

PREA AUDIT REPORT INTERIM FINAL
JUVENILE FACILITIES

Date of report: September 14, 2016

Auditor Information			
Auditor name: Joel T. Whitt M.A.			
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Telephone number: 210-744-4943			
Date of facility visit: July 12, 2016 – July 14, 2016			
Facility Information			
Facility name: Camp Summit Boot Camp			
Facility physical address: 2407 North 500 West La Porte IN 46350			
Facility mailing address: <i>(if different from above)</i> Click here to enter text.			
Facility telephone number: 219 326-1188			
The facility is:	<input type="checkbox"/> Federal	<input checked="" type="checkbox"/> State	<input type="checkbox"/> County
	<input type="checkbox"/> Military	<input type="checkbox"/> Municipal	<input type="checkbox"/> Private for profit
	<input type="checkbox"/> Private not for profit		
Facility type:	<input checked="" type="checkbox"/> Correctional	<input type="checkbox"/> Detention	<input type="checkbox"/> Other
Name of facility's Chief Executive Officer: Cecil Davis			
Number of staff assigned to the facility in the last 12 months: 73			
Designed facility capacity: 94			
Current population of facility: 57			
Facility security levels/inmate custody levels: Medium and High			
Age range of the population: 15-18			
Name of PREA Compliance Manager: Lt. Cmdr. Kenneth Watts		Title: Youth Service Supervisor 5/PREA Compliance Manager	
Email address: kwatts@idoc.IN.gov		Telephone number: (219) 326-1188	
Agency Information			
Name of agency: Indiana Department of Corrections (IDOC)			
Governing authority or parent agency: <i>(if applicable)</i> State of Indiana			
Physical address: 302 W. Washington Street, Room E334, Indianapolis, IN 46204			
Mailing address: <i>(if different from above)</i> Click here to enter text.			
Telephone number: 317-232-5711			
Agency Chief Executive Officer			
Name: Bruce Lemon		Title: Commissioner	
Email address: blemmon@idoc.in.gov		Telephone number: 317-232-5705	
Agency-Wide PREA Coordinator			
Name: Bryan Pearson		Title: PREA Coordinator	
Email address: bpearson@idoc.in.gov		Telephone number: 317-232-5288	

AUDIT FINDINGS

NARRATIVE

The Indiana Department of Corrections (IDOC) requested a PREA Audit for the Camp Summit Boot Camp (CSBC) located in La Porte, Indiana. This PREA Audit Report is specific to the findings related to the CSBC. The pre-audit work began on May 21, 2016 and the onsite portion of the PREA Audit was conducted between July 12, 2016 and July 16, 2016. (NOTE: for the purposes of this PREA Report the term "Agency" at all times represents the IDOC and the term "Facility" at all times represents the Camp Summit Boot Camp (CSBC).

Prior to the onsite auditing conducted between July 12 and July 14 2016, for this PREA Audit it was confirmed, via photographic email evidence provided by the Facility PREA Compliance Manager (PCM) on May 27, 2016 that the required PREA Audit notice was posted at least 42 days in advance. That evidence confirmed that the notices were posted in various, conspicuous, areas throughout the Facility. These postings remained posted and were visible during the onsite component of this PREA Audit.

Starting on June 1, 2016, this Auditor received multiple emails containing the completed Pre-Audit Questionnaire, the Facility and the Facility policies, and other supporting documentation from both the Indiana PREA Coordinator and the Facility PCM. Upon review of the information and data provided, it became clear that the Facility had taken significant steps toward meeting PREA compliance. A conference call with this Auditor and the Facility's Superintendent and the PCM was conducted on June 23rd, 2016 and confirmed that the Facility had made great progress toward PREA compliance. A second PREA Audit conference call was held with the same individuals on July 5th, 2016 confirming that the Facility was ready for the onsite portion of the PREA Audit.

On July 12, 2016 the onsite auditing began with an introduction meeting was held at approximately 9:00 AM with the Facility Superintendent, the Facility PCM, the State PREA Coordinator, and various other Facility Department Heads. It was noted that there were 53 residents on site and 4 new residents were scheduled to arrive at the time of the auditing. Following this meeting, a tour of the entire Facility was conducted and this Auditor noted the location of the security cameras and the layout of the physical grounds and the various structures. Additionally, notices about this PREA Audit as well as notices regarding the rights of the residents to be free from sexual abuse and sexual harassment were observed. These notices included information on how residents could report sexual abuse and sexual harassment. During this tour it was noted that there were no visible "blind spots" that were not located behind locked doors. Cameras did not view "wet areas" and residents were required to change clothes in "wet areas".

During the Facility tour, this Auditor observed residents being supervised by the Facility Custody Staff (i.e., security staff), counseling staff, teaching staff, and/or contractors (i.e., medical and/or mental health). Further, it was observed the majority of the staff were male but there were female staff present as well. During the onsite auditing this Auditor formally interviewed 10 randomly selected residents or 17.5% of the total Facility resident population was interviewed as part of the onsite auditing. Residents reported being informed of the Agency and Facility's Zero-Tolerance Policy related to sexual abuse and sexual harassment and of their right to be free from sexual abuse and sexual harassment as well as their right to be free from retaliation for reporting sexual abuse and/or sexual harassment. All 10 (100%) of the residents interviewed indicated that they received PREA information on what to report, when to report, where to report, and how to report and PREA Education that included a presentation, video, and PowerPoint at the time of their intake. A review of 15 current residents' files (26.3% of current resident population) indicated that all 15 (i.e., 100.0%) received PREA information and PREA Education on the day they arrived at the facility.

During the On-Site PREA Audit component a total 17.5% (10) of the 57 residents were interviewed. Interviews also were conducted with multiple Camp Summit employees and resources, including the Superintendent, the PREA Compliance Manager, PREA Incident Review Committee Members, eleven (11) Security Staff members of both genders and covering all shifts, the Community Service Director, Mental Health Staff, Medical Staff, Investigation Staff, Sexual Abuse Response Team Members, Educational Staff, Training Staff, Staff Responsible for Classification and Living Assignments, and contracted employees and resources. The responses were consistent and all interviews, including those with residents, indicated that there was a culture of Zero Tolerance for Sexual Abuse and Sexual Harassment at the facility.

As part of the routine work assignment(s) during the onsite portion of this PREA Audit, this Auditor interviewed a total of 19 security staff, counselors, contractors, volunteers, and specialized staff. Eleven (11) of the 19 interviewed staff/volunteers/contractors were security staff that were randomly selected and represented security staff from all shifts and all

and units. The staff interviews revealed that staff were trained in the PREA Standards, in their obligations as first-responders, and in their respective responsibilities and duties to prevent, detect, and respond to sexual abuse, sexual harassment, and allegations of retaliation for reporting sexual abuse and sexual harassment. All staff reported being trained in how to search transgender or intersex residents; however there has not been youth who identify as intersex or transgender placed at the facility that any staff were aware of. Staff responsible for conducting intake risk assessments noted that they completed a risk factor analysis (called a SVAT) for each resident to determine proper room assignments. In a review of 15 resident files, all 15 showed a SVAT on the day the resident arrived at the facility. Documentation showed that all youth who had reported they had experienced past sexual abuse were seen by mental health staff and there was consistent evidence that the SVAT was reviewed and updated on a monthly basis.

At the conclusion of the onsite portion (July 14, 2016) of this PREA Audit, it was determined that the Facility “Exceeded Standard” on four PREA Standards [115.318, 115.334, 115.341 & 115.353], was “Compliant” in 26 PREA Standards, required evidence of compliance for nine standards identified at the end of the onsite portion of this PREA Audit as “Pending” receipt of further evidence and was “Non-Compliant” on two Standards [115.321 and 115.364]. This determination was made based on Facility practices being compliant and documentation of directives by the Superintendent of the Facility addressing the vast majority of the Policy conflicts that were identified in other IDOC facility Audits or before. Action taken and evidence of the institution of these changes were evident. It was also apparent that the Facility was compliant in practice and the 9 “Pending” standards and 2 finding of “Non-Compliance” with PREA Standards were based on evidence of official Agency Policy change to meet the PREA requirements for Compliance to support the Facility level of Compliance with Standards.

On August 1, 2016 the Agency and Facility Provided Evidence and Documentation that resolved 9 the “Pending” findings based on Agency Policy (each of these are noted in the Evidence and Observation of the applicable standards). This change in Policy brought 115.367 into the Exceeds Standards determination.

The Facility entered into a Corrective Action Period (CAP) beginning on August 12, 2016. The Corrective Action was to provide documentation and verification that IDOC Policy 00-01-03 and 02-01-115 were received by applicable Agency and Facility Staff and were integrated into the IDOC Investigations and Intelligence Division and at Camp Summit. The CAP was specifically regarding IDOC Policy that conflicted and in IDOC Policy 00-01-03 compliance with 115.321 and 115.364

As of September 14, 2016 Camp Summit’s Final Audit Report was completed and sent for review as the Facility has been found Compliant with PREA Standards.

DESCRIPTION OF FACILITY CHARACTERISTICS

The Camp Summit Boot Camp (CSBC) is a medium security facility that opened in February 1995 at 2407 North 500 West, in La Porte, Indiana. The facility's rated capacity is 94 cadets with a medium custody level. The facility's compound is a single 12 foot high perimeter fence with razor wire at the top and a concrete footing that runs the length of the perimeter fence. There are two breaks in the perimeter fence. There is a staff and visitor entrance at the administration building and a sally-port entrance for cadet and free world deliveries.

Two weeks prior to the on-site PREA Audit component CSBC was monitored by the AMERICAN CORRECTIONAL ASSOCIATION (ACA) and found to be compliant with ACA standards. A copy of the ACA monitoring report was provided for the PREA Audit and although that report was not PREA-focused it provided excellent insight into the current CSBC operations as well as the findings of ACA.

There are seven buildings in the compound. The main building, which is the largest, houses the administrative offices, food services, program areas, central control complex, laundry facilities, and the cadet residential living units. The remaining six buildings house the academic/vocational complex, three portable school buildings that are used for education and staff training, and a maintenance building. The cadet (resident, student, offender) residential living units in the main building are divided into three dormitories consistent with CSBC's three program phases (i.e., recruit, cadet, and senior), which correspond with the orientation, growth, and transition/release levels of the facility's Comprehensive Case Management System (CCMS). Each level represents a step in the development of skills while promoting cognitive and behavioral changes.

A day in the life of a cadet includes reveille promptly at 5:15 a.m., education, physical fitness, health, teambuilding, life skills, counseling, and special programs. The cadets develop pro-social skills of planning, decision-making, problem-solving, peer selection, anger and conflict management, and personal and social responsibility. There are three resident living areas that are all in the main building. These Open Dorm/Bay units are monitored by staff and by motion activated video surveillance. Review showed that if a cadet (resident, student, and offender) turns over in their sleep the camera is activated and utilizes infrared technology to monitor actions in the dark room. Only two of the dorms have "wet areas" this area is for newly arriving residents who complete their orientation and assessment period in this dorm. These residents utilize the shower in one of the two larger dorms and have access to restroom facilities where they are only allowed to enter one at a time and are monitored. Interview with the Superintendent and other staff indicate that when possible restrooms and showers are utilized by one resident at a time. When this is not possible a male staff stands at the door where they can be seen on camera and monitor the residents. All interviews including those with residents indicated this is the practice.

There are a total of 64 cameras at SCBC-- 14 located on the exterior and 50 located in the interior of the buildings. Some are fixed position cameras while some have pan/tilt/zoom capability. The camera system has been upgraded in the past 12 months to create a constant line of sight designed to show any deviations throughout the facilities. There are no cameras in "wet areas" (bathroom and showers) and the camera is posted to view the door but not toilets, showers, or designated changing areas. The upgrades in the camera system during the past year significantly enhanced the safety of the residents and staff at Camp Summit and the placement and implementation is well designed and is functioning well. The camera quality and the capabilities also added to the protection of residents as the cameras are designed to work in light or dark and are motion activated. This capability was viewed and cameras were activated by the movement of a resident rolling over in their bunk during sleeping hours. All cameras, which provide security, safety, and accountability for cadets as well as staff are monitored in central control, in the Superintendent's office, in the shift supervisor's office and the Central Office of the Agency including the PREA Coordinator and Agency Head can view the facility at any time. Camp Summit staff communicates by hand-held radios. Importantly, the Camp Summit cameras can be accessed off-site for random monitoring of the facility at any time by the Agency Head, PREA Coordinator or others designated by the Agency Head.

The Facility design, the use of the video surveillance, level of staff training, structure of the program, commitment of the Superintendent, PCM, and Department Heads, and the screening and assessment of youth both prior to and upon arrival at Camp Summit all significantly impact the safety and protection of Cadets/Residents from Sexual Abuse and Sexual Harassment. It was apparent that Cadets/Residents and staff were aware of the Zero Tolerance Policy, what to report, when to report, how to report and multiple ways to report Sexual Abuse and Sexual Harassment. It was apparent that cross gender viewing would not occur if Facility procedures were followed and all evidence indicated this is consistently followed. Overall the physical design and the use and placement of video surveillance cameras were optimized to meet the requirements for compliance with PREA Standards.

SUMMARY OF AUDIT FINDINGS

Pre-Audit review of Agency Policies and Procedure identified 11 standards that Agency Policy did not comply with standards. Documentation provided by the Facility indicated that the Facility had already taken steps through directives to address these areas and that these Policies had been identified in prior IDOC Facility Audits and that changes to these Policies were in progress.

During the onsite component of this PREA Audit the further review of Facility documentation, practices, Official Directives from the Superintendent and PCM it was apparent that the Facility met the intent of the standards and provided documentation. In practice compliance of the Facility was apparent; however, Agency Policies that had omissions, alternating definitions, or were in need of updating to find the Facility compliant. Interviews with the Superintendent and the PC indicated the Agency was aware of these issues and was already in progress of changing these Policies. At the conclusion of the onsite portion of this PREA Audit, it was determined that the Facility “Exceeded Standard” on four PREA Standards [115.318, 115.334, 115.341 & 115.353], was “Compliant” in 26 PREA Standards, required evidence of compliance for nine standards and was Non-Compliant on two Standards [115.321 and 115.364]. This determination was made based on Facility practices being compliant and documentation of directives by the Superintendent of the Facility addressing the vast majority of the Policy conflicts that were identified in other IDOC facility Audits. Action taken and evidence of the institution of these changes were Agency Policy change to meet the PREA requirements for Compliance to support the Facility level of Compliance with Standards. It was also apparent that the Facility was compliant and the 9 “Pending” standards were based on evidence of official acceptance and implementation of the necessary changes of IDOC Policies.

On August 1, 2016 the Agency and Facility Provided Evidence and Documentation that resolved 9 the “Pending” findings based on Agency Policy (each of these are noted in the Evidence and Observation of the applicable standards). This change in Policy brought 115.367 into the Exceeds Standards determination. The new Policies were adopted and put into place through Executive Directives by the Agency Head. Verification was received by the Facility that these policy updates had been received and were in place. As onsite review found evidence of compliance at the Facility it was found that the updates to Policy and Verification of receipt and acknowledgement by the Facility and Facility Staff was adequate to find the Facility Compliant. This was due to the processes in place at the Facility indicated the institutionalized practice of the standards. Policy changes required the additions of wording around Isolation, truth telling devices, and definition corrections. Camp Summit does not utilize Isolation or truth telling devices and Facility Compliance was evident through review, interviews and records.

The Facility entered into a Corrective Action Period (CAP) beginning on August 12, 2016. The Corrective Action was to provide documentation and verification that IDOC Policy 00-01-03 and 02-01-115 were received by applicable Agency and Facility Staff and were integrated into the IDOC Investigations and Intelligence Division and at Camp Summit. The CAP was specifically regarding IDOC Policy that conflicted and in IDOC Policy 00-01-03 compliance with 115.321 and 115.364

The requirements of the Correction Acton Period were met and verified on September 1, 2016 and the Facility was found have met compliance requirements for 115.321 and 115.364 included in the Corrective Action Period which is detailed in the Narrative by Standard in this report.

As of September 14, 2016 Camp Summit’s Final Audit Report was completed and sent for review as the Facility has been found Compliant with PREA Standards.

Number of standards exceeded: 5

Number of standards met: 36

Number of standards not met: 0

Number of standards not applicable: 0

Standard 115.311 Zero tolerance of sexual abuse and sexual harassment; PREA Coordinator

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

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

REQUIREMENTS: 115.311: This standard has four components (a) An agency shall have a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment and outlining the agency’s approach to preventing, detecting, and responding to such conduct; (b) An agency shall employ or designate an upper-level, agency-wide PREA coordinator with sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards in all of its facilities; and (c) Where an agency operates more than one facility, each facility shall designate a PREA compliance manager with sufficient time and authority to coordinate the facility’s efforts to comply with the PREA standards.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the following: 1) Indiana Department of Corrections (IDOC) policy number 02-01-115; 2) the Pre-Audit Questionnaire; 3) IDOC's Organizational Chart; 4) The Facility’s Organizational Chart; 5) Facility memos; 6) Interviews with staff (i.e., the PREA Coordinator, Facility PREA Compliance Manager, Facility Head, Security Staff, Residents, and Specialized Staff); 7) IDOC Policy Change and Executive Directive D #16-45, IDOC Policy Change and Executive Directive D #16-46; and Documentation that Agency and Facility Staff aware of these changes and signed Acknowledgement Form; and 8) Sexual Abuse Allegations made at the Facility, Investigations, and Findings.

OBSERVATIONS: During the Pre-Audit and On-Site Audit the Agency policy did not appear to meet PREA Standard as the Agency policy did not contain all the required elements. Specifically there were definitions issue that did not contain the required wording in Agency Policy and Agency Created Resident Hand Books. In practice and on the Facility Site it was evident there was Zero Tolerance for Sexual Abuse and Sexual Harassment. Facility compliance was based on training curriculums, interview with staff, response to reported allegations and facility Procedures. The Agency’s Policies required for language be added or modified to ensure all Policies matched and definitions in Policy was the same as Resident and Staff materials. On August 1, 2016 the Agency provided a revised IDOC Policy 02-01-115 that included the necessary language and definitions to meet standard and provided an “Executive Directive” #16-45 that identified the change and revision for the Agency and Facility. Based on these changes and all evidence that they were in place at the Facility and acknowledgement by Facility Staff of these changes brought the Facility in Compliance with 113.311.

DETERMINATION: It was determined that the Facility, in all material ways, *meets* this Standard.

Standard 115.312 Contracting with other entities for the confinement of residents

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

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.

REQUIREMENTS: 115.312: This standard has two components: (a) A public agency that contracts for the confinement of its inmates with private agencies or other entities, including other government agencies, shall include in any new contract or contract renewal the entity’s obligation to adopt and comply with the PREA standards; (b) Any new contract or contract renewal shall provide for agency contract monitoring to ensure that the contractor is complying with the PREA standards.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the following: 1) the Pre-Audit Questionnaire; 2) Samples of signed contracts; and 3) Interview(s) with the Agency and Facility staff responsible for contract monitoring.

OBSERVATIONS: Contracts provided showed that the Agency has two contracts for confinement services. Each of these contracts include the provision for ensuring the contracted facilities adhere to and follow PREA Standards. Interviews with the staff responsible for contract monitoring indicate that one facility has completed a PREA Audit and that the other is undergoing one in July 2016. Further, the interviewees indicated that they have conducted onsite visits to assess the contracted facilities’ compliance with PREA.

DETERMINATION: It was determined that the Facility, in all material ways, *meets* this Standard.

Standard 115.313 Supervision and monitoring

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

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

REQUIREMENTS: 115.313: This standard has four components: (a) a staffing plan has been created; (b) deviations from the staffing plan are documented; (c) the staffing plan is reviewed annually; and (d) for secure facilities, where unannounced rounds occur, staff are prohibited from alerting other staff that such rounds are occurring.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the following: 1) the Indiana Department of Corrections (IDOC) policy number 02-01-115; 2) the Pre-Audit Questionnaire; 3) Facility's Staffing Plan; 4) Review of video monitoring systems; 5) Review of Staff Log Book and Unannounced Rounds; and 6) Interviews with staff (i.e., specifically the Superintendent, PREA Compliance Manager (PCM), and the PREA Coordinator(PC)).

OBSERVATIONS: Interviews and paperwork documented that a Facility Staffing Plan was developed and implemented with zero staffing plan deviations in the past 12-month period due to the ability to utilize voluntary and mandatory overtime pay; as well as the use of supervisory staff to fill in to fill gaps that would result in deviations. The Facility Staffing Plan presented by the Superintendent included an annual assessment to "determine, and document for each Facility whether adjustments are needed relative to the following: (1) the staffing levels established pursuant to this Standard; (2) prevailing staffing patterns; and (3) the Facility's deployment of video monitoring systems and other monitoring technologies." The Standard also adds a requirement that the annual assessments examine the resources the Facility has available to commit to ensure adequate staffing levels; evidence was provided that indicates that this requirement is met. In addition, this Auditor reviewed over 20 documents supporting unannounced round checks in the Facility. A review of the video evidence provided showed that the staff who signed the log for unannounced rounds in the area documented them within the time period and in the eight randomly selected samples reviewed the staff was shown on camera completing unannounced rounds within a two minute window of the time they entered the resident area, monitored the situation and documented in the log in red ink that the round was completed. Thus, it was determined that there was sufficient evidence that unannounced rounds at the Facility were completed as documented.

DETERMINATION: It was determined that the Facility, in all material ways, *Meets* this Standard.

Standard 115.315 Limits to cross-gender viewing and searches

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

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

REQUIREMENTS: 115.315: This standard has six components: (a) The facility shall not conduct cross-gender strip searches or cross-gender visual body cavity searches (meaning a search of the anal or genital opening) except in exigent circumstances or when performed by medical practitioners; (b) The agency shall not conduct cross-gender pat-down searches except in exigent circumstances; (c) The facility shall document all cross-gender strip searches and cross-gender visual body cavity searches, and shall document all cross-gender pat-down searches of female inmates; (d) The facility shall implement policies and procedures that enable inmates to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks. Such policies and procedures shall require staff of the opposite gender to announce their presence when entering an inmate housing unit; (e) The facility shall not search or physically examine a transgender or intersex inmate for the sole purpose of determining the inmate's genital status. If the inmate's genital status is unknown, it may be determined during conversations with the inmate, 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; and (f) The agency shall train security staff in how to conduct cross-gender pat-down searches, and searches of transgender and intersex inmates, in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the following: 1) the Indiana Department of Corrections (IDOC) policy number 02-01-115; 2) the Pre-Audit Questionnaire; 3) The Facility's Staffing Plan; 4) Interviews with 11 security staff; 5) Video footage hallway outside of the communal shower times; 6) Tour of Facility review of camera location and showers, toilet areas and isolation rooms; and 7) Interviews with residents (specifically, 10 randomly selected residents).

OBSERVATIONS: The Pre-Audit Questionnaire and the information gathered during the onsite auditing indicate that cross-gender pat-down searches are prohibited unless there is an exigent circumstance and that there had not been exigent circumstances in the past 12-month period. All staff (100.0%) noted that they announce their presence when entering a housing unit if they are the only representative of their gender in the unit and that cross-gender pat-down searches, or viewing residents while changing did not occur and was prohibited. Interviews with all residents 100% noted that they had never seen or experienced a cross-gender pat-down search and they felt they could change clothes, perform bodily functions, and/or shower without staff of the opposite gender viewing their genitalia, breasts, or buttocks. Both residents and staff members explained how this was done in the open bay/dorm units at a level of consistency that it was apparent that female staff members either remained in the areas of the dorm with no view to the communal shower and toilets or they were shifted to the other dorm to exchange positions with a male staff. The physical design of the communal rest rooms/showers are located where to walk past one must enter a secure door or move to exit through a secure door. Male staff are posted at the door of the showers/restroom unless only one resident is using the toilet or shower. Due to the physical design any viewing by cross gender staff would be deliberate and captured on video due to the location of the camera that views the doorway where staff stand but does not show the shower or toilet areas. There are two shower stalls that can be viewed if directly in front of the door of the restrooms/shower; however the facility has placed doors on these stalls that go from knees to shoulders on a person of average height. It is possible that an unusually tall resident's breasts may be visible over these doors but this would be rare and there are 4 stalls that are not viewable at all if needed; however this is unlikely to be an issue due to the previous mentioned considerations to prevent cross gender viewing. All evidence and interviews considered made it very apparent that components of 115.315 as defined by PREA; except in exigent circumstances identified consistently by security staff as "the safety of residents and staff" due to unforeseen circumstances such as medical or physical conflict are met.

DETERMINATION: It was determined that the Facility, in all material ways, *meets* this Standard.

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

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

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

REQUIREMENTS: 115.316: This standard has three components: (a) The agency shall take appropriate steps to ensure that inmates with disabilities (including, for example, inmates who are deaf or hard of hearing, those who are blind or have low vision, or those who have intellectual, psychiatric, or speech 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; (b) The agency shall 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 inmates who are limited English proficient, including steps to provide interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary; and (c) The agency shall not rely on inmate interpreters, inmate readers, or other types of inmate assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the inmate's safety, the performance of first-response duties under §115.642, or the investigation of the inmate's allegations.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the following: 1) the Indiana Department of Corrections (IDOC) policy number 02-01-115; 2) the Pre-Audit Questionnaire; 3) Various forms; 4) Interviews with 11 security staff; 5) the contract for Interpreter Services through an outside provider; and 6) Interviews with residents (specifically, 10 randomly selected residents).

OBSERVATIONS: IDOC Policy 02-01-115 (Sexual Abuse Prevention Policy, 12/01/2014, on page 10) notes "Offenders shall not be used as interpreters or readers unless there would be an extended delay in obtaining an effective interpreter that could compromise the offender's safety, the performance of first responders, or the investigation of the offender's allegation." The Facility maintains a contract for Interpreter Services with an outside service that is utilized as needed. The Facility supervisors indicated that there is also a call in translation service available for the vast majority of existing languages. Additionally, interviews with the Facility Superintendent and staff indicated that due to the level of physical and mental capacity necessary for success at Camp Summit Boot Camp all residents are assessed at the Logansport Intake Unit prior to placement in the IDOC Juvenile System. Only youth who meet the minimal physical and cognitive abilities are placed into the Camp Summit Boot Camp Program. Because of this assessment and requirements designed to prevent setting youth up to be unsuccessful at Camp Summit; prior to their arrival the Facility would be aware of any special needs in regards to language and learning disabilities as youth do not arrive at Camp Summit without the completion of the Assessment in Logansport. Camp Summit would have advanced notice of the need for any special needs of the youth prior to their placement and would have addressed these needs in the resident's treatment plan.

DETERMINATION: It was determined that the Facility, in all material ways, *Meets* this Standard.

Standard 115.317 Hiring and promotion decisions

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

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

REQUIREMENTS: 115.317: This standard has nine components: (a) The agency shall not hire or promote anyone who may have contact with inmates, and shall not enlist the services of any contractor who may have contact with inmates, who— [(1) 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); (2) 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; or (3) Has been civilly or administratively adjudicated to have engaged in the activity described in paragraph (a)(2) of this section]; (b) The agency shall consider any incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any contractor, who may have contact with inmates; (c) Before hiring new employees who may have contact with inmates, the agency shall: [(1) Perform a criminal background records check; and (2) 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]; (d) The agency shall also perform a criminal background records check before enlisting the services of any contractor who may have contact with inmates; (e) The agency shall either conduct criminal background records checks at least every five years of current employees and contractors who may have contact with inmates or have in place a system for otherwise capturing such information for current employees; (f) The agency shall ask all applicants and employees who may have contact with inmates directly about previous misconduct described in paragraph (a) of this section in written applications or interviews for hiring or promotions and in any interviews or written self-evaluations conducted as part of reviews of current employees. The agency shall also impose upon employees a continuing affirmative duty to disclose any such misconduct; (g) Material omissions regarding such misconduct, or the provision of materially false information, shall be grounds for termination; and (9) Unless prohibited by law, the agency shall 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.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility relied on the following: 1) Pre-Audit Questionnaire; 2) IDOC Policy 02-01-115; 3) IDOC Policy 04-03-103 (effective 12/01/2012); 4) Review of 12 staff files; 5) Copy of all Background Check Forms completed; and 6) Onsite audit interviews with staff (specifically, IDOC Human Resource staff) at the Divisional Office 7 miles away from the facility.

OBSERVATIONS: In a review of 12 staff files and 2 contractor files, 100% had a criminal history check performed in the past five years. The Agency has gone to a rotating background check system that will ensure that all staff have background checks every four (4) years and at this location and in the files reviewed all were up to date. Additionally, records showed that contact with prior institutional employers for information on substantiated allegations of sexual abuse or any resignations during a pending investigation of an allegation of sexual abuse occurred and is in the guidelines and records. Human Resource staff showed these completed records in the randomly selected files or the efforts to secure this information. The Human Resource staff also showed all the various systems they use based on sex offender registries, searches in all areas of former residence, prior contact with those in confinement, and the state's full disclosure policy between state agencies. Interviews with HR Staff noted that the Agency would provide, to the extent allowable by law, information related to a substantiated allegation of sexual abuse or sexual harassment to other law enforcement agencies and that this is public information that can be accessed by employers if so desired and that any private facility can access this information without contacting the Agency. Further, there was nothing in policy to direct staff to provide this information per PREA requirements. The IDOC Divisional Office also provided evidence that the Diana Screening is currently being used as a screening tool for all applicants.

DETERMINATION: It was determined that the Facility, in all material ways, *Meets* this Standard.

Standard 115.318 Upgrades to facilities and technologies

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

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.

REQUIREMENTS: 115.318: This standard has two components: (a) When designing or acquiring any new facility and in planning any substantial expansion or modification of existing facilities, the agency shall consider the effect of the design, acquisition, expansion, or modification upon the agency's ability to protect residents from sexual abuse; and (b) When installing or updating a video monitoring system, electronic surveillance system, or other monitoring technology, the agency shall consider how such technology may enhance the agency's ability to protect residents from sexual abuse.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor 1) the Pre-Audit Questionnaire; 2) a facility tour, review of system, review of lay out, review; 3) ACA report, 4) interviews with staff and residents; and 5) Review of Sexual Abuse Allegation Investigation that included the use of video in the determination.

OBSERVATIONS: The Facilities considered the design of the system when updating it and how it would protect residents from sexual abuse. In doing so the updating and improvement of the video monitoring system profoundly increases the Facility and the Agency's ability to protect residents from sexual abuse. The system put into place is motion activated and views in the dark. If a resident moves the camera in the dorm is activated. There is no reason for staff or residents to leave the line of sight of the system and limited areas where this is possible but they will be seen leaving deliberately. Based on the Agency and Facility policies and procedures, Pre-Audit Questionnaire, and the Onsite Audit (including the Facility tour and the staff and resident interviews), it was determined that the standard was met but though the implementation of this upgraded and expanded video monitoring system not only did the Agency and Facility consider its ability to protect residents from sexual abuse it implemented a video monitoring system that significantly enhances the ability of the Facility to protect residents from Sexual Abuse. Additionally this video monitoring system was the essential in the findings of the recent allegation of staff on resident sexual abuse as the camera showed that at the time of the allegation the staff does not leave the view of the video monitoring system and based on the allegations it would not be possible to occur while staff was on camera without the alleged abuse being captured. Due to the design the enhancements are profound and staff are aware of how the system can and will be used in an investigation as a result and it is also being utilized to change policies to further protect residents and staff based on the findings of the Investigation and the Incident Review Team. Based on this evidence the Facility has exceeded the Standard that requires the consideration as they clearly considered enhanced protection of resident safety from sexual abuse and implemented the system that has proven effective to date.

DETERMINATION: It was determined that the Facility, in all material ways, *Exceeds* this Standard.

Standard 115.321 Evidence protocol and forensic medical examinations

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

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

REQUIREMENTS: 115.321: This standard has eight components: (a) To the extent the agency is responsible for investigating allegations of sexual abuse, the agency shall follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions; (b) The protocol shall be developmentally appropriate for youth and, as appropriate, shall be 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; (c) The agency shall offer all residents who experience sexual abuse access to forensic medical examinations whether on-site or at an outside facility, without financial cost, where evidentiary or medically appropriate. Such examinations shall be performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) where possible. If SAFEs or SANEs cannot be made available, the examination can be performed by other qualified medical practitioners. The agency shall document its efforts to provide SAFEs or SANEs; (d) The agency shall attempt to make available to the victim a victim advocate from a rape crisis center. If a rape crisis center is not available to provide victim advocate services, the agency shall make available to provide these services a qualified staff member from a community-based organization or a qualified agency staff member. Agencies shall document efforts to secure services from rape crisis centers. For the purpose of this standard, a rape crisis center refers to an entity that provides intervention and related assistance, such as the services specified in 42 U.S.C. 14043g(b)(2)(C), to victims of sexual assault of all ages. The agency may utilize a rape crisis center that is part of a governmental unit as long as the center is not part of the criminal justice system (such as a law enforcement agency) and offers a comparable level of confidentiality as a nongovernmental entity that provides similar victim services; (e) 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 and shall provide emotional support, crisis intervention, information, and referrals; (f) To the extent the agency itself is not responsible for investigating allegations of sexual abuse, the agency shall request that the investigating agency follow the requirements of paragraphs (a) through (e) of this section; (g) The requirements of paragraphs (a) through (f) of this section shall also apply to: [(1) Any State entity outside of the agency that is responsible for investigating allegations of sexual abuse in juvenile facilities; and (2) Any Department of Justice component that is responsible for investigating allegations of sexual abuse in juvenile facilities.] (h) For the purposes of this standard, a qualified agency staff member or a qualified community-based staff member shall be an individual who has been screened for appropriateness to serve in this role and has received education concerning sexual assault and forensic examination issues in general.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the 1) Pre-Audit Questionnaire; 2) IDOC Policy 02-01-115; 3) IDOC Policy 00-01-103 (under Section C. Evidence and Case Reporting Procedures and Best Practices); 4) interviews with staff (specifically, the Facility Superintendent, PCM, Staff and Specialized Staff); 5) Revised IDOC Policy 00-01-013; 6) Executive Directive #16-45 Effective 8/12/2016; and 7) Staff Training and Acknowledgement Signature Pages of August 12, 2016 Executive Directives now in effect.

OBSERVATIONS: The Facility does have investigators who conduct both criminal and administrative investigations. Investigators have the required PREA-related training. All staff reported that they understood their role as first responder and all 11 randomly selected staff who were interviewed were able to describe the procedures that a first responder is to use. IDOC Policy 02-01-115 adheres to this Standard. However, IDOC Policy 00-01-103 appears to deviate from this Standard. Specifically, 00-01-103, under Section C. states only DNA from the victim is to be collected. During the on-site review which PREA Audit Report

included a review of policy, the single Investigation based on alleged Sexual Abuse in the past 12 months, the Coordinated Response Plan, use of a Sexual Abuse Response Team interviews and Training Curriculum, and interviews and with the Facility Head, PREA Compliance Manager, PREA Coordinator, Agency Criminal Investigators, Administrative Investigators, and Interviews with both Security and other staff members it was determined that the facility was compliant in its practices related to 115.321. However, the existing IDOC Policy 00-01-103 for Intelligence and Investigations under Section C stated only DNA from the victim is to be collected. There does not appear to be any mention of collecting DNA from the alleged perpetrator. On August 5, 2016 Executive Directive # 16-44 and revised IDOC Policy 02-01-115. On August 1, 2016 Executive Directive #16-45 and revised was released and addressed policy issues identified but the data effective is 8/12/2016 and does not ensure that Administrative and Investigative Staff have receive or are aware of this change. IDOC Policy 02-01-115 had always included both the victim and perpetrator language, as well as the SART Training and all facility staff understood that this was the procedure. Agency Investigation and Intelligence Policy 00-01-103 is limited to Investigators throughout the Agency who have also completed SART and are Correctional Police Officers. All Facility staff were aware of their responsibilities as a first responder and were aware of 02-01-115. All Investigators were also aware of the procedure of collecting or maintaining useable physical evidence on both the victim and alleged perpetrator. The period of Corrective Action was entered into to ensure that all staff were aware of the changes to IDOC Policy 00-01-103 to match the same language as Standard 115.321 and IDOC Policy 02-01-115. The Corrective Action Period and subsequent findings are indicated below.

INTERIM DETERMINATION: It was determined that the Facility, in all material ways, *does not* meet this Standard.

CORRECTIVE ACTION PLAN: 1. Review all revisions and status of implementation after 08/12/2016 regarding changes to IDOC 00-01-103 and Executive Directive #16-45. 2. Provide verification that Facility Administrative Investigative Staff and Agency Criminal Investigative Staff for Juveniles have been made aware of this change and acknowledge receipt of this policy change. 3. Provide Documentation that the indicated staff have been made aware and have received this information to Auditor.

CORRECTIVE ACTION PLAN COMPLETED – EVIDENCE OF COMPLIANCE: On August 30, 2016 the PREA Compliance Manager of Camp Summit Provided Documentation that Applicable Facility Staff and Agency Staff outlined in the Corrective Action Plan as Facility Administrative Investigative Staff and Agency Criminal Investigative staff had received and acknowledged the receipt and awareness of the changes to IDOC Policy for 00-01-103 regarding Investigations. During the on-site review which included a review of policy, the single Investigation based on alleged Sexual Abuse in the past 12 months, the Coordinated Response Plan, use of a Sexual Abuse Response Team interviews and Training Curriculum, and interviews and with the Facility Head, PREA Compliance Manager, PREA Coordinator, Agency Criminal Investigators, Administrative Investigators, and Interviews with both Security and other staff members it was determined that the facility was compliant in its practices related to 115.321. However, the existing IDOC Policy 00-01-103 for Intelligence and Investigations under Section C stated only DNA from the victim is to be collected. There appeared to be no mention of collecting DNA from the alleged perpetrator in IDOC Policy 00-01-103. The Corrective Action Period required that the Facility Provide evidence that IDOC Policy 00-01-103 adopt the language included in 115.321 to match IDOC Policy 02-01-115 that included the preservation and collection of DNA evidence from the victim and the alleged perpetrator, if known. The Corrective Action Period materials were received on 8/30/2016 and have been verified to be in place and that the required IDOC and Camp Summit staff members as identified in the Corrective Action Plan were made aware of this change and had acknowledge awareness of the change in IDOC 00-01-103 by signature. As the On-Site Audit of the Facility and review of all evidence indicated this was already the practice and the wording from IDOC 00-01-103 was an omission and this omitted wording was included in IDOC 02-01-115, SART Training Curriculum, Staff Training, and the Coordinated Response Plan. The evidence of Policy Change and ED #16-45, documentation of the notification of this change, signed acknowledgement form by the IDOC and Camp Summit Facility Administrative Investigative Staff and Agency Criminal Investigative Staff for Juveniles, and contact with the Facility Head and PREA Compliance Manager at Camp Summit to verify that this was completed and was the practice provided was adequate evidence to find Camp Summit to be Compliant with 115.321.

FINAL DETERMINATION: It was determined on September 6, 2016 that the Facility, in all material ways, *Meets* this Standard.

Standard 115.322 Policies to ensure referrals of allegations for investigations

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

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

REQUIREMENTS: 115.322: This standard has five components: (a) The agency shall ensure that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment; (b) The agency shall have in place a policy 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. The agency shall publish such policy on its website or, if it does not have one, make the policy available through other means. The agency shall document all such referrals; (c) If a separate entity is responsible for conducting criminal investigations, such publication shall describe the responsibilities of both the agency and the investigating entity; (d) Any State entity responsible for conducting administrative or criminal investigations of sexual abuse or sexual harassment in juvenile facilities shall have in place a policy governing the conduct of such investigations; (e) Any Department of Justice component responsible for conducting administrative or criminal investigations of sexual abuse or sexual harassment in juvenile facilities shall have in place a policy governing the conduct of such investigations.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the 1) Pre-Audit Questionnaire; 2) IDOC Policy 02-01-115; 3) interviews with staff (specifically, the Facility Superintendent, PCM and Specialized Staff); 4) Copies of completed investigations; 5) the Facility website; 6) Revised Policy 02-01-115 and ED #16-45; and 7) Staff Training Records.

OBSERVATIONS: During the Pre-Audit and On-Site components of this Audit the Agency's policy does not mention that it will investigate all sexual abuse and sexual harassment allegations. The Agency defines sexual abuse as three distinct acts (02-01-115 definitions) however the policy notes that staff will only investigate 2 of the 3 distinct acts. Further, the Facility notes that 02-01-115 will act as the Facility's "Investigation Policy" that will be published on the web. However, the investigation section of 02-01-115 only notes "INVESTIGATION OF SEXUAL ABUSE" and does not reference sexual harassment until the middle of paragraph and that paragraph references "harassment" but not sexual harassment. While interviews indicated that the Facilities and Training Documentation indicated Compliance, the wording within Agency Policy did not adequately meet the requirements for compliance. On August 1, 2016 the Facility provided evidence of Policy Change and ED #16-45, documentation of the notification of this change, signed acknowledgement form by the IDOC and Camp Summit Facility Administrative Investigative Staff and Agency Criminal Investigative Staff for Juveniles, and contact with the Facility Head and PREA Compliance Manager at Camp Summit to verify that this was completed and was the practice provided was adequate evidence to find Camp Summit to be Compliant with 115.322. This evidence was considered adequate as verification of implementation and staff awareness and acknowledgement was made.

DETERMINATION: It was determined that the Facility, in all material ways, *Meets* this Standard.

Standard 115.331 Employee training

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

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

REQUIREMENTS: 115.331: This standard has four components: (a) The agency shall train all employees who may have contact with residents on 11 required topics; (b) Such training shall be tailored to the unique needs and attributes of residents of juvenile facilities and to the gender of the residents at the employee’s facility. The employee shall receive additional training if the employee is reassigned from a facility that houses only male residents to a facility that houses only female residents, or vice versa; (c) All current employees who have not received such training shall be trained within one year of the effective date of the PREA standards, and the agency shall 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. In years in which an employee does not receive refresher training, the agency shall provide refresher information on current sexual abuse and sexual harassment policies; and (d) The agency shall document, through employee signature or electronic verification, that employees understand the training they have received.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the 1) Pre-Audit Questionnaire; 2) IDOC Policy 02-01-115; 3) interviews with staff (specifically, the 11 randomly selected security staff, 2 contractors, and Specialized Staff members; 4) Training forms; and 5) Training curricula.

OBSERVATIONS: All staff interviewed noted that they did receive all of the required PREA training. All staff interviews noted they felt they receive training that was specific to the “unique needs and attributes and gender of the residents at the Facility.” In a review of staff files it was apparent that staff received the required PREA training prior to having contact with residents.

DETERMINATION: It was determined that the Facility, in all material ways, *Meets* this Standard.

Standard 115.332 Volunteer and contractor training

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

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

REQUIREMENTS: 115.332: This standard has three components: (a) The agency shall ensure 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; (b) 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, but all volunteers and contractors who have contact with residents shall be notified of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents; and (c) The agency shall maintain documentation confirming that volunteers and contractors understand the training they have received.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the 1) Pre-Audit Questionnaire; 2) IDOC Policy 02-01-115; 3) interviews with staff (specifically, the 11 randomly selected security staff, 2 contractors, and Specialized Staff members; 4) Training forms and Verification of Records for Contractors and Volunteers; and 5) Training curricula.

OBSERVATIONS: The Facility provided evidence that all contractors and volunteers had received the required training and interviews with contractors noted that they had received the training. A review of volunteer and contractor files noted that volunteers and contractors were provided with the required PREA training prior to having contact with residents.

DETERMINATION: It was determined that the Facility, in all material ways, *Meets* this Standard.

Standard 115.333 Resident education

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

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

REQUIREMENTS: 115.333: This standard has six components: (a) During the intake process, residents shall receive information explaining, in an age appropriate fashion, the agency's zero tolerance policy regarding sexual abuse and sexual harassment and how to report incidents or suspicions of sexual abuse or sexual harassment; (b) Within 10 days of intake, the agency shall provide comprehensive age-appropriate education to residents either in person or through video regarding 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; (c) Current residents who have not received such education shall be educated within one year of the effective date of the PREA standards, and shall receive education upon transfer to a different facility to the extent that the policies and procedures of the resident's new facility differ from those of the previous facility; (d) The agency shall provide resident education in formats accessible to all residents, including those who are limited English proficient, deaf, visually impaired, or otherwise disabled, as well as to residents who have limited reading skills; (e) The agency shall maintain documentation of resident participation in these education sessions; and (f) In addition to providing such education, the agency shall ensure that key information is continuously and readily available or visible to residents through posters, resident handbooks, or other written formats.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor: 1) Pre-Audit Questionnaire; 2) IDOC Policy 02-01-115; 3) interviews with residents (specifically, 10 randomly selected residents and one resident who had made two reports of alleged sexual harassment); 4) Training forms; 5) Training curricula; 6) A review of 15 resident files; 7) Revised Policy 02-01-115 and ED #16-45; and 8) Revised Resident Hand Book August 1, 2016.

OBSERVATIONS: A review of 15 residents' files (100.0% of all residents) indicated that PREA information was received at the time of intake as well as Education on the day they arrived at the facility. Interviews with 10 residents noted that 100% indicated they received it upon arrival; additionally 100.0% of the files and 100.0% of the resident interviews noted that the residents did get their PREA Education within 10 days of intake. In a review of materials presented to the residents, different zero tolerance policies were mentioned (e.g., one zero tolerance policy didn't mention sexual harassment and another stated there was a zero tolerance for sexual misconduct but this term was not defined, etc.) Further, definitions were not consistent as the term "vulva" was replaced with "vagina." Revised Resident Handbook was received on August 1, 2016 that demonstrated that this language was in place and being utilized at Camp Summit. Evidence of staff notification and awareness of the change was provided through notification of staff through Revised Policy 02-01-115 and ED #16-45, verification of staff awareness by PCM, PC, and Facility Superintendent, and staff acknowledgement of the change in definitions. As originally there was at least one place where the correct definitions was included and evidence indicated Facility Compliance based on interviews and practices; the Revisions and Changes to ensure consistency through all Policies, Hand Outs, and Materials along with staff acknowledgement of these changes and verification by the PC, PRC and Superintendent that these had be put in place were adequate to determine the Facility was compliant with 115.333.

DETERMINATION: It was determined that the Facility, in all material ways, *Meets* this Standard.

Standard 115.334 Specialized training: Investigations

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

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

REQUIREMENTS: 115.334: This standard has four components: (a) In addition to the general training provided to all employees pursuant to § 115.331, the agency shall ensure that, to the extent the agency itself conducts sexual abuse investigations, its investigators have received training in conducting such investigations in confinement settings; (b) Specialized training shall include techniques for interviewing juvenile sexual abuse victims, proper use of *Miranda* and *Garrity* warnings, sexual abuse evidence collection in confinement settings, and the criteria and evidence required to substantiate a case for administrative action or prosecution referral; (c) The agency shall maintain documentation that agency investigators have completed the required specialized training in conducting sexual abuse investigations; and (d) Any State entity or Department of Justice component that investigates sexual abuse in juvenile confinement settings shall provide such training to its agents and investigators who conduct such investigations.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor: 1) Pre-Audit Questionnaire; 2) IDOC Policy 02-01-115, 3) interviews with Facility and Agency investigators; 4) Documentation of Qualifications; and 4) Training forms.

OBSERVATIONS: Facility provided evidence that all investigators had completed the required PREA training. The Facility due to its small size utilized the Agency's Investigators who have all completed the Correctional Police Officer course and SART Training; as well as the PCM who will often initiate the Investigation process and secure evidence.

DETERMINATION: It was determined that the Facility, in all material ways, *Exceeds* this Standard

Standard 115.335 Specialized training: Medical and mental health care

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

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

REQUIREMENTS: 115.335: This standard has four components: (a) The agency shall ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in [(1) How to detect and assess signs of sexual abuse and sexual harassment; (2) How to preserve physical evidence of sexual abuse; (3) How to respond effectively and professionally to juvenile victims of sexual abuse and sexual harassment; and (4) How and to whom to report allegations or suspicions of sexual abuse and sexual harassment]; (b) If medical staff employed by the agency conduct forensic examinations, such medical staff shall receive the appropriate training to conduct such examinations; (c) The agency shall maintain documentation that medical and mental health practitioners have received the training referenced in this standard either from the agency or elsewhere; and (d) Medical and mental health care practitioners shall also receive the training mandated for employees under §115.331 or for contractors and volunteers under §115.332, depending upon the practitioner’s status at the agency.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor: 1) Pre-Audit Questionnaire; 2) IDOC Policy 02-01-115; 3) interviews with staff (medical and mental health staff); and 4) Training forms.

OBSERVATIONS: Interviews with the medical and mental health staff confirmed that staff received the required training per PREA. These statements were supported by training documents showing that all medical and mental health staff completed this required training. Interviews and Training documentation indicated that medical and mental health staff had been trained according to standards for staff requirements. This was documented along with all specialized training provided.

DETERMINATION: It was determined that the Facility, in all material ways, *Meets* this Standard.

Standard 115.341 Screening for risk of victimization and abusiveness

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

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

REQUIREMENTS: 115.341: This standard has five components: (a) Within 72 hours of the resident's arrival at the facility and periodically throughout a resident's confinement, the agency shall obtain and use information about each resident's personal history and behavior to reduce the risk of sexual abuse by or upon a resident; (b) Such assessments shall be conducted using an objective screening instrument; (c) At a minimum, the agency shall attempt to ascertain 11 pieces of required information (see standard); (d) This information shall be ascertained through conversations with the resident during the intake process and medical and mental health screenings; during classification assessments; and by reviewing court records, case files, facility behavioral records, and other relevant documentation from the resident's files; and (e) The agency shall implement 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.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor: 1) Pre-Audit Questionnaire; 2) IDOC Policy 02-01-115; 3) interviews with staff (specifically, counseling staff responsible for assessing risk); 4) SVAT (Sexual Violence Assessment Tool); and 5) A review of 15 resident files.

OBSERVATIONS: The Facility uses a risk assessment tool that utilizes each resident's intake responses to a variety of questions, including past victimizations and abusiveness. This information is used to help determine a youth's risk of sexual aggression and sexual vulnerability. The staff uses the SVAT, a personal interview, and any other available relevant records to assess each youth's risk for sexual aggressive behavior and vulnerability to sexual victimization on the day they arrive. Staff is aware that they should consider gender nonconforming or manner or identification. In all records reviewed the SVAT was completed on the day of arrival, it was utilized to determine resident risk of sexual abuse by or on another resident. Evidence in 100% of the records indicate not only that the SVAT was administered on the day of arrival, was utilized to ensure safety of residents, remained in a confidential section of the resident's file, and that it was reviewed and updated monthly. Additionally, interviews with the Facility Superintendent and staff indicated that due to the level of physical and mental capacity necessary for success at Camp Summit Boot Camp, all residents are assessed at the Logansport Intake Unit prior to placement in the IDOC Juvenile System. Only youth who meet the minimal physical and cognitive abilities are placed into the Camp Summit Boot Camp Program. Because of this assessment and requirements designed to prevent setting youth up to be unsuccessful at Camp Summit; prior to their arrival the Facility would be aware of any special needs in regards to language and learning disabilities as youth do not arrive at Camp Summit without the completion of the Assessment in Logansport. While every resident who is placed at Camp Summit receives and documentation indicated all had received an SVAT; a two week assessment period occurs at a minimum where this is reviewed prior to placement at Camp Summit.

DETERMINATION: It was determined that the Facility, in all material ways, *Exceeds* this Standard.

Standard 115.342 Use of screening information

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

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

REQUIREMENTS: 115.342: This standard has nine components: (a) The agency shall use all information obtained pursuant to § 115.341 and subsequently to make housing, bed, program, education, and work assignments for residents with the goal of keeping all residents safe and free from sexual abuse; (b) Residents may be isolated from others only as a last resort when less restrictive measures are inadequate to keep them and other residents safe, and then only until an alternative means of keeping all residents safe can be arranged. During any period of isolation, agencies shall not deny residents daily large-muscle exercise and any legally required educational programming or special education services. Residents in isolation shall receive daily visits from a medical or mental health care clinician. Residents shall also have access to other programs and work opportunities to the extent possible; (c) Lesbian, gay, bisexual, transgender, or intersex residents shall not be placed in particular housing, bed, or other assignments solely on the basis of such identification or status, nor shall agencies consider lesbian, gay, bisexual, transgender, or intersex identification or status as an indicator of likelihood of being sexually abusive; (d) In deciding whether to assign a transgender or intersex resident to a facility for male or female residents, and in making other housing and programming assignments, the agency shall consider on a case-by-case basis whether a placement would ensure the resident's health and safety, and whether the placement would present management or security problems; (e) Placement and programming assignments for each transgender or intersex resident shall be reassessed at least twice each year to review any threats to safety experienced by the resident; (f) A transgender or intersex resident's own views with respect to his or her own safety shall be given serious consideration; (g) Transgender and intersex residents shall be given the opportunity to shower separately from other residents; (h) If a resident is isolated pursuant to paragraph (b) of this section, the facility shall clearly document: [(1) The basis for the facility's concern for the resident's safety; and (2) The reason why no alternative means of separation can be arranged]; and (i) Every 30 days, the facility shall afford each resident described in paragraph (h) of this section a review to determine whether there is a continuing need for separation from the general population.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor: 1) Pre-Audit Questionnaire; 2) IDOC Policy 02-01-115; 3) interviews with residents (specifically, 10 randomly Residents); and 4) Interviews with staff (specifically the 11 randomly selected security staff, mental health staff, PCM, Superintendent, and the medical staff); 5) Revised Policy 02-01-115 and ED #16-45; and 6) Acknowledgement by the Facility Head PMC that the Facility is aware of the change in Policy 02-01-115

OBSERVATIONS: All 11 randomly selected staff interviewed supported the contention that the Facility "never" places a resident in isolation for their own protection against sexual victimization. In a review of the policy (02-01-115) it was stated in Agency Policy that the Facility could place a resident in isolation for their own protection. Further, the policy did not specifically state that during any period of isolation, agencies shall not deny residents daily large-muscle exercise and any legally required educational programming or special education services. Residents in isolation shall receive daily visits from a medical or mental health care clinician. Residents shall also have access to other programs and work opportunities to the extent possible. While extended isolation at Facility is reportedly not utilized and not utilized for the protection of residents against sexual victimization the policy does not reflect this. All on-site data collection and review of the facility indicated that isolation is not utilized and that daily large-muscle exercise is a requirement of Camp Summit. Further the facility did not maintain any "areas" that could be utilized for extended isolation or separation and Facility protocols would be to transfer the resident to another Facility. The language of policy 02-01-115 appeared to be non-applicable to Camp Summit as separation or isolation does not occur at the Facility but Agency policy did indicate it was possible and had omitted required language. On August 1, 2016 that demonstrated that this language (agencies shall not deny residents daily large-muscle exercise and any

legally required educational programming or special education services. Residents in isolation shall receive daily visits from a medical or mental health care clinician. Residents shall also have access to other programs and work opportunities to the extent possible) was in place and being utilized at Camp Summit. Evidence of staff notification and awareness of the change was provided through notification of staff through Revised Policy 02-01-115 and ED #16-45, verification of staff awareness by PCM, PC, and Facility Superintendent, and staff acknowledgement of the change to the Agency Policy.

DETERMINATION: It was determined that the Facility, in all material ways, *Meets* this Standard.

Standard 115.351 Resident reporting

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

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

REQUIREMENTS: 115.351: This standard has five components: (a) The agency shall provide multiple internal ways for residents to privately report sexual abuse and sexual harassment, retaliation by other residents or staff for reporting sexual abuse and sexual harassment, and staff neglect or violation of responsibilities that may have contributed to such incidents; (b) The agency shall also provide at least one way for residents to report abuse or harassment to a public or private entity or office that is not part of the agency and that is able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials, allowing the resident to remain anonymous upon request. Residents detained solely for civil immigration purposes shall be provided information on how to contact relevant consular officials and relevant officials at the Department of Homeland Security; (c) Staff shall accept reports made verbally, in writing, anonymously, and from third parties and shall promptly document any verbal reports; (d) The facility shall provide residents with access to tools necessary to make a written report; and (e) The agency shall provide a method for staff to privately report sexual abuse and sexual harassment of residents.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor: 1) Pre-Audit Questionnaire; 2) IDOC Policy 02-01-115; 3) interviews with residents (specifically, 10 randomly selected residents); 4) Interviews with staff (specifically the 15 randomly selected security staff, administrative and criminal investigators and the medical staff); and 5) Review of allegations and investigations of those allegations.

OBSERVATIONS: All staff and residents were able to identify multiple internal ways for a youth to report privately to Facility officials about sexual abuse, sexual harassment, retaliation, and staff neglect or violation of responsibilities that may have contributed to any such incidents. All of the interviewed residents noted that they would tell a staff member, use the #22 number and/or report to their parent or guardians. Posters with the hotline numbers were observed posted in each residential unit at Facility. These numbers as well as the third party email system established were verified as working by the Auditor. As for residents detained solely for civil immigration purposes, this practice is not allowed per policy. All staff, who were interviewed, acknowledged that they must report all verbal reports, anonymous reports, written reports, and reports from third parties regarding allegations of sexual abuse and sexual harassment. The single allegation and investigation for alleged sexual abuse that was determined unfounded verified that verbal reports would be acted upon, that in less than 8 hours the resident had access to contact with parents who also made a third party report that was received by the Superintendent and that the Investigation was completed according to Agency and Facility Policy and Procedures.

DETERMINATION: It was determined that the Facility, in all material ways, *Meets* this Standard.

Standard 115.352 Exhaustion of administrative remedies

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

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

REQUIREMENTS: 115.352: This standard has seven components: (a) An agency shall be exempt from this standard if it does not have administrative procedures to address resident grievances regarding sexual abuse; (b)(1) The agency shall not impose a time limit on when a resident may submit a grievance regarding an allegation of sexual abuse; (2) The agency may apply otherwise-applicable time limits on any portion of a grievance that does not allege an incident of sexual abuse; (b)(3) The agency shall not require a resident to use any informal grievance process, or to otherwise attempt to resolve with staff, an alleged incident of sexual abuse; (b)(4) Nothing in this section shall restrict the agency's ability to defend against a lawsuit filed by a resident on the ground that the applicable statute of limitations has expired; (c) The agency shall ensure that [(1) A resident who alleges sexual abuse may submit a grievance without submitting it to a staff member who is the subject of the complaint, and (2) Such grievance is not referred to a staff member who is the subject of the complaint]; (d)(1) The agency shall 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; (d)(2) Computation of the 90-day time period shall not include time consumed by residents in preparing any administrative appeal; (d)(3) The agency 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 agency shall notify the resident in writing of any such extension and provide a date by which a decision will be made; (d)(4) 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, the resident may consider the absence of a response to be a denial at that level; (e)(1) Third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, shall be permitted to assist residents in filing requests for administrative remedies relating to allegations of sexual abuse, and shall also be permitted to file such requests on behalf of residents; (e)(2) If a third party, other than a parent or legal guardian, files such a request on behalf of a resident, the facility may require as a condition of processing the request that the alleged victim agree to have the request filed on his or her behalf, and may also require the alleged victim to personally pursue any subsequent steps in the administrative remedy process; (e)(3) If the resident declines to have the request processed on his or her behalf, the agency shall document the resident's decision; (e)(4) A parent or legal guardian of a juvenile shall be allowed to file a grievance regarding allegations of sexual abuse, including appeals, on behalf of such juvenile. Such a grievance shall not be conditioned upon the juvenile agreeing to have the request filed on his or her behalf; (f)(1) The agency shall establish procedures for the filing of an emergency grievance alleging that a resident is subject to a substantial risk of imminent sexual abuse; (f)(2) After receiving an emergency grievance alleging a resident is subject to a substantial risk of imminent sexual abuse, the agency shall 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, shall provide an initial response within 48 hours, and shall issue a final agency decision within 5 calendar days. The initial response and final agency decision shall document the agency's determination whether the resident is in substantial risk of imminent sexual abuse and the action taken in response to the emergency grievance; and (g) The agency may discipline a resident for filing a grievance related to alleged sexual abuse only where the agency demonstrates that the resident filed the grievance in bad faith.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the 1) Pre-Audit Questionnaire; 2) Executive Directive #13-82; 3) Executive Directive 16-26; 4) IDOC Policy 03-02-105; 5) Interviews with 10 randomly selected residents; 6) and Interviews with staff (specifically the 15 randomly selected security staff, administrative and criminal investigators and the medical staff).

OBSERVATIONS: Based on the documents and evidence presented, specifically IDOC 03-02-105, ED #16-26, Resident and Staff Interviews all grievance procedure requirements appear to be met.

DETERMINATION: It was determined that the Facility, in all material ways, *Meets* this Standard.

Standard 115.353 Resident access to outside confidential support services

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

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

REQUIREMENTS: 115.353: This standard has four components: (a) The facility shall provide residents with access to outside victim advocates for emotional support services related to sexual abuse, by providing, posting, or otherwise making accessible mailing addresses and telephone numbers, including toll free hotline numbers where available, of local, State, or national victim advocacy or rape crisis organizations, and, for persons detained solely for civil immigration purposes, immigrant services agencies. The facility shall enable reasonable communication between residents and these organizations and agencies, in as confidential a manner as possible; (b) The facility shall 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; (c) The agency shall 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. The agency shall maintain copies of agreements or documentation showing attempts to enter into such agreements; and (d) The facility shall also provide residents with reasonable and confidential access to their attorneys or other legal representation and reasonable access to parents or legal guardians.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor: 1) Pre-Audit Questionnaire; 2) IDOC Policy 02-01-115; 3) interviews with residents (specifically, 10 randomly selected residents); 4) Interviews with staff (specifically the 11 randomly selected security staff, specialized staff and the medical staff); 5) Memorandum of Understandings; and 6) Investigation Files of Reported Sexual Abuse.

OBSERVATIONS: The Facility provided contact phone numbers and addresses to the local area Rape Crisis Center, Ombudsman, and to the Indiana Coalition Against Domestic Violence (ICADV) as evidence of compliance. A phone interview with ICADV noted that this Facility would provide services to residents from the Facility. All interviews (staff and residents) confirmed and acknowledged that residents are provided with reasonable access to parents or legal guardians and that all residents are provided reasonable and confidential access to their attorneys or other legal representative. Evidence compliance was also determined based on the actions taken in the single investigation of sexual abuse in the past year which demonstrated that the resident who made unfounded allegations did have access and utilized these processes to report.

DETERMINATION: It was determined that the Facility, in all material ways, *Exceeds* this Standard.

Standard 115.354 Third-party reporting

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

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

REQUIREMENTS: 115.354: This standard has one component: (a) The agency shall establish a method to receive third-party reports of sexual abuse and sexual harassment and shall distribute publicly information on how to report sexual abuse and sexual harassment on behalf of a resident.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor: 1) Pre-Audit Questionnaire; 2) IDOC Policy 02-01-115; 3) interviews with residents (specifically, 10 randomly selected residents); 4) Interviews with staff (specifically the 11 randomly selected security staff, PCM, Superintendent, and the medical staff); and 5) Interview with the State of Indiana's PREA Administrator were used to assess compliance with this Standard.

OBSERVATIONS: This Facility has multiple means of receiving third-party reports, including phone calls to the Facility and via the #22 numbers. Further, the Facility's website has a process for families to report sexual abuse and sexual harassment. The IDOC website <https://secure.in.gov/idoc/2832.htm> notes that anyone, who suspects sexual abuse or sexual harassment has happened at an IDOC Facility is free to contact the IDOC via a phone number and email address (as of May 28, 2016 this email is a working email, follow-up on July 12, 2016 found both the number and email to be working and responsive). The single allegation and investigation for alleged sexual abuse that was determined unfounded verified that verbal reports would be acted upon, that in less than 8 hours the resident had access to contact with parents who also made a third party report that was received by the Superintendent and that the Investigation was completed according to Agency and Facility Policy and Procedures.

DETERMINATION: It was determined that the Facility, in all material ways, *Meets* this Standard.

Standard 115.361 Staff and agency reporting duties

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

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

REQUIREMENTS: 115.361: This standard has six components: (a) The agency shall require 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; retaliation against residents or staff who reported such an incident; and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation; (b) The agency shall also require all staff to comply with any applicable mandatory child abuse reporting laws; (c) Apart from reporting to designated supervisors or officials and designated State or local services agencies, staff shall be prohibited from revealing any information related to a sexual abuse report to anyone other than to the extent necessary, as specified in agency policy, to make treatment, investigation, and other security and management decisions; (d)(1) Medical and mental health practitioners shall be required to report sexual abuse to designated supervisors and officials pursuant to paragraph (a) of this section, as well as to the designated State or local services agency where required by mandatory reporting laws; (d)(2) Such practitioners shall be required to inform residents at the initiation of services of their duty to report and the limitations of confidentiality; (e)(1) Upon receiving any allegation of sexual abuse, the facility head or his or her designee shall promptly report the allegation to the appropriate agency office and to the alleged victim's parents or legal guardians, unless the facility has official documentation showing the parents or legal guardians should not be notified; (e)(2) If the alleged victim is under the guardianship of the child welfare system, the report shall be made to the alleged victim's caseworker instead of the parents or legal guardians; (e)(3) If a juvenile court retains jurisdiction over the alleged victim, the facility head or designee shall also report the allegation to the juvenile's attorney or other legal representative of record within 14 days of receiving the allegation; and (f) The facility shall report all allegations of sexual abuse and sexual harassment, including third-party and anonymous reports, to the facility's designated investigators.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the 1) Pre-Audit Questionnaire, 2) IDOC Policy 02-01-115, 3) IDOC Policy 00-01-103 (under Section C. Evidence and Case Reporting Procedures and Best Practices); 4) interviews with staff (specifically, the Facility Superintendent, PCM, Staff and Specialized Staff); 5) Coordinated Response Plan; 6) Staff Training and SART Training Curriculums; 7) Revised IDOC Policy 00-01-013 and 8) Executive Directive #16-45 Effective.

OBSERVATIONS: The Facility does have investigators who conduct both criminal and administrative investigations. Investigators have the required PREA-related training. All staff reported that they understood their role as first responder and all 11 randomly selected staff who were interviewed were able to describe the procedures that a first responder is to use. IDOC Policy 02-01-115 adheres to this Standard. However, IDOC Policy 00-01-103 appears to deviate from this Standard. Specifically, 00-01-103, under Section C. states only DNA from the victim is to be collected. During the on-site review which included a review of policy, the single Investigation based on alleged Sexual Abuse in the past 12 months, the Coordinated Response Plan, use of a Sexual Abuse Response Team interviews and Training Curriculum, and interviews and with the Facility Head, PREA Compliance Manager, PREA Coordinator, Agency Criminal Investigators, Administrative Investigators, and Interviews with both Security and other staff members it was determined that the facility was compliant in its practices related to 115.321. However, the existing IDOC Policy 00-01-103 for Intelligence and Investigations under Section C stated only DNA from the victim is to be collected. There does not appear to be any mention of collecting DNA from the alleged perpetrator. On August 5, 2016 Executive Directive # 16-44 and revised IDOC Policy 02-01-115. On August 1, 2016 Executive Directive #16-45 and revised was released and addressed policy issues identified. IDOC Policy 02-01-115 had always included both the victim and perpetrator language, as well as the SART Training and all facility staff understood that this was the procedure. Agency Investigation and Intelligence Policy 00-01-103 is limited to Investigators throughout the

Agency who have also completed SART and are Correctional Police Officers. All Facility staff were aware of their responsibilities as a first responder and were aware of 02-01-115.

DETERMINATION: It was determined that the Facility, in all material ways, *Meets* this Standard.

Standard 115.362 Agency protection duties

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

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

REQUIREMENTS: 115.362: This standard has one component: (a) When an agency learns that a resident is subject to a substantial risk of imminent sexual abuse, it shall take immediate action to protect the resident.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the 1) Pre-Audit Questionnaire, 2) IDOC Policy 02-01-115, 3) IDOC Policy 00-01-103 (under Section C. Evidence and Case Reporting Procedures and Best Practices); 4) interviews with staff (specifically, the Facility Superintendent, PCM, Security Staff and Specialized Staff); 5) Coordinated Response Plan; 6) Staff Training and SART Training Curriculums.

OBSERVATIONS: IDOC Policy 02-01-115, on page 23 and 23 specifically addresses this requirement. During interviews all 11 randomly selected security staff and other staff interviews noted that they would act immediately to protect a resident who was subject to a substantial risk of imminent sexual abuse. Further, all interviewed residents noted that they would “tell staff” if they felt they were at a substantial risk of imminent sexual abuse.

DETERMINATION: It was determined that the Facility, in all material ways, *Meets* this Standard.

Standard 115.363 Reporting to other confinement facilities

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

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

REQUIREMENTS: 115.363: This standard has four components: (a) Upon receiving an allegation that a resident was sexually abused while confined at another facility, the head of the facility that received the allegation shall notify the head of the facility or appropriate office of the agency where the alleged abuse occurred and shall also notify the appropriate investigative agency; (b) Such notification shall be provided as soon as possible, but no later than 72 hours after receiving the allegation; (c) The agency shall document that it has provided such notification; and (d) The facility head or agency office that receives such notification shall ensure that the allegation is investigated in accordance with these standards.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor: 1) Pre-Audit Questionnaire, 2) IDOC Policy 02-01-115 and August 1, 2016 revision, 3) Interviews with PCM and PC; and 4) Interviews with the Facility Head.

OBSERVATIONS: IDOC 02-01-115 updated on August 1, 2016 meets the requirement of standards. During the Pre and Onsite components of this Audit it was noted that the IDOC Policy did not specifically state that the Facility Head would contact the appropriate contact as defined in the Standard where the alleged abuse had occurred. Policy review, authorization of the Policy by the Agency Head, and contact with Facility Head indicated that he was aware of this change and the Facilities Responsibilities related to this standard and reporting to other confinement facilities.

DETERMINATION: Based on the observations noted above it was determined that the Facility *Meets* this Standard based on Agency Policy.

Standard 115.364 Staff first responder duties

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

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

REQUIREMENTS: 115.364: This standard has two components: (a) Upon learning of an allegation that a resident was sexually abused, the first staff member to respond to the report shall be required to: [(1) Separate the alleged victim and abuser; (2) Preserve and protect any crime scene until appropriate steps can be taken to collect any evidence; and (3) If the abuse occurred within a time period that still allows for the collection of physical evidence, request that the alleged victim not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating; and (4) If the abuse occurred within a time period that still allows for the collection of physical evidence, 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]; and (b) If the first staff responder is not a security staff member, the responder shall be required to request that the alleged victim not take any actions that could destroy physical evidence, and then notify security staff.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the 1) Pre-Audit Questionnaire; 2) IDOC Policy 02-01-115; 3) IDOC Policy 00-01-103 (under Section C. Evidence and Case Reporting Procedures and Best Practices); 4) interviews with staff (specifically, the Facility Superintendent, PCM, Staff and Specialized Staff); 5) Revised IDOC Policy 00-01-013; 6) Executive Directive #16-45 Effective 8/12/2016; and 7) Staff Training and Acknowledgement Signature Pages of August 12, 2016 Executive Directives now in effect.

OBSERVATIONS: The Facility does have investigators who conduct both criminal and administrative investigations. Investigators have the required PREA-related training. All staff reported that they understood their role as first responder and all 11 randomly selected staff who were interviewed were able to describe the procedures that a first responder is to use. IDOC Policy 02-01-115 adheres to this Standard. However, IDOC Policy 00-01-103 appears to deviate from this Standard. Specifically, 00-01-103, under Section C. states only DNA from the victim is to be collected. During the on-site review which included a review of policy, the single Investigation based on alleged Sexual Abuse in the past 12 months, the Coordinated Response Plan, use of a Sexual Abuse Response Team interviews and Training Curriculum, and interviews and with the Facility Head, PREA Compliance Manager, PREA Coordinator, Agency Criminal Investigators, Administrative Investigators, and Interviews with both Security and other staff members it was determined that the facility was compliant in its practices related to 115.321. However, the existing IDOC Policy 00-01-103 for Intelligence and Investigations under Section C stated only DNA from the victim is to be collected. There does not appear to be any mention of collecting DNA from the alleged perpetrator. On August 5, 2016 Executive Directive # 16-44 and revised IDOC Policy 02-01-115. On August 1, 2016 Executive Directive #16-45 and revised was released and addressed policy issues identified but the data effective is 8/12/2016 and does not ensure that Administrative and Investigative Staff have receive or are aware of this change. IDOC Policy 02-01-115 had always included both the victim and perpetrator language, as well as the SART Training and all facility staff understood that this was the procedure. Agency Investigation and Intelligence Policy 00-01-103 is limited to Investigators throughout the Agency who have also completed SART and are Correctional Police Officers. All Facility staff were aware of their responsibilities as a first responder and were aware of 02-01-115. All Investigators were also aware of the procedure of collecting or maintaining useable physical evidence on both the victim and alleged perpetrator. The period of Corrective Action was entered into to ensure that all staff were aware of the changes to IDOC Policy 00-01-103 to match the same language as Standard 115.321 and IDOC Policy 02-01-115. The Corrective Action Period and subsequent findings are indicated below.

DETERMINATION: It was determined that the Facility, in all material ways, *does not* meet this Standard.

CORRECTIVE ACTION PLAN: 1. Review all revisions and status of implementation after 08/12/2016 regarding changes to IDOC 00-01-103 and Executive Directive #16-45. 2. Provide verification that Facility Administrative Investigative Staff and Agency Criminal Investigative Staff for Juveniles have been made aware of this change and acknowledge receipt of this policy change. 3. Provide Documentation that the indicated staff have been made aware and have received this information to Auditor.

CORRECTIVE ACTION PLAN COMPLETED – EVIDENCE OF COMPLIANCE: On August 30, 2016 the PREA Compliance Manager of Camp Summit Provided Documentation that Applicable Facility Staff and Agency Staff outlined in the Corrective Action Plan as Facility Administrative Investigative Staff and Agency Criminal Investigative staff had received and acknowledged the receipt and awareness of the changes to IDOC Policy for 00-01-103 regarding Investigations. During the on-site review which included a review of policy, the single Investigation based on alleged Sexual Abuse in the past 12 months, the Coordinated Response Plan, use of a Sexual Abuse Response Team interviews and Training Curriculum, and interviews and with the Facility Head, PREA Compliance Manager, PREA Coordinator, Agency Criminal Investigators, Administrative Investigators, and Interviews with both Security and other staff members it was determined that the facility was compliant in its practices related to 115.364. However, the existing IDOC Policy 00-01-103 for Intelligence and Investigations under Section C stated only DNA from the victim is to be collected. There appeared to be no mention of collecting DNA from the alleged perpetrator in IDOC Policy 00-01-103. The Corrective Action Period required that the Facility Provide evidence that IDOC Policy 00-01-103 adopt the language included in 115.364 to match IDOC Policy 02-01-115 that included the preservation and collection of DNA evidence from the victim and the alleged perpetrator, if known. The Corrective Action Period materials were received on 8/30/2016 and have been verified to be in place and that the required IDOC and Camp Summit staff members as identified in the Corrective Action Plan were made aware of this change and had acknowledge awareness of the change in IDOC 00-01-103 by signature. As the On-Site Audit of the Facility and review of all evidence indicated this was already the practice and the wording from IDOC 00-01-103 was an omission and this omitted wording was included in IDOC 02-01-115, SART Training Curriculum, Staff Training, and the Coordinated Response Plan. The evidence of Policy Change and ED #16-45, documentation of the notification of this change, signed acknowledgement form by the IDOC and Camp Summit Facility Administrative Investigative Staff and Agency Criminal Investigative Staff for Juveniles, and contact with the Facility Head and PREA Compliance Manager at Camp Summit to verify that this was completed and was the practice provided was adequate evidence to find Camp Summit to be Compliant with 115.364.

FINAL DETERMINATION: It was determined on 9/6/2016 that the Facility, in all material ways, *Meets* this Standard.

Standard 115.365 Coordinated response

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

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

REQUIREMENTS: 115.365: This standard has one component: (a) The facility shall develop 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.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor: 1) Pre-Audit Questionnaire, 2) IDOC Policy 02-01-115, 3) Interviews with staff (specifically the 11 randomly selected security staff, PCM, PC, Investigations and Specialized Staff), and (5) Interviews with the Facility Head.

OBSERVATIONS: The *Sexual Assault Response Team* (SART) policy is written and details the coordinated action that staff are to take in response to an incidence of sexual abuse. This includes the responsibilities of first responders, medical and mental health practitioners, investigators, and Facility leadership. Interviews with staff confirmed that the staff knew of the plan and that it needed to be followed if there was in allegation of sexual abuse. Currently over 50% of Camp Summit Staff have been through the SART Training and are Certified. It is the goal of the Facility to have 100% of its Security staff complete the SART Training. All staff who have not been through training are aware of their role as first responders and it is outlined in the Coordinated Response Plan. The plan is comprehensive and meets the requirements of 115.365.

DETERMINATION: It was determined that the Facility, in all material ways, *Meets* this Standard.

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

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

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

REQUIREMENTS: 115.366: This standard has two components: (a) Neither the agency nor any other governmental entity responsible for collective bargaining on the agency’s behalf shall enter into or renew any collective bargaining agreement or other agreement that limits the agency’s ability to remove alleged staff sexual abusers from contact with residents pending the outcome of an investigation or of a determination of whether and to what extent discipline is warranted, and (b) Nothing in this standard shall restrict the entering into or renewal of agreements that govern: [(1) The conduct of the disciplinary process, as long as such agreements are not inconsistent with the provisions of §§ 115.372 and 115.376; or (2) Whether a no-contact assignment that is imposed pending the outcome of an investigation shall be expunged from or retained in the staff member’s personnel file following a determination that the allegation of sexual abuse is not substantiated.]

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor the 1) Pre-Audit Questionnaire and 2) Interview with the Agency Head Designee.

OBSERVATIONS: An interview with the IDOC Agency Head designee noted that the agency/state *does not* have, nor has it had, any collective bargaining agreements that were completed since August of 2012.

DETERMINATION: It was determined that the Facility, in all material ways, *Meets* this Standard.

Standard 115.367 Agency protection against retaliation

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

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

REQUIREMENTS: 115.367: This standard has six components: (a) The agency shall establish 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 and shall designate which staff members or departments are charged with monitoring retaliation; (b) The agency shall 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; (c) For at least 90 days following a report of sexual abuse, the agency shall monitor the conduct or treatment of residents or staff who reported the sexual abuse and 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, and shall act promptly to remedy any such retaliation. Items the agency should monitor include any resident disciplinary reports, housing, or program changes, or negative performance reviews or reassignments of staff. The agency shall continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need; (d) In the case of residents, such monitoring shall also include periodic status checks; (e) If any other individual who cooperates with an investigation expresses a fear of retaliation, the agency shall take appropriate measures to protect that individual against retaliation; and (f) An agency's obligation to monitor shall terminate if the agency determines that the allegation is unfounded.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor: 1) Pre-Audit Questionnaire; 2) IDOC Policy 02-01-115; 3) Interviews with staff (specifically the 11 randomly selected security staff and the medical staff); 4) Interviews with residents (specifically, 10 randomly selected residents); 5) Interviews with specialized staff; and 6) Revised IDOC Policy 02-01-115 with Executive Directive and Facility Acknowledgement of the change by Superintendent and PCM.

OBSERVATIONS: The PREA Committee at the Facility is tasked with monitoring retaliation with the initial contact person being the PCM. Residents and staff understood that they were protected from retaliation and that the Facility has a zero tolerance toward retaliation. IDOC Policy 02-01-115 addresses this Standard, specifically on page 13. However, IDOC Policy 02-01-115 states "The facility shall employ multiple protection measures, such as housing changes or transfers for offender victims or abusers, removal of alleged staff or offender abusers from contact with victims, and emotional support services for offenders or staff that fear retaliation for reporting sexual conduct or sexual harassment or for cooperating with investigations." However in the definitions included in 02-01-115 "sexual conduct" is not defined and it is impossible to determine that this term is inclusive of all the requirements of PREA. A Revised IDOC Policy 02-01-115 was provided along with the "Executive Directive" that put this revised Policy in place in place August 1, 2016. The needed revision was based on definitions and language in the Policy. Based on the Evidence Received it was determined that compliance was achieved on August 1, 2016. Additionally the Agency and Facility have determined that it will also monitor retaliation for reports of Sexual Harassment for the 90-day period established to monitor retaliation for Sexual Abuse based on this the Facility now exceeds the standards or monitoring of retaliation for the report of sexual harassment.

DETERMINATION: It was determined that the Facility, in all material ways, *Exceeds* this Standard.

Standard 115.368 Post-allegation protective custody

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

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

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor: 1) Pre-Audit Questionnaire; 2) IDOC Policy 02-01-115; 3) interviews with residents (specifically, 10 randomly Residents); and 4) Interviews with staff (specifically the 11 randomly selected security staff, mental health staff, PCM, Superintendent, and the medical staff); 5) Revised Policy 02-01-115 and ED #16-45; and 6) Acknowledgement by the Facility Head and PCM that the Facility is aware of the change in Policy 02-01-115.

OBSERVATIONS: All 11 randomly selected staff interviewed supported the contention that the Facility “never” places a resident in isolation for their own protection against sexual victimization. In a review of the policy (02-01-115) it was stated in Agency Policy that the Facility could place a resident in isolation for their own protection. Further, the policy did not specifically state that during any period of isolation, agencies shall not deny residents daily large-muscle exercise and any legally required educational programming or special education services. Residents in isolation shall receive daily visits from a medical or mental health care clinician. Residents shall also have access to other programs and work opportunities to the extent possible. While extended isolation at Facility is reportedly not utilized and not utilized for the protection of residents against sexual victimization the policy does not reflect this. All on-site data collection and review of the facility indicated that isolation is not utilized and that daily large-muscle exercise is a requirement of Camp Summit. Further the facility did not maintain any “areas” that could be utilized for extended isolation or separation and Facility protocols would be to transfer the resident to another Facility. The language of policy 02-01-115 appeared to be non-applicable to Camp Summit as separation or isolation does not occur at the Facility but Agency policy did indicate it was possible and had omitted required language. On August 1, 2016 that demonstrated that this language (agencies shall not deny residents daily large-muscle exercise and any legally required educational programming or special education services. Residents in isolation shall receive daily visits from a medical or mental health care clinician. Residents shall also have access to other programs and work opportunities to the extent possible) was in place and being utilized at Camp Summit. Evidence of staff notification and awareness of the change was provided through notification of staff through Revised Policy 02-01-115 and ED #16-45, verification of staff awareness by PCM, PC, and Facility Superintendent, and staff acknowledgement of the change to the Agency Policy.

DETERMINATION: It was determined that the Facility, in all material ways, *Meets* this Standard.

Standard 115.371 Criminal and administrative agency investigations

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

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

REQUIREMENTS: 115.371: This standard has 13 components: (a) When the agency conducts its own investigations into allegations of sexual abuse and sexual harassment, it shall do so promptly, thoroughly, and objectively for all allegations, including third-party and anonymous reports; (b) Where sexual abuse is alleged, the agency shall use investigators who have received special training in sexual abuse investigations involving juvenile victims pursuant to § 115.334; (c) Investigators shall gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data; shall interview alleged victims, suspected perpetrators, and witnesses; and shall review prior complaints and reports of sexual abuse involving the suspected perpetrator; (d) The agency shall not terminate an investigation solely because the source of the allegation recants the allegation; (e) When the quality of evidence appears to support criminal prosecution, the agency shall conduct compelled interviews only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution; (f) The credibility of an alleged victim, suspect, or witness shall be assessed on an individual basis and shall not be determined by the person's status as resident or staff. No agency shall require a resident who alleges sexual abuse to submit to a polygraph examination or other truth-telling device as a condition for proceeding with the investigation of such an allegation; (g) Administrative investigations: [(1) Shall include an effort to determine whether staff actions or failures to act contributed to the abuse; and (2) Shall be documented in written reports that include a description of the physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings]; (h) Criminal investigations shall be documented in a written report that contains a thorough description of physical, testimonial, and documentary evidence and attaches copies of all documentary evidence where feasible; (i) Substantiated allegations of conduct that appears to be criminal shall be referred for prosecution; (j) The agency shall retain all written reports referenced in paragraphs (g) and (h) of this section for as long as the alleged abuser is incarcerated or employed by the agency, plus five years, unless the abuse was committed by a juvenile resident and applicable law requires a shorter period of retention; (k) The departure of the alleged abuser or victim from the employment or control of the facility or agency shall not provide a basis for terminating an investigation; (l) Any State entity or Department of Justice component that conducts such investigations shall do so pursuant to the above requirements; and (m) When outside agencies investigate sexual abuse, the facility shall cooperate with outside investigators and shall endeavor to remain informed about the progress of the investigation.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor: 1) Pre-Audit Questionnaire; 2) IDOC Policy 02-01-115; 3) Facility Investigations Files; 4) Interviews with staff (specifically the 13 randomly selected security staff, PCM, PC, Facility Head, and Specialized Staff); 5) Executive Directive # 16-45; 6) Revised Policy and Administrative Procedure 00-01-103: "Investigations and Intelligence" Dated August 1, 2016 and; 7) Verification that the Facility has received and is implementing as applicable the revised Policy 00-01-103.

OBSERVATIONS: It was determined that the Facility has trained staff and that they would conduct investigations into sexual abuse and sexual harassment. During the Pre-Audit and On-Site Audit it was initially determined that there were missing components to 115.371 related components (c) and (f). Prior to the completion of this report the Agency updated their policy IDOC Policy 02-01-115 through Executive Directive to include the required language regarding sexual harassment and to remove conflicts on "evidence collection" procedures that varied between 02-01-115 and 00-01-103. Additionally the Agency revised and updated its Investigations and Intelligence Policy and Procedures to include "Polygraph, Voice Stress Analysis, or other truth-telling device", in Policy and Administrative Procedure 00-01-103, "Investigations and Intelligence" and implanted this through Executive Directive #16-45 dated August 1, 2016. Based on interviews with the PREA Coordinator, PREA Compliance Manager, Facility Head, and Investigations Division the only truth telling device

utilized by the IDOC is a Voice Stress Analysis and Policy included the this wording only the change to include “Polygraph and or other truth-telling device” was a matter of adding language to the Policy. This change was implemented and the no use of the only truth telling device (Voice Stress Analysis) the IDOC utilizes is never utilized to determine if a victim is telling the truth nor is it used with Juveniles. Both the Agency and Facility presented as compliant with the standard in practice and the revisions to the Policy were added and implemented on August first. Based on the evidence presented by both the Agency and the Facility this revision seemed adequate to determine compliance with standard. Additionally the conflict between 02-01-115 and 00-01-103 were also found to be an omission of wording in one policy and were revised and all evidence indicated that the Facility was compliant in practice and the Agency revised its policy and provided documentation of staff receipt and acknowledgement of this change. Based on this evidence it was determined that all issues within Standard 115.371 were related to wording and not practice with in Agency Policy and these changes and evidence were sufficient to find the Facility compliant with the Standard.

DETERMINATION: It was determined that the Facility, in all material ways, *Meets* this Standard.

Standard 115.372 Evidentiary standard for administrative investigations

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

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

REQUIREMENTS: 115.372: This standard has one component: (a) The agency shall impose no standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor: 1) Pre-Audit Questionnaire; 2) IDOC Policy 02-01-115; and 3) Interviews with Facility Head, PC, PCM, and Investigator for Agency.

OBSERVATIONS: Staff noted that they would only use a Standard of “preponderance of evidence” in determining whether allegations of sexual abuse or sexual harassment are substantiated. Further, Facility policy notes that the Facility shall use the Standard of preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated. Interviews with the Facility Head, PC, PCM (Administrative Investigator) and Agency Investigator (Criminal Investigations) confirmed compliance to Agency Policy and 115.372.

DETERMINATION: It was determined that the Facility, in all material ways, *Meets* this Standard.

Standard 115.373 Reporting to residents

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

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

REQUIREMENTS: 115.373: This standard has six components: (a) Following an investigation into a resident's allegation of sexual abuse suffered in an agency facility, the agency shall inform the resident as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded; (b) If the agency did not conduct the investigation, it shall request the relevant information from the investigative agency in order to inform the resident; (c) 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 [(1) The staff member is no longer posted within the resident's unit; (2) The staff member is no longer employed at the facility; (3) The agency learns that the staff member has been indicted on a charge related to sexual abuse within the facility; or (4) The agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility]; (d) 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: [(1) The agency learns that the alleged abuser has been indicted on a charge related to sexual abuse within the facility; or (2) The agency learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility]; (e) All such notifications or attempted notifications shall be documented; and (f) An agency's obligation to report under this standard shall terminate if the resident is released from the agency's custody.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor: 1) Pre-Audit Questionnaire; 2) IDOC Policy 02-01-115; 3) Interviews with Facility Head and PCM; 4) Interviews with investigators; and 5) Review of completed sexual abuse investigations.

OBSERVATIONS: Policy 02-01-115 addresses this Standard. Review of the one reported incident in the past 12 months showed a thorough investigation was completed, report from a third party was received, the Investigation was completed and documented and all procedures were followed. This included notifying the youth of the findings, the youth's parents, and all of this was reviewed on-site and verified during the on-site component of the PREA Audit. Additionally it was verified that the report and investigation were reviewed in less than 30 days by the PREA Incident Review Team and that recommendations of the Investigator were being reviewed for implementation. This report was determined to be unfounded as the staff was on video at the door way at the time of the alleged abuse. Based on the allegation this would not have been possible as the staff would have had to leave the shower room doorway and leave the view of the camera. The staff at no time left the camera view and all evidence supported the findings; however, this investigation showed that the Facility followed Agency Policy, facility protocols, and completed all aspects of an investigation of sexual abuse according to Policy and in compliance with PREA Standards.

DETERMINATION: It was determined that the Facility, in all material ways, *Meets* this Standard.

Standard 115.376 Disciplinary sanctions for staff

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

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

REQUIREMENTS: 115.376: This standard has four components: (a) Staff shall be subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies; (b) Termination shall be the presumptive disciplinary sanction for staff who have engaged in sexual abuse; (c) Disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) 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; (d) 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, shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and to any relevant licensing bodies.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor: 1) Pre-Audit Questionnaire; 2) IDOC Policy 02-01-115; 3) IDOC Policy 04-03-103; 4) Interviews with PCM and Facility Head; 5) Interviews with investigators; and 6) Review of completed sexual abuse investigations.

OBSERVATIONS: Policy 04-03-103 notes that termination is the presumption discipline for violation of policies and procedures related to sexual abuse and sexual harassment. Interviews with the Facility Head and PCM also indicated compliance. There has been only one allegation in the past year. Review of this incident shows that the staff was removed from the Facility until the allegation was found to be unfounded by Agency Correctional Law Enforcement completing an Investigation which was documented as Unfounded.

DETERMINATION: It was determined that the Facility, in all material ways, *Meets* this Standard.

Standard 115.377 Corrective action for contractors and volunteers

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

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

REQUIREMENTS: 115.377: This standard has two components: (a) Any contractor or volunteer who engages in sexual abuse shall be prohibited from contact with residents and shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and to relevant licensing bodies; and (b) The facility shall take appropriate remedial measures, and shall consider 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.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor: 1) Pre-Audit Questionnaire; 2) IDOC Policy 02-01-115; 3) Interview with the PCM and Facility Head; 4) Interviews with Investigators; and 5) Interviews with contractors and volunteers.

OBSERVATIONS: Policy 02-01-115 addresses this Standard and notes that “Volunteers, interns, and contractual staff shall be advised that any form of sexual abuse and sexual harassment with an offender, whether consensual or not, is strictly prohibited and that any volunteer, intern, or contractual staff found to have engaged in such conduct shall be removed from the Facility, not allowed to return and may be subject to criminal prosecution” (p. 9). Interviews with the Facility Head, PCM, contractors and volunteers noted that they were told they would not be allowed to enter the Facility if they engaged in sexual abuse and/or sexual harassment.

DETERMINATION: It was determined that the Facility, in all material ways, *Meets* this Standard.

Standard 115.378 Disciplinary sanctions for residents

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

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

REQUIREMENTS: 115.378: This standard has seven components: (a) A resident may be subject to disciplinary sanctions only pursuant to a formal disciplinary process following an administrative finding that the resident engaged in resident-on-resident sexual abuse or following a criminal finding of guilt for resident-on-resident sexual abuse; (b) Any disciplinary sanctions shall 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. In the event a disciplinary sanction results in the isolation of a resident, agencies shall not deny the resident daily large-muscle exercise or access to any legally required educational programming or special education services. Residents in isolation shall receive daily visits from a medical or mental health care clinician. Residents shall also have access to other programs and work opportunities to the extent possible; (c) The disciplinary process shall consider whether a resident's mental disabilities or mental illness contributed to his or her behavior when determining what type of sanction, if any, should be imposed; (d) If the facility offers therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse, the facility shall consider whether to offer the offending resident participation in such interventions. The agency may require participation in such interventions as a condition of access to any rewards-based behavior management system or other behavior-based incentives, but not as a condition to access to general programming or education; (e) The agency may discipline a resident for sexual contact with staff only upon a finding that the staff member did not consent to such contact; (f) For the purpose of disciplinary action, a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred shall not constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation; and (g) An agency may, in its discretion, prohibit all sexual activity between residents and may discipline residents for such activity. An agency may not, however, deem such activity to constitute sexual abuse if it determines that the activity is not coerced.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor: 1) Pre-Audit Questionnaire; 2) IDOC Policy 02-01-115; 3) IDOC Policy 03-02-101; 4) Interview with the PCM; and 5) Interviews with Facility Head.

OBSERVATIONS: It was noted that IDOC Policy 02-01-115 that youth will be disciplined per the appropriate disciplinary code or code of conduct. Based on the pre-onsite visit conference calls with the PCM and via the Pre-Audit Questionnaire, and via interviews during the onsite, the Facility would not use isolation as the sole sanction for resident-on-resident sexual abuse. Interviews with staff noted that they consider whether a resident's mental disabilities or mental illness contributed to his or her behavior when determining what type of sanction, if any, should be imposed.

DETERMINATION: It was determined that the Facility, in all material ways, *Meets* this Standard.

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

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

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

REQUIREMENTS: 115.381: This standard has four components: (a) If the screening pursuant to § 115.341 indicates that a resident has experienced prior sexual victimization, whether it occurred in an institutional setting or in the community, staff shall ensure that the resident is offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening; (b) If the screening pursuant to § 115.341 indicates that a resident has previously perpetrated sexual abuse, whether it occurred in an institutional setting or in the community, staff shall ensure that the resident is offered a follow-up meeting with a mental health practitioner within 14 days of the intake screening; (c) Any information related to sexual victimization or abusiveness that occurred in an institutional setting shall be strictly limited to medical and mental health practitioners and other staff, as necessary, to inform treatment plans and security and management decisions, including housing, bed, work, education, and program assignments, or as otherwise required by Federal, State, or local law; and (d) Medical and mental health practitioners shall obtain informed consent from residents before reporting information about prior sexual victimization that did not occur in an institutional setting, unless the resident is under the age of 18.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor: 1) Pre-Audit Questionnaire; 2) IDOC Policy 02-01-115; 3) IDOC Policy 01-04-104; 4) Interview with the PCM; and 5) Interview with Facility Head.

OBSERVATIONS: IDOC Policy 02-01-115, page 17, notes that a meeting with a medical or mental health practitioner must be offered to a youth within 14 days of staff learning that the youth has experienced prior sexual victimization or has perpetrated sexual abuse. In a review of 15 resident records all residents requesting follow-up medical or mental health services where provided with these services.

DETERMINATION: It was determined that the Facility, in all material ways, *meets* this Standard.

Standard 115.382 Access to emergency medical and mental health services

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

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

REQUIREMENTS: 115.382: This standard has four components: (a) Resident victims of sexual abuse shall 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; (b) If no qualified medical or mental health practitioners are on duty at the time a report of recent abuse is made, staff first responders shall take preliminary steps to protect the victim pursuant to § 115.362 and shall immediately notify the appropriate medical and mental health practitioners; (c) Resident victims of sexual abuse while incarcerated shall be 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; and (d) Treatment services shall be 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.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor: 1) Pre-Audit Questionnaire; 2) IDOC Policy 02-01-115; 3) Interview with the PCM; and 4) Interviews with medical and mental health staff.

OBSERVATIONS: The onsite visit interviews noted that resident victims of sexual abuse are provided with unimpeded access to emergency medical treatment and crisis intervention services. IDOC Policy 02-01-115 on page 27, provides clear directive that supports subsection (a) of this Standard. During interviews (with staff, who are all trained as first responders, confirmed this component and noted that they are trained to protect the victim and to notify a supervisor who will notify the appropriate medical and mental health practitioners.

DETERMINATION: It was determined that the Facility, in all material ways, *Meets* this Standard.

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

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

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

REQUIREMENTS: 115.383: This standard has eight components: (a) The facility shall 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; (b) The evaluation and treatment of such victims shall 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; (c) The facility shall provide such victims with medical and mental health services consistent with the community level of care; (d) Resident victims of sexually abusive vaginal penetration while incarcerated shall be offered pregnancy tests; (e) If pregnancy results from conduct specified in paragraph (d) of this section, such victims shall receive timely and comprehensive information about and timely access to all lawful pregnancy-related medical services; (f) Resident victims of sexual abuse while incarcerated shall be offered tests for sexually transmitted infections as medically appropriate; (g) Treatment services shall be 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; and (h) The facility shall 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.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor: 1) Pre-Audit Questionnaire; 2) IDOC Policy 02-01-115; 3) Interview with the PCM; 4) Interviews with medical and mental health staff. 5) Executive Directive # 16-45; 6) Revised IDOC Policy 02-01-115 Dated August 1, 2016 and; 7) Verification that the Facility has received and is implementing as applicable the revised Policy 02-01-115 by the Facility Head and PC, and PCM.

OBSERVATIONS: Policy 02-01-115 does address subsection (a) of this section by stating on page 27 that “Victims of sexual abuse shall receive timely, unimpeded access to quality medical and mental health services free of charge following an incident of sexual abuse, whether or not they name an abuser or cooperate with the investigation.” IDOC Policy 02-01-115 initially had omitted components of 115.383 and this had been noted too the Agency by an Auditor at another Facility. Interviews and other evidence indicated compliance at the Facility level. IDOC Policy 02-01-115 was updated and authorized through Executive Directive # 16-45 to include missing language to match 115.383. Evidence that the Facility was aware of this change and that it was already compliant based on other evidence the Policy Update and Verification of Facility implementation was adequate to determine Compliance with 115.383.

DETERMINATION: Based on the observations noted above it was determined that the Facility *Meets* this Standard based on Agency Policy and Facility procedures.

Standard 115.386 Sexual abuse incident reviews

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

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

REQUIREMENTS: 115.386: This standard has five components: (a) The facility shall 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; (b) Such review shall ordinarily occur within 30 days of the conclusion of the investigation; (c) The review team shall include upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners; (d) The review team shall: [(1) Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse; (2) Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; or, gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility; (3) Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse; (4) Assess the adequacy of staffing levels in that area during different shifts; (5) Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff; and (6) Prepare a report of its findings, including but not necessarily limited to determinations made pursuant to paragraphs (d)(1)-(d)(5) of this section, and any recommendations for improvement and submit such report to the facility head and PREA compliance manager]; (e) The facility shall implement the recommendations for improvement, or shall document its reasons for not doing so.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor: 1) Pre-Audit Questionnaire; 2) IDOC Policy 02-01-115; 3) Interview with the PCM; 4) Interviews with investigators; 5) Interview with Facility Head; and 6) Review of investigations.

OBSERVATIONS: There was an allegation of sexual abuse that resulted in the allegation being determined to be "unsubstantiated." All evidence indicates in the investigation file and received through interviews that the Sexual Abuse Incident Review team met to: (1) Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse; (2) Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; or, gang affiliation; or was motivated or otherwise caused by other group dynamics at the Facility; (3) Examine the area in the Facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse; (4) Assess the adequacy of staffing levels in that area during different shifts; (5) Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff; and (6) Prepare a report of its findings, including but not necessarily limited to determinations made pursuant to paragraphs (d)(1)-(d)(5) of this section, and any recommendations for improvement and submit such report to the Facility head and PREA compliance manager. Additionally it was found that the recommendations of the Investigator and the Incident Review Team are to be utilized to ensure the protection of the residents against sexual abuse.

DETERMINATION: It was determined that the Facility, in all material ways, *Meets* this Standard.

Standard 115.387 Data collection

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

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

REQUIREMENTS: 115.387: This standard has six components: (a) The agency shall collect accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions; (b) The agency shall aggregate the incident-based sexual abuse data at least annually; (c) The incident-based data collected shall include, 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; (d) The agency shall maintain, review, and collect data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews; (e) The agency also shall obtain incident-based and aggregated data from every private facility with which it contracts for the confinement of its residents; and (f) Upon request, the agency shall provide all such data from the previous calendar year to the Department of Justice no later than June 30.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor: 1) Pre-Audit Questionnaire; 2) IDOC Policy 02-01-115; 3) Survey of Sexual Victimization; 4) Interview with the PCM; 5) Interviews with investigators; 6) Interview with Facility Head; 7) Interview with the PREA Coordinator; and 8) Review of IDOC Website <https://secure.in.gov/idoc/2832.htm>.

OBSERVATIONS: The Facility did produce a Standardized instrument so that it can collect accurate uniform data for every allegation of sexual abuse at facilities under its direct control using a Standardized instrument and set of definitions. The instrument provided was the SSV. Data from the IDOC website at <https://secure.in.gov/idoc/2832.htm> notes that aggregated data is presented. An interview with the State of Indiana PREA Coordinator, indicated that IDOC maintains, reviews, and collects data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews. Further, the PREA Coordinator noted that the Facility obtains incident-based and aggregated data from every private Facility with which it contracts for the confinement of its residents. The PREA Coordinator also noted that the Facility, upon request, will provide data from the previous calendar year to the Department of Justice no later than June 30 each year.

DETERMINATION: It was determined that the Facility, in all material ways, *Meets* this Standard.

Standard 115.388 Data review for corrective action

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

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

REQUIREMENTS: 115.388: This standard has four components: (a) The agency shall review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including: [(1) Identifying problem areas; (2) Taking corrective action on an ongoing basis; and (3) Preparing an annual report of its findings and corrective actions for each facility, as well as the agency as a whole]; (b) Such report shall include a comparison of the current year's data and corrective actions with those from prior years and shall provide an assessment of the agency's progress in addressing sexual abuse; (c) The agency's report shall be 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; and (d) The agency may redact specific material from the reports when publication would present a clear and specific threat to the safety and security of a facility, but must indicate the nature of the material redacted.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor: 1) Pre-Audit Questionnaire; 2) Interview with the PREA Coordinator; and 3) Annual Report from 2013, 2014 and 2015 at <https://secure.in.gov/idoc/2832.htm>.

OBSERVATIONS: An annual report is posted at https://secure.in.gov/idoc/files/2014_SAP_Program_Report.pdf. This report addresses corrective actions taken by Facility type. IDOC Policy 02-01-115 indicates required compliance.

DETERMINATION: It was determined that the Facility, in all material ways, *meets* this Standard.

Standard 115.389 Data storage, publication, and destruction

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

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

REQUIREMENTS: 115.389: This standard has four components: (a) The agency shall ensure that data collected pursuant to § 115.387 are securely retained; (b) The agency shall 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; (c) Before making aggregated sexual abuse data publicly available, the agency shall remove all personal identifiers; and (d) The agency shall maintain sexual abuse data collected pursuant to § 115.387 for at least 10 years after the date of its initial collection unless Federal, State, or local law requires otherwise.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this Standard, the Facility submitted or provided to this Auditor: 1) Pre-Audit Questionnaire; 2) Interview with the PREA Coordinator; and 3) Annual Report from 2013, 2014 and 2015 at <https://secure.in.gov/idoc/2832.htm>.

OBSERVATIONS: An annual report is posted at https://secure.in.gov/idoc/files/2014_SAP_Program_Report.pdf. This report addresses corrective actions taken by Facility type. IDOC Policy 02-01-115 indicates required compliance. Further, interviews with the PREA Coordinator indicated that sexual abuse data is collected and maintained for 10 years.

DETERMINATION: It was determined that the Facility, in all material ways, *Meets* this Standard.

AUDITOR CERTIFICATION

I certify that:

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

Joel Whitt _____

09/14/2016 _____

Auditor Signature

Date