

PREA AUDIT REPORT INTERIM FINAL
JUVENILE FACILITIES

Date of report: June 6, 2016

Auditor Information			
Auditor name: Patrick J. Sussex			
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Email: sussexp@michigan.gov			
Telephone number: 517-648-6503			
Date of facility visit: May 16-18, 2016			
Facility Information			
Facility name: Pendleton Juvenile Correctional Facility			
Facility physical address: 9310 S. State Road 67, Pendleton, IN 46064			
Facility mailing address: <i>(if different from above)</i> Click here to enter text.			
Facility telephone number: 765-778-3778			
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: Alison Yancey, Superintendent			
Number of staff assigned to the facility in the last 12 months: 258			
Designed facility capacity: 360			
Current population of facility: 187			
Facility security levels/inmate custody levels: Maximum Security / Custody Levels Low, Medium and High			
Age range of the population: 12-21			
Name of PREA Compliance Manager: Tim Greathouse		Title: Program Director I	
Email address: TGreathouse@idoc.in.gov		Telephone number: 765-778-3778	
Agency Information			
Name of agency: Indiana Department of Correction			
Governing authority or parent agency: <i>(if applicable)</i> Click here to enter text.			
Physical address: 302 W. Washington Street, Room E-334, Indianapolis, IN 46204			
Mailing address: <i>(if different from above)</i> Click here to enter text.			
Telephone number: Click here to enter text.			
Agency Chief Executive Officer			
Name: Bruce Lemmon		Title: IDOC Commissioner	
Email address: BLemmon@idoc.in.gov		Telephone number: 317-232-5711	
Agency-Wide PREA Coordinator			
Name: Bryan Pearson		Title: Executive Director of PREA Compliance	
Email address: BPearson@idoc.in.gov		Telephone number: 317-232-5288	

AUDIT FINDINGS

NARRATIVE

The on-site portion of the audit of Pendleton Juvenile Correctional Facility occurred on May 16, 2016 through May 18, 2016. A comprehensive pre-questionnaire and supporting documents were provided by the facility and reviewed by the auditor in the weeks preceding the on-site audit. Proper notice of the audit was posted seven weeks before the audit occurred. The auditor did not receive any mail from facility residents or staff prior to the audit.

The audit commenced with an opening meeting with the auditor, the facility Superintendent Alison Yancey, the PREA Compliance Manager Tim Greathouse, Central Office Administrator Natalie Walker, and various department heads. A tour of all areas and buildings of the facility followed. Access to all areas was provided as was access to employee files and resident files for spot checks for compliance. Facility administrators accommodated all requests for interviews.

Interviews were conducted with 28 facility residents, including two residents that had reported sexual abuse. There were no residents listed on the roster as LEP or as requiring interpretive or other services for the disabled. Interviews were conducted with 14 direct-care staff (including SART members, security staff, and custody staff), and with two teachers. Specialized staff interviewed included: A representative of the Indiana Department of Corrections (IDOC) Commissioner, the facility Superintendent, the PREA Compliance Manager (serves also as staff that monitors for retaliation), the Medical Supervisor, the Mental Health Service Supervisor, staff that conducts Intake/Assessment, a (mental health services) Contractor, Human Resources Supervisor, the state PREA Juvenile Coordinator, and the (internal affairs) Investigator. Several of those interviewed serve as members of the Incident Review Team. The facility does not sub-contract for services and SANE/SAFE services are provided off-site so there were no interviews in those areas. Non-medical staff do not conduct cross-gender searches so no interview was required in that area.

An exit interview was held with the same parties that attended the opening meeting. This facility audit was conducted as part of a multi-state agreement to conduct PREA audits for in-kind consideration only.

DESCRIPTION OF FACILITY CHARACTERISTICS

Pendleton Juvenile Correctional Facility (PJCF) is a 391-bed maximum security juvenile correctional facility operated by the Indiana Department of Corrections (IDOC), located on 91 acres in Pendleton, IN. PJCF houses male adolescents that have been committed to the facility on felony adjudications. Rehabilitation of youth is the stated goal of the facility. PJCF is one of three juvenile facilities serving males in the state and houses the students requiring the highest security. Additionally, PJCF serves as the sole provider of male juvenile sex offender therapy in the State (STEP program) and also houses the Youth Incarcerated as Adults (YIA) population (those sentenced on adult charges prior to turning 18 years of age).

PJCF provides treatment in the areas of: Substance abuse, relapse prevention, anger management, treatment readiness, sex offender treatment and education (STEP), gang alternatives, moral recognition therapy, and cognitive restructuring. PJCF also utilizes specialized housing units in addition to general population units to effect long term change in students as they are preparing to return to the community. The Future Soldiers Program, Purposeful Living Unit, and Venture Scouts are all unit-based programs designed to challenge and motivate the students to become productive and positive citizens. PJCF is accredited by the American Correctional Association (ACA) and is a participant with Performance-based Standards (PbS).

The physical plant consists of three 96-bed general population housing complexes, a 24-bed intake unit/special needs complex and a 24-bed secure housing unit (Making a Change)/YIA unit. A services building comprises medical, food services, and laundry and also housing for special management and behaviorally challenged youths. An administrative building contains the training center, the visiting area, and staff offices. The large programs' building accommodates the Providence Jr./Sr. High School which, in addition to its academic courses, includes several vocational trades' classes including Culinary Arts and Horticulture. It also includes the Staff Wellness Center, indoor recreational facilities, and the chapel. There are outdoor recreational areas within the fenced perimeter, including baseball diamonds, volleyball courts, basketball courts, and a quarter-mile walking/running track. The perimeter has a single arched fence around it and is patrolled around the clock.

While the rated capacity of the facility is 391, the resident population averages in the 170-190 range. There were 187 youth listed on the roster at the time of the audit. The age range for residents is 12-20. PJCF has 24-hour medical services including nursing and access to on call medical personnel, however forensic examinations, if needed, are conducted at a local hospital by a SANE practitioner. PJCF also has contracted mental health providers (three master level, one doctorate level, and medical doctor level) with sex offender treatment also provided by Liberty Health Services (three counselors with at least master's level oversight).

Juvenile facilities in Indiana are under the jurisdiction of the Indiana Department of Corrections (IDOC). Recidivism statistics published by IDOC reported that of the 1,237 juveniles released in 2009, 78.2% (967) were successfully re-integrated into their communities and were not incarcerated in a correctional facility within three years of their release. Juvenile females released in 2009 fared better than their male counterparts, with only 18% of females returning to an IDOC facility in the three years following release versus 37% of males.

SUMMARY OF AUDIT FINDINGS

All youth that were invited to participate in the interview process agreed to be interviewed. No youth requested to speak to the auditor during the on-site audit and no youth contacted the auditor prior to the on-site audit. One youth, who had reported a sexual abuse, did not complete the interview. The youth stated that he felt uncomfortable continuing. The youth was told that he could speak to a counselor if he desired but the youth declined that offer and returned to the general population.

Youth interviewed stated almost unanimously that they felt safe, and all but one (out of 28) stated that they did not fear that they would be sexually victimized by other youths or by staff. The one dissenting youth said that he did not fear for his own safety but for others. All but one recalled receiving information at the time of intake on their right to sexual safety, how to report sexual abuse or harassment, and their right to not be punished or retaliated against for reporting sexual abuse or being a supporting witness for someone that had reported. All could articulate the facility's rules against sexual abuse and harassment. All were able to list at least two ways to report a sexual abuse allegations and all knew of the outside reporting option for reporting abuse. Youth interviewed unanimously stated that they had not been searched by female staff, and that female staff were not able to view them when they were naked or in any stage of partial dress. The majority reported that female staff announced their presence when entering the living unit(s). All reported that they had reasonable access to parent(s) and/or attorneys.

Two of the youth interviewed stated that they had reported a sexual abuse. The youth stated that they had therapeutic support and could speak with counselors or staff about issues including past sexual abuse. A service agreement for outside advocacy and/or counseling for past sexual abuse is in place, however none of the youth interviewed expressed interest in using it.

Random staffs interviewed were well-versed in their responsibilities to prevent, detect, and respond to incidents of sexual abuse and harassment. Staff knew their responsibilities as first responders, were familiar with "red flag" indicators of sexual victimization or predation, knew PREA policy, and had received comprehensive and timely PREA training. Staff demonstrated knowledge of pertinent policies and protocols, including reporting responsibilities, protection of victims and incident scenes, and prohibitions on cross-gender body searches and cross-gender viewing. Staff were aware of the potential for LGTBI youth to be at greater risk for abuse. Staff consistently articulated that actions taken in response to a report, suspicion, or threat of resident sexual abuse must be immediate.

Specialized staff, including administrators, teachers, contractors, intake, medical, and mental health personnel, the assigned investigator, human resources, and SART team members/security staff were equally cognizant of their roles and responsibilities. Each was able to demonstrate knowledge of his or her roles and responsibilities relative to PREA compliance, and documentation of compliance activities was ample. Administrators were open to collaboration with the auditor to discuss and implement practices that might further strengthen the facility's efforts to prevent, detect, and respond to sexual abuse. One example of that was completion of specialized training for medical and mental health care staff. While all of those persons were educated to at least a Master's level, and one to a Doctorate level, it was decided that completion of the National Institute of Corrections (NIC) specialized training might fill possible gaps in their knowledge relative to sexual abuse detection and response. The facility compelled that training and provided verification of completion to the auditor two weeks after the on-site audit.

Documentation was complete. Documentation reviewed included, but was not limited to, staff criminal history checks, staff training records, youth PREA orientation records, documentation of unannounced supervisory rounds, policy articles, incident reports, training curriculum, PREA Review Team Minutes, a PREA brochure specific to the facility, informed consent forms used by the facility, and screening instruments. Finally, the youth living units, the school, and youth common areas such as the gymnasium were clean and in good repair, and the grounds, security fencing, and security checkpoints were well-maintained. Posters listing options for reporting sexual abuse, reminders of the zero-tolerance policy, and options for outside advocacy were evident throughout the facility.

In summary, Pendleton Juvenile Correctional Facility was found to be materially compliant with the PREA Juvenile Standards.

Number of standards exceeded: 1

Number of standards met: 38

Number of standards not met: 0

Number of standards not applicable: 2

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.

The facility and its governing agency, the Indiana Department of Corrections, has developed and implemented a comprehensive written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment. The policy includes all requirements listed in the subsections of Standard 115.311. Documentation review and interviews with facility personnel supported that the practices and protocols listed in the policy are followed. The Agency had designated a PREA Coordinator that verified that he has the time and authority to implement and oversee agency efforts to comply with the PREA standards in all of its facilities. He is listed on the Agency's organizational chart. The facility has a PREA Compliance Manager that is listed on the facility's organizational chart.

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.

The agency does not contract with other entities for the confinement of residents so this does not apply.

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.

The facility has developed and implemented a thoughtful and comprehensive staffing plan that contains the elements required in the applicable standard. The plan is reviewed annually. In addition monthly meetings are held by a designated PREA Committee to discuss PREA Audit Report

PREA-related issues, incidents, and security. Minimum direct care staff ratios are 1:8 during waking hours and 1:16 during sleeping hours. There are adequate numbers of Supervisory personnel. Teachers and supervisory-level personnel are fully trained and able to supervise youth but are only counted in the staffing ratio when directly supervising youth. There were no deviations from the staffing plan reported during the most recent 12 month period. The facility uses American Correctional Association (ACA) standards and participates in Performance-based Standards (PbS). Unannounced supervisory rounds are conducted frequently and are documented.

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.

Facility policy prohibits cross-gender searches except in the case of exigent circumstances, and prohibits cross-gender viewing of youth when they are naked, performing bodily functions, showering, or otherwise in a state of undress or partial dress. Inspection of the shower/bathroom areas indicated that half-doors would even prevent inadvertant viewing of male residents’ private parts by female staff. Practice is for youth to shower alone, or if more than one stall (multi-stall showers) is in use, a male staff monitors. There were no reports of cross-gender searches or cross-gender viewing in the previous 12 months. Interviews with youth and staff strongly supported this. Policy requires opposite gender youth to announce their presence when entering an area where youth might be changing clothes or undressed. That this occurs was confirmed by staff during interviews, and youth also stated that this occurred. “Female on the unit” announcements are made from the security office on each wing when female staff are granted entrance to the area. Policy prohibits staff from searching or physically examining a transgender or intersex youth for the sole purpose of determining the resident’s genital status. There were no known transgender or intersex youth in residence so this had not occurred. Staff interviews confirmed that staff were aware of this prohibition. Policy provides for a transgender or intersex youth to shower separately if desired.

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.

Resident interpreters are not allowed per policy unless there would be a substantial delay that could jeopardize the safety of the youth. No resident interpreters were utilized during the audit period. The facility has services available to provide interpretation services should that be required. Services are also available to accommodate hearing impaired youth. No disabled or LEP youth were listed on the youth rosters during the past 12 months.

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.

Policy review, interview with Human Resources, and review of randomly-selected files confirmed that the facility conducts required background checks on all employees and contractors at the time of hire, and every year thereafter, exceeding the PREA requirement. The facility also exceeds the expectation by checking each employee on the state and national sex offender registry annually. In addition policy and the employee on-line application system incorporates the questions listed in 115.317(a)-1 regarding previous sexual misconduct. Human Resources policy and notifications include the expectation of continuing affirmative duty to disclose such misconduct. Material omissions regarding such conduct is grounds for termination, per policy. Contractors are subject to the same background checks and expectations for conduct as employees. Policy requires that consideration be given to any incidents of sexual harassment when determining whether to hire or promote employees. There were 98 employees hired, and 46 contracts let, in the previous 12 months that had background checks conducted as prescribed.

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.

The facility did not make significant upgrades to the facility in recent years, however it did add additional cameras for video monitoring. Policy requires that upgrades to video monitoring systems consider improving youth safety as the primary goal of the upgrade. Per the PCM, the facility PREA committee identified blind spots and installed the additional cameras to provide better video coverage for youth safety. In addition, fence-style locking doors were installed in several alcove areas in youth common areas to prevent youth from access outside of staff view. The alcoves are used for storage so the “fence” design also provides for view inside the storage area so that staff and/or youth cannot be out of sight of cameras or other staff.

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.

The facility conducts both criminal and administrative investigations. Investigative staff is assigned from the Internal Affairs Division. The agency (IDOC) has approximately 50 such investigators. The investigator assigned to PJCF has received specialized training for investigating allegations of sexual abuse from both the Internal Affairs Academy and the National Institute for Corrections. When investigating allegations the investigator refers incidents that might result in criminal charges to the Indiana State Police, and the investigator consults with police and prosecutors before conducting compelled interviews. Uniform evidence protocol is followed. If a forensic examination is warranted it is conducted off grounds at a designated SANE-staffed hospital, St. Vincent Anderson Regional Hospital, at no charge to the youth. There was one such medical examination performed in the past 12 months. The facility has an agreement with an outside entity, the Indiana Coalition Against Domestic Violence, to provide an advocate in the case of a sexual assault allegation and resultant forensic examination. The facility's Sexual Abuse Response Team (SART) members have all been trained as victim advocates and can provide these services in lieu of an outside provider if the youth does not want an outside provider.

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.

Policy 02-01-115 requires that the Superintendent or PCM order an investigation when any allegation of sexual abuse is received, and that all investigations must be completed. The facility had 14 allegations of sexual abuse or sexual harassment that were made in the past 12 months. All were administratively investigated by a qualified (Internal Affairs) investigator. The investigations were all completed. There was one allegation where there was an administrative finding substantiated. None were referred for criminal prosecution. Referrals and investigation outcomes are documented. Agency policy regarding referral and conducting investigations is also listed on the IDOC / Pendleton Juvenile Correctional Facility website.

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.

Policy 02-01-115 requires PREA training for all new employees and that periodic in-service refresher training be conducted throughout the year for all employees. The policy requires that the training curriculum address the 11 key elements listed in the standard, and review of the curriculum confirmed that those topics are taught. The facility provided training to all employees of record that have contact with youth and provided documentation that the training occurred. There were 258 staff, including 98 staff hired within the past 12 months, that received PREA training. The training curriculum is tailored to the needs and gender of the youth. Employees sign that they attended the training and understood the materials presented.

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)

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Policy 02-01-115 requires that contractors and volunteers receive the same information on PREA as employees and also receive periodic in-service refresher training, and that the curriculum includes the 11 key elements listed in the standard. The facility provided training to all contractors and volunteers that had contact with youth during the 12-month period and provided documentation that the training occurred. Contractors and volunteers sign that they attended the training and understood the materials presented.

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)

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Resident education is provided at the time of intake about the zero-tolerance policy and how to report. Comprehensive information is provided within 10 days. Youths unanimously stated that they received this information. All youths interviewed were able to articulate rules regarding sexual contact, how to report, their right to not be sexually abused or harassed, and that they would be protected from retaliation. All were able to list at least two ways to report sexual abuse or harassment. All stated that they knew about the outside reporting option, and could list the outside reporting option and/or the option to contact the facility's investigator, confidentially by telephone, without charge for the call. The facility listed 252 youth intakes in the past 12 months and provided documentation in the form of youth signature sheets that the information had been provided. There were no LEP or disabled youth listed as intakes during the period however the facility has contracts with interpretive and disabled services to provide PREA education to such youths. Posters are placed throughout the housing units and common areas that reinforces key information for youths.

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)

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

Internal Affairs Investigators conduct both administrative and criminal investigations of sexual abuse and sexual harassment complaints and are required to receive specialized training through National Institute of Corrections and required to complete the IDOC Internal Affairs Academy training for investigators. Certificates of completion are on file verifying that this occurred. All investigators also participate in SART training.

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)

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Specialized training for medical and mental health care staff had not been completed at the time of the onsite audit. It was completed within the next two weeks, and verification of completion sent to the auditor by both department heads (medical and mental health). The training curriculum was the training provided online by the National Institute of Corrections (NIC). In addition all of the mental health staff have advanced degrees, and medical staff have appropriate degrees and training in the health care field.

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)

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Policy requires that this screening occur within 24 hours after a youth's admission to the facility. Policy also requires that the youth's risk level be re-assessed upon a referral, incident, request, or receipt of any information that might bear upon the youth's risk for victimization or abusiveness. In addition youth are reviewed at regular intervals. Documentation review of completed screening instruments occurred. The standardized screening instrument used is the Sexual Violence Assessment Tool. In interviews with youth, almost all of the youth recalled this screening at intake, and recalled that they were asked about their sexual orientation and sexual abuse history.

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.

The screening instrument rates each youth as a likely victim, likely aggressor, or no flag. Policy (02-01-115) requires that individualized determinations be made on the assignments of each youth based on their identified risks. Policy prohibits housing (in some sleeping room, shower, etc.) a likely aggressor with a likely victim. Policy further requires that youth at high risk for victimization will not be placed in involuntary restrictive housing unless no other alternative exists to separate the youth from likely abusers. If it should happen that a youth is placed in restrictive housing as a means to ensure safety then policy further states that the youth must be allowed daily exercise periods and special education and regular education must be provided. Review of housing status must occur at least every 30 days. There were no youth placed in restrictive housing standard for this reason during the previous 12 months. Policy prohibits placing LGTBI youth in restrictive housing solely based on such identification status. Decisions on housing or other elements of daily routine are made on a case-by-case basis. The facility prohibits considering LGTBI youth as more likely to be sexually aggressive based solely on their sexual orientation. No LGTBI youth were placed in restrictive housing during the previous 12 months.

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.

The agency provides youth with multiple ways to report sexual abuse and sexual harassment allegations and informs youth of these reporting options during orientation. In addition wall posters and youth orientation handouts remind youth of these options. An outside reporting option exists that can be utilized by youth privately using kiosks in the facility, at no charge to youth. Calls made using the outside reporting option reach the state's Ombudsman, or youth can use the kiosks to report directly to Internal Affairs in the building. All youth interviewed were able to list multiple reporting options, including the outside reporting option. The majority of youths interviewed stated that they would report directly Internal Affairs in the facility by dialing the number established for just that purpose, #22, or they would report verbally to their staff or to Administration. All staff interviewed stated that they are required to accept verbal, written, and third party allegations and that they must act immediately upon receiving such reports. Staff must document allegations by the end of their shift. Staff have options for reporting privately, including use of the IDOC sexual abuse reporting line, and are informed of these options through training and orientation. Youth are provided with materials and assistance if required in making reports.

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.

Youth may submit a grievance alleging sexual abuse or harassment without submitting it to the staff that is the subject of the allegation. No informal processing of grievances is required, and there is no time limit set on when a youth may report an allegation of sexual abuse. Policy and practice regarding the processing and answering of grievances, Policy 03-02-105, falls within the PREA time limits. Facility policy requires that grievances be answered within five days. Policy requires that the youth receive a written answer to the grievance and that emergency grievances be immediately brought to the attention of Administration and be answered within 48 hours. There were no reports of grievances having been filed in the past 12 months alleging sexual abuse or sexual harassment. There were no reports of emergency grievances having been filed. There were no youth listed as having been disciplined for intentionally filing a malicious grievance. There were no third party grievances filed. Policy requires that third party grievances be accepted and processed in the same manner and time frames.

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.

Policy 02-01-115 requires that this be provided. Confidentiality is required, with the exceptions required by law relative to mandated reporting of sexual abuse allegations to minors. Outside confidential services are provided through an agreement between the facility and the Indiana Coalition Against Domestic Violence. Youths are notified of limits to confidentiality, per policy. There are no immigrant-status youth at the facility. Youth are provided with access to parents and if they request, attorneys. Youth interviewed all reported that they had contact with parents, and the majority stated that they were certain they could speak confidentially with an attorney if they wanted, although few claimed to have requested that. The facility's Sexual Abuse Response Team (SART) members have all been trained as victim advocates. As such SART members can provide these services in lieu of an outside provider if the youth does not want an outside provider. During interviews youths overall did not express much interest in this PREA right. With prompting, most were aware of the postings in the facility listing contact information for this, and most remembered being provided with written information on this.

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.

Third-party reports can be made electronically by sending an email to IDOCPREA@idoc.in.gov or my calling, toll free, the IDOC Sexual Assault hot line. These reporting options are posted in visiting areas and on the IDOC website.

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.

Agency policy 02-01-115 requires all staff to immediately report any knowledge, suspicion or information that they receive regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not the facility is part of an agency. Policy lists specific protocols for this and staff are trained on these protocols and on the requirements to report. All facility staff are also mandated reporters under state law. Policy directs staff to not discuss the information with anyone except Supervision, investigators, or others that need to know. All staff interviewed, including specialty staff, knew of this requirement and could list response protocol.

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.

Facility policy (02-01-115) requires that if staff learn that a resident is subject to a substantial risk of imminent sexual abuse that immediate steps are taken to protect the resident. There were no reports listed by the facility of this occurring in the past 12 months.

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.

Policy 02-01-115 requires that the Superintendent notify the head of another facility within 72 hours if the Superintendent receives an allegation that sexual abuse occurred in the other facility. All other reporting obligations still apply to the Superintendent that received the report. No such reports were received or forwarded during the past 12 months. In addition, no reports were received from other facilities

alleging that a youth had been sexually abused at PJCF.

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.

Staff were consistently able to list the steps that must be taken—separate the alleged victim and abuser, preserve and protect the incident scene, request that the victim and require that the suspect not do anything to destroy physical evidence, immediately notify Supervision, and if within 96 hours arrange for a forensic examination—when an allegation of sexual abuse has been received, in accordance with policy. Policy details the protocol in accordance with the standard, and staff receive training on this. If the staff receiving the report is not a security staff, a SART team member and security staff are notified immediately, per policy. In the past 12 months there was one allegation of sexual abuse where a forensic examination was conducted at the SANE-staffed local hospital. Incident reviews were conducted and indicated that proper steps were taken when allegations were made.

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.

The facility developed a written plan, listed as PJCF Directive #103, that coordinates actions taken in response to an incident of sexual abuse. The plan details actions that must be taken by all pertinent parties, including first responders, medical and mental health practitioners, investigators, security staff and SART team members, and Administrators.

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.

There is not collective bargaining at the facility so this does not apply.

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.

Facility policy lists the youth's right to be free from sexual abuse and to be protected from retaliation for reporting abuse. Policy 02-01-115 requires that the facility employ multiple protection measures, such as housing changes or removal of offending staff or youth from contact with the victim/reporter. For at least 90 days, or three consecutive (monthly) PREA meetings, the treatment of the victim youth and of youth and staff that were supporting witnesses must be monitored. Policy requires monitoring to be extended beyond 90 days if needed. Monitoring is done by the PREA Committee but overall responsibility is by the PREA Compliance Manager. In the preceding 12 months there were no incidents of retaliation reported. Monitoring activities are documented.

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.

Facility PREA policy requires that protective custody may only be used if no other alternative measures would be adequate. Policy requires that youth in protective custody for any reason receive large muscle exercise daily and education programming, and that any youth held in protective custody be reviewed at least every 30 days to determine the need for continued protective custody. The facility reported that there were no incidents where youth were placed in protective custody in the past 12 months.

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.

The facility has a policy related to criminal and administrative investigations. Investigations are conducted by the agency's Internal Affairs Department. Policy states that the agency does not terminate investigations because the source of the allegations recants the allegation. Allegations that appeared to be criminal are referred to the Indiana State Police. There were no sustained allegations of conduct that appeared to be criminal during the preceding 12 months, and no referrals for prosecution. Investigators must confer with police and prosecutors before conducting compelled interviews. Records and written reports are retained as long as the offender is incarcerated or employed by the agency, plus five years, per policy.

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.

Per policy 02-01-115 an allegation of sexual abuse is substantiated based on a preponderance of the evidence.

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.

Agency policy (02-01-115) requires that following completion of an investigation into a resident's allegation of sexual abuse or harassment that the PREA Compliance Manager will inform the resident in writing as to whether the allegation was substantiated, unsubstantiated, or unfounded. A standardized form used for these notifications was reviewed. The form includes the information required in Standard 115.373 c and d on the disposition of staff if staff was the subject of the allegation, and the disposition of another resident if another resident was the subject of the allegation. There were no substantiated or unsubstantiated allegations against staff during the reporting period. Policy requires that notification, and/or attempt at notification (in cases where the victim has been released from custody) be documented.

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.

Staff are notified that any form of sexual activity between staff and residents, whether consensual or not, is strictly prohibited and that any staff found to have engaged in such behaviors will be subject to disciplinary action up to and including dismissal and criminal prosecution. Disciplinary actions will consider the nature of the offense, the employee history and work record, and any mitigating or aggravating circumstances, per the Employee Handbook. There were no allegations that staff had engaged in sexual activity with youth in that past 12 months. Terminations for violation of this policy, or resignations in lieu of termination, are reported to pertinent licensing bodies and are reported to law enforcement unless the activity was clearly not criminal.

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.

Contractors and volunteers are notified that any form of sexual activity between them and residents, whether consensual or not, is strictly prohibited and that any contractor or volunteer found to have engaged in such behaviors will be restricted from further contact with residents, and will be reported to pertinent licensing bodies and to law enforcement unless the activity was clearly not criminal. There were no allegations of sexual abuse or harassment made against contractors or volunteers in the past 12 months.

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.

appropriate disciplinary code or code of conduct. Further, any finding of sexual abuse that appears to be at the level of criminal behavior will be reported per policy and referred for criminal prosecution. There was one administrative finding of resident-on-resident sexual abuse at the facility in the past 12 months. Isolation was not used as a response to the finding. There were no youth isolated as a disciplinary response to sexual abuse in the past 12 months. The facility does not consequence a youth for making an allegation in good faith, even if the allegation is determined to be unfounded, and protects residents from retaliation. The facility does not consequence youth for sexual contact with staff unless staff did not consent to such contact.

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.

Policy requires that if assessment or screening determines that a resident was a victim of past sexual abuse that the resident be offered a follow-up meeting with a medical or mental health provider within 14 days. As a matter practice and protocol all residents meet with both a medical and mental health provider within 14 days of initial screening, regardless of whether a previous sexual abuse or victimization is reported at intake. Sharing of information relating to a resident's past victimization is limited to the medical and mental health provider and only those others that need to know to inform bed, housing, and related assignments, and to develop treatment plans. Informed consent must be obtained from youth's age 18 or older. The facility utilizes a standard template for providing informed consent.

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.

Victims of sexual abuse are offered timely, unimpeded access to emergency medical treatment and crisis intervention services (policy 02-01-115). The nature of these services is determined by medical and mental professionals. Information on contraception and sexually transmitted infections prophylaxis must be provided. Policy also requires that these services be provided at no charge and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. Medical and mental health records are confidential.

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.

Policy requires that a sexual abuse victim be referred to the facility's health care staff for examination in accordance with Health Care Services Directive (HCSD and JHCSD 2.30) and the Health Care Sexual Assault Manual. Information on contraception and sexually transmitted infections prophylaxis must be provided in a sensitive, understandable, and culturally competent manner. Policy also requires that the facility attempt to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history and provide treatment as deemed appropriate, as well as provide mental health care for victims. PJCF is an all-male facility so 115.383(d)1 and (e)1 do not apply.

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.

Policy requires the facility PREA Committee to meet on a monthly basis. In addition to other sexual abuse prevention activities and reviews, the Committee must review all sexual abuse incidents, unless the allegation was determined to have been unfounded. The Committee is comprised of upper-level management and other key personnel. Findings are documented. The auditor reviewed documentation of a completed investigation, review committee monthly minutes, the incident review(s), and an annual facility PREA committee report.

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.

The agency/facility collects uniform data on allegations of sexual abuse from its facilities. Data collected is, at a minimum, the data necessary to answer all questions from the Survey for Sexual Violence. Raw data and data analysis collected for calendar year 2015 was reviewed. The agency does not contract with other entities for confinement of its residents. 2015 data and annual report is still under development so not yet approved or posted on the website (as of June 5, 2016).

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.

Data collected as required in Standard 115.387 is aggregated and reviewed in order to assess and improve sexual abuse prevention, detection, and response policies and training. An annual report, in addition to the aggregated data, is approved by the IDOC Commissioner (agency head) and made publicly available on the IDOC website. Personal identifiers are not made public. The most recent data listed on the IDOC public website is from calendar year 2014. Data and the annual report for 2015 is still awaiting final approval and posting.

Recommendation: While PREA does not list a deadline date for posting the previous year's data and annual report, it is this auditor's recommendation that this posting occur no later than the end of June each year.

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.

Administrative policy and procedure 02-01-115 lists protocols for secure retention of agency documents, including sexual abuse data, and sets a retention schedule that complies with the Standard. Policy requires publication of sexual abuse data as required in Standard 115.388. Required reporting is posted on the agency website and can be reviewed by the public.

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.

Patrick J. Sussex

June 6, 2016

Auditor Signature

Date