# PREA AUDIT REPORT Interim X Final

## ADULT PRISONS & JAILS

**Date of report:** May 2, 2016

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| **Auditor Information** | | | |
| **Auditor name:** Bryan Pearson | | | |
| **Address:** 302 W. Washington St., Indianapolis, IN 46204 | | | |
| **Email:** bpearson@idoc.in.gov | | | |
| **Telephone number:** 317-232-5288 | | | |
| **Date of facility visit:** 9/29/15 – 10/1/15 | | | |
| **Facility Information** | | | |
| **Facility name:** Carson City Correctional Facility | | | |
| **Facility physical address:** 10274 Boyer Rd., Carson City, MI 48811 | | | |
| **Facility mailing address:** *(if different from above)* Click here to enter text. | | | |
| **Facility telephone number:** 989-584-3941 | | | |
| **The facility is:** | ☐ Federal | X State | ☐ County |
| | ☐ Military | ☐ Municipal | ☐ Private for profit |
| | ☐ Private not for profit | | |
| **Facility type:** | X Prison | ☐ Jail | |
| **Name of facility's Chief Executive Officer:** Sherman Campbell | | | |
| **Number of staff assigned to the facility in the last 12 months:** 441 | | | |
| **Designed facility capacity:** 2512 | | | |
| **Current population of facility:** 2139 | | | |
| **Facility security levels/inmate custody levels:** 1, 2 & 4 | | | |
| **Age range of the population:** 18-86 | | | |
| **Name of PREA Compliance Manager:** Khris Nevins | | **Title:** Inspector | |
| **Email address:** NevinsK@Michigan.gov | | **Telephone number:** 989-584-3941 | |
| **Agency Information** | | | |
| **Name of agency:** Michigan Department Of Corrections | | | |
| **Governing authority or parent agency:** *(if applicable)* State of Michigan | | | |
| **Physical address:** 06 E. Michigan Ave, Lansing, MI 48933 | | | |
| **Mailing address:** *(if different from above)* PO Box 30003, Lansing, MI 48909 | | | |
| **Telephone number:** (517) 373-3966 | | | |
| **Agency Chief Executive Officer** | | | |
| **Name:** Heidi E. Washington | | **Title:** Director | |
| **Email address:** WashingtonM6@Michigan.gov | | **Telephone number:** (517) 373-0720 | |
| **Agency-Wide PREA Coordinator** | | | |
| **Name:** Todd Butler | | **Title:** PREA Administrator | |
| **Email address:** ButlerT4@Michigan.gov | | **Telephone number:** (517) 373-3966 | |

## AUDIT FINDINGS

### NARRATIVE

On September 29 to October 1, 2015, an audit was conducted at the Carson City Correctional Facility to determine compliance with the Prison Rape Elimination Act standards. This audit was a result of a MOU between state departments of correction for Indiana, Michigan and California. No conflict of interest exists with respect to this auditor's ability to conduct an audit of the Carson City Correctional Facility and the Michigan Department of Corrections.

This auditor sent a notice of the scheduled audit and auditor's contact information to the facility that was posted in the living units prior to the facility visit. The Pre-audit Questionnaire, training curriculum, offender education video, staff quick reference guide and documents were received approximately 20 days prior to the facility visit. The electronic documents were placed on a flash drive and mailed. The MDOC PREA Administrator (PREA Coordiantor) sent additional revised documents just after the others were mailed. A conference call was conducted with the PREA Coordinator, Warden and Compliance Manager just prior to the facility visit. Questions about documents and requests for additional documents were addressed just prior to the visit. Additional documents were provided during the facility visit.

The facility visit began with a brief meeting with the facility executive staff and agency PREA Coordinator on September 29th. A complete tour of the facility was conducted. The tour covered offender living areas in segregation, level 4, level 2, and level 1. Additionally the tour also included foodservice areas, education areas, recreation areas, maintenance areas, medical areas, mental health areas, visitation areas, warehouses, and industry. Staff supervision was found to be adequate in all areas based on security level. The facility has a camera system in place and is expanding that system to add over 300 more cameras. Information about reporting sexual abuse was prominent in housing units and other areas where offenders frequent throughout the facility.

Formal interviews were conducted with 11 randomly selected offenders and an offender that made a report. Offenders to be interviewed were selected at random by this auditor from an offender list for each housing unit. 22 staff were interviewed including 7 random and 15 specialized staff. Custody staff from all shifts were interviewed. Interviews indicated a positive PREA culture at this facility as well as compliance with the standards. Staff knew their responsibilities in the sexual abuse prevention, response and detection. Offenders knew how to make a report, were aware of zero tolerance and felt safe.

After review of provided documents and interviews with offenders and staff, this auditor found the Carson City Correctional Facility to meet 39 standards, exceed 1 standard and not to meet 1 standard. Two were found to be not applicable (Youthful Offenders and Contracts). The plan of correction was to change the grievance policy to allow for third party grievances pertaining to sexual abuse and to create a time frame schedule for sexual abuse grievances that meets the standard's requirements. The POC was completed on April 28, 2016, just prior to the deadline.

## DESCRIPTION OF FACILITY CHARACTERISTICS

Carson City Correctional Facility is a 2512 bed multi level state correctional facility located in a rural setting in southwestern Michigan. The facility population ranges from age 18 to 86. Youthful offenders are not housed at this facility. The facility employs 441 staff, 17 of which are investigators. The facility has 140 contractors and volunteers that have contact with offenders. There are 14 housing units with 1 segregation housing unit, 5 cell houses in level 2/4 and 8 open dormitories in level 1. The cell houses have 2 man cells. The open dormitories have cubicles with 6 men to a cube. The facility has a medical clinic and provides emergency services/forensic exams through the local hospital in Carson City or Lansing. Medical coverage is not 24 hours a day at this time. An on-call doctor is utilized for off-duty hours to triage for emergency issues. If there is an emergent issue, the facility is directed to take the offender to the local emergency room. A plan is in place to provide 24 hour nursing coverage in the near future. Foodservices are provided by Trinity through a new contract. As a result, all foodservice staff had recently completed the PREA training and background checks. The foodservice supervisor had worked for the previous contractor and was very knowledgeable of sexual abuse prevention and response. Foodservice areas were appropriately supervised. Recreation areas had a correctional officer controlling access to the area and another monitoring the gym.

Video monitoring is utilized in many areas of the facility, but not throughout the entire facility. There is work on expanding the current video system. Previously the facility was two separate facilities, a level 1 and a level 2/4. It is now combined under one Warden and his administration. As a result, there are two areas for medical, foodservice, recreation, and programs. The facility offers offenders a GED program and training in food technology. They are also provided employment and training in industries, maintenance, laundry, and warehouse. Level 1 offenders do not work on community work crews. They only work on the prison property outside the perimeter performing sanitation and grounds keeping under staff supervision.

## SUMMARY OF AUDIT FINDINGS

After documentation review, interviews and the facility tour, this auditor found that Carson City Correctional Facility has a program in place to prevent, detect and respond to sexual abuse and harassment. The facility staff have done a lot of work to create a safe environment and continue to work on improving the sexual abuse prevention program. The agency grievance policy does not allow third party grievances and does not meet the time frames of standard 115.52. The agency will have to develop a plan of correction to change its policy and procedures for grievances to meet this standard. This will have to be developed and implemented during the corrective action period that ends on 5/2/2016.

The PREA Coordinator provided a plan for the policy change and provided updates during the POC. A Director's Office Memorandum was signed on April 27, 2016 and distributed to all offenders and staff on April 28, 2016. The DOM provided the changes needed to meet the standard.

Number of standards exceeded: 1

Number of standards met: 40

Number of standards not met: 0

Number of standards not applicable: 2

**Standard 115.11 Zero tolerance of sexual abuse and sexual harassment; PREA Coordinator**

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The agency has a Zero Tolerance policy and procedures for offenders to report sexual abuse and staff to respond to reports. This policy and procedures were provided in PD 03-03-140 and the PREA Manual. All staff and offenders interviewed knew the zero tolerance policy and procedures for reporting and responding. The agency has a PREA Coordinator and Compliance Managers at each facility as well as 3 regional assistants for the PREA Coordinator. All seem to have sufficient time and authority to coordinate the state and facility efforts in complying with PREA.

**Standard 115.12 Contracting with other entities for the confinement of inmates**

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

This standard does not apply at this time. The agency does not have contracts for the confinement of offenders.

**Standard 115.13 Supervision and monitoring**

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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Interviews with the Warden, PREA Coordinator, HR, Shift Supervisor, and random offenders demonstrated compliance with this standard. The facility provided a Custodial Staff Assignment Sheet, Org chart and an annual review form that contained all elements of (a) and (c). The Warden said he discusses the staffing plan in monthly meetings with HR, Assistant Wardens and Fiscal where they monitor the staff vacancies and the plan to fill them. The staffing plan is also reviewed annually and documented on the Annual Staffing Plan Review form.

The facility claims no deviations from the staffing plan. Posts are closed, but only if the post is above the set staffing plan for the shift. This was explained by the Warden, shift supervisor and PREA Coordinator. It is required to use overtime per union agreements to cover the staffing plan. Only excess staff assignments are not covered with overtime. Dorm and Cell house logs show unannounced rounds by supervisors are being documented on each shift. Rounds by Executive staff are also documented in the dorm/cell house logs. All are clearly identified by writing them in green ink. During the tour of the facility it appeared there was sufficient staff supervision to ensure the safety of offenders. All offenders interviewed felt safe and saw staff make frequent rounds.

### Standard 115.14 Youthful inmates

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The facility can only house offenders that are 18 and over, therefore this standard does not apply to this facility.

### Standard 115.15 Limits to cross-gender viewing and searches

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The search policy 04-04-110 provided requires emergency circumstances for opposite gender staff to conduct a strip search. A supervisor must be present during the search and the exigent circumstances must be documented in a report. No cross gender strip searches were reported being conducted by the facility. Only medical staff are allowed to perform a body cavity search. PD 04-04-110 requires female staff to knock and announce their presence on the housing units at the entrance of the dorm or cell house. Most offenders interviewed said they heard the announcements. Signs are displayed that inform the offenders of the knock and announce requirement. There are also privacy notice signs in English and Spanish informing offenders to be properly clothed as female staff may be present. The facility had addressed cross gender views in showers with curtains that did not hinder security but blocked the view of the offender's genitalia. Offender interviews verified there are rules for undress communicated and offenders felt they were not being seen in a state of undress by female staff. During the tour a few cross gender viewing issues were discovered. Two segregation cells had cameras that could be viewed by female staff if they were to be assigned to the post. Currently none were assigned to work this unit. However, the facility completed a corrective action

to black out the toilet area in the cell without compromising the safety of the offender being observed. The offenders were not allowed to completely undress in the observation cell, so the only viewing was when they sat on the toilet. Also in the same segregation unit, the showers were in a direct line of sight from the control post window. Curtains were hung in the control window that female staff can use to block the view of the offender genitalia during showers without completely blocking the view of the offender. An offender bathroom in foodservice had a window looking into it from the supervisors office that provided a view of the offender on the toilet. The bottom half of the window was covered to prevent staff from seeing the offender below the chest without compromising security in the area. PD 04-06-184 Gender Dysphoria policy demonstrated compliance with (e). Interviews with staff about searches of transgender offenders indicated they had been trained on how to conduct these searches as required by the standard.

### Standard 115.16 Inmates with disabilities and inmates who are limited English proficient

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The PREA Manual provides the policy that complies with the requirements of this standard. Based on the materials provided to offenders, and interviews with the staff that provide the education, the requirements of the standard are met. Offender interviews indicate that written materials are provided as well as video information. Offenders reported that staff read the PREA brochure to them individually. This would accomodate any illiterate offenders. Staff interpreters and contracted interpreters are available for LEP offenders. The facility provided documentation of a sign language interpretor for a deaf offender that was utililzed during the last 12 months. Staff that provide the PREA education described how they would accommodate offenders that were illiterate, deaf, blind, or LEP demonstrating compliance.

### Standard 115.17 Hiring and promotion decisions

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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PD 02.06.11 Employment Screening and the PREA Manual provided the policy that covered the requirements of this standard. State employee applications have questions that cover element (a) that are asked of every applicant to the MDOC. Several examples of completed applications were provided as verification of practice. Questions about harassment are asked during the interview board. Employment backgrounds checks are documented on a state form. Examples were provided. All employees, contractors and volunteers have a criminal background check completed annually. Examples of LIEN checks (criminal background checks) were provided on staff, contractors and

volunteers. LIEN checks are conducted annually on all employees, contractors and volunteers which supersedes the 5 years requirement. During the interview with the HR Director it was explained that if HR staff are asked for information about substantiated findings of sexual abuse or harassment of offenders by a former employee it would be provided to a correctional institution considering them for a job.

### Standard 115.18 Upgrades to facilities and technologies

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

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

The facility has not had any new, expansion or modifications of the facility in the last 12 months. The facility is in the process of upgrading and expanding the video monitoring system by adding over 300 cameras. Documentation was provided of the planning on this upgrade to improve monitoring in vulnerable areas. The facility PREA compliance manager was present in those meetings and provided input on the placement of cameras. He is directly involved in completing work on the project.

### Standard 115.21 Evidence protocol and forensic medical examinations

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

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

PREA Manual provided an evidence protocol based on the National protocol, provided in the NIC investigations curriculum. All investigators are trained to handle evidence and have completed the NIC SA investigation training online. The facility would utilize a SANE at the hospital in Lansing. Staff were aware of their role in evidence preservation based on interviews with random custody staff and non custody staff. All cases that could potentially be criminal violations are referred to the Michigan State Police. These referrals are reviewed and approved by the Warden. The PREA Coordinator provided emails to the Michigan State Police making them aware of the evidence protocol and requesting that they follow it when conducting investigations at MDOC facilities. The MSP Deputy Director responded in a letter indicating they will follow all elements of this standard.

### Standard 115.22 Policies to ensure referrals of allegations for investigations

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

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

PD 01.01.140 Internal Affairs and PD 03.03.140 Prohibited Sexual Conduct provide policy that cover the requirements of the standard. An example of investigation reports and findings was provided. The MDOC Inspectors begin all investigations and refer all possible criminal investigations to the State Police. MDOC Inspectors complete all administrative investigations. The Warden must approve the referral of investigations to the MSP. The MSP determines if there is a criminal case. If not, it goes back to the MDOC Inspector to complete as an administrative investigation. The MSP were notified of the requirements of this standard. They responded by saying their policy follows the standard but did not provide the policies. The MDOC has made the required effort to request the MSP follow the standard.

### Standard 115.31 Employee training

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The facility training coordinator was interviewed about the training process and asked to provide training records for new employees and current employees. The Program A curriculum and PREA CBT together cover all elements of the standard. Documentation of staff training completion were provided. Interviews with staff, both custody and non-custody, indicated a good knowledge of the training material and the required elements of this standard. Training on PREA is provided annually.

### Standard 115.32 Volunteer and contractor training

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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Volunteers and Contractors complete the same training as staff. Documentation of contractor and volunteer training were provided. The training coordinator and volunteer coordinator were interviewed about training for contract staff and volunteers. This training is provided annually. A volunteer was interviewed and demonstrated knowledge of the zero tolerance policy and their responsibilities in detecting, responding to sexual abuse and harassment reports.

### Standard 115.33 Inmate education

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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Information is being provided both verbally and in written/video formats. The facility reported all offenders have received the zero tolerance policy and how to report. All offenders interviewed indicated they knew the zero tolerance policy and how to report. The facility provides a video and a pamphlet to all offenders. The intake staff provide a one on one explanation of the material. Staff are available for Spanish speaking offenders and the materials are provided in Spanish. PD 03.03.140 Prohibited Sexual Conduct, PD 04.01.140 Prisoner Orientation require a PREA education and materials be provided to all offenders received at the facility. Documentation of completed offender education was provided. Both staff and offender interviews indicated the education was being provided within the required time frame.

### Standard 115.34 Specialized training: Investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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All facility Inspectors have completed the NIC sexual abuse investigation training as documented by a certificate of completion from NIC. Inspectors also receive investigations training from the MDOC. Inspectors are trained in all required elements of the standard. The MSP receives training on sexual assault investigations as part of their overall training and have been asked in writing by the PREA Coordinator to meet the requirements of this standard. The interview with a facility Inspector indicated the required training was completed.

### Standard 115.35 Specialized training: Medical and mental health care

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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The facility reported all medical staff have been trained as required. The curriculum used was the same as what other staff complete. I interviewed a nurse, a mental health staff and the health care supervisor. All knew how to respond to a report, preserve evidence and the

zero tolerance policy. The training is documented. Forensic exams are provided by a SANE at a hospital in Lansing, therefore (b) is not applicable.

### Standard 115.41 Screening for risk of victimization and abusiveness

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

**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.**

Initial assessments are completed at the MDOC intake facility. The counselors and unit managers review the assessments for accuracy within 30 days of arrival and if an offender is the subject of a substantiated report. This was demonstrated from staff interviews and provided documentation of the offender arrival date and the date of review. The assessment instrument covers all required elements. The assessments and reviews are documented in the OMNI system. I was shown the OMNI system and found it to be compliant. The PREA Risk Assessment Manual contains the policy and training details covering the requirements for the standard.

### Standard 115.42 Use of screening information

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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PD 05.01.10, PD 04.06.184 Gender Dysphoria, PREA Manual, and the PREA Risk Assessment Manual pg 32 provide the policy that covers the requirements of this standard. The OMNI system is used to ensure offenders are not housed together that are assessed as potential victim and aggressor. The offender lists that were provided to me for interviews show the assessment designation of each offender and can be used to review bed assignments. PREA flags are considered for program assignments on an individual basis based on the level of monitoring. Line officers were not aware of the flag status of an offender. All showers in the facility are stall showers that would provide transgender offenders privacy. Staff indicated they would also allow them to shower at a different time from other offenders if the offender felt the need to do so. That facility has not had any transgender offenders in the last 12 months.

### Standard 115.43 Protective custody

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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The PREA Manual pg 17 covers this standard. PD 04.05.120 covers the requirements for review of segregation if used and only allows a temporary segregation for up to 7 days. The facility reports no offender was placed in PC that was high risk of victimization based on the assessment. The facility has a 22 bed segregation unit for a population of 2500. The warden and Inspector reported in interviews that offenders can be moved to another section of the prison to provide protection. If an offender is placed in segregation due to no safe alternative, the offender will be transferred. Examples were provided of offenders being placed in temporary segregation involuntarily for their safety that made a report of sexual abuse. They were reviewed and approved for transfer to another facility.

### Standard 115.51 Inmate reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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The facility provides offenders multiple ways to report sexual abuse or harassment. Offenders can tell any staff, write any staff, use the MDOC Sexual Abuse hotline, file a grievance, or contact the Ombudsman through a hotline. All offenders interviewed knew of the many ways to make a report. All staff interviewed knew how to make a private report. All staff knew to document a verbal report before the end of their shift if not sooner. An MOU with the Legislative Corrections Ombudsman was provided.

### Standard 115.52 Exhaustion of administrative remedies

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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After reviewing the Grievance policy, PREA Manual and a memo regarding Step I grievances to the field from the PREA Coordinator, I find that the facility does not meet elements (b)1, 2, 3 and (e). There is no allowance in the policy for a sexual abuse grievance to be filed with no time limit after the incident of sexual abuse. The time frames in (d) cannot be met if the policy is to suspend the grievance until the sexual abuse investigation is completed and then resume the grievance policy time frames of up to 120 for a final decision. This could take much longer than the time frames allowed in this standard for a final decision. The third party grievance requirement in (e) is not met because the MDOC policy says a third party can encourage an offender to file a grievance and prohibits a third party from filing on behalf of the offender. If this prohibition language is removed and the word "encourage" is changed to "assist", the policy will meet the standard even with the requirement of the offender to sign and submit the third party grievance. Examples of grievances reporting sexual abuse filed by the offender were provided that resulted in an immediate response and timely investigation, however the policy does not fully support the

standard.

During the POC, the MDOC worked to change the policy to allow third party grievances and meet the time frames required by this standard. A Director's Office Memorandum 2016-29 was signed on April 27, 2016 that changes the MDOC grievance policy to allow fellow prisoners, staff, family, and outside advocates to file a sexual abuse grievance on behalf of the offender. All time frames of the standard are now met with the DOM. A PREA Prisoner Greivance form was created specifically for filing grievance regarding sexual abuse. The DOM and form were emailed out to all MDOC staff on April 28, 2016 and posted in the housing units and law library. The DOM is also on the MDOC website. Pictures were provided of the posting in a housing unit at Carson City.

### Standard 115.53 Inmate access to outside confidential support services

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

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

Currently the MDOC does not have an official agreement with a victim advocacy organization to provide services. Offenders have access to the An End to Silence Inmate Handbook with the mailing address for Michigan Coalition to End Domestic and Sexual Violence so they can correspond. If an offender reports he is a victim, he will be referred to this resource and mental health staff will attempt to arrange for contact with a local victim advocate. I interviewed a social worker in mental health that said he would provide victim advocacy services and also assist the victim in contacting a local victim advocate. The policy on offender telephone use and offender correspondence provides the limits to confidentiality. An email exchange between the PREA Coordinator and Director of RAVE (Relief After Violent Encounter) was provided. The discussion was about providing victim advocacy services to sexual abuse victims at Carson City CF and another facility in the region. RAVE needed funding that MDOC was unable to provide. This was an attempt by MDOC to arrange VA services at Carson City CF. MDOC will be seeking funding to use for VA services through zero tolerance grants. It appears the facility is making an effort to provide VA services by an outside entity. The Regional PREA Coordinators continue to contact local rape crisis centers for a possible agreement.

### Standard 115.54 Third-party reporting

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

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

The MDOC has a PREA Hotline and email address for third party reports. The MDOC website has the hotline, email and mailing address for making reports as well as the instructions for how to make a report. This information is also on posters in the visiting room. All offenders interviewed knew they could tell their family about an incident and how their family could report it for them.

### Standard 115.61 Staff and agency reporting duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

PD 03.03.140 and the PREA Manual require staff to report as required in the standard. Interviews with random staff, both custody and non-custody, demonstrate compliance. All staff interviewed knew they had to report sexual abuse, sexual harassment and retaliation immediately and who receives the report. Medical staff were aware of the duty to report. Offenders were aware of the medical/mental health staff duty to report. They were informed of this at intake to the MDOC. The facility reported no incidents of mandatory reporting. This facility does not have offenders under 18. All staff knew that information provided by an offender or staff about an incident of sexual abuse is confidential and only shared with appropriate staff, i.e. shift supervisor, inspectors.

### Standard 115.62 Agency protection duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

PREA Manual provides the immediate action requirement for imminent risk situations. Interviews with staff confirmed staff know to protect an offender that may be in imminent risk of sexual abuse by keeping the offender separated from the alleged perpetrator or keeping him in a safe place. The interview with the Warden confirmed the facility's plan and response. A case was reviewed where an offender reported being sexually assaulted two months prior. The staff responded by immediately contacting the shift supervisor and the offender being place in segregation pending the investigation. In other cases the offender was moved away from the alleged perpetrator to another part of the facility. The response was immediate.

### Standard 115.63 Reporting to other confinement facilities

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

PD 03.03.140 outlined the facility's responsibility as required for this standard. The facility provided documentation of an offender that made a report of an incident that occurred at another facility. They made the notification to the other facility within the required time frame and referred the case to the MSP.

### Standard 115.64 Staff first responder duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The PREA Manual provides the policy requirement that meets the standard. The custody staff are provided a pocket PREA guide that also contains these requirements. Examples were provided that met the standard. Interviews with custody and non-custody staff provided responses that meet the standard and demonstrate the staff are properly trained. Staff knew to keep the offender safe, who they have to contact and how to protect evidence.

### Standard 115.65 Coordinated response

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The facility has a plan for response in an operation procedure OP 03.03.140 that describes the responsibilities of first responders, medical, inspectors and leadership (shift supervisor, Deputy Warden, Warden). All staff interviewed demonstrated working knowledge of the facility plan.

### Standard 115.66 Preservation of ability to protect inmates from contact with abusers

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

The MDOC staff have collective bargaining representation. Six union agreements were provided. None prevent the MDOC from putting an employee on emergency suspension pending investigation of an allegation or limit or dictate the discipline that may be imposed for a substantiated finding.

### Standard 115.67 Agency protection against retaliation

X 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 plan for monitoring for retaliation is covered in the PREA Manual. Examples were provided where the alleged victim and perpetrator were placed in segregation during an investigation. A form is used to monitor for retaliation that has a box that is to be completed for each week to document the meeting with the offender or staff. A Counselor, Asst. Unit Manager, or Unit Manager is assigned to conduct the monitoring weekly, which is thoroughly documented on a state form. This is reported on weekly during the 90 days to the Compliance Manager and Warden. Interviews with a Counselor, Compliance Manager and Warden confirm the monitoring process. If an offender reports retaliation, he may be moved to another unit or transferred to another facility for his safety. The monitoring may exceed 90 days if it is determined to be necessary based on the case. The MDOC and this facility have an excellent monitoring program that could be modeled as a best practice.

### Standard 115.68 Post-allegation protective custody

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The PREA Manual and Segregation policy demonstrate compliance for this standard and 115.43. Examples of involuntary segregation to protect offenders that made a report of sexual abuse were provided. Placement in segregation was temporary until alternative safe placements could be determined. The alternative placement was to transfer the offenders. Transfers occurred less than 30 days from placement in segregation.

### Standard 115.71 Criminal and administrative agency investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The PREA Manual pg28-31 provides policy for sexual abuse investigations and covers all elements of this standard. PD 03.03.140 and PD 01.01.140 provide additional policy on investigations. The basic investigations and crime scene preservation curriculum were provided. All investigators complete this training as well as the NIC sexual assault investigations training. Proof of completion was provided. Criminal cases are referred to the Michigan State Police. Examples of referrals were provided. Only MSP refers cases for prosecution. None have been referred. Administrative investigations are conducted by MDOC Inspectors. The Carson City CF PREA Compliance Manager is an Inspector also. The MDOC PREA Coordinator has asked that MSP investigators that conduct sexual abuse investigations in their facilities comply with this standards requirements. Documentation was provided to verify the request. He has received no response to date. Interviews with the facility investigator and Warden confirm compliance with this standard.

### Standard 115.72 Evidentiary standard for administrative investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The evidence standard for administrative investigations is defined in the PREA Manual as preponderance of the evidence. There have been no substantiated investigations in the last 12 months. Interviews with facility investigators confirm compliance with this standard.

### Standard 115.73 Reporting to inmates

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The PREA Manual provides the policy requirements for this standard on pg 30-31. Examples of investigation results were provided for staff harassment and inmate on inmate cases. State form CAJ-1021 is the form that is provided to the offender notifying him of the outcome. It covered all elements of the standard. All offenders were notified of the outcome in all completed investigations.

### Standard 115.76 Disciplinary sanctions for staff

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The PREA Manual page 31, PD 02.03.100 Employee Discipline, and work rules provide the policy that meets this standard. All elements of this standard are covered in the policies. No staff have been disciplined from a substantiated finding during the last 12 months. Interviews with the HR director and Warden verify compliance.

### Standard 115.77 Corrective action for contractors and volunteers

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The PREA Manual page 31 provides the policy that meets this standard. The facility reports no contractors or volunteers have been disciplined or prevented from having contact with offenders as a result of a substantiated sexual abuse case. Interviews with the facility investigator and HR confirmed compliance.

### Standard 115.78 Disciplinary sanctions for inmates

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

PD 03.03.105 Prisoner Discipline and PREA manual page 31-32 provide policy that covers all elements of the standard. There have been no substantiated findings in either an administrative case or a criminal case, therefore no offenders were disciplined as a result. Carson City CF has not had to discipline offenders for consensual sex acts during the last 12 months. Interviews with offenders indicated they were aware

that consensual sex acts were prohibited and that they would be disciplined if found guilty of such violations.

### Standard 115.81 Medical and mental health screenings; history of sexual abuse

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

OP 03.04.100H Health Care Management, PD 03.04.100 Health Services and PREA manual pg 13-15 provide policy that covers all elements of the standard. Interviews with medical staff and offenders confirm practice that is compliant. Examples of referrals to mental health after an offender reports being a victim of prior sexual abuse were provided. A Social Worker in mental health described the program he would provide to a perpetrator. Medical staff knew of the duty to report in (d) and informed consent in (e). Offenders reported in interviews they were informed of the duty to report and informed consent at intake to the MDOC.

### Standard 115.82 Access to emergency medical and mental health services

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

PD 03.04.125 Medical Emergencies, OP 03.04.100H Health Care Management of Reported Sexual Assaults and PREA Manual pg 24 provide the policy that meets the elements of the standard. Examples of medical referrals for 4 offenders that reported sexual abuse were provided demonstrating practice that meets the standard. All offenders were seen in medical immediately and examined for emergent medical issues. Interviews with medical staff also confirmed practice that meets the standard.

### Standard 115.83 Ongoing medical and mental health care for sexual abuse victims and abusers

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

Health Services and Mental Health Services OP and PD, PREA Manual page 27 provide the policy that meets the standard. Elements (d) and (e) are NA. Examples were provided of referrals to medical and mental health with follow up that show practice that meets the standard. My interview with a Social Worker in mental health provided a description of programming that would be used for a former perpetrator of sexual abuse and victims. Interviews with medical staff supported compliance with this standard.

### Standard 115.86 Sexual abuse incident reviews

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

PREA Manual page 32 provides the policy that meets the standard. Examples of incident reviews were provided. Reviews are documented on state form CAJ-1025 that covers all required elements of the review in (d). The review team includes the Warden, Deputy Wardens, Inspector, and other supervisors in custody.

### Standard 115.87 Data collection

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The DOJ SSV reports from 2004 to 2014 were provided to demonstrate the required data has been collected. Data is put into APIS, an electronic system to track PREA incidents. When a case is substantiated, a SSV Incident Form is to be completed by the facility and submitted to the PREA Coordinator to provide the information required by the DOJ report. MDOC does not have a contract with private facilities at this time.

### Standard 115.88 Data review for corrective action

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The PREA Coordinator collects all sexual abuse incident data from all MDOC facilities and completes the DOJ SSV report each year. He tracks the corrective actions from the facilities and by the agency. Corrective actions from the facilities were not provided prior to 2014, therefore there is no comparison for prior years. This will be included on the 2015 report. The agency corrective actions during 2014 and 2015 were reviewed with the MDOC Director as well as the data for SSV reports in the last two years. Documentation of this review was provided and will be posted on the website. The 2013 and 2014 SSV reports are posted on the website.

### Standard 115.89 Data storage, publication, and destruction

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The PREA Manual page 33 provides the requirements for data storage that meet the standard. The DOJ reports are posted on the website from 2004 to 2014. No personal identifiers were contained in the reports. The data for these reports is collected in an electronic data base APIs that is accessible to only authorized staff. The Inspector/Compliance Manager's office is outside of the perimeter and all files are in a secured electronic format or locked in a cabinet in his office. The FOIA is followed for any requests for information relating to PREA cases.

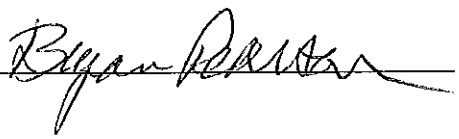
### AUDITOR CERTIFICATION

I certify that:

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

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

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

Bryan Pearson  May 2, 2016

Auditor Signature Date