the agency/facility is responsible for conducting criminal investigations. See 115.221(a).)	yes
115.231 (a)	**Employee training**	
	Does the agency train all employees who may have contact with residents on: Its zero-tolerance policy for sexual abuse and sexual harassment?	yes
	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
	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
	Does the agency train all employees who may have contact with	yes

	residents on: The right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment?	
	Does the agency train all employees who may have contact with residents on: The dynamics of sexual abuse and sexual harassment in confinement?	yes
	Does the agency train all employees who may have contact with residents on: The common reactions of sexual abuse and sexual harassment victims?	yes
	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?	yes
	Does the agency train all employees who may have contact with residents on: How to avoid inappropriate relationships with residents?	yes
	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
	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
115.231 (b)	**Employee training**	
	Is such training tailored to the gender of the residents at the employee's facility?	yes
	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
115.231 (c)	**Employee training**	
	Have all current employees who may have contact with residents received such training?	yes
	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
	In years in which an employee does not receive refresher training,	yes

	does the agency provide refresher information on current sexual abuse and sexual harassment policies?	
115.231 (d)	**Employee training**	
	Does the agency document, through employee signature or electronic verification, that employees understand the training they have received?	yes
115.232 (a)	**Volunteer and contractor training**	
	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
115.232 (b)	**Volunteer and contractor training**	
	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
115.232 (c)	**Volunteer and contractor training**	
	Does the agency maintain documentation confirming that volunteers and contractors understand the training they have received?	yes
115.233 (a)	**Resident education**	
	During intake, do residents receive information explaining: The agency's zero-tolerance policy regarding sexual abuse and sexual harassment?	yes
	During intake, do residents receive information explaining: How to report incidents or suspicions of sexual abuse or sexual harassment?	yes
	During intake, do residents receive information explaining: Their rights to be free from sexual abuse and sexual harassment?	yes

	During intake, do residents receive information explaining: Their rights to be free from retaliation for reporting such incidents?	yes
	During intake, do residents receive information regarding agency policies and procedures for responding to such incidents?	yes
115.233 (b)	**Resident education**	
	Does the agency provide refresher information whenever a resident is transferred to a different facility?	yes
115.233 (c)	**Resident education**	
	Does the agency provide resident education in formats accessible to all residents, including those who: Are limited English proficient?	yes
	Does the agency provide resident education in formats accessible to all residents, including those who: Are deaf?	yes
	Does the agency provide resident education in formats accessible to all residents, including those who: Are visually impaired?	yes
	Does the agency provide resident education in formats accessible to all residents, including those who: Are otherwise disabled?	yes
	Does the agency provide resident education in formats accessible to all residents, including those who: Have limited reading skills?	yes
115.233 (d)	**Resident education**	
	Does the agency maintain documentation of resident participation in these education sessions?	yes
115.233 (e)	**Resident education**	
	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
115.234 (a)	**Specialized training: Investigations**	
	In addition to the general training provided to all employees pursuant to §115.231, does the agency ensure that, to the extent	yes

	the agency itself conducts sexual abuse investigations, its investigators receive training in conducting such investigations in confinement settings? (N/A if the agency does not conduct any form of criminal or administrative sexual abuse investigations. See 115.221(a)).	
115.234 (b)	**Specialized training: Investigations**	
	Does this specialized training include: Techniques for interviewing sexual abuse victims?(N/A if the agency does not conduct any form of criminal or administrative sexual abuse investigations. See 115.221(a)).	yes
	Does this specialized training include: Proper use of Miranda and Garrity warnings?(N/A if the agency does not conduct any form of criminal or administrative sexual abuse investigations. See 115.221(a)).	yes
	Does this specialized training include: Sexual abuse evidence collection in confinement settings?(N/A if the agency does not conduct any form of criminal or administrative sexual abuse investigations. See 115.221(a)).	yes
	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 criminal or administrative sexual abuse investigations. See 115.221(a)).	yes
115.234 (c)	**Specialized training: Investigations**	
	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 criminal or administrative sexual abuse investigations. See 115.221(a).)	yes
115.235 (a)	**Specialized training: Medical and mental health care**	
	Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to detect and assess signs of sexual abuse and sexual harassment? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)	na

	Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to preserve physical evidence of sexual abuse? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)	na
	Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to respond effectively and professionally to victims of sexual abuse and sexual harassment? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)	na
	Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How and to whom to report allegations or suspicions of sexual abuse and sexual harassment? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)	na
115.235 (b)	**Specialized training: Medical and mental health care**	
	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 does not employ medical staff or the medical staff employed by the agency do not conduct forensic exams.)	na
115.235 (c)	**Specialized training: Medical and mental health care**	
	Does the agency maintain documentation that medical and mental health practitioners have received the training referenced in this standard either from the agency or elsewhere? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)	na
115.235 (d)	**Specialized training: Medical and mental health care**	
	Do medical and mental health care practitioners employed by the agency also receive training mandated for employees by §115.231? (N/A for circumstances in which a particular status (employee or contractor/volunteer) does not apply.)	na
	Do medical and mental health care practitioners contracted by	na

	and volunteering for the agency also receive training mandated for contractors and volunteers by §115.232? (N/A for circumstances in which a particular status (employee or contractor/volunteer) does not apply.)	
115.241 (a)	**Screening for risk of victimization and abusiveness**	
	Are all residents assessed during an intake screening for their risk of being sexually abused by other residents or sexually abusive toward other residents?	yes
	Are all residents assessed upon transfer to another facility for their risk of being sexually abused by other residents or sexually abusive toward other residents?	yes
115.241 (b)	**Screening for risk of victimization and abusiveness**	
	Do intake screenings ordinarily take place within 72 hours of arrival at the facility?	yes
115.241 (c)	**Screening for risk of victimization and abusiveness**	
	Are all PREA screening assessments conducted using an objective screening instrument?	yes
115.241 (d)	**Screening for risk of victimization and abusiveness**	
	Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has a mental, physical, or developmental disability?	yes
	Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: The age of the resident?	yes
	Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: The physical build of the resident?	yes
	Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has previously been incarcerated?	yes
	Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization:	yes

	Whether the resident's criminal history is exclusively nonviolent?	
	Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has prior convictions for sex offenses against an adult or child?	yes
	Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident is or is perceived to be gay, lesbian, bisexual, transgender, intersex, or gender nonconforming (the facility affirmatively asks the resident about his/her sexual orientation and gender identity AND makes a subjective determination based on the screener's perception whether the resident is gender non-conforming or otherwise may be perceived to be LGBTI)?	yes
	Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has previously experienced sexual victimization?	yes
	Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: The resident's own perception of vulnerability?	yes
115.241 (e)	**Screening for risk of victimization and abusiveness**	
	In assessing residents for risk of being sexually abusive, does the initial PREA risk screening consider, when known to the agency: prior acts of sexual abuse?	yes
	In assessing residents for risk of being sexually abusive, does the initial PREA risk screening consider, when known to the agency: prior convictions for violent offenses?	yes
	In assessing residents for risk of being sexually abusive, does the initial PREA risk screening consider, when known to the agency: history of prior institutional violence or sexual abuse?	yes
115.241 (f)	**Screening for risk of victimization and abusiveness**	
	Within a set time period not more than 30 days from the resident's arrival at the facility, does the facility reassess the resident's risk of victimization or abusiveness based upon any additional, relevant information received by the facility since the intake screening?	yes

115.241 (g)	**Screening for risk of victimization and abusiveness**	
	Does the facility reassess a resident’s risk level when warranted due to a: Referral?	yes
	Does the facility reassess a resident’s risk level when warranted due to a: Request?	yes
	Does the facility reassess a resident’s risk level when warranted due to a: Incident of sexual abuse?	yes
	Does the facility reassess a resident’s risk level when warranted due to a: Receipt of additional information that bears on the resident’s risk of sexual victimization or abusiveness?	yes
115.241 (h)	**Screening for risk of victimization and abusiveness**	
	Is it the case that residents are not ever disciplined for refusing to answer, or for not disclosing complete information in response to, questions asked pursuant to paragraphs (d)(1), (d)(7), (d)(8), or (d)(9) of this section?	yes
115.241 (i)	**Screening for risk of victimization and abusiveness**	
	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
115.242 (a)	**Use of screening information**	
	Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Housing Assignments?	yes
	Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Bed assignments?	yes
	Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Work Assignments?	yes

	Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Education Assignments?	yes
	Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Program Assignments?	yes
115.242 (b)	**Use of screening information**	
	Does the agency make individualized determinations about how to ensure the safety of each resident?	yes
115.242 (c)	**Use of screening information**	
	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
	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
115.242 (d)	**Use of screening information**	
	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
115.242 (e)	**Use of screening information**	
	Are transgender and intersex residents given the opportunity to shower separately from other residents?	yes
115.242	**Use of screening information**	

(f)		
	Unless placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting lesbian, gay, bisexual, transgender, or intersex residents, does the agency always refrain from placing: lesbian, gay, and bisexual residents in dedicated facilities, units, or wings solely on the basis of such identification or status? (N/A if the agency has a dedicated facility, unit, or wing solely for the placement of LGBT or I residents pursuant to a consent decree, legal settlement, or legal judgement.)	yes
	Unless placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting lesbian, gay, bisexual, transgender, or intersex residents, does the agency always refrain from placing: transgender residents in dedicated facilities, units, or wings solely on the basis of such identification or status? (N/A if the agency has a dedicated facility, unit, or wing solely for the placement of LGBT or I residents pursuant to a consent decree, legal settlement, or legal judgement.)	yes
	Unless placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting lesbian, gay, bisexual, transgender, or intersex residents, does the agency always refrain from placing: intersex residents in dedicated facilities, units, or wings solely on the basis of such identification or status? (N/A if the agency has a dedicated facility, unit, or wing solely for the placement of LGBT or I residents pursuant to a consent decree, legal settlement, or legal judgement.)	yes
115.251 (a)	**Resident reporting**	
	Does the agency provide multiple internal ways for residents to privately report: Sexual abuse and sexual harassment?	yes
	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
	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
115.251 (b)	**Resident reporting**	

	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
	Is that private entity or office able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials?	yes
	Does that private entity or office allow the resident to remain anonymous upon request?	yes
115.251 (c)	**Resident reporting**	
	Do staff members accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously, and from third parties?	yes
	Do staff members promptly document any verbal reports of sexual abuse and sexual harassment?	yes
115.251 (d)	**Resident reporting**	
	Does the agency provide a method for staff to privately report sexual abuse and sexual harassment of residents?	yes
115.252 (a)	**Exhaustion of administrative remedies**	
	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.	no
115.252 (b)	**Exhaustion of administrative remedies**	
	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
	Does the agency always refrain from requiring a resident to use any informal grievance process, or to otherwise attempt to resolve	yes

	with staff, an alleged incident of sexual abuse? (N/A if agency is exempt from this standard.)	
115.252 (c)	**Exhaustion of administrative remedies**	
	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
	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
115.252 (d)	**Exhaustion of administrative remedies**	
	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
	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 is 70 days per 115.252(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
	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
115.252 (e)	**Exhaustion of administrative remedies**	
	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
	Are those third parties also permitted to file such requests on behalf of residents? (If a third party files such a request on behalf	yes

	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.)	
	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
115.252 (f)	**Exhaustion of administrative remedies**	
	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
	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
	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
	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
	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
	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
	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
115.252 (g)	**Exhaustion of administrative remedies**	
	If the agency disciplines a resident for filing a grievance related to	yes

	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.)	
115.253 (a)	**Resident access to outside confidential support services**	
	Does the facility provide residents with access to outside victim advocates for emotional support services related to sexual abuse by giving residents mailing addresses and telephone numbers, including toll-free hotline numbers where available, of local, State, or national victim advocacy or rape crisis organizations?	yes
	Does the facility enable reasonable communication between residents and these organizations, in as confidential a manner as possible?	yes
115.253 (b)	**Resident access to outside confidential support services**	
	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
115.253 (c)	**Resident access to outside confidential support services**	
	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
	Does the agency maintain copies of agreements or documentation showing attempts to enter into such agreements?	yes
115.254 (a)	**Third party reporting**	
	Has the agency established a method to receive third-party reports of sexual abuse and sexual harassment?	yes
	Has the agency distributed publicly information on how to report sexual abuse and sexual harassment on behalf of a resident?	yes
115.261 (a)	**Staff and agency reporting duties**	
	Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or	yes

	information regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency?	
	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
	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
115.261 (b)	**Staff and agency reporting duties**	
	Apart from reporting to designated supervisors or officials, do staff always refrain 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
115.261 (c)	**Staff and agency reporting duties**	
	Unless otherwise precluded by Federal, State, or local law, are medical and mental health practitioners required to report sexual abuse pursuant to paragraph (a) of this section?	yes
	Are medical and mental health practitioners required to inform residents of the practitioner’s duty to report, and the limitations of confidentiality, at the initiation of services?	yes
115.261 (d)	**Staff and agency reporting duties**	
	If the alleged victim is under the age of 18 or considered a vulnerable adult under a State or local vulnerable persons statute, does the agency report the allegation to the designated State or local services agency under applicable mandatory reporting laws?	yes
115.261 (e)	**Staff and agency reporting duties**	
	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

115.262 (a)	**Agency protection duties**	
	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
115.263 (a)	**Reporting to other confinement facilities**	
	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
115.263 (b)	**Reporting to other confinement facilities**	
	Is such notification provided as soon as possible, but no later than 72 hours after receiving the allegation?	yes
115.263 (c)	**Reporting to other confinement facilities**	
	Does the agency document that it has provided such notification?	yes
115.263 (d)	**Reporting to other confinement facilities**	
	Does the facility head or agency office that receives such notification ensure that the allegation is investigated in accordance with these standards?	yes
115.264 (a)	**Staff first responder duties**	
	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
	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
	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,	yes

	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?	
	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
115.264 (b)	**Staff first responder duties**	
	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
115.265 (a)	**Coordinated response**	
	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
115.266 (a)	**Preservation of ability to protect residents from contact with abusers**	
	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
115.267 (a)	**Agency protection against retaliation**	
	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

	Has the agency designated which staff members or departments are charged with monitoring retaliation?	yes
115.267 (b)	**Agency protection against retaliation**	
	Does the agency employ multiple protection measures, such as housing changes or transfers for resident victims or abusers, removal of alleged staff or resident abusers from contact with victims, and emotional support services for residents or staff who fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations?	yes
115.267 (c)	**Agency protection against retaliation**	
	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
	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
	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
	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
	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:4. Monitor resident housing changes?	yes
	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

	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
	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 reassignment of staff?	yes
	Does the agency continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need?	yes
115.267 (d)	**Agency protection against retaliation**	
	In the case of residents, does such monitoring also include periodic status checks?	yes
115.267 (e)	**Agency protection against retaliation**	
	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
115.271 (a)	**Criminal and administrative agency investigations**	
	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 115.221(a).)	yes
	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 115.221(a).)	yes
115.271 (b)	**Criminal and administrative agency investigations**	
	Where sexual abuse is alleged, does the agency use investigators who have received specialized training in sexual abuse investigations as required by 115.234?	yes
115.271 (c)	**Criminal and administrative agency investigations**	
	Do investigators gather and preserve direct and circumstantial	yes

	evidence, including any available physical and DNA evidence and any available electronic monitoring data?	
	Do investigators interview alleged victims, suspected perpetrators, and witnesses?	yes
	Do investigators review prior reports and complaints of sexual abuse involving the suspected perpetrator?	yes
115.271 (d)	**Criminal and administrative agency investigations**	
	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
115.271 (e)	**Criminal and administrative agency investigations**	
	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
	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
115.271 (f)	**Criminal and administrative agency investigations**	
	Do administrative investigations include an effort to determine whether staff actions or failures to act contributed to the abuse?	yes
	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
115.271 (g)	**Criminal and administrative agency investigations**	
	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
115.271	**Criminal and administrative agency investigations**	

(h)		
	Are all substantiated allegations of conduct that appears to be criminal referred for prosecution?	yes
115.271 (i)	**Criminal and administrative agency investigations**	
	Does the agency retain all written reports referenced in 115.271(f) and (g) for as long as the alleged abuser is incarcerated or employed by the agency, plus five years?	yes
115.271 (j)	**Criminal and administrative agency investigations**	
	Does the agency ensure that the departure of an alleged abuser or victim from the employment or control of the facility or agency does not provide a basis for terminating an investigation?	yes
115.271 (l)	**Criminal and administrative agency investigations**	
	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 any form of administrative or criminal sexual abuse investigations. See 115.221(a).)	yes
115.272 (a)	**Evidentiary standard for administrative investigations**	
	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
115.273 (a)	**Reporting to residents**	
	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
115.273 (b)	**Reporting to residents**	
	If the agency did not conduct the investigation into a resident’s allegation of sexual abuse in an agency facility, does the agency	yes

	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.)	
115.273 (c)	**Reporting to residents**	
	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
	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
	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
	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
115.273 (d)	**Reporting to residents**	
	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
	Following a resident's allegation that he or she has been sexually abused by another resident, does the agency subsequently inform	yes

	the alleged victim whenever: The agency learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility?	
115.273 (e)	**Reporting to residents**	
	Does the agency document all such notifications or attempted notifications?	yes
115.276 (a)	**Disciplinary sanctions for staff**	
	Are staff subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies?	yes
115.276 (b)	**Disciplinary sanctions for staff**	
	Is termination the presumptive disciplinary sanction for staff who have engaged in sexual abuse?	yes
115.276 (c)	**Disciplinary sanctions for staff**	
	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
115.276 (d)	**Disciplinary sanctions for staff**	
	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
	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
115.277 (a)	**Corrective action for contractors and volunteers**	

	Is any contractor or volunteer who engages in sexual abuse prohibited from contact with residents?	yes
	Is any contractor or volunteer who engages in sexual abuse reported to: Law enforcement agencies (unless the activity was clearly not criminal)?	yes
	Is any contractor or volunteer who engages in sexual abuse reported to: Relevant licensing bodies?	yes
115.277 (b)	**Corrective action for contractors and volunteers**	
	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
115.278 (a)	**Disciplinary sanctions for residents**	
	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, are residents subject to disciplinary sanctions pursuant to a formal disciplinary process?	yes
115.278 (b)	**Disciplinary sanctions for residents**	
	Are 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
115.278 (c)	**Disciplinary sanctions for residents**	
	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
115.278 (d)	**Disciplinary sanctions for residents**	
	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 require the offending resident to participate in such interventions as a	yes

	condition of access to programming and other benefits?	
115.278 (e)	**Disciplinary sanctions for residents**	
	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
115.278 (f)	**Disciplinary sanctions for residents**	
	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
115.278 (g)	**Disciplinary sanctions for residents**	
	Does the agency always refrain from considering non-coercive sexual activity between residents to be sexual abuse? (N/A if the agency does not prohibit all sexual activity between residents.)	yes
115.282 (a)	**Access to emergency medical and mental health services**	
	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
115.282 (b)	**Access to emergency medical and mental health services**	
	If no qualified medical or mental health practitioners are on duty at the time a report of recent sexual abuse is made, do security staff first responders take preliminary steps to protect the victim pursuant to § 115.262?	yes
	Do security staff first responders immediately notify the appropriate medical and mental health practitioners?	yes
115.282 (c)	**Access to emergency medical and mental health services**	
	Are resident victims of sexual abuse offered timely information	yes

	about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate?	
115.282 (d)	**Access to emergency medical and mental health services**	
	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
115.283 (a)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	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
115.283 (b)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	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
115.283 (c)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	Does the facility provide such victims with medical and mental health services consistent with the community level of care?	yes
115.283 (d)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	Are resident victims of sexually abusive vaginal penetration while incarcerated offered pregnancy tests? (N/A if “all-male” facility. Note: in “all-male” facilities, there may be residents who identify as transgender men who may have female genitalia. Auditors should be sure to know whether such individuals may be in the population and whether this provision may apply in specific circumstances.)	na
115.283 (e)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	If pregnancy results from the conduct described in paragraph § 115.283(d), do such victims receive timely and comprehensive	na

	information about and timely access to all lawful pregnancy-related medical services? (N/A if “all-male” facility. Note: in “all-male” facilities, there may be residents who identify as transgender men who may have female genitalia. Auditors should be sure to know whether such individuals may be in the population and whether this provision may apply in specific circumstances.)	
115.283 (f)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	Are resident victims of sexual abuse while incarcerated offered tests for sexually transmitted infections as medically appropriate?	yes
115.283 (g)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	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
115.283 (h)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	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
115.286 (a)	**Sexual abuse incident reviews**	
	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
115.286 (b)	**Sexual abuse incident reviews**	
	Does such review ordinarily occur within 30 days of the conclusion of the investigation?	yes
115.286 (c)	**Sexual abuse incident reviews**	
	Does the review team include upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners?	yes

115.286 (d)	**Sexual abuse incident reviews**	
	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
	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
	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
	Does the review team: Assess the adequacy of staffing levels in that area during different shifts?	yes
	Does the review team: Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff?	yes
	Does the review team: Prepare a report of its findings, including but not necessarily limited to determinations made pursuant to §§ 115.286(d)(1)-(d)(5), and any recommendations for improvement and submit such report to the facility head and PREA compliance manager?	yes
115.286 (e)	**Sexual abuse incident reviews**	
	Does the facility implement the recommendations for improvement, or document its reasons for not doing so?	yes
115.287 (a)	**Data collection**	
	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
115.287 (b)	**Data collection**	
	Does the agency aggregate the incident-based sexual abuse data at least annually?	yes
115.287	**Data collection**	

(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
115.287 (d)	**Data collection**	
	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
115.287 (e)	**Data collection**	
	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.)	na
115.287 (f)	**Data collection**	
	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.)	na
115.288 (a)	**Data review for corrective action**	
	Does the agency review data collected and aggregated pursuant to § 115.287 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
	Does the agency review data collected and aggregated pursuant to § 115.287 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
	Does the agency review data collected and aggregated pursuant to § 115.287 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

115.288 (b)	**Data review for corrective action**	
	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
115.288 (c)	**Data review for corrective action**	
	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
115.288 (d)	**Data review for corrective action**	
	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
115.289 (a)	**Data storage, publication, and destruction**	
	Does the agency ensure that data collected pursuant to § 115.287 are securely retained?	yes
115.289 (b)	**Data storage, publication, and destruction**	
	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
115.289 (c)	**Data storage, publication, and destruction**	
	Does the agency remove all personal identifiers before making aggregated sexual abuse data publicly available?	yes
115.289 (d)	**Data storage, publication, and destruction**	
	Does the agency maintain sexual abuse data collected pursuant to § 115.287 for at least 10 years after the date of the initial collection, unless Federal, State, or local law requires otherwise?	yes

115.401 (a)	**Frequency and scope of audits**	
	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
115.401 (b)	**Frequency and scope of audits**	
	Is this the first year of the current audit cycle? (Note: a “no” response does not impact overall compliance with this standard.)	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
	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.)	na
115.401 (h)	**Frequency and scope of audits**	
	Did the auditor have access to, and the ability to observe, all areas of the audited facility?	yes
115.401 (i)	**Frequency and scope of audits**	
	Was the auditor permitted to request and receive copies of any relevant documents (including electronically stored information)?	yes
115.401 (m)	**Frequency and scope of audits**	
	Was the auditor permitted to conduct private interviews with residents?	yes
115.401 (n)	**Frequency and scope of audits**	
	Were inmates, residents, and detainees permitted to send confidential information or correspondence to the auditor in the	yes

	same manner as if they were communicating with legal counsel?	
115.403 (f)	**Audit contents and findings**	
	The agency has published on its agency website, if it has one, or has otherwise made publicly available, all Final Audit Reports. The review period is for prior audits completed during the past three years PRECEDING THIS AUDIT. The pendency of any agency appeal pursuant to 28 C.F.R. § 115.405 does not excuse noncompliance with this provision. (N/A if there have been no Final Audit Reports issued in the past three years, or, in the case of single facility agencies, there has never been a Final Audit Report issued.)	yes