PREA AUDIT REPORT ☐ **Interim** ☒ **Final**

ADULT PRISONS & JAILS

Date of report: September 11, 2017

Auditor Information			
Auditor name: Thomas E. Greishaw			
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Telephone number: (717) 728-2573			
Date of facility visit: Start 2017-01-30; End 2017-01-31			
Facility Information			
Facility name: West Shoreline Correctional Facility (MTF)			
Facility physical address: 2500 South Sheridan Road, Muskegon, Michigan 49444			
Facility mailing address: *(if different from above)* Same			
Facility telephone number: (231) 773-9200			
The facility is:	☐ Federal	☒ State	☐ County
	☐ Military	☐ Municipal	☐ Private for profit
	☐ Private not for profit		
Facility type:	☒ Prison	☐ Jail	
Name of facility's Chief Executive Officer: Warden Shirlee Harry			
Number of staff assigned to the facility in the last 12 months: 184			
Designed facility capacity: 1282			
Current population of facility: 1265			
Facility security levels/inmate custody levels: Custody Level 1			
Age range of the population: 18-83			
Name of PREA Compliance Manager: Stephanie King-McAllister		**Title:** Captain/PREA Coordinator	
Email address: mcallister-kings@michigan.gov		**Telephone number:** (231) 773-9200	
Agency Information			
Name of agency: Michigan Department of Corrections			
Governing authority or parent agency: *(if applicable)* Click here to enter text.			
Physical address: 206 East Michigan Avenue, Lansing, MI 48909			
Mailing address: *(if different from above)* Click here to enter text.			
Telephone number: (517) 373-3966			
Agency Chief Executive Officer			
Name: Heidi Washington		**Title:** Director	
Email address: washingtonm6@michigan.gov		**Telephone number:** (517) 780-5811	
Agency-Wide PREA Coordinator			
Name: Todd Butler		**Title:** PREA Administrator	
Email address: butlert4@michigan.gov		**Telephone number:** (517) 373-3960	

AUDIT FINDINGS

NARRATIVE

A Prison Rape Elimination Act audit of the West Shoreline Correctional Facility (MTF) was conducted from January 30, 2017 to January 31, 2017, pursuant to an audit consortium formed between the Maryland Department of Public Safety and Correctional Services, the Michigan Department of Corrections, the Pennsylvania Department of Corrections and Wisconsin Department of Corrections. The purpose of the audit was to determine compliance with the Prison Rape Elimination Act standards which became effective August 20, 2012. I, Thomas Greishaw, was assisted during this audit by Department of Justice certified PREA Auditors David Radziewicz and Rene Adams-Kinzel.

The auditors wishes to extend appreciation to Warden Shirlee Harry and her staff for the professionalism they demonstrated throughout the audit and their willingness to comply with all requests and recommendations made by the auditors both during the site visit and post audit. The auditors would also like to recognize PREA Administrator Todd Butler, Regional PREA Analyst Mary Mitchell and PREA Coordinator Stephanie King-McAllister for their hard work and dedication to ensure the facility is compliant with all PREA standards.

Prior to the audit, an agreement to use the PREA Online Auditing System (OAS) was reached. Due to technical difficulties an OAS account was unable to be created prior to the audit. The agency PREA Administrator provided relevant policy and audit documentation for review in advance of the audit downloaded onto a compact disk. These materials will be maintained by this auditor at the Pennsylvania Department of Corrections Central Office. This auditor created this PREA audit report utilizing the pre-audit documents, onsite materials, interview notes and physical plant audit notes. A review of pre-audit documentation took place in advance of the audit and supplemental document requests were made onsite as well as during the post-audit period.

The agency head's designee and agency PREA Administrator were interviewed in person at an agency-level interview conducted by DOJ certified PREA Auditor David Radziewicz.

The auditors arrived onsite at approximately 0830 hours on the morning of January 30, 2017, and an entrance meeting was held beginning at approximately 0900 hours. The auditors were greeted by the facility's administrative team and the agency's PREA staff to include Warden Shirlee Harry, acting Deputy Warden Brett Barbier, Inspector/Investigator Daniel Miller, agency PREA Administrator Todd Butler, Regional PREA analyst Mary Mitchell, and other key members of the administration. Introductions were made and logistics for the audit were planned during this approximately 20 minute meeting. A tour of the facility commenced immediately thereafter. Captain/facility PREA Coordinator Stephanie King-McAllister was not available during the entrance; however, she was promptly introduced following the introduction.

Immediately after the entrance meeting the auditors conducted a formal interview of the warden using the questionnaire interview template available from the National PREA Resource Center for the specialized staff position. A roster of all inmates per housing unit was provided to the auditors for the selection of random inmate interviews. Auditor Adams-Kinzel was provided a private space to conduct interviews of randomly selected inmates from each housing. Upon conclusion of the warden interview, Auditors Greishaw and Radziewicz were given a tour of all areas of the facility, including; the medical services building, library and education/programming building, chapel, kitchen/dining hall, all eight general population dormitory-style housing units, recreation areas, control room, visitation area, and medical/intake (including exam rooms). During the tour, informal interviews were conducted with multiple inmates and staff in each area toured throughout the facility. These informal and spontaneous interviews proved useful in determining facility culture and were used to supplement the formal random interviews in determining compliance with the standards. Auditor Greishaw informally interviewed one inmate who wrote correspondence to the auditor. During the tour, the auditor also informally interviewed the agency PREA Administrator, Regional PREA Analyst Mitchell and facility PREA Coordinator to determine operational procedures and to gain an overall sense of how the institution implements the PREA standards. These informal interviews were used to supplement formal interviews in determining compliance with the standards.

During the tour, the auditors observed the control center's camera monitoring station to verify that cameras were positioned in such a way as to provide adequate coverage of the housing units, yet afford privacy in bathroom/shower areas of the facility. On each of the housing units, a privacy notice was posted in the bathroom/shower areas, reminding inmates of the potential

for opposite gender staff to view them. Inmates are required to be fully dressed when walking to and from the shower areas of the facility to limit the potential for opposite gender viewing. On the tour, the auditors took notice to the robust "Knock and Announce" notices posted at the entrance to each housing unit, reminding opposite gender staff of the obligation to knock and verbally announce their presence before entering the housing unit. During the tour, it was observed that opposite gender announcements were consistently made. There are no gender specific posts at this facility (i.e. female officers are not permitted to work the unit). Following the knock and announce, opposite gender staff waited several seconds prior to entering the housing unit.

When the tour concluded by approximately 1330 hours, interviews with select specialized staff commenced with at least one staff member interviewed from each interview category specified by the PREA Resource Center's Interview Guide for Specialized Staff, with the exception of the interviews related to educational staff who work with youthful inmates, line staff who supervise youthful inmates (youthful inmates are not housed at this facility), contract administrator (the agency does not contract for the housing of its inmates) and Non-Medical Staff involved in cross gender searches. The specialized interviews included: an intermediate/higher level facility staff and incident review team member, medical staff, mental health staff, staff charged with monitoring retaliation, first responders and intake staff. The first day of the onsite audit concluded at approximately 1700 hours. The facility provided copies of investigations that were reviewed by this auditor following the onsite portion of the audit.

The second day of the onsite audit commenced at approximately 0500 hours and concluded by approximately 1730 hours. The second day consisted of staff and inmate interviews and an exit briefing. Upon arrival this auditor was given a copy of the institution's shift rosters in order to select staff for random interviews. A minimum of one officer from each housing area was selected, covering all three shifts, with a total sample size of nine random staff interviews conducted. In addition to interviews with staff, there was a period of question and answering that occurred with the PREA Administrator, Regional PREA Analysts and PREA Coordinator to clarify observations by this auditor during review of the Pre-Audit Questionnaire (PAQ) and pre-audit materials, facility procedures, and agency practices that were not apparent from policy or the tour. The facility provided copies of investigations selected by this auditor that were reviewed following the onsite audit.

A total of 26 staff were interviewed (including random and specialized staff) with at least one staff member interviewed from each interview category specified by the PREA Resource Center's Interview Guide for Specialized staff, with the exception of the interviews related to educational staff who work with youthful inmates, line staff who supervise youthful inmates (youthful inmates are not housed at this facility), contract administrator (the agency does not contract for the housing of its inmates) and Non-Medical Staff involved in cross gender searches. Interviews followed the format prescribed by the PREA Resource Center's interview templates for each specialized category of staff and inmate interviews. Random interviews also followed the format prescribed by the PREA Resource Center's interview templates for random staff and inmates. The auditors addressed each question on the template tools with the subjects of the interviews. Responses were later compared against the standards to assist this auditor with determining compliance with the provisions of applicable standards. This auditor notes that, due to some staff fulfilling multiple roles within the facility, certain staff members who were interviewed represented more than one category of interview (i.e. the Deputy Warden satisfied the intermediate or higher level facility staff and incident review team).

A total of 21 inmates were interviewed with at least one inmate interviewed from each interview category prescribed by the PREA Resource Center's Interview Guide for Inmate Interviews, with the exception of the interviews related to youthful inmates (youthful inmates are not housed at this facility) and inmates who disclosed victimization during intake screening (the facility does not conduct intake screening and has no tracking mechanism in place to identify these individuals). This auditor was provided a copy of the housing unit roster sheets on day one of the audit. This auditor randomly selected two inmates from each housing, with a total sample size of 12 random inmates.

A telephone interview was conducted with a representative of Mercy Hospital to verify the availability of SAFE/SANE practitioners and victim advocate services at the hospital.

Throughout the pre-audit, onsite audit, and post audit, open and positive communication was established between the auditors and both the agency and facility staff. During this time, this auditor discussed all concerns with PREA Administrator Todd Butler and Regional PREA Analyst Mary Mitchell, who filtered requests to the appropriate staff. Through a coordinated

effort by Mr. Butler, staff members within his PREA Analyst unit and key staff at the West Shoreline Correctional Facility all informational requests of the auditors were accommodated prior to the completion of the onsite audit.

The auditors conducted an exit briefing on February 2, 2017 upon completion of the onsite PREA audit portions for the MTF and the Earnest C. Brooks Correctional Facility. The auditors explained that documentation would need to be reviewed further and any additional requests for information would be coordinated through the agency PREA Administrator.

DESCRIPTION OF FACILITY CHARACTERISTICS

The MTF is located on the western side of Michigan, off of South Sheridan Road in Muskegon. The MTF is one of three state correctional facilities for adult (18 years of age or older) male inmates located on a campus that all share select operations, resources and management. The other two facilities include the Earnest C. Brooks Correctional Facility and the Muskegon Correctional Facility. The MTF was opened in 1987 as a temporary prison, originally named the Muskegon Temporary Facility – MTF. In 1991, the facility was reclassified from a security level II to security level I, housing minimum security inmates. In 2002, the facility was designated as a permanent structure and renamed as the West Shoreline Correctional Facility; however, maintaining the original initials MTF.

The MTF contains one-story buildings for housing, educational and vocational instruction, food services, chapel, a health services trailer, administrative offices and security. The facility perimeter security is provided by two 12-foot fences, electronic detection systems, razor-ribbon wire, two gun towers and patrol vehicles. The physical plant consists of 9 buildings inside of the secure perimeter, an administration building outside of the secure perimeter attached to the security offices/main health services/control building through a pedestrian sally port, and a transport building and exterior administrative offices that are restricted access from all inmates. There are four buildings containing two open-bay/dormitory housing units each, and two corridor sides per housing unit. There are no provisions for restrictive housing at the facility. Inmates are housed together in eight person cubes based upon compatible PREA risk assessments. The facility does have two temporary housing cells in the main health services area that are used for medical observation purposes or separation pending removal from the facility/completion of investigations. Staffing of the housing units is not gender specific.

The administrative complex is located at the front of the facility where facility administrative staff are housed. This area is not accessible to the general inmate population unless under direct supervision for housekeeping details. When entering the facility, there is a sally port area that goes past the facility control center before accessing the security offices/medical building and exiting to the larger compound of the facility. The four housing unit buildings surround a main open area where inmates walk to the various buildings within the compound. This open area is also utilized for recreation and includes an open-air structure with a roof that contains exercise equipment for inmate use. There is a large outdoor recreation field that is in back end of the facility. This area is monitored by roving security staff and cameras while in use.

Population turnover within the MTF is moderate for a state level correctional facility, with inmates spending an average of approximately one year and two months at the facility. The MTF is a Michigan Prison Re-entry in-reach facility that only houses inmates approved for minimum security. The facility's academic program provides for Adult Basic Education, General Education Development and Employment Readiness/Pre-Release. Additional programming includes: Career Technical Counseling, Bridges/Domestic Violence, Phase I and II, Narcotics/Alcoholics Anonymous, Advanced Substance Abuse Treatment, the Michigan Sex Offender Program, Cage Your Rage and Violence Prevention programs, Thinking for a Change, and various religious, self-help and volunteer programs.

Health care is provided at the facility or at Mercy Hospital in the event of emergencies.

The facility is designed to operate a maximum capacity of 1,282 inmates. On day one of the audit, there were 1,265 inmates present and on the second day of the audit, the population reduced to 1,263 inmates. This auditor observed that the inmate population consisted predominately of Caucasian and African-American inmates. Other ethnic groups were not widely observed throughout the tour. From this auditor's observations, the majority of the inmate population appeared to trend towards an age range of 30 or greater.

There are a total of 184 staff at the facility who may have contact with inmates, providing adequate supervision within the housing units. The command structure within the security ranks includes corrections officers, Sergeants, Lieutenants (shift supervisors), a Captain, Deputy Warden and Warden. The layout of the housing units permits the officer to have view of the unit entrance, the entrance to one of the unit’s inmate lavatory/shower rooms (within audible range) and down one corridor of the housing unit from their designated work station. Supplemental rounds take place throughout the unit with random roving movement that cover periodic routine observation of all other areas.

The educational and programming building has group rooms and a library with windows to permit security staff an open view into areas where programming takes place. The chapel is equipped with video cameras and is staffed by a Chaplin, with periodic

routine visits from roving security staff. The MTF utilizes contracted food service staff and inmate workers in the food service building, with posted and roving security staff during hours of operation.

During the audit tour and through informal interviews with staff and inmates, the auditors were left with the general sense that staff and inmates felt safe at the facility.

SUMMARY OF AUDIT FINDINGS

An interim audit report was issued to the facility on March 15, 2017. This interim report described areas of noncompliance and corrective action recommendations. Several conversations and email exchanges followed between the auditor and the agency's PREA Administrator and Analyst to arrive at an agreed upon plan to demonstrate compliance with all provisions of each standard. The corrective action plan included two central themes. The first involved intake risk screening procedures for all receptions at the facility and creating a documention trail to verify that information gathered through this process was acted upon by the facility in accordance with the standards. The second theme involved the timely processing of responsiblilities. Specifically, timely referral of sexual abuse or sexual harassment allegations for investigation to an agency with the legal authority to conduct criminal investigations, notification of an allegation of sexual abuse or sexual harassment from facility head to facility head, and the timely processing of emergency grievances alleging sexual abuse or sexual harassment.

The agency is relatively new to the PREA auditing process. The audit of the West Shoreline Correctional Facility represents the 9th audit within the agency. At the time of the audit, there were several items that require being addressed at the agency level to ensure compliance at the facility.

The lack of a facility 72-hour risk assessment screening process pursuant to standard 115.41 created interrelated non-compliance for several other standards within the audit, specifically as such a screening is necessary for effective implementation of 115.41, 115.42, 115.81 and 115.83. The agency and facility practice with respect to reporting to other confinement facilities lead to non-compliance with standard 115.63. Additionally, a minor revision to agency policy brought compliance to 115.73.

Specific corrective action recommendations included:

115.22:

The MTF is required to ensure that allegations of sexual abuse or sexual harassment are referred for investigation to an agency with the legal authority to conduct criminal investigations, unless the allegation does not involve potentially criminal behavior, specific to provision (b) of this standard. The facility has proactively conducted additional training with its investigators on November 10, 2016 including the proper referral of sexual abuse and sexual harassment allegations to the Michigan State Police (MSP). The facility provided evidence that all outstanding administrative investigations, where the allegations involved potentially criminal behavior, had been referred to the MSP by January 31, 2017.

The MTF will be required to demonstrate that all allegations of sexual abuse or sexual harassment involving potentially criminal behavior are referred to MSP during the corrective action period. The facility should forward evidence of all referrals made to MSP consistent with this standard to this auditor during the firsts 90 days of the corrective action period to demonstrate compliance with provision (b) of this standard. Should no referrals to the MSP be received during this timeframe, this element of corrective action will continue until the corrective action period of 180 days is exhausted or a sample is received. If the 180 day corrective action period lapses with no referrals to the MSP this auditor will accept the additional staff training as sufficient evidence to validate substantial compliance with provision (b) of this standard.

115.41:

The MTF is required to implement a 72-hour intake screening process to screen all new receptions and transfers into the facility to demonstrate compliance. This screening process shall consist of the use of the initial victim and aggressor screening tools and not a review of the previous assessment that was completed at the reception center. Intake staff shall affirmatively address each question on the victim and aggressor scales to ensure each new reception to the facility has the opportunity to address any changes in gender identity, sexual orientation or history of victimization from the initial reception center. The MTF is required to reassess each individual within 30 days of receipt at the facility by using its established 30-day review process.

Compliance will be measured by the facility providing this auditor with a copy of the facility's incoming receptions on a minimum of (3) three randomly selected dates each month during the course of the first 90 days. This auditor will then select a representative sample of those inmates. After 30 days have elapsed, this auditor will request that the facility submit inmate

movement reports and corresponding 72-hour and 30-day assessments to ensure that each reception at the MTF and transfer into the MTF has been assessed in accordance with provisions (a), (b) and (f) of this standard. If compliance is demonstrated during this period, this auditor will be satisfied that the matter has been corrected.

115.42:

The MTF is required to implement a 72-hour intake screening process to screen all new receptions and transfers into the facility to demonstrate full compliance with both 115.41 and 115.42, as any use of screening information must consider the most recent and accurate information to be effective. This screening process shall consist of the use of the initial victim and aggressor screening tools and not a review of the previous assessment that was completed at the reception center. Intake staff shall affirmatively address each question on the victim and aggressor scales to ensure each new reception to the facility has the opportunity to address any changes in gender identity, sexual orientation or history of victimization from the initial reception center. The MTF is required to reassess each individual within 30 days of receipt at the facility by using its established 30-day review process.

Specific to provision (a) of this standard, the MTF will be required to identify those work assignments that are isolated from direct staff observation and provide blind spots where sexual activity could go undetected, such as the food service area, within the facility where identified victims and identified aggressors should not work together. Direction should be issued to the employment coordinator via memorandum to direct that identified victims and identified aggressors should not be paired together in these work assignments to satisfy the requirements of provisions of this standard.

115.52:

The MTF is required to follow established procedures under the Director's Office Memorandum 2016 – 29, dated April 27, 2016, specific to provision (f) of this standard. After receiving an emergency grievance alleging an inmate is subject to a substantial risk of imminent sexual abuse, the agency shall immediately forward the grievance (or any portion thereof that alleges the substantial risk of imminent sexual abuse) to a level of review at which immediate corrective action may be taken, shall provide an initial response within 48 hours, and shall issue a final agency decision within 5 calendar days. Reportedly, there has only been one emergency grievance indicating risk of sexual abuse that has been received by the facility within this audit period. The dates associated with this grievance for an initial response and final agency decision did not validate compliance with provision (f) of this standard. The agency has proactively conducted additional training with the PREA Coordinators on November 10, 2016 including the proper procedures for an emergency grievance.

The MTF will be required to demonstrate that all emergency grievances are processed within the timeframes specified under provision (f) of this standard during the corrective action period. The facility should forward evidence of all emergency grievances received, including an initial response and the final agency decision, to this auditor during the firsts 90 days of the corrective action period to demonstrate compliance with provision (f) of this standard. Should no emergency grievances be received during this timeframe, this element of corrective action will continue until the corrective action period of 180 days is exhausted or a sample is received. If the 180 day corrective action period lapses with emergency grievances this auditor will accept the additional staff training as sufficient evidence to validate substantial compliance with provision (f) of this standard.

115.63:

The agency will be required to revise its policies regarding notification of alleged sexual abuse outside of the MDOC to ensure that such reports are made by the facility head of the facility receiving the report. The forwarding of this document by the agency PREA Administrator is not consistent with the specific language within provision (a) of this standard. Due to the lengthy delays associated with policy changes within the agency, this agency and facility may satisfy this corrective measure through the issuance of a Director's Office Memorandum and demonstration that this DOM is forwarded to agency PREA Coordinators and Wardens, including the MTF.

115.73:

Agency policy is not compliant with provision (c) of this standard. Specifically, the *PREA Manual* specifies that notification of the factors enumerated in provision (c) of this standard are only provided for substantiated/sufficient evidence allegations that a staff member sexually abused a prisoner. The agency policy will require updating to allow for notification for the factors enumerated under provision (c) to when an investigation results in a finding of insufficient evidence/unsubstantiated. Due to the delays associated with policy revisions, this corrective action can be accomplished via a memoranda that is accompanied by proof of distribution to all facility PREA Coordinators to satisfy compliance while policy revisions are pending.

115.81:

The MTF is required to implement a 72-hour intake screening process to screen all new receptions and transfers into the facility to demonstrate compliance. This screening process shall consist of the use of the initial victim and aggressor screening tools and not a review of the previous assessment that was completed at the reception center. Intake staff shall affirmatively address each question on the victim and aggressor scales to ensure each new reception to the facility has the opportunity to address any changes in history of victimization or perpetration from the initial reception center.

The MTF will be required to maintain secondary logs related to referrals for medical or mental health services consistent with provisions (a) and (b) of this standard. This secondary documentation can be in the form of a spreadsheet that lists the name and number of each inmate referred for services or in the form of a copy of the agency's mental health referral form CHX-212: Reasoning Orientation Behavior Emotion Recall/Memory Talk Appearance Relationship (ROBERTAR). Regardless of the facility's preferred method of maintaining secondary logs, the MTF will be required to clearly demonstrate the nexus between an inmate's responses to the 72-hour screening log to any subsequent mental health referral to address instances of purported victimization or perpetration of sexual abuse.

Compliance will be measured by the facility providing this auditor with a copy of all applicable referrals during the first 90 days of the corrective action period. Compliance measuring will include copies of any medical or mental health follow-up offered at the reception center prior to transfer to the MTF that the facility offered in satisfaction of this standard. Again, this auditor makes clear that there should be an observable nexus between an inmate reporting sexual victimization or sexual perpetration when selecting proof that this standard has been satisfied. Should the facility not have an example of a referral for medical or mental health services consistent with provisions (a) and (b) of this standard, corrective action will continue until such time as an example can be provided to demonstrate compliance with provisions (a) and (b) or 180 days have been exhausted.

115.83:

The MTF is required to implement a 72-hour intake screening process to screen all new receptions and transfers into the facility to demonstrate compliance. This screening process shall consist of the use of the initial victim and aggressor screening tools and not a review of the previous assessment that was completed at the reception center. Intake staff shall affirmatively address each question on the victim and aggressor scales to ensure each new reception to the facility has the opportunity to address any changes in history of victimization or perpetration from the initial reception center so that it may have procedures in place to adequately identify all inmates qualifying for services under provisions (a) and (f) of this standard. The MTF will also be required to demonstrate that it refers all alleged victims of sexual abuse for medical and mental health evaluations that are consistent with the nature of their allegations in order to demonstrate its commitment to meeting the requirements of provision (a) of this standard.

Compliance will be measured by the facility providing this auditor with a copy of all applicable referrals for medical and mental health treatment evaluation or continuation records for treatment that may have been initiated at the reception center and continued at the MTF, consistent with this standard during the first 90 days of the corrective action period. This auditor will also measure compliance through a review of all facility investigations in the 90 days following the implementation of the corrective action plan. This auditor will expect to see documentation of medical examinations for all purported victims of sexual abuse involving contact and mental health examinations for all who allege sexual abuse. Documentation of medical and mental health evaluations should include dates and times of the evaluation as well as the specific referral information that prompted the evaluation. Any applicable ongoing treatment records (such as progress notes) which were prompted by the

evaluation relative to this standard must also be provided to this auditor to satisfy compliance with provisions (a) and (f). Should the facility not have an example of a referral for medical or mental health services consistent with provisions (a) and (f) of this standard, corrective action will continue until such time as an example can be provided to demonstrate compliance with provisions (a) and (f) or 180 days have been exhausted.

Post Audit Activity

To demonstrate its compliance with the corrective action plan, the following corrective actions were taken and reassessment of compliance was determined as follows:

115.22:

Corrective Actions Taken:

The MTF proactively conducted additional training with its investigators on November 10, 2016 including the proper referral of sexual abuse and sexual harassment allegations to the MSP. The facility provided evidence that all outstanding administrative investigations, where the allegations where the allegations involved potentially criminal behavior, had been referred to the MSP by January 31, 2017. The MTF reported that only one new allegation during the 180 day corrective action period required referral to the MSP for potential criminal investigation. Documentation supporting this referral within appropriate timeframes was provided to this auditor on July 26, 2017.

Based upon the investigative staff training, MSP referrals of all outstanding administrative investigations with potential criminal behavior, and the sample referral provided during the 180 day corrective action period, this auditor concludes that the MTF has adequately addressed this audit observation and now substantially complies with the provisions of 115.22.

115.41:

Corrective Actions Taken:

The MTF implemented procedures to conduct 72-hour risk screenings on April 4, 2017, after discussions between the Department PREA Administrator and the auditors on the corrective action plan. The agency revised its PREA related policy, Policy Directive (PD) 03.03.140. This auditor was provided a copy of this revised policy on March 15, 2017 for review and noted that Section Q specifically addresses the need to conduct a risk assessment within 72-hours of arrival at all correctional facilities. Section R specifically addresses the need to complete a review of the assessment within 30 days of arrival. Additionally, the policy now includes a provision for an annual reassessment, which exceeds the standard.

During the corrective action plan, the facility PREA Coordinator provided this auditor with a copy of a secondary risk screening log that was designed to track the dates of reception, due dates of the initial 72 hour and 30-day reviews required by provisions (a), (b) and (f) of the standard. Moreover, this log also tracked whether or not the inmate has completed PREA education, and whether or not the inmate being screened reported victimization or perpetration that would require an evaluation required by standard 115.81. Although the initial corrective action plan was intended to randomly sample specific dates; the secondary risk screening log developed by the facility provided the auditor with ample information on each reception and transfer into the facility and was thus utilized as a tool to measure compliance with the standard.

To authenticate the reliability of this risk screening log, this auditor requested computer assessment records for three randomly sampled inmates on May 10, 2017, which the facility provided the auditor on May 12, 2017. These computerized assessment reports authenticated the veracity of the information recorded within the risk screening log. A second random sample of three inmates whose risk screenings were due in May of 2017 were requested by the auditor on June 7, 2017 and provided on June 8, 2017. Again, as found during the previous sample, the data contained within the secondary risk screening log was verified as accurate. A third random sample of three inmates was requested on July 10, 2017 and were provided on July 11, 2017. Consistent with previous random samples, the accuracy of the secondary tracking log was verified.

Based on the facility's detailed secondary risk screening log and the confirmation of that log's accuracy through random

sampling, this auditor is satisfied that the MTF has established sufficient practice to demonstrate its commitment to perform risk screening for all inmates received at the facility, consistent with provisions (a), (b) and (f) of the standard. The information gathered through compliance with this standard, ultimately provides secondary evidence of compliance with related standards 115.42, 115.81 and 115.83.

115.42:

Corrective Actions Taken:

As noted within the corrective action plan, the facility was required to implement an intake screening process for all new receptions to the facility in order to be considered fully compliant with the standard, as compliance hinged upon having the most reliable and up-to-date information to effectively implement the standard's intent. Recent agency wide revisions to policies PD 03.03.140 and the *PREA Manual* now ensure that a 72-hour intake screening process for all incoming inmates is in place and negates the opportunity for key aspects of vulnerability to go undetected consistent with the intent of provision (a). Through the information provided in support of standard 115.41, the auditor is satisfied that the MTF has established sufficient practice to demonstrate its commitment to perform risk screening for all inmates received at the facility. Specifically, the facility developed a secondary risk screening log that was designed to track the dates of reception, due dates of the initial 72-hour and 30-day reviews required by standard 115.41. The veracity of that log was verified through random sampling by the auditor. Through the establishment of these intake risk screening practices, the auditor is confident that the MTF is now fulfilling the requirements under this standard with the most reliable and timely information available, while also providing another opportunity to report sexual abuse that could have occurred at the preceding facility.

Based upon confirmation of intake risk screening practices required under 115.41, the auditor is satisfied that the facility is also basing its safety, housing, work, programming and educational decisions required by 115.42 with the guidance of the most accurate and recent information available. Evidence of substantial compliance with the standard has been established.

115.52:

Corrective Actions Taken:

During the 180 day corrective action period, the facility was unable to provide any samples of emergency grievance submissions. The agency had proactively conducted additional training with the PREA Coordinators on November 10, 2016 including the proper procedures for an emergency grievance. The *Director's Office Memorandum (DOM) 2016 – 29*, dated April 27, 2016, which was reviewed by this auditor in determining compliance with the provisions of 115.52 coupled with the additional training conducted on November 10, 2016 will be accepted to supplant the absence of any tangible emergency grievance samples during the corrective action period. This auditor is satisfied that the DOM provides adequate written direction, and the additional training should mitigate the initial audit observation, to demonstrate compliance with all provisions of 115.52.

115.63:

Corrective Actions Taken:

The agency revised its PREA related policy PD 03.03.140. This auditor was provided a copy of this revised policy on March 15, 2017 for review and noted that Section X specifically addresses the need for the Warden to forward all allegations to the facility head or office of the agency where the allegation is alleged to have occurred when the allegation pertains to a non-MDOC facility. This policy became effective on April 24, 2017 and now satisfies the requirements of provision (a) of the standard. The facility PREA Coordinator provided this auditor with a sample of this notification from

115.73:

Corrective Actions Taken:

The agency revised its PREA related policy 03.03.140. This auditor was provided a copy of this revised policy on 03/15/2017 for review and noted that Section VV specifically addresses the need to notify prisoners of the factors enumerated under provision (c) of the standard for all allegations unless the investigation determines the claim was unfounded. This policy

became effective on April 24, 2017. This revision of agency policy satisfies compliance with this standard.

115.81:

Corrective Action Taken:

On May 12, 2017, June 8, 2017 and July 11, 2017 the facility provided this auditor with secondary documentation to confirm that referrals were made for follow-up mental health/medical care of individuals who disclosed victimization or perpetration during the intake risk screening process required by standard 115.41. Secondary tracking logs indicated that multiple inmates reported victimization or documentation review verified a history of perpetration. The auditor requested random samples of referrals and progress notes for three inmates who made such reports during each of the months of April, May and June.

Based on evidence that intake risk screening procedures have been established as required under standard 115.41, the facility's secondary logs that document individuals who disclosed victimization or perpetration during said screenings, evidence of appropriate referrals to mental health care providers and secondary documentation that the referrals were acted upon; this auditor determines the facility has developed adequate procedures to ensure compliance with provisions (a) and (b) of the standard.

115.83:

Corrective Action Taken:

The MTF provided this auditor with sufficient evidence that it has established intake screening procedures as required by standard 115.41 to effectively identify those individuals potentially in need of medical or mental health evaluations as required by 115.81 and 115.83. Random sampling of the facility's secondary risk screening log verifies that the information contained within the log accurately recorded the dates of a full intake risk screening assessment. Through the intake risk screening process, the facility has identified multiple individuals who required mental health evaluations for past instances of victimization or perpetration. The auditor requested random samples of three inmates for each of the screening months of April, May and June to ensure individuals were evaluated consistent with the requirements of 115.81. Referral documentation and secondary progress notes were forwarded to the auditor on May 12, 2017, June 8, 2017 and July 11, 2017. Progress notes verify that individuals with a history of sexual victimization or perpetration were evaluated as required by 115.81. In review of the randomly sampled cases each was evaluated and either declined or was not in need of further services. Moreover, the MTF has also provided sufficient evidence to prove that it refers all known victims of sexual abuse to medical and mental health practitioners commensurate with the nature of the allegation, as required by 115.82. Therefore, the facility has now sufficiently demonstrated that it has established the practices necessary to identify those inmates in need of ongoing care as required by provisions (a) and (f) of the standard.

Based upon supporting documentation verifying access to ongoing medical and mental health care for known sexual abuse victims that is proportionate to the type of reported victimization, with care that is consistent with community standards, this auditor is satisfied that the facility has developed sufficient procedures to demonstrate its capability of substantial compliance with provisions (a) and (f) of the standard.

Number of standards exceeded: 1

Number of standards met: 42

Number of standards not met: 0

Number of standards not applicable: N/A

Standard 115.11 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.

Agency policy, Policy Directive (PD) 03.03.140 and the *PREA Manual* outline the agency approach to implementing the zero tolerance policy. Local Operating Procedures (OP) 03.03.140 outlines the facility's approach to implementing agency policy covered by the agency policy and the agency *PREA Manual*. This auditor reviewed these documents in their entirety to determine compliance with provision (a) of this standard.

The agency *PREA Manual* is a document that serves to unify the agency's approach to implementing the PREA standards that were previously covered by a network of policies relative to such areas as segregation, employee training, prisoner placement, health care, etc. The agency *PREA Manual* supersedes all policies that were issued prior to its issuance of September 15, 2015. The agency *PREA Manual* addresses relevant topics such as definitions, prevention, planning, training, placement screening, medical and mental health screenings, cross-gender viewing, searches of prisoners, protective custody, protection from retaliation, disabled and limited English proficiency inmates, human resource decision making processes, staffing plans, management rounds, facility and technological upgrades, contracting for the confinement of inmates, collective bargaining, reporting sexual abuse and sexual harassment, prisoner grievances, response procedures to reports of sexual abuse and harassment, medical and mental health services following an allegation of sexual abuse, victim advocates, confidential support services, sexual abuse and sexual harassment investigations, disciplinary sanctions and corrective action, sexual abuse incident reviews, data collection, data review and data storage, auditing and compliance.

Provision (b) was audited at the agency level; however, it will be addressed in part in this report. According to the *PREA Manual*, the position of PREA Administrator fulfills the role of an Agency PREA Coordinator. This position is four layers removed from the agency Director with sufficient authority to implement agency efforts to comply with the PREA standards. During an agency-level interview conducted in November 2016 with the PREA Administrator, it was explained that the title of PREA Administrator is used to accommodate existing Michigan Civil Service title rules. Through this interview the PREA Administrator acknowledged that he has sufficient time and authority to implement PREA standards throughout the agency.

According to the *PREA Manual* and PD 03.03.140, the position of PREA Coordinator at the facility oversees the duties of a facility PREA Compliance Manager. During an agency-level interview the PREA Administrator explained that the agency titles were modified to accommodate existing Civil Service title rules within the state of Michigan. The OP 03.03.140 for the West Shoreline Correctional Facility (MTF) designates the facility PREA Coordinator as the Captain / 2P-10P Corrections Shift Supervisor-3. The position of Captain within the MDOC has oversight of each facility's security and is an upper-level management position with authority over facility shift commanders. The facility PREA Coordinator is charged with ensuring the security of the MTF. Through an interview with the PREA Coordinator, it was identified that the position has adequate authority to coordinate the facility's efforts to comply with PREA standards and is permitted a varying work schedule to allot sufficient time to complete PREA related responsibilities. Based on a review of the *PREA Manual* and interviews with the PREA Administrator and facility PREA Coordinator, this auditor determined compliance with provision (c).

Standard 115.12 Contracting with other entities for the confinement of inmates

☐ 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.

Through a review of the PAQ, the *PREA Manual* and interviews with the PREA Administrator and PREA Coordinator, this auditor determined that neither the agency nor the MTF contract with any outside entities for the confinement of its inmate population. The facility provided documentation for a Request For Proposal (RFP) for reentry services that the agency was considering. This RFP contained language to ensure that any successful bidder for an awarded contract would be required to be compliant with the PREA Standards. As of the date of the audit, no contracts have been awarded. The absence of any contracts for the confinement of its inmates, policy provisions within the *PREA Manual* and the language within its RFP demonstrates the agency's intended compliance with provisions (a) and (b) should it contract for confinement of its inmates.

Standard 115.13 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 *PREA Manual* specifies the eleven factors enumerated within provision (a) of this standard are taken into account when developing the staffing plan for MDOC prisons. The facility staffing plan, dated 08/26/2016 verifies that all eleven factors within provision (a) of this standard were used to formulate the facility staffing plan.

Interviews with the Warden and PREA Coordinator indicate that no recent modifications were made to the staffing plan regarding the allotted staff complement. However, the facility has recent completed an upgrade to the video monitoring system that has now expanded from 11 to 161 cameras. A review of the facility's staffing plan and an agency-level interview with the PREA Administrator revealed that, although the agency no longer participates in audits by the American Correctional Association (ACA), its staffing levels are predicated on these standards and are audited by the state's Auditor General. According to the MTF 2016 Staffing Plan and the PAQ, the operational staffing plan for the 1282 bed facility was predicated on an average daily population of 1260 inmates.

According to an agency-level interview with the PREA Administrator, the agency does not ordinarily deviate from its staffing plan. The PREA Administrator reported that all posts are filled either through voluntary overtime or mandated overtime; however, the facility documents on the PAQ that it deviates from the staffing plan based on the following five factors, 1) Staff Vacancies, 2) Sick Leave, 3) Emergency Weather, 4) Family Medical Leave Act (FMLA) and 5) Lack of Staff to Mandate. The

facility provided ten examples of deviations from its staffing plan for the calendar year through November 2016 that were consistent with the stated reasons for deviation. When deviations from the staffing plan are necessary, the facility identified one position on the 0600-1400 and 1400-2200 shifts, as well as one post on the 2200-0600 shift, that would be closed and were least disruptive to facility security. On first and second shift, the facility will close the "Yard #26 (Rover #4)" position and on third shift, the facility closes the "Yard #21" post. An interview with the Warden confirmed that overtime is used to fill each required post designated on the facility staffing plan to demonstrate compliance with provision (b) of this standard.

The *PREA Manual* states that the Warden and PREA Coordinator are involved in the review of the facility staffing plan. This plan is subsequently forwarded to the agency PREA Administrator for review. The PREA Administrator reports involvement in the staffing plan process for each facility within the agency.

This auditor was provided a copy of the Annual Staffing Plan Review for the MTF on form CAJ-1027 dated August 19, 2016 and a copy of the official 2016 staffing plan dated August 26, 2016 under § 115.13 (a). The official 2016 staffing plan was predicated on a list of considerations on the CAJ-1027 that include prevalence of substantiated and unsubstantiated incidents of sexual abuse, components of the facility's physical plant and video monitoring systems or other monitoring technologies to better protect prisoners from sexual abuse. The official 2016 staffing plan explains the elements considered in the August 19, 2016 review in further detail and provides supporting documentation of internal and/or external audits. The plans found no need to change current operations based on the eleven factors denoted within provision (a) of this standard.

Interviews with the Warden, PREA Coordinator and PREA Administrator, as well as a review of the agency policy, confirm that that staffing plan is reviewed annually by the facility and the agency PREA Administrator. The agency as a whole, has taken action to upgrade its camera technology at each facility to demonstrate compliance with provision (c) of this standard.

PD 04.04.100 *Custody, Security and Safety Systems*, the *PREA Manual*, and OP 04.04.100-A establish policy for unannounced supervisory rounds. Facility supervisory staff document unannounced rounds in the unit log book in green ink. Pre-audit, the facility provided sample log-book entries to demonstrate unannounced supervisory rounds taking place within the facility during all three shifts. During the onsite portion of the audit, this auditor observed consistent log book entries on the housing units to demonstrate compliance with provision (d) of this standard with sufficient rounds in each unit to cover each shift.

Through an interview with the PREA Coordinator and review of log book activity, facility Lieutenants complete rounds on a daily basis on all shifts. Shift Commanders and the Deputy Warden complete weekly rounds within the housing units, with those rounds covering all three shifts on a monthly basis. The PREA Coordinator reported that each housing unit is covered by a daily supervisory round. Radio traffic is not permitted to ensure rounds are not announced. Rounds are documented in the unit log books in green ink. During the tour, informal interviews with line staff reported that supervisory staff make regular rounds throughout the housing units and confirmed the daily presence of Lieutenants on the housing units. Following the review of agency policy, interviews with the facility administration, informal interviews with line staff and a review of log book entries this auditor concludes validation of compliance with provision (d) of this standard.

Standard 115.14 Youthful inmates

☐ 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 PD 05.01.140, *Prisoner Placement and Transfer* and the *PREA Manual* were reviewed in determining compliance of the agency's outlined approach to housing youthful inmates. Agency policy dictates that male youthful inmates will have a portion of their intake completed at Charles Egeler Reception and Guidance Center (RGC) and then will be housed at the Thumb Correctional Facility (TCF), and female youthful inmates are housed at Women's Huron Valley Correctional Facility (WHV). If a youthful inmate must be placed at another facility for the purposes of medical or mental health care, the placement must be approved by an agency Deputy Director and accommodations for sight, sound and physical contact separation must be made.

During the audit tour and through interviews with the Warden, PREA Administrator and PREA Coordinator, it was observed that the MTF does not house youthful offenders and is therefore compliant with provisions (a) (b) and (c) of this standard.

Standard 115.15 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.

Agency policy PD 04.01.110 *Search and Arrest in Correctional Facilities*, OP 04.04.110 and the *PREA Manual* establish procedures to limit cross gender viewing and were reviewed in determining compliance with provision (a) of this standard. On the PAQ, the facility stated no cross gender strip searches or visual body cavity searches were conducted during this audit period.

PD 04.01.110 permits a supervisor of the opposite gender to be present during a strip search if a supervisor of the searched inmate's gender is not readily available. Readily available is not consistent with exigent circumstances as defined in the standards. PD 04.01.110 does not specify who may view recorded body cavity searches (Y-4). According to the PREA Resource Center's FAQ's, a facility should use a privacy screen or other similar device to obstruct viewing of an inmate breast, buttocks or genitalia in cases where supervisors of the opposite gender are present with the inmate being strip searched.

This auditor also noted a provision within the facility's local procedure OP 04.01.110 that was inconsistent with both agency policy and provision (a) of this standard. Specifically, under section L, page 4 of the local procedure, cross-gender strip searches may be performed when a prisoner is transported to a destination outside the prison facility and none of the transportation staff are of the same sex. This auditor determines that this scenario does not meet the level of exigent circumstances required by the standards to prompt a cross-gender strip search insomuch as the facility has the opportunity to plan for transportation teams in advance of any transport taking place, providing sufficient grounds to ensure gender specific staff are available. The MTF promptly addressed this observation and provided amended local procedures OP 04.01.110, in compliance with the provision of this standard, during the onsite audit.

An agency-level interview with the agency PREA Administrator confirms that privacy screens are to be used when an opposite gender supervisor must be present during a strip search. The facility PREA Coordinator confirms that no cross-gender strip searches or visual body cavity searches were conducted to demonstrate compliance with provision (a) of this standard and clarified the ambiguity in agency policy.

Agency policy PD 04.01.110, which was reviewed in determining compliance with provision (b) of this standard, permits searches of female inmates when female staff are not readily available to conduct a search in an emergency or where there is

a reasonable suspicion that the prisoner is in possession of contraband. Reasonable suspicion that the prisoner is in possession of contraband is not consistent with the definition of exigent circumstances. Additionally, while PD 04.01.110 provides these exceptions to cross-gender pat-search procedures for female inmates, the written direction does not clearly defined what type of contraband could be considered an exigent circumstance that would trigger the authorization of a cross-gender pat search of a female inmate; this auditor also notes that the MTF does not house female inmates.

Through review of the PAQ, PD 05.01.140, *Prisoner Placement and Transfer*, the *PREA Manual*, the facility tour and interviews with the PREA Administrator, PREA Coordinator and Warden, this auditor observed that the facility does not house female inmates. Therefore, the facility demonstrates that it does not restrict female inmates' access to regularly available programming or other out-of-cell opportunities in order to comply with provision (b) of this standard.

Agency policy PD 04.04.110, local procedure OP 04.04.110 and the *PREA Manual* establish policy for provision (c) of this standard and were reviewed in determining compliance. PD 04.04.110 requires that a written report be submitted to the Warden of the facility by the end of shift when a cross-gender strip search was conducted by or in the presence of an opposite gender employee. The *PREA Manual* directs that pat-searches of female inmates be conducted by female staff only. These policies require that visual body cavity searches be completed by licensed medical professionals. It is recommended within policy that an additional staff be present during the course of such a search and that staff person must be of the same gender as the person receiving the visual body cavity search.

The facility PREA Coordinator confirmed there were no reported cross gender strip, visual body cavity or pat-searches conducted by the facility. Random staff interviews confirmed that line staff are well aware of the prohibition against cross-gender strip searches and this auditor notes that the facility does not house female inmates, allowing this auditor to determine compliance with provision (c) of this standard.

Agency policy PD 03.03.140 *Prohibited Sexual Conduct Involving Prisoners*, the *PREA Manual*, Privacy Notice signs, Knock and Announce signs and photographs of toileting/showering facilities were reviewed pre-audit in determining compliance with provision (d) of this standard.

During the audit tour, this auditor observed that the facility has numerous Privacy Notice signs and Knock and Announce signs displayed at entrances to the housing units and in the bathroom areas of the housing units. Opposite gender staff announcements were made on all housing unit tours and staff waited several seconds after making the announcement prior to entering the unit to afford time to ensure privacy.

Most inmates informally interviewed on the housing units stated that female staff consistently announce their presence when entering the housing unit. Several inmates throughout various housing units stated that they often do not hear the announcement if they are at the far end of the corridor. However, it was noted by this auditor that inmates have a clear expectation of being in a constant state of dress other than permissible undress in the lavatory. The announcement was reasonably audible in the area of the lavatories, where there may be an expectation of undress. The practice of opposite gender announcements was routinely observed during the audit tour and robust signage was observed throughout the facility to advise inmates of their privacy expectations. Informal interviews with line staff during the audit tour led this auditor to determine that opposite gender announcements were being made and that inmates were able to dress, shower or toilet without being viewed by staff of the opposite gender, consistent with provision (d) of this standard.

The *PREA Manual* and PD 04.06.184 *Gender Identity Disorder (GID)/Gender Dysphoria* establish policy prohibitions against searching transgender inmates for the sole purpose of determining genital status and were reviewed pre-audit when determining compliance with provision (e) of this standard. Random and informal interviews during the audit tour lead this auditor to the conclusion that staff are aware of the prohibition against searching transgender inmates for the sole purpose of determining genital status. There was no identified transgender inmate housed at the facility during the audit; however, based on adequate policy and staff responses this auditor finds compliance with provision (e) of this standard.

Custody and Security in Corrections Part 2 - Searches: The Application of Search Procedures for GID and Transgender Prisoners is the training curriculum for the MDOC reviewed in determining compliance with provision (f) of this standard. Staff were

able to demonstrate proper cross gender search techniques during random interviews and all staff were able to demonstrate the "praying hands" technique for searching the breast area of a female or transgender inmate. The facility reported that 100% of security staff have been provided training to conduct professional cross-gender and transgender pat searches. The facility provided adequate documentation, in the form of pre-audit sample training records relative to transgender/intersex searches. A review of the training materials, random interviews with staff and a review of training records demonstrates compliance with provision (f) of this standard.

While the facility is found compliant with this standard due to its absence of a female population, as a means to remove any potential ambiguity, it is recommended that an agency-wide memorandum be issued similar to a *Director's Office Memorandum* (*DOM*), specifying that if a supervisor of opposite gender is overseeing a strip or body cavity search that appropriate barriers be utilized to block viewing of breasts, buttocks and genitalia. Additionally, this memorandum should include direction that female inmates may only be pat searched under exigent circumstance and should specify what types of contraband would be considered exigent circumstances to trigger a cross-gender pat-search of a female inmate.

Standard 115.16 Inmates with disabilities and inmates 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.

The agency *PREA Manual* requires that the Department provide prisoner education in formats understandable by the entire prisoner population. PD 03.03.140 specifies that the agency PREA Administrator is responsible for the creation and distribution of standardized training materials and the agency will contract with any interpreters as necessary to reach disabled or limited English proficiency (LEP) inmates. The *PREA Manual*, along with training materials, were reviewed by this auditor in determining compliance with provision (a) of this standard.

This auditor observed, through a review of agency educational materials, that the agency makes significant efforts to reach limited English proficient inmates and those who may be deaf by captioning PREA inmate training videos in English and Spanish. An interview with the PREA Administrator confirms that the agency is in the process of captioning the PREA video in Arabic. The agency also produces a PREA specific brochure in Spanish, as well as publishing its *Prisoner Guidebook*s in Spanish.

A braille version of the PREA pamphlet was created for blind inmates and a sign language interpreting service is available. Documentation of staff training on PREA compliant practices for LEP and disabled inmates is located on slide 59 of 102 in 2016 PREA Web Based Training.

An interview with the agency head's designee confirmed that the agency takes significant steps to ensure that materials are provided in various formats to include captioning of the PREA inmate video in multiple languages, including Arabic and Spanish.

Posters displaying PREA reporting information were observed to be posted in each housing unit in Spanish. The facility provides its *Prisoner Guidebook* in both English and Spanish. The agency publishes a Spanish version of its *PREA brochure*. Privacy signs are translated in Spanish and were observed during the audit tour. This auditor reviewed translation invoices from the facility to confirm that the facility has an active interpretation services account to reach LEP inmates. This auditor successfully utilized the interpretation services during the interview of an LEP inmate. The facility provided invoices from Real Time Translation,

Inc. (RTT) Mobile Interpretation in 2015 and invoices from Language Line Services, Inc. in 2016 that this auditor reviewed in determining compliance with provisions (a) and (b) of this standard.

Agency policy PD 03.03.140 and the *PREA Manual* prohibit the use of inmate interpreters and were reviewed in determining compliance with provision (c) of this standard. During random interviews with custody staff and informal interviews with line staff during the audit tour, staff appeared to understand that the use of an inmate interpreter for complaints of sexual abuse was only acceptable under the circumstances where a delay could compromise an effective response. Eight of fourteen randomly interviewed staff were able to effectively articulate that inmate interpreters could only be used under those circumstances where a delay could negatively impact the ability to respond to a report of sexual abuse or sexual harassment. While this auditor determines substantial compliance with provision (c) of this standard, it would benefit the MTF to provide additional direction regarding the availability of the interpretation language service and use of inmate interpreters.

Standard 115.17 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.

Agency policy PD 02.06.111 *Employment Screening* and the *PREA Manual* establish procedures for hiring and were reviewed in determining compliance with provision (a) of this standard. The employment screening policy and *PREA Manual* clearly prohibit hiring and promoting staff who have engaged in all of the elements denoted within provision (a) of this standard.

An online application for Corrections Officer job postings and a promotional application for Sergeant were reviewed and provided as proof to demonstrate the agency and facility considers these factors for hiring and promotional decisions. The agency's background checks are conducted in the Law Enforcement Information Network (LEIN) system. The facility is not responsible for conducting initial background checks of correctional officer staff, which are hired by the agency. These background screenings are conducted by the agency's Central Office. The facility is, however, responsible for directly hiring non-correctional officer personnel. The facility conducts checks on those staff and contractors directly hired or transferring into the facility. Through an interview with Human Resource (HR) staff, it was explained that criminal background checks are run locally at the facility by staff in the Deputy's Office, Security Office and the Records Department. HR staff are required to review the criminal background (LEIN check) verification form within files prior to issuing staff their identification to enter the facility.

A review of facility hiring records, agency application materials, interviews with the agency PREA Administrator and HR staff confirm that the MTF is compliant with provision (a) of this standard.

Agency policy PD 02.06.111, the *PREA Manual* and applications for employment were reviewed in determining compliance with provision (b) of this standard. Adequate screening for incidents of sexual harassment are present within the materials. Sample applications for a new hire and promotion were reviewed. Both employment and promotion application materials demonstrate consideration of incidents of sexual harassment in the hiring process. The HR staff person explained in an interview that any candidate with a history of engaging in sexual harassment would not be hired or promoted.

A review of policy and the interview with HR staff confirms that the facility is not responsible for conducting initial background checks of custody staff. This function in completed at the agency level by Central Office staff. However, every applicant to the

MDOC must complete an electronic application process where sexual harassment screening takes place. HR staff at the facility monitor responses in those application materials to consider the sexual harassment history of candidates for hire and promotion. Sample applications for a new hire and promotion were reviewed to demonstrate consideration of incidents of sexual harassment in the hiring process to determine compliance with provision (b) of this standard.

Agency policy PD 02.06.111 and the *PREA Manual* establish procedures for hiring and were reviewed in determining compliance with provision (c) of this standard. A review of policy and the interview with HR staff confirms that the facility is not responsible for conducting initial background checks of custody staff. This function in completed at the agency level by Central Office staff.

On the pre-audit questionnaire, the facility indicated that four (4) background checks were completed on new hires to the facility who may have contact with inmates. During an interview with HR staff, this auditor was informed that the facility is responsible for direct hiring and background checks for non-inmate contact positions, promotions and transfers into the facility. The facility provided background check documentation for all four (4) of these new hires pre-audit to demonstrate compliance with provision (c) of this standard.

Agency policy PD 02.06.111 and the *PREA Manual* were reviewed in determining compliance with provision (d) of this standard. The facility provided adequate sample documentation of background checks for contractors as proof of this provision of this standard. An interview with HR staff revealed that background checks for contractors are conducted by the facility's Records Department for any of the specialty functions they serve (i.e. medical). The facility provided a secondary dissemination log of LEIN check information for contractors and volunteers, along with a sample check of an individual on this list in support of finding compliance for provision (d) of this standard.

According to agency policy PD 02.06.111, the *PREA Manual* and staff interviews, LEIN checks are completed by the records supervisor during designated years for facility employees. While agency policy dictates that background checks be conducted in June of specified years, the facility's formal documentation of its 5-year background checks demonstrates these screenings were conducted over a period of several months, from April through October of 2015. Nevertheless, the documentation confirms such checks were completed for all facility employees. This auditor did review LEIN logs relative to contractors and volunteers for other background screening provisions under this standard and did notice that contract employees are required to have an annual LEIN clearance completed, as each one has an expiration date of one year from the prior screening. Through review of agency policy, interview with HR and records staff, and observation of background check documentation this auditor determines compliance with provision (e) of this standard.

The facility provided and this auditor reviewed sample applications for hires of new corrections officers and a promotional application to demonstrate that the agency requires all applicants to provide information regarding the misconduct described in provision (a) of this standard when applying for employment or promotion and during any self-evaluations. In addition to application materials, the employee work rules, specified in the employee handbook that this auditor reviewed, requires that employees have an ongoing obligation to disclose any sexual misconduct. There are no self-evaluation procedures in place. The facility demonstrates compliance with provision (f) of this standard.

Agency policy PD 02.06.111 and the *PREA Manual*, which were reviewed by this auditor, affirmatively state that material omissions regarding such misconduct or the provision of materially false information are grounds for termination. The agency policy and work rules within the employee handbook sufficiently cover provision (g) of this standard. The facility indicates that there have been no instances where such material omissions have been noted.

Agency policy PD 02.01.140 *Human Resource Files*, PD 02.06.111 *Employment Screening* and the *PREA Manual* establish procedures for provision (h) of this standard and were reviewed by this auditor. The facility provided one example of the facility responding to a request from an outside agency request for such information on a former employee and one example of the agency responding to a request from an outside agency that were reviewed by this auditor to establish compliance with provision (h) of this standard. Although the facility specific example occurred prior to the audit period and the second request was processed at the agency level, this auditor is satisfied that sufficient procedures are in place to ensure information on

substantiated allegations of sexual abuse or sexual harassment are provided to requesting agencies regarding former MDOC employees.

Standard 115.18 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 *PREA Manual*, which was reviewed in determining compliance with provision (a), states that when acquiring a new facility and when modifying or expanding existing facilities, to include the expansion of video or other monitoring technology, the agency and facility must consider the ability to protect inmates from sexual abuse within the plans. Interviews with the agency head's designee and the Warden confirm that neither the agency has not substantially expanded or altered the physical structure of existing facilities since August 20, 2012. No new facilities were reportedly acquired by the agency. Agency level interviews confirm the agency did modify a portion of the physical plant at the women's correctional facility at Huron Valley to accommodate youthful female inmates at the facility. Additional cameras with audio capabilities were added to that facility to ensure inmate safety and PREA compliance. The Warden confirmed that there have been no physical plant expansions or modifications to the MTF. However, the MTF has undergone significant monitoring upgrades to the video monitoring system. Meeting minutes and plans for this video monitoring upgrade were reviewed by this auditor and proved to include elements of PREA consideration. During the tour, there were no areas of the facility that appear to have undergone physical expansion or modification; though the video monitoring system upgrades observed substantiate compliance with provision (a) of this standard.

The agency head's designee reported during an interview that the agency has approved expansion of camera coverage at all facilities and deployed electronic round readers at each facility to ensure adequate management tours of the facility that will be used in part, to prevent sexual abuse and sexual harassment. The facility Warden stated in an interview that the facility's recently upgraded camera system expanded coverage from 11 to 161 cameras. The facility carefully considered the placement of its cameras to cover virtually all common areas within its housing units where viewing is permissible. This auditor observed the view from all cameras and was particularly impressed with the "fish-eye" style cameras that allowed for a 360-degree view of the area under monitoring with excellent zoom capabilities. During the demonstration of the camera system, staff articulated that the cameras have significantly deterred physical assaults and other forbidden activity. The facility also installed an electronic tour scan verification system that was observed during the audit tour. This system is in operation. Not only does this system ensure that rounds are being made, it also ensures that such rounds are done irregularly and by whom. The camera upgrade and tour verification system demonstrates that the agency and facility are dedicated to compliance with provision (b) of this standard.

Standard 115.21 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.

According to the agency's *Crime Scene Management and Preservation Training Manual*, principles incorporated into the *PREA Manual* and an interview with the agency PREA Administrator, the agency's crime scene preservation is predicated upon the United States Army Criminal Investigation Command.

During interviews with facility medical staff and investigators, this auditor was informed the facility is not responsible for collecting forensic evidence from those involved in criminal sexual abuse investigations. The agency's protocol, which is outlined in the *PREA Manual* and *Crime Scene Management and Preservation Training Manual*, demonstrates that the agency and facility have procedures in place for preserving evidence and maintaining the integrity of any crime scene. These procedures allow for the criminal investigative agency, Michigan State Police (MSP), to maximize the collection of available evidence within the crime scene. Forensic examinations are conducted at by SAFE/SANE examiners at Mercy Hospital.

During random staff interviews and informal interviews during the audit tour, it was apparent to this auditor that security staff are aware of their responsibility to secure any potential crime scene and their duty to ensure those involved do not take actions that could destroy evidence. *Basic Investigator* training and *Crime Scene Management and Preservation* training materials cover the necessary technical detail to aid first responders in preserving available evidence to demonstrate compliance with provision (a) of this standard.

Uniform evidence protocol is covered in the *Crime Scene Management and Preservation* and *Basic Investigator* trainings. Both training manuals were reviewed by this auditor in determining compliance with provision (b) of this standard. Training materials cover the necessary technical detail to aid first responders in preserving available evidence. Youthful inmates are not housed at this facility; however, staff are adequately prepared to address the needs of this population through training materials and the *PREA Manual*'s guidance. All random staff interviews confirm that potential first responder security staff are aware of their responsibilities to protect any applicable crime scene and ensure that those involved take no action to destroy physical evidence. According to the agency's *Crime Scene Management and Preservation* training manual and an interview with the agency PREA Administrator, the agency's crime scene preservation is predicated upon the United States Army Criminal Investigation Command, which demonstrates compliance with provision (b) of this standard.

The agency policy PD 03.04.100 and the *PREA Manual*, reviewed by this auditor in determining compliance with provision (c) of this standard, specify that forensic examinations are provided without cost to victims of sexual abuse. The facility reports that no forensic examinations were conducted during the audit review period. Through an interview of a staff member at the Mercy Hospital Emergency Services Department; it was confirmed that inmates at the MTF are provided with this service via its use of Mercy Hospital as its outside medical provider. While no formal agreement for SAFE/SANE services is in place, an interview with the Mercy Hospital staff confirms that these services are in place for inmates of the MTF, as they are for any member of the community. The established protocol between the facility and the Hospital require that the facility notify the hospital that an inmate is being transported to the facility for an examination. Mercy Hospital will make arrangements for victim advocacy services while the inmate is in transport to the facility for accompaniment through the examination process if requested.

Through a review of agency policy and an interview with a staff person at Mercy Hospital, this auditor determined that the facility is in compliance with provision (c) of this standard.

Documented attempts to reach an agreement with the Detroit Rescue Mission Ministries at the agency level and the Muskegon Sheriff were provided and reviewed by this auditor in determining compliance with provision (d) of this standard. Additionally, this auditor reviewed a facility memorandum that describes advocacy services that are available through the facility's outside medical provider, Mercy Hospital. According to the memorandum, with proper notification, the hospital can provide a victim advocate to accompany the victim through the forensic examination process. The auditor called Mercy Hospital and confirmed with the Emergency Room charge nurse that the hospital receives inmates from the MTF for the purposes of conducting forensic examinations and the hospital provides a social worker to act as an advocate. The social worker will make applicable referrals for follow-up care; however, does not provide ongoing services once the inmate victim departs from the hospital. The facility has not been able to provide proof that it secured an agreement with victim advocacy services from an outside agency; however, has documented its attempts to do so. The facility also provides access to "An End to Silence" for state organizational contact information within the facility library.

The facility PREA Coordinator and the Regional PREA Analyst for the facility confirmed during onsite discussions that efforts have been made to secure rape crisis services and that qualified facility staff members have been identified and were provided training to deliver victim advocacy services in the absence of a formal rape crisis service agreement. During an interview with the inmate at the facility who reported sexual abuse, he claims that he was not provided information about outside support services; however, this would be consistent with the fact that the facility has yet to establish a formal agreement with an outside provider. It is noted that the interviewed inmate did not report abuse that required a forensic examination. Interviews with the PREA Coordinator, PREA Administrator and a review of facility correspondence with multiple outside advocacy agencies demonstrates that the facility is in compliance with provision (d) of this standard.

The *PREA Manual*, a memo regarding availability of victim advocacy through Mercy Hospital or Express Connect, and a letter from Michigan State Police, which were reviewed by the auditor, confirm that the agency, the facility, and the criminal investigative unit will permit a victim advocate to accompany a victim through the forensic medical examination and investigatory interviews. The auditor called Mercy Hospital and confirmed with the Emergency Room charge nurse that the hospital may receive inmates from the MTF for the purposes of conducting forensic examinations and the hospital provides a social worker to act as an advocate during said examinations. The social worker will make applicable referrals for follow-up care; however, does not provide ongoing services once the inmate victim departs from the hospital. According to the PAQ there have not been any forensic medical exams conducted during the audit period, as such there was no additional documentation provided regarding the facility's attempts to utilize a victim advocate during these examinations or subsequent investigatory interviews.

The facility has identified mental health staff to serve as the qualified staff member to provide advocacy services during any investigatory interviews in the current absence of a rape crisis advocacy agreement or the availability of the rape crisis advocate at the Mercy Hospital. During the onsite portion of the audit, the Regional PREA Analyst for the facility and mental health staff confirmed that the agency has trained and continues to train facility staff to serve as qualified staff members for the purpose of providing advocacy services. Training rosters and materials were provided and reviewed to the auditor's satisfaction that such qualified staff members currently exist at the facility and additional staff will be trained. The MSP memorandum confirms that the investigative agency has agreed to allow this individual access during forensic medical examinations and interviews consistent with standard 115.21. Absent a formal agreement with a rape crisis center, the facility has appropriate measures in place to provide advocacy services during a forensic examination and investigatory interviews to demonstrate compliance with provision (e) of this standard; however, has not had to exercise these plans.

The memorandum between the MDOC and MSP that this auditor reviewed, confirm that MSP will abide by the provisions set forth under §115.21 (a)-(e) in order to demonstrate compliance with provision (f) of this standard.

The auditor is not required to audit provision (g) of this standard to determine facility compliance.

The facility attempts to make a rape crisis advocate available; however, has yet to enter into a formal agreement. The auditor called Mercy Hospital and confirmed with the Emergency Room charge nurse that the hospital may receive inmates from the MTF for the purposes of conducting forensic examinations and the hospital provides a social worker to act as an advocate during said examinations. The social worker will make applicable referrals for follow-up care; however, does not provide ongoing services once the inmate victim departs from the hospital. In the event, such services are necessary, the facility uses qualified mental health staff. During the onsite portion of the audit, the Regional PREA Analyst for the facility and mental health staff confirmed that the agency has trained and continues to train facility staff to serve as qualified staff members for the purpose of affording advocacy services. Training rosters and materials were provided and reviewed to the auditor's satisfaction. Completion of the training delivers an awareness of the specialized knowledge required to provide support to a victim of sexual abuse consistent with provision (h) of this standard.

Standard 115.22 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.

The auditor reviewed agency policies PD 03.03.140, PD 01.01.140 and the *PREA Manual* when assessing compliance with provision (a) of this standard. While section G of PD 01.01.140 requires that the allegations must contain facts, rather than mere assertions or rumor to be entered into the internal affairs division investigation database, the *PREA Manual* (which supersedes all prior policies) confirms that all allegations are entered into the database for investigation. An interview with the agency head's designee confirms that all allegations of sexual abuse and sexual harassment are investigated. The Michigan State Police (MSP) are responsible for conducting criminal investigations upon referral should criminal behavior be observed during the facility's administrative response. A review of agency policies and interviews with the agency head's designee and agency PREA Administrator confirm that a referral process is in place to both notify and receive allegations of sexual abuse reported at or from other facilities. The facility provided multiple examples of referrals for administrative investigation pre-audit. The auditor observed consistency between the receipt of allegations and completion of administrative investigations. Agency policies, interviews and a review of facility investigations demonstrates that the facility is in compliance with provision (a) of this standard.

The agency policy PD 03.03.140 was reviewed by the auditor and found to address referrals of prisoner on prisoner sexual abuse, and all allegations, if true, to the MSP. PD 03.04.140 refers staff sexual misconduct/sexual harassment allegations for investigation as set forth in PD 01.01.140. Policy PD 01.01.140 was reviewed by the auditor, and specifies that the Internal Affairs Manager shall coordinate the investigation of all cases under the jurisdiction of the Internal Affairs Division, which are referred to the MSP for criminal investigations. Both policies are published on the agency's website. The *PREA Manual*, which supersedes all prior policies is not published on the agency's website; however, is not necessary to meet provision (b) of this standard. The auditor observed inconsistency in the documentation of referral for criminal investigation of all allegations of sexual abuse and sexual harassment. This did not validate compliance with provision (b) of this standard. The MSP are responsible for conducting criminal investigations upon referral should criminal behavior be observed during the facility's administrative response. The facility has proactively conducted additional training with its investigators on November 10, 2016 including the proper referral of sexual abuse and sexual harassment allegations to the MSP. The facility provided evidence that all outstanding administrative investigations, where the allegations involved potentially criminal behavior, had been referred to the MSP by January 31, 2017.

This auditor reviewed and verified that policies PD 01.01.014 and PD 03.03.140 are available on the agency website. The policies outline the specific responsibilities of the agency and the MSP when conducting criminal investigations to demonstrate compliance with provision (c) of this standard.

The auditor is not required to audit provisions (d) and (e) of this standard to determine facility compliance.

Corrective Actions Taken:

The MTF proactively conducted additional training with its investigators on November 10, 2016 including the proper referral of sexual abuse and sexual harassment allegations to the MSP. The facility provided evidence that all outstanding administrative investigations, where the allegations where the allegations involved potentially criminal behavior, had been referred to the MSP by January 31, 2017. The MTF reported that only one new allegation during the 180 day corrective action period required referral to the MSP for potential criminal investigation. Documentation supporting this referral within appropriate timeframes was provided to this auditor on July 26, 2017.

Based upon the investigative staff training, MSP referrals of all outstanding administrative investigations with potential criminal behavior, and the sample referral provided during the 180 day corrective action period, this auditor concludes that the MTF has adequately addressed this audit observation and now substantially complies with the provisions of 115.22.

Standard 115.31 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.

The agency's *PREA Manual*, PREA training curriculum *"PREA: Sexual Abuse and Sexual Harassment in Confinement"*, computer based training modules for PREA and training reports were reviewed in determining compliance with provision (a) of this standard. A review of these materials provides a robust explanation of all 10 points required by this standard. The training curriculum is provided as part of an employee's initial 320 Hour Corrections Training Program. Computer based training is provided for existing employees and contractors through two detailed training modules. Facility training record samples demonstrate that the facility staff have completed the existing training modules. Informal interviews with staff during the audit tour confirm that individuals are well informed of all ten factors required by the employee training standard. All staff who were randomly interviewed were able to clearly describe elements from the training to demonstrate knowledge of the factors required for compliance with provision (a) of this standard.

The MTF does not house female inmates. The agency training materials that were provided to and reviewed by this auditor adequately cover the dynamics of sexual abuse for male and female inmates as required by provision (b) of this standard. Based on a review of PREA training materials and a sampling of training records; the facility demonstrates compliance with provision (b) of this standard.

The MTF provided ample documentation that was reviewed by this auditor to verify that staff at the facility have completed the agency's computer based training on sexual abuse and sexual harassment in confinement settings. Employees are required to complete this training at a minimum of every two years as noted within the agency *PREA Manual*; however, the training is

available annually to aid in fulfillment of annual training requirements. Training records and the agency training plans demonstrate compliance with provision (c) of this standard.

Employees are required to complete a comprehension test relative to the training materials to verify their understanding of the materials at the end of the agency's computer based training modules. This comprehension test comes with electronic verification by employee ID number to signify individual comprehension of the training, demonstrating compliance with provision (d) of this standard.

Standard 115.32 Volunteer and contractor training

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Agency policy PD 03.02.105 addresses the need for volunteers and contractors to be trained on their responsibilities under the agency's sexual abuse and sexual harassment prevention, detection, and response policies and procedures. According to policy PD 03.03.140 and the *PREA Manual*, the MDOC treats all contractors and volunteers as an employee and therefore trains these individuals with the same computer based training materials available to directly hired employees. The agency's training curriculum for contractors and volunteers sufficiently addresses the concepts of sexual abuse, sexual harassment, reporting and response procedures. In addition to this auditor's review of the training materials, this auditor reviewed a sampling of training records across multiple contractor and volunteer disciplines to determine compliance with provision (a) of this standard.

Policy PD 03.02.105 addresses the requirement for volunteers and contractors to be trained on their responsibilities under the agency's sexual abuse and sexual harassment prevention, detection, and response policies and procedures. According to policy PD 03.03.140 and the *PREA Manual*, the MDOC treats all contractors and volunteers as an employee and therefore trains these individuals with the same training materials available to directly hired employees. Contractors and volunteers receive a PREA reference guide and are required to sign a form to acknowledge they could be a first responder. A formal interview with a facility contractor demonstrated knowledge of facility reporting and first responder procedures. Informal interviews during the audit tour with contractors demonstrated that they were aware of their responsibilities to both report incidences of sexual abuse and sexual harassment, as well as how to act as a first responder to preserve potential evidence. The review of policy, training materials, training records and both formal and informal interviews demonstrate compliance with provision (b) of this standard.

The agency *PREA Manual* requires that the Department maintain documentation confirming that volunteers and contractors receive and understand the agency's PREA training. The MTF provided ample samples of orientation and PREA training completion for contractors and/or volunteers. The review of policy, training materials, training records and both formal and informal interviews demonstrate compliance with provision (c) of this standard.

Standard 115.33 Inmate education

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policies PD 03.03.140, PD 04.01.105, PD 04.01.140, OP-RGC-04.01.140 and the *PREA Manual*, which were reviewed by this auditor, address the standard's requirements to train inmates during the intake process regarding the agency's zero-tolerance policy, how to report sexual abuse and sexual harassment, as well as available services. Through interviews with facility intake staff the PREA Coordinator and random inmates, this education is reportedly completed through a video based presentation, accompanied by a brochure that specifically covers the zero- tolerance policy, the definitions of sexual abuse, sexual harassment, retaliation, how to report sexual abuse, the process following a report, available services to victims and how to avoid sexual abuse. A review of these materials by this auditor, satisfies compliance with this element of provision (a) of this standard.

Through interviews with the PREA Administrator, it was reported that the agency provides comprehensive inmate education at RGC, required under OP-RGC-04.01.140. Inmates who are transferred from that facility to the MTF, will have received comprehensive education at RGC. The facility PREA Coordinator and education staff who were interviewed informally during the physical audit reported that the MTF also conduct an orientation process within the first week for all new receptions that includes PREA training, and issuance of the *PREA brochure*. A sampling of inmate training records were compared against the inmates' reception dates to confirm that training is ordinarily completed for inmates within approximately seven (7) days of reception to MTF to demonstrate compliance with provision (a) of this standard.

During the audit tour, this auditor observed that PREA posters were adequately displayed in those areas where inmates would go for other pertinent facility operational information and in other high traffic areas to also demonstrate compliance with provision (a) of this standard.

Policies PD 03.03.140, PD 04.01.105, PD 04.01.140, OP-RGC-04.01.140 and the *PREA Manual*, address this standard's requirements to train inmates during the intake process regarding the agency's zero-tolerance policy, how to report sexual abuse and sexual harassment, as well as available services. This education is completed through a video based presentation accompanied by a brochure that specifically covers the zero-tolerance policy, the definitions of sexual abuse, sexual harassment, retaliation, how to report sexual abuse, the process following a report, available services to victims and how to avoid sexual abuse. Additionally, information is available in the *Prisoner Guidebook*. Through interviews with the PREA Administrator and the PREA Coordinator, it was reported that the MDOC has an intake facility for all male inmates, RGC, where intake is completed for prisoners who are assigned to the MTF.

Fifteen of the sixteen random inmate interviews confirm that education materials and the PREA video, *Taking Action*, are shown during the quarantine period (first week after reception). These inmates also reported that information is continuously displayed throughout the housing units on posters and is available in handbooks. During the audit tour, random inmates were informally interviewed confirming that they received PREA education. Facility staff were able to pull inmate files on the units to verify these inmates had completed education, and were additionally provided a copy of the *PREA brochure*. Inmate training receipts provided by the facility and inmate interviews by the auditor demonstrate sufficient compliance with this standard.

Through interviews with the PREA Administrator and a review of agency materials, it is clear that PREA policies and reporting mechanisms are universal throughout the agency, negating the need to retrain inmates upon transfer from the RGC to the

MTF. Documentation was reviewed by this auditor pre-audit for verification of inmate orientations upon reception to the MTF, which included who and how to notify in the event of sex pressure. Most orientations were observed to be conducted within seven (7) days of reception to the MTF. An interview with the agency PREA Administrator indicates that the agency has been providing PREA training for inmates at the agency reception center since approximately 2007 and the agency made a sweeping effort to train existing inmates at that time in 2007 to ensure existing inmates were trained on PREA. An interview with the individual responsible for facility orientation confirms that all inmates go through an orientation process that includes PREA education within the first week of reception. A sampling of inmate training records corroborates this report to demonstrate that the facility has procedures in place to ensure that all inmates at the MTF have been provided training consistent with provision (c) of this standard.

The agency publishes written educational materials, such as the *PREA brochure*, PREA posters and *Prisoner Guidebook* in both English and Spanish. The agency has a braille version of the *PREA brochure* available for visually impaired inmates. The PREA video, *Taking Action*, has been closed captioned for the deaf and hard of hearing population. Each facility within the agency is responsible for maintaining an interpretation service contract for communication purposes. The MTF submitted invoices from RTT Mobile Interpretation and Language Line Services, Inc. as proof of its provision of interpretative services for LEP inmates during the intake education process. The MTF also maintains copies of PREA training materials, The PREA Resource Center's "An End to Silence", agency PREA publications and the PREA standards in the law library that are available for check-out to the inmate population. This auditor reviewed these training materials, the library inventory and interpretation invoices to determine compliance with provision (d) of this standard.

The agency and facility maintain documentation of inmate education via form CAJ-1036. Sample records were provided and random inmate files were reviewed on the units during the course of the physical audit to confirm the facility's assertion that education records are consistent with provision (e) of this standard.

The agency publishes posters that contain record of the agency's zero-tolerance policy and methods to report allegations of sexual abuse and sexual harassment. During a tour of the MTF, these posters were visible throughout the housing units and common areas of the facility. Inmates receive a tri-fold *PREA brochure* that is published in both English and Spanish during the intake process and these materials were observed to be available to inmates during the audit tour. The facility library holds a copy of the PREA Resource Center's "An End to Silence" handbook, the PREA Standards, the agency *PREA Manual*, training materials and *Prisoner Guidebook*s that are available for the inmate population to check out. Signage was clearly posted and visible in the library as to the location for these materials. Fifteen of sixteen randomly interviewed inmates reported receiving written materials for their retention to allow this auditor to determine compliance with provision (f) of this standard.

Standard 115.34 Specialized training: Investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The agency policy PD 03.03.140 and *PREA Manual* require that investigations of prohibited sexual conduct be completed by staff who have received specialized investigator training. The agency has a *Basic Investigator Training Manual: Interview and Investigation Techniques and Fundamentals*, which was reviewed by this auditor. This manual provides additional, specialized training for agency investigators to conduct all forms of administrative investigations, including PREA administrative investigations. This investigative course covers a PREA specific module that includes the dynamics of sexual abuse within

confinement settings, interview techniques for victims of sexual abuse and also contains modules specific to the preservation of evidence, interview techniques and employee rights, such as Garrity and Miranda warnings. The evidentiary standard of preponderance of the evidence is noted within the training on administrative investigations. Training records were provided to confirm that 11 active staff at the MTF completed the agency's specialized investigator training. In addition to the agency's *Basic Investigator* training, training records confirm that seven (7) staff completed the NIC specialized investigator's training in satisfaction of provision (a) of this standard.

The agency's investigative course covers a PREA specific module that includes the dynamics of sexual abuse within confinement settings, interview techniques for victims of sexual abuse and also contains modules specific to the preservation of evidence, interview techniques and employee rights, such as Garrity and Miranda warnings. The evidentiary standard of preponderance of the evidence is noted within the training on administrative investigations. The training informs participants on the requirements and procedures for referring potentially criminal acts for criminal investigation/prosecution. In addition to the agency's *Basic Investigator* training, seven (7) staff have participated in the NIC specialized investigator's training to provide additional information on the required standard topics. A review of training materials and training records for facility investigators demonstrates compliance with provision (b) of this standard.

The agency maintains documentation of investigator training in the employee's training file. The facility provided documentation that was reviewed by this auditor to verify that 11 active employees have completed the *Basic Investigator* training. Training records were provided to confirm that seven (7) of these investigators also completed the NIC specialized investigator training in satisfaction of provision (c) of this standard.

The auditor is not required to audit provision (d) of this standard to determine facility compliance.

Standard 115.35 Specialized training: Medical and mental health care

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Agency policies PD 02.05.100 and PD 02.05.101 establish procedures for ensuring staff, including contract staff, are adequately trained based on their positions within the agency. The agency has developed a training curricula specific to medical and mental health staff that was reviewed by this auditor. These materials expand upon the basic training *Module 2* to cover the four points required by this standard. Training materials cover the detection of sexual abuse and harassment, preservation of evidence specific to facility responsibility (forensic examinations are conducted at an outside medical provider and no evidence is collected by medical or mental health practitioners), how to respond to victims of sexual abuse and harassment and facility reporting responsibilities for allegations of sexual abuse and harassment.

The facility provided documentation of medical and mental health practitioners having completed the training modules related to their specific disciplines that were reviewed by this auditor. Through formal and informal interviews during the audit tour, both medical and mental health staff confirmed that they have received computer based training that covers the standard requirements in satisfaction of provision (a) of this standard.

Neither the facility nor its staff conduct forensic examinations, therefore, training records consistent with provision (b) of this standard are not required.

The facility provided documentation of medical and mental health practitioners' completion of the specialized training modules that was reviewed by this auditor. These training records are kept in the computerized training records for employees and demonstrate compliance with provision (c) of this standard.

The agency has developed a training curricula specific to medical and mental health staff that includes and expands upon the basic training *Module 2* to cover the key points required by the standards. Employees must complete the traditional *Module 1* and *2* training required of all employees as part of accessing this expanded training specific to each discipline. This auditor's review of these training materials and corresponding completion records determines compliance with provision (d) of this standard.

Standard 115.41 Screening for risk of victimization and abusiveness

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The agency policies PD 03.03.140, PD 05.01.140, the *PREA Manual* and the *PREA Risk Assessment Manual*, which were reviewed by this auditor, state that an intake screening shall be conducted at reception centers during intake. However, the *PREA Manual* and the *PREA Risk Assessment Manual* provide an exception to the completion of a 72-hour intake assessment at placement facilities provided said 72-hour assessment was previously completed. This auditor determined that agency policy regarding risk screening is not compliant with provision (a) of this standard.

Pre-audit documentation in support of this standard demonstrates that 72-hour complete intake assessments were completed at RGC. During the course of the audit, through formal and informal interviews with the PREA Administrator, PREA Coordinator, facility intake and facility case management staff, it was determined that the MTF does not complete 72-hour intake assessments for inmates transferred into the facility. The agency policy only requires the facility to conduct a review of the initial assessment within 30 days of arrival.

A staff person responsible for risk screening states in an interview that only reviews of the initial assessment are completed at the facility. Eight of nine random inmate interviews, of inmates that had arrived at the facility within the past 12 months of the audit, reported that they were not asked questions consistent with required elements of the risk screening process. All of the aforementioned audit activities demonstrate the need for corrective action to meet the requirements of provision (a) of this standard.

Agency policies PD 03.03.140, PD 05.01.140, the *PREA Manual* and the *PREA Risk Assessment Manual* state that an intake screening shall be conducted at reception centers during intake. However, the *PREA Manual* and the *PREA Risk Assessment Manual* provide an exception to the completion of a 72-hour intake assessment at placement facilities provided said 72-hour assessment was previously completed at another facility. The agency policy only requires the facility to conduct a review of the initial assessment within 30 days of arrival. The facility provided pre-audit documentation to confirm the Department's reception center, RGC, completed initial risk screenings within 72 hours; however, that does not fulfill the requirements of replicating this screening upon transfer into the facility. While the MTF follows agency policy, its compliance with this standard is a casualty of the overall agency policy not meeting the requirements of provision (b) of this standard.

The agency PREA Administrator reported during discussion that the agency is in the process of updating its risk screening procedures to implement a 72-hour risk screening upon transfer and reception to other MDOC facilities consistent with provision (b) of this standard.

The *PREA Risk Assessment Worksheet*, CAJ-1023, which was reviewed by this auditor meets objective criteria as required by provision (c) of this standard. The assessment is an objective set of instruments that measures both an inmate's risk of victimization and risk for predatory behavior. The tool generates a numerical score based on weighted factors to determine an inmate's classification as either an aggressor, potential aggressor, no score, potential victim or victim.

Based on a review of the *PREA Manual*, the *PREA Risk Assessment Manual* and form CAJ-1023, as well as through a discussion with the agency PREA Administrator, this auditor is satisfied that the intake screening instrument meets the ten (10) criteria set forth in provision (d) of this standard. While the tool does not affirmatively address criteria 10, neither the agency nor the MTF house inmates solely for civil immigration purposes. An affirmative assessment of a risk factor that does not exist within the agency (civil immigration) was determined unnecessary. The *PREA Risk Assessment Manual*, which outlines the procedures for the use of the intake screening tool, clarifies that the remaining nine (9) elements of this standard are affirmatively addressed within the intake screening process to demonstrate compliance with provision (d) of this standard.

Based on a review of the *PREA Manual*, the *PREA Risk Assessment Manual* and form CAJ-1023, as well as through a discussion with the agency PREA Administrator, this auditor is satisfied that the intake screening instrument meets the requirements of provision (e) of this standard. The *PREA Risk Assessment Manual's* reference to documented history of sexual abuse, violent convictions and a history of institutional violence (including sexual) demonstrates that the risk factors enumerated under provision (e) of this standard are adequately inclusive of both convictions and known institutional behavior.

The *PREA Manual*, the *PREA Risk Assessment* Manual, agency policy PD 05.01.140 and local procedure OP 03.03.140, which were reviewed by this auditor, clearly specify applicable time frames for risk assessment review. The facility's reassessment process consists of three questions, two of which are certification by the assessor that the original victim and aggressor instruments are accurate. These reassessment procedures may cause those inmates being reassessed not to recall the assessment process during the random interviews.

During the tour, a minimum of two inmate files were randomly sampled on four of the eight housing units. The facility provided pre-audit sample documentation that demonstrates consistent review of inmate risk within the 30-day period required by agency policy and this standard. Records related to 30-day reassessments were compared against the inmate reception dates. The review of these assessments revealed that the facility is consistently conducting its reassessments within the required 30-day timeframe to demonstrate compliance with provision (f) of this standard.

The agency policy PD 03.03.140, the *PREA Manual* and the *PREA Risk Assessment Manual* specify that assessments shall be conducted when warranted due to the factors enumerated by this standard. The facility did not provided documentation of inmates being reassessed. No records were available to review to demonstrate compliance or non-compliance with provision (g) of this standard, as no requests have been documented and no incidents have been deemed to warrant a reassessment. Based on adequate policy and procedures for directive on conducting reassessments, this auditor determines compliance with provision (g) of this standard.

The *PREA Manual*, which was reviewed by this auditor, specifically states “prisoners may not be disciplined for refusing to answer or not disclosing complete information in response to questions relating to mental, physical, or developmental disabilities, whether they are, or are perceived to be, gay, lesbian, bisexual, transgender, intersex, or gender nonconforming, previous victimization, or their own perception of vulnerability.” The PREA Administrator, PREA Coordinator and staff responsible for conduct assessments confirm during interviews that the assessment is voluntary and that there are no disciplinary consequences for failing to participate, consistent with provision (h) of this standard.

The *PREA Manual*, which was reviewed by this auditor, confirms that information obtained during the risk assessment process shall be treated as confidential information and only shared with designated staff in accordance with Department policy. Risk assessment information shall not be shared with prisoners. During a prior interview with the PREA Administrator it was

identified that only those staff with a supervisory role within the facility have access to the electronic screening system. Access to this system is governed by the individual user's log-on information to demonstrate compliance with provision (i) of this standard.

Corrective Actions Taken:

The MTF implemented procedures to conduct 72-hour risk screenings on April 4, 2017, after discussions between the Department PREA Administrator and the auditors on the corrective action plan. The agency revised its PREA related policy, Policy Directive (PD) 03.03.140. This auditor was provided a copy of this revised policy on March 15, 2017 for review and noted that Section Q specifically addresses the need to conduct a risk assessment within 72-hours of arrival at all correctional facilities. Section R specifically addresses the need to complete a review of the assessment within 30 days of arrival. Additionally, the policy now includes a provision for an annual reassessment, which exceeds the standard.

During the corrective action plan, the facility PREA Coordinator provided this auditor with a copy of a secondary risk screening log that was designed to track the dates of reception, due dates of the initial 72 hour and 30-day reviews required by provisions (a), (b) and (f) of the standard. Moreover, this log also tracked whether or not the inmate has completed PREA education, and whether or not the inmate being screened reported victimization or perpetration that would require an evaluation required by standard 115.81. Although the initial corrective action plan was intended to randomly sample specific dates; the secondary risk screening log developed by the facility provided the auditor with ample information on each reception and transfer into the facility and was thus utilized as a tool to measure compliance with the standard.

To authenticate the reliability of this risk screening log, this auditor requested computer assessment records for three randomly sampled inmates on May 10, 2017, which the facility provided the auditor on May 12, 2017. These computerized assessment reports authenticated the veracity of the information recorded within the risk screening log. A second random sample of three inmates whose risk screenings were due in May of 2017 were requested by the auditor on June 7, 2017 and provided on June 8, 2017. Again, as found during the previous sample, the data contained within the secondary risk screening log was verified as accurate. A third random sample of three inmates was requested on July 10, 2017 and were provided on July 11, 2017. Consistent with previous random samples, the accuracy of the secondary tracking log was verified.

Based on the facility's detailed secondary risk screening log and the confirmation of that log's accuracy through random sampling, this auditor is satisfied that the MTF has established sufficient practice to demonstrate its commitment to perform risk screening for all inmates received at the facility, consistent with provisions (a), (b) and (f) of the standard. The information gathered through compliance with this standard, ultimately provides secondary evidence of compliance with related standards 115.42, 115.81 and 115.83.

Standard 115.42 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.

This auditor reviewed the *PREA Manual*, agency policy PD 05.01.140, and local procedure OP 05.01.140 MTF, and found that the agency policies are compliant and mirror the language set forth in provision (a) of this standard. The agency uses a computerized assessment process to arrive at an inmate classification for risk. The results generated from the assessment

preclude housing potential victims with potential abusers within the computerized bed assignment program. The facility provided a copy of their count sheets that identifies housing assignments along with assessed risk which this auditor believed was great tool to demonstrate use of the screening information for housing decisions. However, the lack of a 72-hour intake screening process for all incoming inmates creates an opportunity for key aspects of vulnerability to go undetected or for inappropriate housing decisions to stand based off of prior assessments should an individual have changed key criteria regarding risk, such as their identification status as a member of the lesbian, gay, bisexual, transgender, intersex (LGBTI) community or have experienced victimization at the agency's reception center that is not consistent with the intent of provision (a) of this standard.

The PREA Coordinator at the facility stated that the risk screening tool is used to identify factors required by the standards to prevent housing high risk abusers with high risk victims. An interview with a staff person responsible for reviewing the risk screening at the facility was confident regarding the tool's use for determining housing decisions; however, there was no nexus of using the risk screening information for programming or employment assignments. During the audit tour, this auditor observed work assignments within the food services building where potential victims and abusers could work together in isolated areas. Recent video surveillance upgrades and moderate staffing in the food service area mitigate much of the concern; however, a nexus for some consideration should be given to these employment assignments with respect to assessed risk. This auditor is satisfied with the high level of supervision in the programming and education building to ensure that any risk identified by the screening tool is outweighed by the intensive staff to inmate ratio and direct observation.

Agency policy PD 05.01.140 *Prisoner Placement and Transfer* and the *PREA Manual*, which were reviewed by this auditor, establish agency policy regarding individualized safety determinations. Policy and an interview with an inmate identified to be vulnerable to sexual victimization demonstrated that the facility makes individualized determinations to ensure the safety of each inmate, consistent with provision (b) of this standard. Though this inmate reported during the interview that he had allegedly been sexually assaulted at this facility. He explained that it was investigated by the facility and he was provided the results of the investigation as unsubstantiated. This inmate clearly stated that he did feel safe, comfortable reporting to staff and that the staff of the MTF care about his safety. This inmate acknowledged that the alleged perpetrating inmate was separated from him and ultimately transferred from the facility. In addition to the risk screening process and its use to determine proper housing assignments, there is a degree of flexibility to make individual accommodations. Through informal interviews during the audit tour, staff charged with risk screening and making housing decisions were well aware of the proper use of screening information for bed assignments. While the agency demonstrates that it meets the requirements of provision (b) within its practices, there is concern about the reliability of the information that it is basing decisions upon due to the lack of a 72-hour intake screening process for all receptions and transfers into the facility.

The *PREA Manual* and agency policy PD 04.06.184 *Gender Identity Disorder(GID)/Gender Dysphoria*, reviewed by this auditor, contains language and provisions to satisfy the standard requirements that the agency make case-by-case determinations for transgender and intersex housing and programming assignments consistent with provision (c) of this standard. During an interview the facility PREA Coordinator stated that policy requires consideration in making housing and programming assignments for transgender inmates on an individualized basis to ensure the inmate's health and safety. Pre-audit documentation was available for an assessment documented on agency form CHJ-339 by health services personnel for a transgender inmate that had transferred from MTF prior to the audit. The auditor notes this review appears to be from a medical/mental health perspective and considers the inmate's health and safety, demonstrating compliance with provision (c) of this standard.

Agency policy PD 04.06.184 and the *PREA Manual* were reviewed by the auditor. The policy indicates that placement and programming assignments for transgender, intersex and GID inmates will be reassessed twice yearly by facility medical or mental health staff.

During an interview the facility PREA Coordinator stated that policy requires transgender inmate be reviewed twice per year. It was noted that no identified transgender inmates were housed at the MTF during the course of the onsite audit, and as such no transgender inmates were available to be interviewed by the auditor. No records for semiannual transgender reviews were available to demonstrate compliance or non-compliance with the provision of this standard. Based on the affirmative

interview with the facility PREA Coordinator, and adequate policy and procedures directing the semiannual transgender reviews, this auditor determines compliance with provision (d) of this standard.

The *PREA Manual*, reviewed by this auditor, provides for a transgender or intersex inmate's own views to be considered in the placement process. During an interview the facility PREA Coordinator identified that policy requires transgender or intersex inmate's own view be given serious consideration with respect to his or her safety. It was noted that no identified transgender inmates were housed at the MTF during the course of the onsite audit, and as such no transgender inmates were available to be interviewed by the auditor. Based on the facility PREA Coordinator interview and policy, it appears that the transgender or intersex inmate's views will be given consideration when making determinations for housing and other programming determinations consistent with provision (e) of this standard.

Agency policy PD 04.06.184, reviewed by this auditor, specifies that transgender and intersex (GID) inmates are given the opportunity to shower with relative privacy; while the *PREA Manual* provides that transgender and intersex (GID) inmates shall be given the opportunity to shower separately. Informal interviews with staff on the housing units during the audit tour corroborated that transgender or intersex inmates are able to shower during count time when all other inmates are locked in their cells to demonstrate compliance with provision (f) of this standard.

Agency policy PD 05.01.140 and the *PREA Manual*, reviewed by this auditor, address provision (g) of this standard; however, the *PREA Manual* provides a unique exception to place inmates in a dedicated unit when it is in the interest of the safety and security of the prisoner. This provision of the policy is open for interpretation and is contrary to the PREA Resource Center FAQ's in that the reader is led to believe that the facility has the sole right, without taking the inmate's own views with respect to safety, to determine placement. An interview with the agency's PREA Administrator clarified this point to indicate that the agency considers some of its facilities with open bay style housing to be an unsafe environment for individuals who identify as transgender or intersex; thus placing them in facilities with a high level of security and medical care to meet their transitional needs.

The PREA Administrator stated in an interview that the agency does not have any dedicated facilities or housing units that are specific to LGBT populations. There are facilities within the agency that are not conducive to the safety and privacy needs of transgender and intersex inmates, such as the MTF, with open bay or dormitory housing, that the agency attempts to avoid placing such inmates within to ensure safety and privacy. During the audit tour there were no observed units or wings identified in the MTF for sole purpose of housing inmates based on LGBTI identification or status.

The facility and the agency practice demonstrate compliance with provision (g) of this standard and this auditor makes the determination that the MTF is in compliance with this provision of the standard; however, it is recommended that the PREA Administrator issue direction via memorandum to all facility PREA Coordinators to ensure that each is aware of the prohibition of placing transgender and intersex inmates in dedicated units for safety and security of the prisoner to remove any ambiguity contained within the agency's *PREA Manual*.

Corrective Actions Taken:

As noted within the corrective action plan, the facility was required to implement an intake screening process for all new receptions to the facility in order to be considered fully compliant with the standard, as compliance hinged upon having the most reliable and up-to-date information to effectively implement the standard's intent. Recent agency wide revisions to policies PD 03.03.140 and the *PREA Manual* now ensure that a 72-hour intake screening process for all incoming inmates is in place and negates the opportunity for key aspects of vulnerability to go undetected consistent with the intent of provision (a). Through the information provided in support of standard 115.41, the auditor is satisfied that the MTF has established sufficient practice to demonstrate its commitment to perform risk screening for all inmates received at the facility. Specifically, the facility developed a secondary risk screening log that was designed to track the dates of reception, due dates of the initial 72-hour and 30-day reviews required by standard 115.41. The veracity of that log was verified through random sampling by the auditor. Through the establishment of these intake risk screening practices, the auditor is confident that the MTF is now fulfilling the requirements under this standard with the most reliable and timely information available, while also providing

another opportunity to report sexual abuse that could have occurred at the preceding facility.

Based upon confirmation of intake risk screening practices required under 115.41, the auditor is satisfied that the facility is also basing its safety, housing, work, programming and educational decisions required by 115.42 with the guidance of the most accurate and recent information available. Evidence of substantial compliance with the standard has been established.

Standard 115.43 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.

The agency *PREA Manual* and policy PD 04.05.120 were reviewed by this auditor in determining compliance with provision (a) of this standard. The *PREA Manual* contains language that mirrors the provision of this standard. This auditor observed onsite and through pre-audit documentation that the facility has a robust computerized assessment and bed management system in place to ensure that inmates at high risk of victimization are not housed with inmates at high risk of predatory behavior. As evidenced during the tour and through informal interviews with inmates, the facility takes adequate measures to ensure individualized safety needs are considered.

The facility provided a memorandum to state that the MTF does not have a segregation housing unit available on facility grounds. The Warden stated in an interview that segregation is not used to protect inmates at high risk of sexual victimization. The MTF has two (2) temporary holding cells located in the intake medical area. In those circumstances where placement in these cells is determined to be necessary, such placement is limited to a very short period, less than 24 hours, until a determination is made if the inmate can be safely managed at the facility or will require a transfer. There are no other provisions for segregated housing in the MTF. This auditor is satisfied that the facility refrains from placing inmates at high risk of victimization in segregated housing consistent with provision (a) of this standard.

Agency policy PD 04.05.120 and the *PREA Manual*, which were reviewed by this auditor, specify that inmates shall maintain access to programs, privileges, and education and work opportunities. In the event such things are restricted, the facility is required to document the nature of the restrictions according to standard language. Pre-audit, the MTF provided a memorandum to explain that the facility does not have a segregation housing unit available on facility grounds. This response implies compliance with provision (b) of this standard by omission of segregated housing.

During a tour of the MTF, it was clear to this auditor that segregation is not utilized at the facility. The facility reports that no inmates have been placed into voluntary or involuntary segregation for protection from victimization. This auditor is satisfied that the facility refrains from placing inmates at high risk of victimization in segregated housing consistent with provision (b) of this standard.

The facility reports to this auditor through a memorandum and through interviews with the PREA Coordinator that the MTF does not have a segregation housing unit available on facility grounds and no inmates have been placed into involuntary segregation due to risk of victimization. In an interview with the Warden, confirmed that if an inmate were placed into involuntary segregation in one of the holding cells, due to risk of victimization, an assessment would be made for managing the inmate at the facility or transfer them out to another facility within 24 hours.

This auditor is satisfied that the facility refrains from placing inmates at high risk of victimization in segregated housing consistent with provision (c) of this standard.

The facility reports to this auditor through a memorandum and through interviews with the PREA Coordinator that the MTF does not have a segregation housing unit available on facility grounds and no inmates have been placed into involuntary segregation due to risk of victimization, therefore, there are no records to review to demonstrate compliance or non-compliance with provisions (d) and (e) of this standard, this auditor determines compliance.

Standard 115.51 Inmate 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.

Agency policy PD 03.03.140, the *PREA Manual*, the *Prisoner Guidebook*, Sexual Abuse Poster (advertising the sexual abuse hot-line) and the *PREA brochure* were reviewed by this auditor in determining compliance with provision (a) of this standard. All provide information to advise inmates of reporting options. The agency permits PREA allegations to be reported verbally to any staff or in writing via a request system known as "kites", reported via message to the PREA hot-line or writing to the PREA Administrator, in writing via the prisoner grievance process, in writing to the Correctional Legislative Ombudsman, and directly to the Michigan State Police.

The facility provided pre-audit documentation to this auditor that demonstrated use of inmate kites, and emails from staff following inmate verbal reports that were referred for investigation. During formal and informal interviews during the audit tour, staff were able to identify the hot- line, the kite and grievance systems and third party reporting mechanisms if an inmate were unwilling to report such allegations directly to staff at the facility. All random inmates were well aware of their abilities to report within the facility. The majority of the inmates interviewed claimed their first line of reporting would be to a staff member at the facility, indicating a reporting culture has been established at the facility. Inmates were able to identify the hot-line, as well as the ability for third parties to make a report on their behalf.

During the tour, adequate reporting hot-line posters were prominently displayed throughout the facility. During audit tour informal interviews, staff were aware of their obligations to accept reports from inmates and most inmates who were informally interviewed stated they were comfortable making a report to a staff member. Staff and inmates were aware of the ability to make written reports through the various available means and were aware of the hot-line. PREA Auditor Radziewicz had previously left a test message on the reporting hot-line established by the agency. During that audit, the instructions left on the reporting hot-line were followed, confirming the functionality of the hot-line to demonstrate compliance with provision (a) of this standard.

Agency policy PD 03.03.140, the *PREA Manual* and the *Prisoner Guidebook*, which were reviewed by this auditor, confirm that reports of sexual abuse and harassment may be reported outside the agency to the Legislative Corrections Ombudsman. Such reports can be made anonymously. The Memorandum of Understanding (MOU) between the two agencies specifies that reports must be forwarded immediately. Neither the facility nor the agency hold individuals for civil immigration purposes to require information with this section of provision (b) of this standard. The MTF provided a memorandum prior to the audit to verify that no reports were received from the Legislative Corrections Ombudsman during the audit period.

During an interview with the facility PREA Coordinator, she identified that the facility uses the Legislative Ombudsman to take and forward reports of sexual abuse and sexual harassment at the facility. Interviews with randomly sampled inmates demonstrated difficulty identifying the Legislative Ombudsman as a reporting mechanism. None of the 16 interviewed inmates were affirmatively able to identify this option without prompting when asked; however, it is noted within the *Prisoner Guidebook* that this resource is available. Two of the randomly interviewed Inmates were also aware of a crime stoppers number to make reports outside the agency. Most of the inmates were aware of their ability to make anonymous reports. During the tour, inmates who were informally interviewed were well aware of the reporting hot-line and their ability to make anonymous written reports. Again, the Legislative Ombudsman was not regularly identified during informal interviews; however, it is published within the *Prisoner Guidebook* to sufficiently demonstrate compliance with provision (b) of this standard.

Agency policy PD 03.03.140 and the *PREA Manual*, which were reviewed by this auditor, require staff to accept verbal, written, anonymous and third party reports. Any verbal reports are required to be forwarded to a supervisor and documented as soon as possible. The facility provided ample pre-audit documentation to demonstrate that the facility accepts reports that were made verbally, in writing (via kite, grievance or other note) and from third parties. Through informal interviews during the audit tour, this auditor determined that both staff and inmates were well aware of the need for staff to accept and immediately act upon verbal, written, anonymous and third-party reports consistent with provision (c) of this standard.

During formal interviews with randomly selected staff, all staff interviewed were well aware of their obligation to accept all forms of reports required by the standards and immediately document verbal reports. Inmates that were randomly interviewed were aware of their ability to make reports to staff and were confident that action would be taken on said reports. Randomly interviewed inmates were also aware of the ability of family members or other third parties to make reports on their behalf consistent with provision (c) of this standard.

Agency policy PD 03.03.140, the *PREA Manual* and *Module 2* of the PREA training educates staff on their reporting options. These materials were reviewed by this auditor. Staff may make a private report to a supervisor, via the hot-line and via the agency's website reporting form. The agency provides multiple methods for staff to make private reports of sexual abuse and harassment of inmates. While policy and training materials provide multiple options for private reports, most staff reported during formal and informal interviews that they were comfortable making reports directly to through the chain of command, to the facility Inspector/Investigator, PREA Coordinator or agency PREA Administrator.

The MTF provided a memorandum from a staff member reporting suspicion of PREA activity to supervisory staff and an Inspector/Investigator, and a subsequent email validating follow-up action. Random interviews of staff confirmed they were aware of private means to report and identified the hot-line, direct reports to the Inspector/Investigator, PREA Coordinator at the facility or the PREA Administrator in Lansing as their methods to privately report sexual abuse and harassment of inmates consistent with provision (d) of this standard.

Standard 115.52 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.

The agency utilizes administrative procedures to address sexual abuse and is not exempt as specified in provision (a) of this standard.

Director's Office Memorandum 2016 – 29, dated April 27, 2016, which was reviewed by this auditor in determining compliance with provision (b), allows for an inmate's grievance (form *CAJ-1038A*) to be submitted at any time to the facility PREA Coordinator or Inspector. Inmates are not required to informally resolve the alleged incident prior to filing a PREA grievance. The PREA grievance will address the elements of the grievance dealing with sexual abuse; however, will require the inmate to resubmit non-PREA related items in accordance with policy PD 03.02.130 *Prisoner/Parolee Grievances*. This auditor notes that the Director's Office Memorandum was issued to supplement existing grievance policy PD 03.02.130, which has not been updated to contain language consistent with provision (b) of this standard.

Director's Office Memorandum 2016 – 29, dated April 27, 2016, which was reviewed by this auditor in determining compliance with provision (c), allows for an inmate's grievance (form *CAJ-1038A*) to be submitted to the facility PREA Coordinator or the facility Inspector. The *DOM* specifies that the grievances will not be referred to the staff member subject to the complaint within. The *Prisoner Guidebook* and the grievance policy, PD 03.02.130, do not contain language specific to provision (c) of this standard. The *DOM* supersedes these documents and establishes procedure until said policies can be revised or updated to reflect standard requirements. Grievances may also be submitted in locked boxes throughout the facility. The facility provided pre-audit sample documentation of investigations that were initiated by inmate grievance forms. A review of the subsequent investigations reveals that the grievances were investigated by the facility's Inspector/Investigator.

Director's Office Memorandum 2016 – 29, dated April 27, 2016, which was reviewed by this auditor in determining compliance with provision (d), states the PREA coordinator or inspector shall ensure a written response is provided to the prisoner within 60 calendar days of receipt of the Step I PREA grievance (form *CAJ-1038A*) unless an extension has been approved by the Internal Affairs Division in order to conduct an appropriate investigation. An extension of up to 70 calendar days may be approved by Internal Affairs if 60 calendar days is insufficient to make an appropriate decision. The prisoner shall be informed in writing of any extension and provided a date by which a decision will be made. If no response was received, the prisoner shall submit the appeal within 10 calendar days after the date the response was due, including any extension. A final agency determination on the merits of a PREA grievance shall be provided by the PREA Administrator within 90 calendar days from the original filing of the grievance. Computation of the 90 days does not include the 10 days allowed for the prisoner to file an administrative appeal.

On the PAQ, the facility reports that six (6) grievances alleging sexual abuse were received during the audit period. The facility provided pre-audit sample documentation to confirm that they provided responses to grievances with notice of investigation within two weeks. This auditor observed the responses to the inmates who alleged sexual abuse via grievance within the proper timeframes (generally within 30 days) by review of investigations. It was noted that the final agency decision responses to the inmates were not provided through the grievance process, they were consistently observed to be provided through notification of the investigation outcome.

A review of the agency *DOM* and facility investigations demonstrates that facility practice is in compliance with provision (d) of this standard.

The *DOM*, which was reviewed by this auditor in determining compliance with provision (e) of this standard, permits that third parties, including fellow prisoners, staff members, family members, attorneys, and outside advocates, may file a PREA grievance (form *CAJ-1038A*) on behalf of a prisoner. A third party may also assist a prisoner in filing the prisoner's PREA grievance in accordance with policy. If a third party files a PREA grievance on behalf of a prisoner, the prisoner must sign the PREA grievance in the area provided indicating the prisoner authorizes the grievance to be filed on his/her behalf for the grievance to be processed. If the prisoner refuses to sign, the PREA grievance shall be immediately dismissed. All Department responses to a PREA grievance filed by a third party will be provided only to the prisoner on whose behalf the grievance was filed. PREA grievance form *CAJ-1038A* has a section to identify if the grievance is submitted via third party and if the victim consents to the filing of the grievance on their behalf. If consent is not given, the grievance is denied and documented. The facility provided a pre-audit memorandum to confirm that the facility did not receive a third-party grievance during the audit period. A review of investigations confirms this. Through review of the *DOM* and agency documentation, this auditor is

satisfied that the agency and facility have adequate procedures in place to ensure compliance with provision (e) of this standard.

The *DOM*, which was reviewed by this auditor in determining compliance with provision (f), establishes procedure for the processing of any emergency grievance in accordance with this standard's requirements. The *DOM* states a prisoner or a third party may file an emergency PREA grievance if s/he believes that the prisoner is subject to substantial risk of imminent sexual abuse. The Prison Rape Elimination Act (PREA) Prisoner Grievance Form (STEP I) (*CAJ-1038A*) must clearly indicate that the grievance is an emergency PREA grievance and the nature of the risk. Upon receipt of an emergency PREA grievance, the receiving staff member shall immediately forward the emergency PREA grievance, or any portion of the emergency PREA grievance that alleges the substantial risk of imminent sexual abuse, to the warden. The warden shall take immediate action to remove the prisoner from any identified real or potential harm and ensure an initial response is provided to the prisoner within 48 hours. A final agency decision from the PREA Administrator regarding whether the prisoner is in substantial risk of imminent sexual abuse shall be provided to the prisoner within five calendar days. The initial response and final agency decision shall document the agency's determination of whether the prisoner was in substantial risk of imminent sexual abuse and the action taken in response to the emergency PREA grievance. The *DOM* establishes procedure for the processing of any emergency grievance in accordance with the requirements of provision (f) of this standard.

Through the PAQ and interviews with the facility PREA Coordinator, the facility claims that only one emergency grievance has been filed by an inmate during the audit review period. This auditor reviewed the pre-audit sample documentation and confirmed that one emergency grievance (form *CAJ-1038A*) was submitted on June 22, 2016, specifically, investigation #17953. The subsequent documentation related to this grievance does not indicate a date that the response was provided or that action was taken until a *Request for Investigation* form was submitted on June 28, 2016, approximately 96 hours after the *CAJ-1038A* was submitted. The *Request for Investigation* form is incomplete and does not indicate an authorization to investigate date. The *Emergency PREA Grievance Initial Response* form associated with this grievance indicates a date that it was completed to be provided to the grievant on December 5, 2016, over five (5) months after the grievance was submitted. The dates indicated on the emergency grievance sample for the MTF do not validate the requirements of an initial response provided within 48 hours and a final response within five days required under provision (f) of this standard.

Pre-audit documentation that was provided by the MTF supports that only one emergency grievance was filed (#17953). No documentation supports that the grievant received a notice of investigation and monitoring. However, this auditor notes that the *Emergency PREA Grievance Initial Response* form lacks specific actions taken by the facility. Specifically, the initial response form only states that the Warden has determined you are not at risk as you have indicated, with no date indicated of this determination. The pre-audit sample confirms that final agency determinations were provided well outside of the five calendar-day requirement of this standard. The auditor notes that is only one occurrence; however, this is reportedly the only one emergency grievance submitted within this audit period by which to gauge and determine the facility's compliance with implementation of this standard.

Agency policy PD 03.03.140, PD Attachment 03.03.105B, and the *Prisoner Guidebook*, which were reviewed by this auditor in determining compliance with provision (g) of this standard, direct that if a prisoner intentionally files a PREA grievance which is investigated and determined to be unfounded and which, if proven true, may have caused an employee or a prisoner to be disciplined or an employee to receive corrective action, the prisoner may be issued a misconduct report if approved by the warden. The *DOM 2016 – 29* directs that staff shall not retaliate against a prisoner for using the PREA grievance process. The MTF provided pre-audit memorandum to confirm that no inmate had filed a PREA grievance that resulted in discipline; therefore, no records are available to review to demonstrate compliance or non-compliance with provision (g) of this standard, this auditor determines compliance.

Corrective Actions Taken:

During the 180 day corrective action period, the facility was unable to provide any samples of emergency grievance submissions. The agency had proactively conducted additional training with the PREA Coordinators on November 10, 2016 including the proper procedures for an emergency grievance. The *Director's Office Memorandum (DOM) 2016 – 29*, dated April 27, 2016, which was reviewed by this auditor in determining compliance with the provisions of 115.52 coupled with the

additional training conducted on November 10, 2016 will be accepted to supplant the absence of any tangible emergency grievance samples during the corrective action period. This auditor is satisfied that the DOM provides adequate written direction, and the additional training should mitigate the initial audit observation, to demonstrate compliance with all provisions of 115.52.

Standard 115.53 Inmate 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.

Through interviews with the PREA Administrator and the facility PREA Coordinator, it was determined by this auditor that the agency and facility work collaboratively to establish relationships with outside support services. Documented attempts to reach an agreement with the Detroit Rescue Mission Ministries at the agency level and the Muskegon County Sheriff were provided and reviewed by this auditor in determining compliance with provision (a) of this standard. Additionally, this auditor reviewed a facility memorandum that describes advocacy services that are available through the facility's outside medical provider, Mercy Hospital. According to the memorandum, with proper notification, the hospital can provide a victim advocate to accompany the victim through the forensic examination process. The auditor called Mercy Hospital and confirmed with the Emergency Room charge nurse that the hospital receives inmates from the MTF for the purposes of conducting forensic examinations and the hospital provides a social worker to act as an advocate. The social worker will make applicable referrals for follow-up care; however, does not provide ongoing services once the inmate victim departs from the hospital. The facility has not been able to provide proof that it secured an agreement with victim advocacy services from an outside agency; however, has documented its attempts to do so, consistent with provision (a) of this standard.

While no formal agreement has been reached nor is in place, the facility and the agency maintain a copy of the "*An End to Silence*" handbook published by the PREA Resource Center. This book is maintained in the facility library and is accessible to inmates. Neither the agency nor the facility house civil immigration detainees; therefore, resources under this element of provision (a) are not applicable. The facility is determined compliant with the language within provision (a) of the standard by its provision of the An End to Silence resource guide in the absence of a formal agreement with advocacy services.

Agency policies PD 05.03.118 *Prisoner Mail*, PD 05.03.130 *Prisoner Telephone Use*, the *PREA Manual* and the *Prisoner Guidebook*, which were reviewed by this auditor in determining compliance with provision (b) of this standard, adequately inform inmates of how communications are monitored and which lines of communication are unmonitored for confidentiality purposes.

Through discussion and interview with the Regional PREA Analyst and the PREA Coordinator for the MTF, it was determined by this auditor that the agency and facility work collaboratively to establish relationships with outside support services. Documented attempts to reach an agreement with the Detroit Rescue Mission Ministries at the agency level and the Muskegon County Sheriff were provided and reviewed by this auditor in determining compliance with provision (c) of this standard. Additionally, this auditor reviewed a facility memorandum that describes advocacy services that are available through the facility's outside medical provider, Mercy Hospital. According to the memorandum, with proper notification, the hospital can provide a victim advocate to accompany the victim through the forensic examination process. The auditor called Mercy Hospital and confirmed with the Emergency Room charge nurse that the hospital receives inmates from the MTF for the purposes of conducting forensic examinations and the hospital provides a social worker to act as an advocate. The social

worker will make applicable referrals for follow-up care; however, does not provide ongoing services once the inmate victim departs from the hospital. The facility has not been able to provide proof that it secured an agreement with victim advocacy services from an outside agency; however, has documented its attempts to do so, consistent with provision (c) of this standard. The facility also provides access to *An End to Silence* for state organizational contact information within the facility library.

Standard 115.54 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.

Through a review of *DOM 2016 – 29* (regarding prisoner PREA related grievances), the Ombudsman MOU, the Sexual Abuse reporting poster, and the online reporting form; this auditor is satisfied that the agency and the facility permit third-party reports of sexual abuse and sexual harassment via all methods that are accessible to an inmate directly reporting sexual abuse and sexual harassment, with the additional option of utilizing the agency's website to make a report. The MTF provided a memorandum that stated the facility did not receive any third-party reports of prisoner sexual abuse or sexual harassment during this audit period. Third-parties may use the internal kite system, call the reporting hot-line, contact the Legislative Ombudsman, access the agency's on-line reporting form, contact facility staff directly and file PREA grievances. Based on a review of the aforementioned, compliance with provision (a) of this standard was determined.

Standard 115.61 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 PD 03.03.140, the *PREA Manual* and work rules published within the *Employee Handbook*, which were reviewed by this auditor, confirm that staff are required to report all elements denoted within provision (a) of this standard. Local procedure OP-MTF 03.03.140 dictates that staff at the MTF are responsible for making reports to their immediate supervisor. The MTF provided pre-audit samples of documented staff reports to supervisors and investigative staff. Formal and informal interviews during the audit tour indicate that staff are aware of their need to take immediate action with any reports of sexual abuse, sexual harassment or retaliation that comes to their attention, complaint with provision (a) of this standard.

Agency policy PD 03.03.140, local procedure OP-MTF 03.03.140 and the *PREA Manual*, which were reviewed by this auditor, contain distinct prohibitions against sharing any information received from a sexual abuse report, consistent with provision

(b) of this standard. The only acceptable disclosures are relative to investigative, treatment, security and management decisions. Agency policy and random interviews with selected staff confirm that individuals within the facility are aware of their obligations to protect the confidentiality of the information they obtained from a report of sexual abuse to demonstrate compliance with provision (b) of this standard.

Agency policy PD 03.03.140, local procedure OP-MTF 03.03.140 and the *PREA Manual*, which were reviewed by this auditor, clearly require medical and mental health care staff to report any knowledge of sexual abuse within an institutional setting. Clinicians are required to disclose their duties to report. Through formal and informal interviews with medical and mental health care staff, both classes of staff affirmed their obligation to disclose their limits of confidentiality before each encounter and both articulated their obligations to convey any reports of facility based sexual abuse consistent with provision (c) of this standard to demonstrate compliance.

Agency policy PD 03.03.140 and the *PREA Manual*, which were reviewed by this auditor, require the facility staff to report any allegation involving a victim under the age of 18 to the agency PREA Administrator for forwarding to the proper state authorities under mandatory reporting laws. The facility does not house inmates under the age of 18 and has not had to make such reports during the audit period identified by provision (d) of this standard.

The Warden stated in an interview that juvenile inmates are not housed at this facility and there has been no experience reporting such an allegation. The agency PREA Administrator confirmed in an interview with PREA Auditor Radziewicz that mandatory reports are forwarded to his attention and he is responsible for making the report to the mandated agency.

Through agency policy and interviews with the PREA Administrator, the agency has sufficiently demonstrated that it has procedures in place for making necessary mandatory reports in compliance with provision (d) of this standard. Such reports have not come from the MTF; however, the agency has experience forwarding such reports to applicable state agencies.

Agency policy PD 03.03.140, *DOM 2016 – 29* and the *PREA Manual*, which were reviewed by this auditor in determining compliance with provision (e) of this standard, direct that all reports of sexual abuse and sexual harassment are brought to the attention of the appropriate supervisory staff and subsequently referred for investigation. A review of investigation files by this auditor confirms that the practice of referral is carried out within the facility, with examples of written and verbal allegations that were immediately forwarded to the attention of investigatory staff. An interview with the Warden confirms that investigations are conducted for all reports of sexual abuse and sexual harassment, regardless of how they were reported. The MTF provided pre-audit memorandum to confirm that no third-party or anonymous reports have been received during this audit period; therefore, no records are available to review to demonstrate compliance or non-compliance with provision (e) of this standard. Based on the review of policy, the *PREA Manual*, investigation files, and interview with the Warden, this auditor determines compliance with provision (e) of this standard.

Standard 115.62 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.

Agency policy PD 05.01.140 and the *PREA Manual*, which were reviewed by this auditor in determining compliance with the provision of this standard, state whenever a prisoner is subject to imminent risk of sexual abuse or is the alleged victim of

sexual abuse, the facility shall take immediate action to protect the prisoner by preventing contact between the alleged abuser and alleged victim. Action to protect the prisoner may include, but is not limited to, changes in housing units and/or assignments, transfers, and stop orders.

The agency head's designee confirms that action is taken immediately by the facility to protect inmates. The facility head is required to review the actions within 48 hours to ensure appropriate measures have been taken to protect potential victims. An interview with the Warden confirms that the facility takes immediate action on a case-by-case basis to determine what measures are required to ensure the safety of each inmate. All random staff interviewed recognized their need to take immediate action to protect inmates from victimization.

The MTF provided a memorandum in the pre-audit materials that states the facility did not receive any reports of a prisoner being found to be subject to a substantial risk of imminent sexual abuse during this audit period. However, this auditor observed sample documents related to staff reports provided under §115.61(a) of the pre-audit materials that validated inmates have been moved from units to separate alleged victims and abusers. Provided that the agency policy requires action to protect and materials validating that these actions do occur, this auditor determines compliance with the provision of this standard.

Standard 115.63 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.

Agency policy PD 03.03.140, local procedure OP-MTF 03.03.140 and the *PREA Manual*, which were reviewed by this auditor, establish procedures for notifying other facilities of allegations of sexual abuse that did not occur in the receiving institution. This auditor observed that PD 03.03.140, V. specifies that allegations must be forwarded from the Warden (facility head); however, it does not specify the report of allegations must be made to the head of the facility where the alleged abuse occurred. Furthermore, this policy directs that the PREA Administrator shall notify for allegations outside the Department, which does not comply with the facility head requirement of provision (a) of this standard. The two (2) examples provided by the facility of reports received from other confinement facilities were not forwarded by the Warden, for a determination of non-compliance with provision (a) of this standard.

Agency policy PD 03.03.140, local procedure OP-MTF 03.03.140 and the *PREA Manual*, which were reviewed by this auditor, establish procedures for notifying other facilities of allegations of sexual abuse that did not occur in the receiving institution within 72 hours. The two (2) examples of such reports within the audit period, that were reviewed by this auditor in determining compliance with provision (b) of this standard, were both forwarded within approximately 72 hours of the date the allegations were received/reviewed by staff.

Agency policy PD 03.03.140, local procedure OP-MTF 03.03.140 and the *PREA Manual*, which were reviewed by this auditor, require that such notifications are made within 72 hours. Both facility examples reviewed by this auditor were reportedly forwarded within approximately 72 hours of the date the allegations were received/reviewed by staff. Both examples contained the email trail to verify the time frame of notification. This auditor determined that emails with date and time were sufficient to demonstrate compliance with provision (c) of this standard.

Agency policy PD 03.03.140 and the *PREA Manual*, which were reviewed in determining compliance with provision (d) of this standard, establish procedures for ensuring that any allegations received from other confinement facilities are investigated. The facility receiving the allegation must ensure the allegation was not previously investigated. If the allegation was not investigated, the facility shall conduct an investigation of the allegations. Both the agency head's designee and the Warden confirm that allegations received from other confinement facilities are properly investigated. The facility reports on the PAQ, that it received two (2) notices of sexual abuse from other facilities during this adit period. Through interviews with the agency head's designee, the Warden and the facility PREA Coordinator, this auditor is satisfied that sufficient procedures are in place to address allegations consistent with provision (d) of this standard should they be reported.

Corrective Actions Taken:

The agency revised its PREA related policy PD 03.03.140. This auditor was provided a copy of this revised policy on March 15, 2017 for review and noted that Section X specifically addresses the need for the Warden to forward all allegations to the facility head or office of the agency where the allegation is alleged to have occurred when the allegation pertains to a non-MDOC facility. This policy became effective on April 24, 2017 and now satisfies the requirements of provision (a) of the standard. The facility PREA Coordinator provided this auditor with a sample of this notification from

Standard 115.64 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.

The *PREA Manual* and the *PREA Pocket Guide*, which were reviewed by this auditor, require the first responding security staff member to take the four actions specified by provision (a) of this standard to ensure the safety of the victim and preservation of any forensic evidence should the allegation have taken place within a period of time for the collection of such evidence from the victim and the abuser.

An interview with a first responder indicated that as soon as an allegation is known, immediate action is taken to separate the alleged victim and abuser, as well as to inform them not to take any actions that could destroy evidence, such as washing or changing clothes. Any clothing that is collected should be placed into a paper bag. A medical assessment follows, where it is determined if a forensic examination is necessary. If there is an allegation that is reported to have taken place in a cube, that area would be secured. An interview with an inmate who reported sexual abuse confirmed that staff acted promptly and separation took place. The inmate's reported allegation involve sexual contact was outside of the time period for the collection of forensic evidence by examination.

It is noted that the facility's statistical responses to the PAQ were inconsistent; however, through communication with the Regional PREA Analyst the statistics were clarified and corrected there were 24 total allegations, of which 10 were for sexual abuse and 14 were for sexual harassment. Based on a formal interview with a first responder, a review of policies and informal interviews with staff during the audit tour, this auditor was satisfied that the MTF staff are well aware of their first responder obligations under provision (a) of this standard and has executed these obligations when necessary.

The *PREA Manual*, which was reviewed by this auditor, requires that a non-custody first responder staff immediately notify a supervisor in their chain of command for a referral to the facility Inspector. Non-custody staff are directed to request that the

alleged victim not take any actions that could destroy physical evidence. According to the PAQ there were three (3) non-custody first responders during the audit period, of which, sample documentation did not support the request that the victim not take any actions that could destroy physical evidence. However, this auditor noted that these samples included a 23 year-old allegation, and there were no allegations of penetration. During the audit tour, staff were informally interviewed and demonstrated that they were well aware of their responsibilities to request that the alleged victim not take any actions that could destroy physical evidence to demonstrate compliance with provision (b) of this standard.

Standard 115.65 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 has developed its own local procedures OP-MTF 03.03.140 from the agency policy PD 03.03.140 and the PREA Manual, which was reviewed by this auditor, describes the procedures employed by the facility when responding to allegations of sexual abuse among supervisory, investigative staff and facility leadership. An interview with the Warden outlined the facility's coordination among first responders, medical staff, investigators and the review team to process an allegation from start to finish, allowing the auditor to find compliance with provision (a) of this standard.

Standard 115.66 Preservation of ability to protect inmates 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.

The MDOC's *PREA Manual*'s language, which was reviewed by this auditor, mirrors the language of provision (a) of this standard. A review of the seven collective bargaining agreements entered into on behalf of the agency since the effective date of the PREA standards, includes agreements with the Michigan State Employee's Association (MSEA), American Federation of State, County, Municipal Employees (AFSCME), Michigan Corrections Organization (MCO), Service Employee's International Union (SEIU)-Scientific and Engineering Bargaining Unit, Service Employee's International Union (SEIU)-Technical Bargaining Unit, Service Employee's International Union (SEIU)-Human Services Support Bargaining Unit and United Auto Workers (UAW)-Administrative Support Unit and Human Services Unit. This auditor was satisfied that all agreements preserve the ability of the employer to remove alleged staff abusers from contact with inmates, consistent with provision (a) of this standard. Specifically, when warranted, the employer may take actions that include suspension of an employee during the course of an investigation. This suspension may continue until the time where disciplinary actions are determined.

An interview with the agency head's designee confirms that the agency maintains the right to assign staff, even in the case of such employee winning a bid position. There are no terms within the bargaining contracts that prevent the employer from removing staff for cause during an investigation to demonstrate compliance with provision (a) of this standard.

The auditor is not required to audit provision (b) of this standard to determine facility compliance.

Standard 115.67 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.

Agency policy PD 03.03.140, local procedure OP-MTF 03.03.140 and the *PREA Manual*, which were reviewed by this auditor in determining compliance with provision (a) of this standard, articulate that both staff and inmates who cooperate with sexual abuse and sexual harassment investigations shall be protected from retaliation. The agency designates that Supervisory staff, other than the direct supervisor, shall monitor for retaliatory performance reviews, reassignments and other retaliatory action not substantiated as legitimate discipline or performance matter for staff. Supervisory staff shall also monitor for disciplinary sanctions, housing/program changes and also conduct periodic status checks for prisoners who report or have reported alleged victimization. At the MTF, the Resident Unit Manager (RUM), Assistant Resident Unit Manager (ARUS) or Prison Counselor (PC) are responsible for inmate retaliation monitoring. Staff retaliation monitoring may also be conducted by the PREA Coordinator or Inspector/Investigator. The agency utilizes form *CAJ-1022*, *Sexual Abuse Retaliation Monitoring*, to document and track retaliation monitoring activities. This auditor reviewed sample CAJ-1022 documentation provided pre-audit by the MTF. The aforementioned allow this auditor to determine compliance with provision (a) of this standard.

Through interviews with the agency head's designee, the PREA Administrator, the PREA Coordinator and the Warden of the facility, it was determined that both the agency and the facility employ multiple measures to ensure that inmates and staff who report sexual abuse and sexual harassment or cooperate with investigations into such actions are protected from retaliation consistent with provision (b) of this standard.

Through a review of facility investigations, the MTF demonstrated the use of STOP orders against staff who were alleged to have committed acts of sexual abuse, housing unit transfers, and facility transfers. The agency and the facility demonstrate that it takes immediate action to ensure protections against retaliation are put into place.

Agency policy PD 03.03.140 and the *PREA Manual*, which were reviewed by this auditor in determining compliance with provision (c), articulate that both staff and inmates who cooperate with sexual abuse and sexual harassment investigations shall be protected from retaliation from staff and inmates. The *PREA Manual* states that individuals who report sexual abuse are monitored for at least 90 days. The agency and the facility monitor for 90 days unless the allegation is unfounded, at which time, retaliation monitoring would cease. In the event retaliation is observed, policies ensure that it is remedied promptly and that monitoring can be extended beyond 90 calendar days if necessary. An interview with the Warden and staff charged with retaliation monitoring confirm that if retaliation is noticed, it is referred for investigation.

The facility reported no instances of retaliation during the audit period on the PAQ. Investigatory files were reviewed and it was observed that most investigations included appropriate retaliation monitoring consistent with this standard. The agency

policy, *PREA Manual*, interviews and review of retaliation monitoring documentation are indicative of substantial compliance with provision (c) of this standard.

The *PREA Manual*, which was reviewed by this auditor in determining compliance with provision (d), directs that prisoners who report sexual abuse or have been an alleged victim of a report of sexual abuse shall also have supervisory staff monitor retaliation by conducting periodic status checks. Staff responsible for retaliation monitoring stated in an interview that the monitoring takes place for 90 days and considers a wide array of factors, such as work assignment changes and discipline. Monitoring is conducted by a review of these activities and face-to-face meetings, consistent with provision (d) of this standard.

The *PREA Manual*, which was reviewed by this auditor, specifies that if any other individual who cooperates with an investigation expresses a fear of retaliation, the Department shall take appropriate measures to protect that individual against retaliation, including 90 calendar day retaliation monitoring if deemed necessary. The MTF provided a memorandum in the pre-audit materials for this audit period that states the facility has not conducted retaliation monitoring on any individual other than the victim or complainant as no one else has expressed a fear of retaliation. The agency head's designee and the Warden both confirm in interviews that allegations of retaliation are taken seriously and investigated when reported by anybody who cooperates with sexual abuse and sexual harassment allegations to determine compliance with provision (e) of this standard.

The *PREA Manual*, which was reviewed by this auditor, confirms that retaliation monitoring ceases when an allegation is unfounded and one instance was observed through facility investigations where monitoring concluded after the allegation was determined to be unfounded consistent with provision (f) of this standard.

Standard 115.68 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.

The facility reports to this auditor through a memorandum and through an interview with the PREA Coordinator that the MTF does not have a segregation housing unit available on facility grounds and no inmates who alleged to have suffered sexual abuse have been placed into segregation for protection, therefore, there are no records to review to demonstrate compliance or non-compliance with the provisions of this standard or § 115.43, this auditor determines compliance.

Standard 115.71 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.

Agency policy PD 03.03.140, the *PREA Manual* and the *Sexual Violence Response and Investigation Guide*, which were reviewed by this auditor in determining compliance with provision (a), state that when receiving an allegation of sexual abuse or sexual harassment, as described in the definitions of this manual, whether reported verbally or in writing, shall be investigated. Staff shall ensure all allegations are referred to the appropriate law enforcement agency in accordance with policy and law for criminal investigation in conjunction with the Department's administrative investigation. Referrals to law enforcement shall be documented in the Department's investigative report, PREA investigation worksheet(s) and pertinent computerized database entry(ies). A Warden's or Administrator's designee will refer the allegation no later than 72 hours after the report was made to the Internal Affairs Division by creating the Allegations Investigation Personnel Action System (AIPAS) entry for each alleged incident. Agency policy requires that all reports, regardless of their source of origination, be taken and referred for investigation.

An interview with a facility Inspector/Investigator stated that investigations are initiated within 72 hours of report. All reports of sexual abuse and sexual harassment, including anonymous or third party reports are investigated in the same manner as those allegations that have been directly reported by an alleged victim. A review of investigatory files demonstrates that the facility responds promptly to allegations and initiates investigations after an allegation is made. Based on the review of policy and investigatory files, and interview with the facility Inspector/Investigator this auditor determines compliance with provision (a) of this standard.

Agency policy PD 03.03.140 and the *PREA Manual*, which were reviewed by this auditor, requires that Department investigators receive specialized training from the Training Division to be able to conduct sexual abuse investigations in confinement settings. Specialized training shall include techniques for interviewing sexual abuse victims, proper use of Miranda and Garrity warnings, sexual abuse evidence collection in confinement settings, and the criteria and evidence required to substantiate a case for administrative action or prosecution referral.

The MTF provided records, reviewed by this auditor in determining compliance with provision (b) of this standard, to demonstrate that it has eleven (11) current investigators on staff who completed the MDOC's Basic Investigator's Training course. Seven (7) of these investigators also completed the NIC Specialized Investigator's course.

An interview with a facility Inspector/Investigator demonstrated a great degree of professionalism and knowledge of investigatory procedures consistent with the training provided by the agency and provision (b) of the standard.

Agency policy PD 03.03.140, the *PREA Manual* and the MDOC's *Basic Investigator* training, which were reviewed by this auditor in determining compliance with provision (c), provide sufficient background training to enable investigators to fulfill the elements set forth within the standards.

Through an interview with the PREA Coordinator and a review of investigations, the MTF has not had a report of sexual abuse where there was the opportunity to still collect forensic evidence. The facility demonstrates that it makes its best efforts to preserve evidence, whether that be in the form of video, shift rosters, log books, etc. supporting a determination of compliance with provision (c) of this standard.

Basic Investigator training and the *PREA Manual*, which were reviewed by this auditor in determining compliance with provision (d), specify that when the evidence appears to support criminal prosecution, the assigned investigator shall coordinate interviews with law enforcement to avoid obstacles to subsequent criminal prosecution. In a review of investigations, there was no evidence of compelled interviews. The PAQ indicates that four (4) investigations were referred for prosecution during this audit period. This auditor finds compliance with provision (d) of this standard.

The *PREA Manual*, which was reviewed by this auditor, states that an alleged victim's credibility will be assessed on an individual basis and not determined by the person's status as an inmate or staff member. An interview with a facility Inspector/Investigator confirmed that he would treat every situation individualized, and that staff do not have any more credibility that an inmate. Through review of the *PREA Manual* and interview with the Inspector/Investigator it was observed that truth-telling devices are prohibited from use in the investigatory process. An inmate who reported sexual abuse confirmed that he was not subjected to any truth-telling device to allow this auditor to find compliance with provision (e) of this standard.

A review of the *PREA Manual* and sample investigations indicate that staff actions are considered during the course of investigations where applicable in compliance with provision (f) of this standard. Reports are formatted to outline both physical and testimonial evidence, credibility assessments and investigative facts. Supporting documentation is also referenced that either proves or disproves the investigative outcome. An interview with a facility Inspector/Investigator confirms that staff acts are considered and investigative reports documenting investigatory activities that support a conclusion are generated. This auditor finds compliance with provision (f) based on the agency *PREA Manual* requirements and review of the investigations that the facility has conducted.

The MTF reports in a memorandum in the pre-audit materials that no criminal investigations were conducted during the audit period. However, the PAQ indicates that four (4) substantiated allegations of conduct that appeared to be criminal were referred for prosecution during the audit period. A review of facility investigations by this auditor confirms this report. According to discussion with the Regional PREA Analyst, the Michigan State Police conduct criminal investigations and there was a request that the agency comply with applicable PREA standards. It was reported that while the four (4) identified cases were referred by the facility appropriately, the MSP chose not to pursue criminal investigations for any of the cases. This auditor reviewed the *PREA Manual* which also requires that criminal investigative reports are generated to outline both physical and testimonial evidence, credibility assessments and investigative facts. No records of criminal investigations were available to review to demonstrate compliance or non-compliance with the provisions of this standard. Based on adequate policy and documentation to support the facility's referral to the MSP for criminal investigation, this auditor determines compliance with provision (g) of this standard.

This auditor reviewed agency policies PD 03.03.140 and the *PREA Manual*. The MTF reports in a memorandum in the pre-audit materials that no criminal investigations were conducted during the audit period. However, the PAQ indicates that four (4) substantiated allegations of conduct that appeared to be criminal were referred for prosecution during the audit period. A review of facility investigations by this auditor confirms this report. According to discussion with the Regional PREA Analyst, the Michigan State Police conduct criminal investigations and there was a request that the agency comply with applicable PREA standards. It was reported that while the four (4) identified cases were referred by the facility appropriately, the MSP chose not to pursue criminal investigations or prosecution for any of the cases. Following a review of policy, coupled with an interview with the PREA Coordinator and a facility Inspector/Investigator; this auditor is satisfied that the MTF has procedures in place to refer substantiated allegations of criminal conduct for prosecution consistent with provision (h) of this standard.

The *PREA Manual*, which was reviewed by this auditor, specifies that all investigative reports are retained for as long as the alleged abuser is incarcerated or employed by the Department plus an additional 5 years in compliance with provision (i) of this standard.

The *PREA Manual*, which was reviewed by the auditor in determining compliance with provision (j), specifies that investigations will continue despite the departure of any alleged victim or abuser. There were no examples of the facility terminating an investigation based on the departure of an alleged victim or abuser. During an interview with a facility Inspector/Investigator, the facility makes every effort to keep applicable parties at the facility until the investigation is complete; demonstrating compliance with provision (j) of this standard.

The auditor is not required to audit provision (k) of this standard to determine facility compliance.

Interviews with the Warden, PREA Coordinator, PREA Administrator and Inspector/Investigator support the fact that facility staff are required to comply with outside investigators and the facility Inspector is the responsible party for ensuring coordination with the MSP, allowing this auditor to find compliance with provision (l) of this standard.

Standard 115.72 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.

The *PREA Manual* and the *Basic Investigator Training Manual*, which were reviewed by this auditor in determining compliance with the provision of this standard, specify that the agency's standard of proof is to be the preponderance of the evidence. Through a review of investigations, this auditor observed evidence of substantial compliance with the provision of this standard.

Standard 115.73 Reporting to inmates

☐ 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 PD 03.03.140 and the *PREA Manual*, which were reviewed by this auditor, dictate that both the complainant and victim in alleged incidents of sexual abuse will be notified of the investigatory outcome. Both the Warden and facility Inspector/Investigator confirm that inmate victims are notified of the investigatory results. The MTF provided documentation of inmate notification in sampled investigations to demonstrate compliance with provision (a) of this standard. It was noted that the initial PAQ indicated an inaccurate number of investigations combining both the sexual abuse and sexual harassment investigations. Upon clarification during the onsite audit it was determined that the MTF substantially complied with notifying the alleged victim of the investigation results for determination to be substantiated, unsubstantiated, or unfounded.

Agency policy PD 03.03.140 and the *PREA Manual*, which were reviewed by this auditor, dictate that both the complainant and victim in alleged incidents of sexual abuse will be notified of the investigatory outcome. This auditor interviewed the PREA Coordinator at the facility and reviewed facility investigations to determine there were no investigations completed by an outside law enforcement entity during the review period. Adequate procedures are in place for compliance with provision (b) of this standard should an outside agency investigate an allegation at the MTF.

The *PREA Manual*, which was reviewed by this auditor in determining compliance with provision (c), indicates that both the complainant and victim in alleged incidents of sexual abuse will be notified of the investigatory outcome. The *PREA Manual* is found noncompliant with provision (c) of this standard. Specifically, the *PREA Manual* directs that notification of the factors enumerated in provision (c) of this standard are only provided for substantiated/sufficient evidence allegations that a staff

member sexually abused a prisoner, the omission of unsubstantiated/insufficient evidence cases is found to be in noncompliance with provisions of this standard. The facility's sampled investigations involving staff were classified as insufficient evidence/unsubstantiated and no evidence/unfounded. It is noted that supporting documentation validates the MTF substantially complies with provision (a) establishing notification to the inmate of the investigation outcomes; however, no supporting documentation validates the practice of notification for the factors enumerated in provision (c) of this standard for the unsubstantiated cases. The only sample observed (#16304) that substantiated staff over-familiarity (sexual nature) and unsubstantiated sexual abuse, was related to a contractor and no further disposition was tracked following the issuance of a STOP Order to prohibit the contractor from returning, as contractors are not considered employees.

The *PREA Manual*, which was reviewed by this auditor in determining compliance with provision (d), indicates that both the victim in alleged incidents of sexual abuse will be notified of criminal indictments and convictions. A review of facility investigations reveals that no outcomes included indictment or conviction on a charge of sexual abuse. It was identified that no referrals to the MSP have been pursued for criminal investigation during this audit period. Through a review of policy and examples of notification of administrative investigatory outcomes, this auditor is satisfied that the facility has adequate procedures in place to make such notifications to determine compliance with provision (d) of this standard.

This auditor notes that facility reported statistics on the PAQ are inaccurate. The facility provided documented notifications following sexual abuse investigations pursuant to this standard. The facility exceeds provision (e) of this standard by also providing documented notification of sexual harassment investigatory results. The MTF provided documentation of inmate notification in all sampled investigations to demonstrate compliance with provision (e) of this standard.

The *PREA Manual* specifies that an obligation to notify an inmate of investigatory results terminates if the inmate is discharged from the facility's custody, consistent with provision (f) of this standard.

Corrective Actions Taken:

The agency revised its PREA related policy 03.03.140. This auditor was provided a copy of this revised policy on 03/15/2017 for review and noted that Section VV specifically addresses the need to notify prisoners of the factors enumerated under provision (c) of the standard for all allegations unless the investigation determines the claim was unfounded. This policy became effective on 04/24/2017. This revision of agency policy satisfies compliance with this standard.

Standard 115.76 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.

Agency policies PD 02.03.100, PD Attachment 02.03.100A, PD 03.03.140, the *PREA Manual* and the *Employee Handbook* work rules were reviewed by this auditor in determining compliance with provision (a) of this standard. The agency clearly establishes through existing policies that staff are subject to disciplinary action, up to and including termination for violating agency sexual abuse and sexual harassment policies, in compliance with provision (a) of this standard.

The staff sanctioning matrix, PD Attachment 02.03.100A, provided to and reviewed by this auditor verifies that termination is the presumptive disciplinary action for staff who engage in sexual abuse in compliance with provision (b) of this standard. There have been no substantiated instances of sexual abuse within the audit period to confirm agency practice. Based on policy provisions, the facility demonstrates it is in compliance with provision (b) of this standard.

The *PREA Manual* and staff sanctioning matrix, PD Attachment 02.03.100A, verify that violations of sexual abuse and sexual harassment policies, other than engaging in sexual abuse, will be disciplined commensurate with the nature and circumstances of the acts, discipline history and comparable disciplinary actions consistent with provision (c) of this standard. According to PD 02.03.100A, the Chief Deputy Director is responsible in determining the sanctions for these violations. There were no official acts of discipline issued by the facility during the course of the audit period for violations of sexual abuse and sexual harassment policies to confirm agency practice with respect to provision (c) of this standard. Based on policy provisions, this auditor determines compliance with provision (c) of this standard.

Agency policies PD 02.03.100, PD Attachment 02.03.100A, PD 03.03.140, the *PREA Manual* and the *Employee Handbook* work rules establish that all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and to any relevant licensing bodies, consistent with provision (d) of this standard. A review of the facility's investigations revealed no substantiated allegations of sexual abuse or sexual harassment against a staff member. There were no terminations or resignations in lieu of termination to demonstrate facility practice with respect to provision (d) of this standard. Based on policy provisions, this auditor determines compliance with provision (d) of this standard.

Standard 115.77 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.

Agency policy PD 03.03.140 and the *PREA Manual*, which were reviewed by this auditor in determining compliance with provision (a) of this standard, both contractors and volunteers are held to the same standards as employees directly hired by the agency when it comes to disciplinary action for engaging in sexual abuse and sexual harassment. Therefore, any contractor or volunteer engaging in these behaviors would presumptively be terminated or barred from the facility. The *PREA Manual* contains specific language to provide consideration for terminating contracts and prohibiting further contact with inmates in the case of any other violation of Department sexual abuse and sexual harassment policies. Finally, the *PREA Manual* requires reporting of such conduct to law enforcement and relevant licensing bodies consistent with provision (a) of this standard. The MTF provided investigative documentation (#16304) including notification to MSP regarding a contractor where a determination was concluded that sufficient evidence of staff over-familiarity (sexual nature) existed. Based upon policy provisions, and support of the sample STOP Order provided, this auditor determines compliance with provision (a) of this standard.

The *PREA Manual* contains specific language to provide consideration for terminating contracts and prohibiting further contact with inmates in the case of any other violation of Department sexual abuse and sexual harassment policies, consistent with provision (b) of this standard. An interview with the Warden confirmed that any contractor or volunteer who violated sexual abuse or sexual harassment policies would be removed from the facility. There were no substantiated allegations of sexual abuse upon which to gauge facility practice; however, the facility did provide an example of its use of a STOP Order to bar a

contractor from entering the MTF while a sexual abuse investigation was ongoing. Based upon policy provisions, the demonstrated use of a STOP Order for a contractor while a sexual abuse investigation was underway and the Warden's interview, this auditor determines compliance with provision (b) of this standard.

Standard 115.78 Disciplinary sanctions for inmates

☐ 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 PD 03.03.105 and the *PREA Manual*, which were reviewed by this auditor in determining compliance with provision (a) of this standard, confirm that inmates are only subjected to disciplinary sanctions pursuant to a formal disciplinary process following an administrative or criminal finding that sexual abuse occurred. There were no substantiated allegations of sexual abuse upon which this auditor could gauge facility practice. Based upon policy requirements prior to the imposition of discipline, this auditor determines compliance with provision (a) of this standard.

Agency policy PD Attachment 03.03.105A and PD Attachment 03.03.105D, which were determined to establish a consistent sanctioning matrix for all substantiated allegations of sexual abuse and sexual harassment consistent with provision (b) of this standard. An interview with the Warden confirms that the facility Security Classification Committee and Hearing Officer would additionally consider programming needs or restrictions, mental health and the security level of the alleged abuser when applying sanctions. There were no substantiated allegations of sexual abuse upon which this auditor could gauge facility practice. Based upon the established sanctioning matrix relative to the imposition of discipline, this auditor determines compliance with provision (b) of this standard.

Agency policy PD 03.03.105 and the *PREA Manual*, which establish procedures for the consideration of mental disabilities and mental illness when considering the appropriate type of sanction to be imposed, were reviewed by this auditor to be consistent with provision (c) of this standard. An interview with the Warden confirms that facility Hearing Officer considers the mental status of an inmate when determining sanctions. There were no substantiated allegations of sexual abuse upon which this auditor could gauge facility practice. Based upon an interview with the Warden and the agency's policies for the consideration of mental health status prior to the imposition of discipline, this auditor determines compliance with provision (c) of this standard.

This auditor reviewed the agency *PREA Manual*, which directs that facilities offering relevant treatment modalities to address the underlying reasons or motivations for abuse, consider placing offending inmates into such programs. During an interview with facility mental health staff who would deliver any applicable sex offender treatment, the facility reports no direct experience placing inmates into programming for sexual offenders following a substantiated act of sexual abuse between inmates consistent with provision (d) of this standard. Facility mental health staff described an evaluation procedure that would be employed if an inmate were found to have engaged in sexual abuse. The evaluation procedures would consist of the administration of the MDOC's assessment tools (Static 99 and Stable) to determine any relevant treatment need. There were no substantiated allegations of sexual abuse upon which this auditor could gauge facility practice. Based upon an interview with facility mental health staff and policy requirements, this auditor determines compliance with provision (d) of this standard.

Agency policy PD 03.03.140, which was reviewed by this auditor, dictates that allegations of inmate sexual assaults against staff shall be reported to MSP for investigation and shall be subject to discipline in accordance with PD 03.03.105. The MTF reports that no inmates have been found guilty of sexually assaulting a staff member during this reporting period. Based on adequate policy requirements, this auditor determines compliance with provision (e) of this standard.

This auditor reviewed the *PREA Manual* when determining compliance with provision (f) of this standard. This document prohibits disciplinary action against an inmate for making a report in good faith based upon a reasonable belief that an alleged act occurred. A review of facility investigations demonstrate that inmates are not subjected to disciplinary action for making reports of sexual abuse that cannot be proven, allowing this auditor to find compliance with provision (f) of this standard.

Through a review of the *PREA Manual*, the *Prisoner Guidebook* and interviews with the PREA Administrator and PREA Coordinator, this auditor was informed that the agency prohibits sexual activity between all inmates. The *PREA Manual* indicates that inmates who engage in consensual sexual activity may be disciplined and sanctioned according to policy 03.03.105; however, the activity will not be considered sexual abuse unless it is determined that the sexual contact was the result of coerced consent or protective pairing. Based upon interviews and policy directives, this auditor determines compliance with provision (g) of this standard.

Standard 115.81 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.

Agency policies PD 03.04.140, PD 04.01.105, PD 04.06.180 and the *PREA Manual*, which were reviewed by this auditor in determining compliance with provision (a), combine to form the agency's approach to providing the required medical and mental health services for victims of sexual abuse. Through a review of policy and an interview conducted by PREA Auditor Radziewicz with the agency PREA Administrator, the agency screening procedures relative to § 115.41 indicate that a 72-hour, full intake screening instrument is completed at reception centers only. If sexual victimization is reported during that intake screening, medical and mental health services are offered at the reception facility.

Given that the 72-hour, full intake screening instrument is not replicated upon transfer and placement at subsequent MDOC facilities, such as the MTF, it stands to reason that no records would exist to measure compliance with this standard at the MTF for the predominate number of inmates transferred into the MTF. Although it is reported by the PREA Administrator that each inmate is provided medical and mental health examinations at the reception center to fulfill the obligations of this provision by default, theoretically, it is possible that an inmate could experience victimization at reception centers which may not be captured by the facility to which they are transferred. Additionally, those inmates who may temporarily move to other facilities, whether in the MDOC or outside of the MDOC for court purposes, could also experience victimization that could elude identification.

The facility was found to not meet compliance with standard § 115.41 based partly on its lack of a 72-hour intake assessment process for inter-facility transfers. Until intake screening procedures are established for inter-facility transfers within the agency; the agency and this facility cannot accurately document or report compliance with provision (a) of this standard.

Agency policies PD 03.04.140, PD 04.01.105, PD 04.06.180 and the *PREA Manual*, which were reviewed by this auditor to determine compliance with provision (b) of this standard, combine to form the agency's approach to providing the required medical and mental health services for perpetrators of sexual abuse. The agency screening procedures relative to § 115.41 indicate that a 72-hour, full intake screening instrument is completed at reception centers only. If sexual perpetration is reported during that intake screening, medical and mental health services are offered at the reception facility. Given that the 72-hour, full intake screening instrument is not replicated upon transfer and placement at subsequent MDOC facilities, such as the MTF, it stands to reason that no records exist to measure compliance with this standard at the MTF. Although each inmate is provided medical and mental health examinations at the reception center to fulfill the obligations of this provision by default, theoretically, it is possible that an inmate could perpetrate sexual abuse at reception centers or while temporarily out at other facilities for such matters as court, which may not be captured by the facility. Until intake screening procedures are established for inter-facility transfers within the agency; the agency and this facility cannot accurately document or report compliance with provision (b) of the standard.

The MTF operates under the definition of a prison; therefore, compliance for provision (c) is measured under provision (a) of this standard.

Agency policy PD 03.03.140 and the *PREA Manual*, which were reviewed by this auditor, as well as interviews with random staff, confirm that information pertaining to sexual victimization occurring in an institutional setting is treated confidentially. All staff who were either formally or informally interviewed during the audit tour were aware that information pertaining to sexual abuse is only shared with those who are required to know to inform security and management decisions in compliance with provision (d) of this standard.

This auditor reviewed agency policy PD 03.03.140 and the *PREA Manual* when determining compliance with provision (e) of this standard. These policies require any victimization that did not occur in an institutional setting to be accompanied by an informed consent prior to disclosure. Interviews with facility medical and mental health providers affirmed that the provider must obtain consent prior to disclosure of this information; additionally, sample documentation was provided as evidence in the pre-audit materials, allowing this auditor to determine compliance with provision (e) of this standard.

Corrective Action Taken:

On May 12, 2017, June 8, 2017 and July 11, 2017 the facility provided this auditor with secondary documentation to confirm that referrals were made for follow-up mental health/medical care of individuals who disclosed victimization or perpetration during the intake risk screening process required by standard 115.41. Secondary tracking logs indicated that multiple inmates reported victimization or documentation review verified a history of perpetration. The auditor requested random samples of referrals and progress notes for three inmates who made such reports during each of the months of April, May and June.

Based on evidence that intake risk screening procedures have been established as required under standard 115.41, the facility's secondary logs that document individuals who disclosed victimization or perpetration during said screenings, evidence of appropriate referrals to mental health care providers and secondary documentation that the referrals were acted upon; this auditor determines the facility has developed adequate procedures to ensure compliance with provisions (a) and (b) of the standard.

Standard 115.82 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.

This auditor reviewed agency policies PD 03.03.140, OP 03.04.100H, PD 03.04.125, PD 04.06.180 and the *PREA Manual*, which combine to form the agency's policy to ensure victims of sexual abuse are provided timely and unimpeded access to medical, mental health care and crisis intervention services at no expense. The standard of care is required to be consistent with community standards and is determined by the judgement of the practitioner. Interviews with mental health staff confirm that a response occurs within 24 hours of an allegation of sexual abuse and that services are delivered according to the clinical judgment of the practitioner. Medical staff confirmed that responses are conducted immediately and that services are delivered according to the clinical judgment of the practitioner, sample referrals were observed on CHX-212 forms, and most investigatory files reviewed included referral to medical or mental health services, or both, allowing this auditor to determine compliance with provision (a) of this standard.

The *PREA Manual*, which was reviewed by this auditor, contains language that mirrors the standard's language to demonstrate compliance with this provision (b) of this standard. Random staff interviews and informal interviews during the audit tour confirm that security staff are aware of their need to contact medical providers upon learning of a sexual abuse allegation, allowing this auditor to determine compliance with provision (b) of this standard.

The *PREA Manual*, which was reviewed by this auditor, contains language that mirrors the standard's language to demonstrate compliance with this provision (c) of this standard. Medical staff confirmed that responses are conducted immediately and that services are delivered according to the clinical judgment of the practitioner, sample referrals observed on CHX-212 forms, and a sample medical record validating the prescription of prophylaxis medication, allow this auditor to determine compliance with provision (c) of this standard.

This auditor reviewed agency policies PD 03.03.140 and the *PREA Manual*, which combine to form the agency's policy to ensure victims of sexual abuse are provided timely and unimpeded access to medical, mental health care and crisis intervention services at no expense. Based on policy provisions, this auditor determines compliance with provision (d) of this standard.

Standard 115.83 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.

This auditor reviewed agency policies PD 03.04.140, PD 03.04.125, PD 04.06.180, local procedure OP-MTF 03.03.140 and the *PREA Manual*, which combine to form the agency's approach to providing required medical and mental health services for victims of sexual abuse.

As cited under standard § 115.81, the facility does not conduct routine intake assessment procedures, consistent with § 115.41. Therefore, the facility does not have adequate procedures in place to be aware of all inmates qualifying for services

under provision (a) of this standard. Based on the cited examples, this auditor does not find that the MTF's procedures and practice adequately afford it the opportunity to identify all inmates who would require services consistent with compliance of provision (a) of this standard.

This auditor reviewed agency policies PD 03.04.100, PD 04.06.180, OP 03.04.100H and the *PREA Manual*, which combine to adequately outline the agency's approach to providing appropriate medical and mental health services to victims of sexual abuse. An interview with a facility medical provider confirmed that a physician would examine an alleged victim and make appropriate decisions to treat injuries, infections, sexually transmitted infections (STI), etc. An interview with facility mental health staff confirmed that an assessment of adjustment would be conducted and ongoing support would be provided to normalize the emotions the victim may be going through.

It is noted that the medical and mental health care providers articulate what is required by provision (b) of this standard and the facility is found to be compliant based upon the actions employed when such cases have been referred to medical and mental health staff's attention; however, as previously expressed under provision (a), the facility's referral process to ensure these initial evaluations are conducted is of concern.

Interviews with mental health staff confirm that services are delivered according to the clinical judgment of the practitioner. Medical staff confirmed that responses are conducted immediately and that services are delivered according to the clinical judgment of the practitioner. Medical and mental health staff confirmed that they are licensed professionals in their respective disciplines and their licensure requires that they deliver care that is consistent with care afforded in the community, allowing this auditor to determine compliance with provision (c) of this standard.

This auditor reviewed the *PREA Manual* which specifies that victims of vaginal penetration are offered pregnancy tests. If the test is positive, the victim will receive timely and comprehensive information and access to all lawful pregnancy related services. A review of investigations during the audit period reveal no applicable cases to provision (d) of this standard. The MTF is a facility designated for male inmates. Based on policy provisions, the facility is determined to be compliant with provision (d) of this standard.

This auditor reviewed the *PREA Manual* which specifies that victims of vaginal penetration are offered pregnancy tests. If the test is positive, the victim will receive timely and comprehensive information and access to all lawful pregnancy related services. A review of investigations during the audit period reveal no applicable cases to provision (e) of this standard. The MTF is a facility designated for male inmates. Based on policy provisions, the facility is determined to be compliant with provision (e) of this standard.

This auditor reviewed agency policy PD 03.04.100 and the *PREA Manual*, which state that victims of sexual abuse will be offered testing for sexually transmitted infections as medically appropriate with respect to provision (f) of this standard. This auditor observed a sample medical record validating the prescription of prophylaxis medication; however, as cited under provision (a) of this standard, the facility does not have adequate procedures in place to identify all inmates who would qualify for STI testing consistent with provision (f) of this standard.

This auditor reviewed agency policy PD 03.04.100 and the *PREA Manual*, which specify that treatment is provided to victims of sexual abuse, free of charge, regardless of their cooperation with any ensuing investigation. Based on policy provisions, this auditor determines compliance with provision (g) of this standard.

The *PREA Manual*, which was reviewed by this auditor, states that within 60 days of learning of prisoner on prisoner abuser, the facility mental health staff will conduct a mental health evaluation of the abuser's history and offer treatment as deemed appropriate. Mental health staff reported during an interview that evaluative procedures are in place to address known inmate-on-inmate abusers for applicable treatment modalities. There have been no instances at the MTF where an inmate was found or known to have engaged in sexual abuse of another inmate. Based on policy provisions, this auditor determines compliance with provision (h) of this standard.

Corrective Action Taken:

The MTF provided this auditor with sufficient evidence that it has established intake screening procedures as required by standard 115.41 to effectively identify those individuals potentially in need of medical or mental health evaluations as required by 115.81 and 115.83. Random sampling of the facility's secondary risk screening log verifies that the information contained within the log accurately recorded the dates of a full intake risk screening assessment. Through the intake risk screening process, the facility has identified multiple individuals who required mental health evaluations for past instances of victimization or perpetration. The auditor requested random samples of three inmates for each of the screening months of April, May and June to ensure individuals were evaluated consistent with the requirements of 115.81. Referral documentation and secondary progress notes were forwarded to the auditor on May 12, 2017, June 8, 2017 and July 11, 2017. Progress notes verify that individuals with a history of sexual victimization or perpetration were evaluated as required by 115.81. In review of the randomly sampled cases each was evaluated and either declined or was not in need of further services. Moreover, the MTF has also provided sufficient evidence to prove that it refers all known victims of sexual abuse to medical and mental health practitioners commensurate with the nature of the allegation, as required by 115.82. Therefore, the facility has now sufficiently demonstrated that it has established the practices necessary to identify those inmates in need of ongoing care as required by provisions (a) and (f) of the standard.

Based upon supporting documentation verifying access to ongoing medical and mental health care for known sexual abuse victims that is proportionate to the type of reported victimization, with care that is consistent with community standards, this auditor is satisfied that the facility has developed sufficient procedures to demonstrate its capability of substantial compliance with provisions (a) and (f) of the standard.

Standard 115.86 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.

This auditor reviewed the *PREA Manual*, which establishes the requirement that form CAJ-1025 be completed to document the Sexual Abuse Incident Review for allegations of sexual abuse that are substantiated or unsubstantiated. In a review of investigations that the MTF determined to be unsubstantiated, a sexual abuse incident review was completed to demonstrate compliance with provision (a) of this standard.

This auditor's review of relevant investigations determined that seven (7) of the 10 reported sexual abuse incident reviews had taken place within 30 days of the investigation's conclusion. The Regional PREA Analyst acknowledged key staff turnover at the MTF allegedly resulting in the delay of review for three of the investigations. Based on observed policy requirements and the substantial fulfillment of the 30-day review, this auditor finds compliance with provision (b) of this standard.

In a sampled incident review, this auditor notes that the facility did involve upper-level managers, investigators and line supervisors. A mental health manager or health services manager were not observed as part of the review team in samples reviewed by this auditor; however, the incident review staff interviewed during this audit acknowledged that input from the mental health and medical practitioners is considered. Interviews with the Warden and facility PREA Coordinator confirm that upper level managers are part of the review team and input is considered from multiple angles, to include medical and mental

health practitioners. Based on interviews and incident review documentation, this auditor finds compliance with provision (c) of this standard.

Agency form CAJ-1025, which was reviewed by this auditor, mirrors the standard language to confirm that the facility must consider the six factors required by provision (d) of this standard in order to complete the agency review form. A sampled review observed by this auditor validated that the facility made the determination to review the anatomy of staff meetings, additional cameras were identified, though noted as already planned for the area. Interviews with the Warden and facility PREA Coordinator confirms that the MTF's review team considers the six factors enumerated under provision (d) of this standard in its review process. Based on interviews and the sampled reviews, this auditor determines compliance with provision (d) of this standard.

As noted under provision (d) of this standard, the MTF made the determination that cameras were already planned for the area, following the incident review. During the onsite portion of the audit, this auditor observed recent expansion of the cameras in the food service area. Given the expansion of these cameras, this auditor is satisfied that the facility acted upon the recommended corrective action to demonstrate compliance with provision (e) of this standard.

Standard 115.87 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.

This standard was audited at the agency level; however, will be addressed in part within this report.

The *PREA Manual* states that the Department PREA Administrator gathers data on each reported incident to aggregate an annual incident report. Through an interview with the PREA Administrator, it was identified that all allegations are entered into the Department's investigative data base so that uniform data can be obtained. The agency has a standard definition of sexual abuse and sexual harassment contained within its PREA Manual that guides data collection consistent with provision (a) of this standard.

As noted within the agency audit, the agency prepares an annual statistical report that is published on the agency's public website consistent with provision (b) of this standard. This report aggregates information collected through the investigatory database and provides comparative summaries to the previous year's data. The agency began its commitment to PREA compliance in 2014, therefore, statistical information only exists for 2014 and 2015 at the time of this audit.

As noted within the agency audit, the agency's annual PREA statistical report for 2015 and its surveys of sexual violence for 2013 through 2015 are posted on the agency's website to demonstrate compliance with provision (c) of this standard. The data collected allowed for the answering of all questions required by the Department of Justice's surveys.

As noted within the agency audit, the agency's investigation database is utilized to collect data. Additionally, the agency PREA Administrator receives a courtesy copy of all facility based sexual abuse incident reviews to collect data consistent with provision (d) of this standard.

As noted in the agency audit and within this audit, the agency does not contract with other entities for the confinement of its inmates; therefore, there is no aggregate data to collect under provision (e) of this standard.

As noted in the agency audit, the agency prepares its annual PREA report prior to June 30th so that it may have such information available to the Department of Justice upon request in compliance with provision (f) of this standard.

Standard 115.88 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.

This standard was audited at the agency level; however, will be addressed in part within this report.

As noted within the agency audit, the agency prepares an annual PREA statistical report to assess and improve its effectiveness of preventing and detecting sexual abuse. The agency's 2015 report identified its efforts to continue training Department investigators, the inmate population and expanded reporting options for 3rd parties. The agency also reported that it began conducting PREA audits of its facilities during 2015, with the goal of enhancing compliance until all facilities in the agency have been audited, consistent with provision (a) of this standard.

As noted within the agency audit, the agency's 2015 annual PREA report compares data from 2014. The auditor notes that the agency committed to PREA compliance in 2014; therefore, limited comparative data exists at the time of this audit. The 2015 annual report does summarize the agency's progress with achieving PREA compliance at its facilities, citing its training efforts and audit progress as steps to enhance compliance consistent with provision (b) of this standard.

As noted within the agency audit, the audit report is approved by the agency head and the auditor confirmed that the annual report is published on the agency's website consistent with provision (c) of this standard.

As noted within the agency audit, the agency does not redact information from its annual report consistent with provision (d) of this standard.

Standard 115.89 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.

This standard was audited at the agency level; however, will be addressed in part within this report.

As noted within the agency audit, the MDOC establishes procedures within its PREA Manual to direct that data must be securely retained. The agency PREA Administrator reported that he alone has access to the agency's overall data pool for PREA. There are a limited number of upper agency administrators above the PREA Administrator's rank who would have access to the agency investigation database. These procedures are consistent with provision (a) of this standard.

As noted within the agency audit, the agency's annual PREA statistical report for 2015 and its surveys of sexual violence for 2013 through 2015 are posted on the agency's website to demonstrate compliance with provision (b) of this standard.

As noted within the agency audit, the agency's reports that are published on the agency website do not contain personally identifying information, consistent with provision (c) of this standard.

AUDITOR CERTIFICATION

I certify that:

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

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

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

Thomas E. Greishaw — September 11, 2017

Auditor Signature — Date