Prison Rape Elimination Act (PREA) Audit Report
Adult Prisons & Jails

☐ **Interim** ☒ **Final**

Date of Report December 5, 2019

Auditor Information

Name: David Radziewicz	**Email:** daveradziewicz@yahoo.com
Company Name: Click or tap here to enter text.	
Mailing Address: PO Box 74	**City, State, Zip:** Wrightsville, PA 17368
Telephone: 717-728-4135	**Date of Facility Visit:** May 20-22, 2019

Agency Information

Name of Agency: Michigan Department of Corrections		**Governing Authority or Parent Agency** *(If Applicable)*: Click or tap here to enter text.	
Physical Address: 206 E. Michigan Ave, Grandview Plaza		**City, State, Zip:** Lansing, MI 48909	
Mailing Address: PO Box 30003		**City, State, Zip:** Lansing, MI 48909	
The Agency Is:	☐ Military	☐ Private for Profit	☐ Private not for Profit
☐ Municipal	☐ County	☒ State	☐ Federal

Agency Website with PREA Information: https://www.michigan.gov/corrections/0,4551,7-119-68854_70096---,00.html

Agency Chief Executive Officer

Name: Heidi E. Washington	
Email: WashingtonM6@michigan.gov	**Telephone:** 517-780-5811

Agency-Wide PREA Coordinator

Name: Charles J. Carlson	
Email: CarlsonC2@michigan.gov	**Telephone:** Click or tap here to enter text.
PREA Coordinator Reports to: Julie Hamp, Administrator Procurement Division	**Number of Compliance Managers who report to the PREA Coordinator** 33

Facility Information

Name of Facility: Muskegon Correctional Facility (MCF)			
Physical Address: 2400 S. Sheridan Drive		**City, State, Zip:** Muskegon, MI 49442	
Mailing Address (if different from above): Click or tap here to enter text.		**City, State, Zip:** 231-773-3201	
The Facility Is:	☐ Military	☐ Private for Profit	☐ Private not for Profit
☐ Municipal	☐ County	☒ State	☐ Federal
Facility Type:	☒ Prison	☐ Jail	

Facility Website with PREA Information: https://www.michigan.gov/corrections/0,4551,7-119-68854_70096---,00.html

Has the facility been accredited within the past 3 years? ☐ Yes ☒ No

If the facility has been accredited within the past 3 years, select the accrediting organization(s) – select all that apply (N/A if the facility has not been accredited within the past 3 years):

☐ ACA

☐ NCCHC

☐ CALEA

☐ Other (please name or describe: Click or tap here to enter text.

☒ N/A

If the facility has completed any internal or external audits other than those that resulted in accreditation, please describe:
N/A

Warden/Jail Administrator/Sheriff/Director

Name:	Sherry Burt		
Email:	BurtS@michigan.gov	**Telephone:**	231-780-7418

Facility PREA Compliance Manager

Name:	John Kludy		
Email:	kludyj@michigan.gov	**Telephone:**	231-799-5063

Facility Health Service Administrator ☐ N/A

Name:	Mike Wilkinson		
Email:	wilkinsonm2@michigan.gov	**Telephone:**	231-773-3201

Facility Characteristics		
Designated Facility Capacity:	1338	
Current Population of Facility:	1295	
Average daily population for the past 12 months:	1321	
Has the facility been over capacity at any point in the past 12 months?	☐ Yes ☒ No	
Which population(s) does the facility hold?	☐ Females ☒ Males ☐ Both Females and Males	
Age range of population:	18-84	
Average length of stay or time under supervision:	2Y3M26D	
Facility security levels/inmate custody levels:	2 (medium)	
Number of inmates admitted to facility during the past 12 months:		696
Number of inmates admitted to facility during the past 12 months whose length of stay in the facility was for *72 hours or more*:		695
Number of inmates admitted to facility during the past 12 months whose length of stay in the facility was for *30 days or more:*		655
Does the facility hold youthful inmates?	☐ Yes ☒ No	
Number of youthful inmates held in the facility during the past 12 months: (N/A if the facility never holds youthful inmates)		Click or tap here to enter text. ☒ N/A
Does the audited facility hold inmates for one or more other agencies (e.g. a State correctional agency, U.S. Marshals Service, Bureau of Prisons, U.S. Immigration and Customs Enforcement)?		☐ Yes ☒ No
Select all other agencies for which the audited facility holds inmates: Select all that apply (N/A if the audited facility does not hold inmates for any other agency or agencies):	☐ Federal Bureau of Prisons ☐ U.S. Marshals Service ☐ U.S. Immigration and Customs Enforcement ☐ Bureau of Indian Affairs ☐ U.S. Military branch ☐ State or Territorial correctional agency ☐ County correctional or detention agency ☐ Judicial district correctional or detention facility ☐ City or municipal correctional or detention facility (e.g. police lockup or city jail) ☐ Private corrections or detention provider ☐ Other - please name or describe: Click or tap here to enter text. ☐ N/A	
Number of staff currently employed by the facility who may have contact with inmates:		239

Number of staff hired by the facility during the past 12 months who may have contact with inmates:	15
Number of contracts in the past 12 months for services with contractors who may have contact with inmates:	2
Number of individual contractors who have contact with inmates, currently authorized to enter the facility:	110
Number of volunteers who have contact with inmates, currently authorized to enter the facility:	180
Physical Plant	
Number of buildings: **Auditors should count all buildings that are part of the facility, whether inmates are formally allowed to enter them or not. In situations where temporary structures have been erected (e.g., tents) the auditor should use their discretion to determine whether to include the structure in the overall count of buildings. As a general rule, if a temporary structure is regularly or routinely used to hold or house inmates, or if the temporary structure is used to house or support operational functions for more than a short period of time (e.g., an emergency situation), it should be included in the overall count of buildings.**	12
Number of inmate housing units: **Enter 0 if the facility does not have discrete housing units. DOJ PREA Working Group FAQ on the definition of a housing unit: How is a "housing unit" defined for the purposes of the PREA Standards? The question has been raised in particular as it relates to facilities that have adjacent or interconnected units. The most common concept of a housing unit is architectural. The generally agreed-upon definition is a space that is enclosed by physical barriers accessed through one or more doors of various types, including commercial-grade swing doors, steel sliding doors, interlocking sally port doors, etc. In addition to the primary entrance and exit, additional doors are often included to meet life safety codes. The unit contains sleeping space, sanitary facilities (including toilets, lavatories, and showers), and a dayroom or leisure space in differing configurations. Many facilities are designed with modules or pods clustered around a control room. This multiple-pod design provides the facility with certain staff efficiencies and economies of scale. At the same time, the design affords the flexibility to separately house inmates of differing security levels, or who are grouped by some other operational or service scheme. Generally, the control room is enclosed by security glass, and in some cases, this allows inmates to see into neighboring pods. However, observation from one unit to another is usually limited by angled site lines. In some cases, the facility has prevented this entirely by installing one-way glass. Both the architectural design and functional use of these multiple pods indicate that they are managed as distinct housing units.**	6
Number of single cell housing units:	0
Number of multiple occupancy cell housing units:	6
Number of open bay/dorm housing units:	0
Number of segregation cells (for example, administrative, disciplinary, protective custody, etc.):	27
In housing units, does the facility maintain sight and sound separation between youthful inmates and adult inmates? (N/A if the facility never holds youthful inmates)	☐ Yes ☐ No ☒ N/A
Does the facility have a video monitoring system, electronic surveillance system, or other monitoring technology (e.g. cameras, etc.)?	☒ Yes ☐ No

Has the facility installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology in the past 12 months?	☒ Yes ☐ No

Medical and Mental Health Services and Forensic Medical Exams

Are medical services provided on-site?	☒ Yes ☐ No
Are mental health services provided on-site?	☒ Yes ☐ No
Where are sexual assault forensic medical exams provided? Select all that apply.	☐ On-site ☒ Local hospital/clinic ☐ Rape Crisis Center ☐ Other (please name or describe: Click or tap here to enter text.)

Investigations

Criminal Investigations

Number of investigators employed by the agency and/or facility who are responsible for conducting CRIMINAL investigations into allegations of sexual abuse or sexual harassment:	N/A
When the facility received allegations of sexual abuse or sexual harassment (whether staff-on-inmate or inmate-on-inmate), CRIMINAL INVESTIGATIONS are conducted by: Select all that apply.	☐ Facility investigators ☐ Agency investigators ☒ An external investigative entity
Select all external entities responsible for CRIMINAL INVESTIGATIONS: Select all that apply (N/A if no external entities are responsible for criminal investigations)	☐ Local police department ☐ Local sheriff's department ☒ State police ☐ A U.S. Department of Justice component ☐ Other (please name or describe: Click or tap here to enter text.) ☐ N/A

Administrative Investigations

Number of investigators employed by the agency and/or facility who are responsible for conducting ADMINISTRATIVE investigations into allegations of sexual abuse or sexual harassment?	18
When the facility receives allegations of sexual abuse or sexual harassment (whether staff-on-inmate or inmate-on-inmate), ADMINISTRATIVE INVESTIGATIONS are conducted by: Select all that apply	☒ Facility investigators ☐ Agency investigators ☐ An external investigative entity
Select all external entities responsible for ADMINISTRATIVE INVESTIGATIONS: Select all that apply (N/A if no external entities are responsible for administrative investigations)	☐ Local police department ☐ Local sheriff's department ☐ State police ☐ A U.S. Department of Justice component ☐ Other (please name or describe: Click or tap here to enter text.) ☒ N/A

Audit Findings

Audit Narrative

The auditor's description of the audit methodology should include a detailed description of the following processes during the pre-onsite audit, onsite audit, and post-audit phases: documents and files reviewed, discussions and types of interviews conducted, number of days spent on-site, observations made during the site-review, and a detailed description of any follow-up work conducted during the post-audit phase. The narrative should describe the techniques the auditor used to sample documentation and select interviewees, and the auditor's process for the site review.

A Prison Rape Elimination Act audit of the Muskegon Correctional Facility, located at 2400 South Sheridan Drive, Muskegon, MI, was conducted from May 20, 2019 to May 22, 2019, pursuant to a circular 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, David Radziewicz, was assisted during this audit by DOJ Certified Auditor Stephen Noll, and Pennsylvania Department of Corrections (PA DOC) PREA Administrative Officer Jamie Wilson. Auditor Noll assisted with the audit tour and interviews of both staff and inmates. Ms. Wilson assisted with interviews of staff and inmates. The report and all compliance determinations were generated their entirety by David Radziewicz. The auditor notes, throughout the pre-audit period and post-audit period associated with this audit, the Michigan Department of Corrections had seven other overlapping audits scheduled between April 1, 2019 and May 22, 2019. Moreover, subsequent to this audit, PA DOC consortium auditors had entered into pre-audit periods with the MDOC's remain three facilities, which will be audited by July 22, 2019. Due to the overlapping nature of these audits being conducted under the consortium; agency-wide findings that impacted individual audits were shared among consortium auditors and tasks relative to agency-wide interviews with Just Detention International, the Agency Head and PREA Manager were either conducted jointly or assigned to specific auditors actively engaged in audits.
.
The audit team wishes to extend its appreciation to Warden Burt and her staff for the professionalism they demonstrated throughout the audit and their willingness to comply with all requests and recommendations made by the auditor during the site visit. The auditor would also like to recognize PREA Analyst Mary Mitchell, PREA Coordinator John Kludy, and current PREA Manager, Charles Carlson, for their hard work and dedication to ensure the facility is compliant with all PREA standards.

Audit notices were provided to the facility on April 1, 2019 and photographic evidence of its posting was provided by April 4, 2019, more than six weeks in advance of the audit. During the audit tour, the auditor confirmed that an audit notice was posted within each housing unit and common area of the facility. The auditor had received correspondence from one inmate during the pre-audit period, who had grievances with his risk designation as a potential abuser; however, this inmate was not present during the audit to interview.

Prior to the audit, this auditor was provided a flash drive that contained pre-audit documentation. This flash drive contained applicable policies and sample documentation in support of compliance with the standards and their provisions. The auditor notes that several of the policies on this flash drive, as identified in the individual standard findings, were outdated due to agency updates that the auditor located on the agency's website. Within those updates, the auditor found that several previous recommendations had been incorporated into those agency policies and there is no longer a full reliance of the agency's PREA Manual

to substitute as official guidance. This auditor notes that the pre-audit samples in support of most standards were robust and clearly demonstrated evidence of practice. As noted within the individual findings, some standards were further supported with documentation gathered onsite. Additionally, the auditor notes that upon further examination, there were minor inaccuracies on the pre-audit questionnaire that were resolved through the auditor's review of supporting documentation or through accounting of incidents that had occurred since the submission of the pre-audit questionnaire.

Auditors arrived onsite at approximately 0745 hours on May 20, 2019. An entrance meeting was held with key administrative staff. Auditors were greeted by the facility's administrative team and the agency's PREA Analyst responsible for the facility. Introductions were made and logistics for the audit were planned during this meeting. The population on day one of the audit was 1295.

Following introductions and logistics discussions, the audit team began selecting inmates and staff for random and targeted interviews. The audit team utilized the facility's count boards to make random selections of inmates from each housing unit to fulfill the random inmate quotas. The audit team uniformly selected cells 125, 130, 202, and 257 in all housing units, except unit 6. In unit six, cell 237 was selected because the cell numbers stopped at 240. Targeted inmates were selected from the facility's PREA Risk Tracker. This spreadsheet contained identifiers for targeted populations disclosed or discovered during the risk screening process. The audit team selected random staff for interview through the facility's shift rosters. Auditors selected specific posts identified within each housing unit to ensure adequate representation of the different purposed units. The staff member assigned to that post, via the facility's shift roster, was then selected for interview.

The total sample size of the random inmate selections was 24, with the assumption that the over selection would likely be reduced to the required minimum 20 interviews by inmates who may have transferred since the count boards had been produced, or those inmates who may decline to be interviewed. The total targeted selections were aimed at 20 inmates, with additional alternates selected for those whom may have transferred since the facility's PREA Risk Tracker had been printed. As described under 115.41, the audit team encountered difficulty identifying inmates who agreed that they disclosed sexual victimization during risk screening. Thus, the audit team reselected six targeted inmates to fulfill targeted quotas; however, maintained the random question protocol obtained from those six who refuted that they had disclosed sexual victimization during risk screening. The audit team later learned that this conflicting information was gathered through pre-sentence reports, reviews of previous assessments, and reviews of agency records in the absence of an affirmative response by an inmate.

The audit team ended up with a total sample size of 46 inmates, including random and targeted inmates. The total sample size of random staff was 15. The total specialized staff sample was 26, with some staff overlapping into multiple categories. Breakdowns of targeted interviews are as follows:

Staff:

Agency Head Designee: 1
Agency PREA Manager: 1
Incident Review Team: 1
Intermediate or Higher-Level Staff Conducting Rounds: 2
Investigative Staff: 2
Victim's Services Staff: 1
SANE Examiner: 1
Mental Health Staff: 2
Medical Staff: 3
Facility PREA Coordinator: 1
Retaliation Monitoring: 3

Risk Screening Staff: 3
Intake Staff: 1
Staff Who Supervise Inmates in Segregated Housing: 2
Volunteers: 2
Contractors: 2
Warden: 1
First Responder: 1
Huan Resource Staff: 1
Line Staff Who Supervise Youthful Inmates: 0 (No such staff exist in the facility)
Education/Program Staff Who Work with Youthful Inmates: 0 (No such staff exist in the facility)
Non-Medical Staff Involved in Cross Gender Strip Searches: 0 (No such staff exist in the facility)
Agency Contract Administrator: 0 (Agency claimed not to contract – discussed further in 115.12)

Inmates:

Inmates Who Reported Sexual Abuse: 4
Inmates Who Disclosed Victimization During Risk Screening: 7
Inmates with Disabilities:
Cognitively Disabled: 2
Physically Disabled: 2
Hearing Impaired: 1
Limited English Proficiency: 0 (No such inmate was housed at the facility)
Transgender Inmates: 1 (only one was housed at the facility)
Gay and Bisexual Inmates: 4
Youthful Inmates: 0 (No such inmate was housed at the facility)
Inmates in Segregated Housing for Risk of Victimization: 0 (No such inmate was housed at the facility)

All inmate interviews were conducted in private offices and conference rooms in the Deputy Warden's suite, which is located in the School/LTA building. The majority of staff interviews were conducted in these same inmate interview locations or in the Warden's conference room. All interviews were conducted utilizing the standardized question protocols as outlined by the PREA Resource Center. The auditor notes that the template questions designed to elicit information regarding risk screening was not clearly reflective of agency procedures, thus, led to inconsistent reports form inmates as described under 115.41.

Following the selection process for interviews, the audit team divided into two functions, with Ms. Wilson starting with inmate interviews and auditors Radziewicz and Noll conducting a tour of the facility, maximizing the use of facility's and audit team's time onsite. The tour started at approximately 0920 hours.

At the start of the facility tour, the audit team went to the facility's control station and was given a demonstration of the facility's video surveillance capabilities. The audit team reviewed the 239 facility cameras. The technology employed by the facility allowed it to digitally screen out any areas from view that could create an opportunity for cross-gender viewing or opportunities for voyeurism, such as the toileting area of the observation cells. Cameras on the housing units were placed in locations that did not permit viewing into showering and toileting areas. During a review of the camera system, the auditors saw evidence of rounds being conducted by security staff within the facility and supervisory staff. The auditors observed that the camera system provides sufficient view of the housing unit wings and their common areas, while precluding view of the authorized changing areas within the shower and restroom areas. The camera system also includes multiple views of the kitchen, food preparation areas, education, programming, recreation and internal walkways within the compound. The camera system provides a noteworthy supplement to existing direct supervision in each area of the facility and provides a means to retroactively review allegations within the facility. The auditor notes; however, that the facility's outside maintenance and commissary storage areas are not covered by cameras, where a total of ten staff and two inmates work.

After the review of facility cameras, the auditors were given a tour of all areas of the facility, including all six of the facility's housing units. All six housing units are identically constructed in the shape of a "Y" style celled environment, with an upper and lower tier, an officer station is located on the first floor strategically placed in front of the unit's 3 day room/recreation areas where inmates may congregate during out of cell time. From the station, the officers have the vantage point of viewing each wing. Through the open tier system, they can also monitor traffic on the second floor of the unit, while maintaining access to monitor activity in those day rooms behind them. Showers are located on the first floor on one of the wings. The restrooms would be located on the first and second tiers of the opposite wing of where the showers are located. From the officer's station, the entryways to the showers and restrooms can be monitored. Additionally, camera coverage can also monitor entries and exits from the unit's hygiene facilities. The only unique structural change between the housing units is that Housing Unit 6 was constructed several years after the facility was opened and incorporated more of the agency's modernized approach to increasing visibility by placing the officer's station at an elevated vantage point, allowing greater view of the upper tier. Additionally, this unit does not have the group shower configuration of the remaining five units and houses 70 less inmates. It is noted that housing units can hold the following maximum populations:

Unit 1: 226
Unit 2: 238
Unit 3: 238
Unit 4: 238
Unit 5: 238
Unit 6: 160

The tour also included Education/Programming Building, Administrative Buildings, visiting room, control room, intake, medical (including exam rooms) recreation, kitchen/dining hall and the outside commissary storage/maintenance area.

A privacy notice was posted in each of the housing units, 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 auditor took notice to the "Knock and Announce" postings 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. Following the knock and announce, opposite gender staff waited at least 10 seconds prior to entering the housing unit. During a tour of the education area, it was noted that the facility's PREA "An End to Silence" handbook was readily accessible within the library.

During the tour, informal interviews were conducted with at least one inmate and one staff in each area toured throughout the facility. At multiple points during the audit tour, inmates stopped the auditors to voice their concerns about the group shower configurations within the housing units, asking whether the PREA standards could be used to mandate individual shower stalls. These informal and spontaneous interviews proved useful in determining facility culture and were used to supplement the formal interviews in determining compliance with the standards. During the tour, the auditor also informally interviewed the facility staff escorting the audit team to gather an understanding of institutional operations and to clarify observations made during the tour. These informal interviews included discussions with the facility's Inspector, the facility PREA Coordinator, and the agency's Regional PREA Analyst to determine operational procedures and to gain an overall sense of how the institution implements the PREA standards, as well as agency policy. These informal interviews were used to supplement formal interviews in determining compliance with the standards and clarify matters not addressed on the applicable interview protocols for the respective parties. Additionally, during the audit tour, the auditor sampled 2 random inmate files on toured housing units to verify documentation of comprehensive inmate PREA education. While on the

housing unit, staff who fulfilled the role of Prison Counselor were asked to provide access to their inmate files, where the auditor randomly selected files from respective drawers to assess whether there was documentation of inmate education within.

The audit tour concluded at approximately 1530 hours on day one with all areas of the facility observed, except for the outside maintenance and commissary storage area, which were toured on May 21, 2019 in conjunction with a visit to Earnest C. Brooks Correctional Facility to interview the facility's HR representative.

Following the audit tour, auditors Noll and Radziewicz assisted with both staff and inmate interview selections. The audit team remained in the School/LTA building until approximately 1730 hours on day 1, before returning to the Warden's conference room and departing the facility at approximately 1800 hours.

Auditors arrived onsite at approximately 0745 hours on May 21, 2019 and were greeted by key facility administrative staff in preparation for the second day of the audit. The facility's population remained 1295. Audit logistics were discussed, and the audit team commenced with interviews of specialized staff and specialized inmates. The audit team was housed in the School/LTA building and had staff assigned to keep the interview pool of staff and inmates continuously flowing without delay between interviews. As the audit team finished their respective interviews, the next individual in cue was identified and interviewed.

The auditor notes that the facility operates on a 12-hour shift schedule; therefore, the two shifts of 0600-1800 and 1800-0600 were selected for random interviews. The auditors remained onsite and interviewed second shift staff as they were entering the facility at 1800 hours on day 2 of the audit. Following the morning round of interviews, lead auditor Radziewicz completed the tour of the maintenance area and traveled to neighboring Earnest C. Brooks Correctional Facility to interview the facility's HR staff and to view HR records, while auditor Noll and Ms. Wilson continued with interviews. Interviews concluded on day 2 of the audit by approximately 1900 hours and the audit team subsequently left the facility.

Prior to return to the facility for day three of the audit, the audit team convened to tally totals of staff and inmate interviews to determine whether minimum quotas established by the auditor handbook had been met. The audit team identified which category of interviews remained and key points to address during the exit briefing.

The audit team returned on day three at approximately 0745 to finish remaining audit activities, including remaining interviews, a review of investigations, a selection of investigations for in-depth analysis, gathering of additional documentation to analyze risk screening, medical/mental health referrals, and to conduct the exit briefing. The facility population dropped to 1293 on this date. The audit team divided into its respective assignments to wrap-up the remaining audit tasks. Hard copies and electronic copies of documents were obtained from the facility for analysis of compliance with the standards. The audit team concluded its activities by approximate 0930 and a brief exit meeting was held with the facility to advise them of the team's most significant findings. At the time of the exit briefing, the most significant item for address was the investigation process and the doors to the restrooms. The audit team also relayed the inmate concerns with respect to privacy in the group shower configurations on the housing units. While the inmate concerns with the showers are not enforceable under the standards, the facility was amenable to considering how to address the inmate's privacy concerns. The facility was informed that the auditor would be required to conduct further analysis of the information gathered during the interviews and further review documentation gathered onsite to triangulate its findings of compliance. The auditor also advised the facility that it was likely that additional document requests would follow during the post-audit analysis period.

During the post audit analysis, the auditor discovered a significant issue with respect to contracting standard 115.12, following a search of the state of Michigan's public contract website. Specifically, the auditor found that the agency contracted with two county prisons within the state of Michigan for the housing of parole violators as discussed further in the narrative for 115.12. Due to the disagreement between the auditor and

the agency over whether the contracts were applicable to 115.12 or 115.212 and the agency's responsibilities for contract monitoring under 115.12; the auditor contacted the auditor helpline on May 31, 2019 and received guidance that contract monitoring responsibilities would be applicable for auditing within this audit and all prisons audits under 115.12. The absence of data collection and reporting for these contracted facilities within the agency's annual report also spilled into compliance issues with 115.87 and 115.89 applicable to this audit. Following a discussion with the agency PREA Analyst on June 27, 2019, the auditor was informed that the agency still contends that it is not subject to audit of these contracts under 115.12. There was an agreement to request a facilitated discussion between the agency and the audit team from the PREA Resource Center. The auditor made a request to the individual who provided the response to the helpline request on June 27, 2019 to coordinate a facilitated discussion. As of the date of this interim report, the auditor has not yet received a response to said request.

Throughout the pre-audit, onsite audit, and post audit, open and positive communication was established between the auditor and both the agency and facility staff. During this time, the auditor discussed concerns with the agency's Regional PREA Analyst and the facility's PREA Coordinator. Due to the timing of the auditor's request for additional documentation falling on June 26, 2019 and the facility's PREA Coordinator's absence from the facility extending through the interim report due date of July 6, 2019; informational requests of this auditor were unable to be accommodated prior to the completion of the Interim Report. However, the PREA Coordinator was advised that the facility's audit will remain in corrective action for agency level standards; regardless of what documentation was provided. Therefore, items where additional documentation was requested could be held as temporary corrective action items and resolved through submission of requested documentation following the issuing of an interim report.

POST INTERIM REPORT:

To preserve the original findings and differentiate the actions taken by the facility to improve the effectiveness of its prevention, detection, and response procedures to allegations of sexual abuse and sexual harassment, the auditor will identify those actions taken as corrective actions taken in the report as POST INERIM REPORT CORRECTIVE ACTIONS TAKEN. All text following such headers in this report describe the methodology by which the auditor was able to find compliance with those factors identified in need of corrective action at the time of the submission of the interim report.

Following the submission of the interim report, the auditor maintained contact with the agency's PREA Analyst for the for the facility and the facility's PREA Coordinator. There was also contact with the agency's PREA Manager and agency's procurement division to ensure that a procedure was established to garner compliance with contract monitoring provisions required by 115.12.

Upon return of the facility's PREA Coordinator, the auditor was provided information that was requested prior to the submission of the interim report; allowing the auditor to find compliance with those standards in need of additional supporting documentation to find sufficient evidence of compliance. Those findings satisfied by additional documentation are described in the individual standard narratives.

The agency level standards took considerably longer and greater effort to resolve, due to a disagreement on the applicability of 115.12. To resolve the issue, the agency and audit team agreed to a facilitated discussion by the PREA Resource Center, who later consulted the PREA Management Office (PMO) with the Department of Justice. Following guidance issued by the PMO, the agency agreed to the applicability of 115.12 to its audits of Adult Prisons and Jails and engaged the audit team with an interactive process to resolve the compliance at its contracted facilities.

The auditor requested sample documentation from the facility's PREA Analyst and PREA Coordinator at various times throughout the corrective action period. All requested documentation was provided timely and included the information as requested by the auditor.

There were several physical plant resolutions delayed by the vendor supplying doors ordered by the facility to eliminate a blind spot in a fire exit corridor and to limit cross-gender viewing opportunities in the housing unit restrooms. Ultimately, on November 19, 2019, the facility received and were able to provide verification that all physical plant modifications necessary for compliance were complete.

Facility Characteristics

The auditor's description of the audited facility should include details about the facility type, demographics and size of the inmate, resident or detainee population, numbers and type of staff positions, configuration and layout of the facility, numbers of housing units, description of housing units including any special housing units, a description of programs and services, including food service and recreation. The auditor should describe how these details are relevant to PREA implementation and compliance.

The Muskegon Correctional Facility (MCF) first opened in 1974, with its original five housing units. The facility is designated as a Security Level II (medium) facility. It was later expanded, with the addition of housing unit 6, which originally was designed to operate as an outside secure housing unit; however, was later incorporated into the secure perimeter of the facility. After 35 years of operations, the facility was slated for closure in 2009, following a population decrease within the agency. Through discussion with the Warden and a search of historical media coverage, the prison ultimately closed for two weeks in 2010 before it reopened as a contractual facility to house approximately 1100 inmates from the state of Pennsylvania. Pennsylvania's inmates were ultimately removed from the prison approximately 1 year later, with all out-of-state inmates exiting by May 25, 2011. The facility closed again in 2011, following the departure of Pennsylvania's inmates. The facility reopened in the fall of 2012, as part of agency restructuring to create the Detroit Reentry Center.

The Muskegon Correctional Facility is comprised of eleven (11) buildings – six (6) housing units, Food Service, Educational/Leisure Time Activities and Programs and Administration. Housing Unit One contains a 27-bed segregation unit, Health Care and 180 general population prisoners. Unit Six is our Faith Base Unit housing 160 general population prisoners. Remaining Housing Unit houses 238 general population prisoners. The auditor notes one unusual feature within the facility is the horticulture program, with a wide array of plants and trees throughout the facility's compound that are atypical for the inner compound of correctional facilities.

Muskegon Correctional facility offers programs which includes, Special Education and GED preparation and testing, a state-of-the-art Welding program, Horticulture and Employment Readiness classes. Reentry programing is offered in the form of Violence Prevention Programing, Thinking for a Change, Building Responsible Dynamic Gaining Essential Safety, Substance Abuse Education Phase 2, as well as Advanced Substance Abuse. A variety of leisure activities are provided. Religious services are provided along with general and legal library services. Muskegon Correctional Facility also host Prison Fellowships Pre-release Academy and Urban Ministry Institute programing, as well as PAW's for a Cause Dog Training program. Prisoners are provided with on-site routine medical and dental care. Serious problems are treated at the department's Duane L. Waters Hospital and Henry Ford Allegiance Hospital in Jackson.

All of the housing units of the same security level are of a similar structure. All six housing units are identically constructed in the shape of a "Y" style celled environment, with an upper and lower tier, an officer station is located on the first floor strategically placed in front of the unit's 3 day room/recreation areas where inmates may congregate during out of cell time. From the station, the officers have the vantage point of viewing each wing. Through the open tier system, they can also monitor traffic on the second floor of the

unit, while maintaining access to monitor activity in those day rooms behind them. The only unique structural change between the housing units is that Housing Unit 6 was constructed several years after the facility was opened and incorporated more of the agency's modernized approach to increasing visibility by placing the officer's station at an elevated vantage point, allowing greater view of the upper tier. Additionally, this unit does not have the group shower configuration of the remaining five units and houses 70 less inmates.

The facility hosts a Faith-Based Unit in Housing Unit 6, operated with a partnership with Prison Fellowship. This is an intensive pre-release program for those inmates within 24-48 months of their earliest release dates. Participants are selected through a screening process and all applicants to the program must be at least 12 months free of any misconduct reports.

Housing Unit 5 is home to the Growth, Opportunity, and Life Skills (GOALS) program. The program offers a positive living environment which promotes communication, mutual respect, and encouragement. Inmates within this program interact with staff and volunteers in programming designed to intensively skill development that will affect positive behavioral change, including Ethics, Financial Ethics, Music Theory, Inside-out Dads, and RARE (responsibility, accountability, remorse, and empathy). Additionally, this housing unit is home to the PAWS program, which is a canine program designed to provide reinforcement training. Once dogs have completing the facility's program, they are tested for whether they will become assistance dogs or another career.

Housing Unit 2, is an incentive based unit, driven by recognizing positive behavior through extra incentives and quick accountability. Inmates must apply to be housed on the unit, be screened by staff, must be at least one year free of any misconduct reports, have not security threat group affiliation, and display positive behavior. Remaining housing units consist of general population inmates.

The facility is designed to operate a maximum capacity of 1338 inmates, according to its staffing plan and has been operating at an average of 1321 inmates. On day one of the audit, there were 1295 inmates present and the final day of the audit ended with a population of 1293 inmates. The auditor observed that the inmate population to consist predominately of Caucasian and African- American inmates. Other ethnic groups were not widely observed throughout the tour. From the auditor's observations, the majority of the inmate population appeared to trend towards an older population age above 30, which correlates with the Warden's description of the facility housing a high lifer population. The average length of stay for inmates is approximately 2 years, 3months, 26 days.

There are a total of 239 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 from their designated work stations, with supplemental rounds taking place throughout the unit with random roving movement.

The education and programming building consist of a single floor. The building is set up in a fashion that all classrooms and areas where staff may be with inmates are visible through a series of windows, eliminating a number of potential isolated areas or blind spots. Education and programming staff are supervised by roving officers within the building. As described in 115.13, the auditor had concerns with one isolated fire escape area where an inmate could be trapped during a tour of the auditorium within the school building. The facility had ordered doors with windows to permit inward viewing of this area to prevent this soft spot from being utilized for unauthorized activity.

During the audit tour and through informal interviews with staff and inmates, the auditor was left with the general sense that staff and inmates felt safe at the facility; however, most were desirous of additional privacy within the facility's group shower configurations on housing units 1-5.

Summary of Audit Findings

*The summary should include the number of standards exceeded, number of standards met, and number of standards not met, **along with a list of each of the standards in each category**. If relevant, provide a summarized description of the corrective action plan, including deficiencies observed, recommendations made, actions taken by the agency, relevant timelines, and methods used by the auditor to reassess compliance.*

***Auditor Note:** No standard should be found to be "Not Applicable" or "NA". A compliance determination must be made for each standard.*

Number of Standards Exceeded: 0

Click or tap here to enter text.

Number of Standards Met: 45

115.11, 115.14, 115.16, 115.17, 115.18, 115.21, 115.22, 115.31, 115.32, 115.33, 115.34, 115.43, 115.51, 115.53, 115.54, 115.61, 115.62, 115.63, 115.64, 115.65, 115.66, 115.67, 115.68, 115.72, 115.76, 115.77, 115.78, 115.82, 115.83, 115.86, 115.88 115.401, 115.403. After Corrective Action: 115.12, 115.13, 115.15, 115.35, 115.41, 115.42, 115.52, 115.71, 115.73, 115.81, 115.87, 115.89

Number of Standards Not Met: 0

Summary of Corrective Action (if any)

This is a final report that is accompanied by the original corrective action plan recommendations made by the auditor.. The auditor notes that the facility was not consistently conducting risk screening within the required timeframes. Additionally, the facility's investigations were not consistently completed in accordance with the agency policy's requirements to physically interview all applicable parties. Due to the timing request by this auditor for additional supporting documentation and the PREA Coordinator's absence from the facility, some standards were held in corrective action for the simple fact that supporting documentation requests were unable to be honored prior to the issuance of the interim report. Upon receipt of requested documentation that demonstrated compliance with those specific standards; the auditor considered those corrective action items resolved. Other areas of non-compliance will required firm establishment of practice within the facility to demonstrate compliance. As the agency gains experience in the PREA auditing process, it has made substantial efforts to enhance its policies and institute practices that are demonstrative of standards compliance. The audit of the Muskegon Correctional Facility comes at the close of the third year of the second audit cycle and occurred during a period where the agency had eight overlapping audits during the pre-audit and post-

audit period. It is evident that most agency policies have been implemented and institutionalized; however, risk screening and enhanced investigatory procedures had not firmly rooted.

POST INTERIM REPORT:

A brief summary of the corrective action process is provided here; however, please refer to the narrative section for the individual standards for additional information.

Following the issuing of the interim report, the auditor maintained contact with the facility's PREA Coordinator and the agency's PREA Analyst assigned to the facility. Multiple consultations with the PREA Resource Center occurred, including a facilitated phone discussion in August 2019 to attempt to resolve the agency's disagreement with the applicability of the contract monitoring requirements of 115.12. Following a series of discussions between the audit team, the agency PREA Manager and agency Contract Monitors, there was an agreement to resolve the most significant issue of contract monitoring in September 2019. At this time and with an understanding that the contracted facilities have little infrastructure to comply with the PREA standards, the audit team agreed upon the agency issuing a formal corrective action plan to the contracted facilities, describing outstanding objectives to be completed within intervals during the next year. The agency issued the corrective action plan to both contracted facilities, with a due date of October 8, 2019. The audit team received the official responses from both contracted facilities, agreeing to the milestones set forth in the formal contract corrective action plan to resolve this standard.

As described in the narrative sections for multiple standards and as noted in the summary of corrective action, there were findings of a need for corrective action, simply based upon the unavailability of the facility's PREA Coordinator to supply requested supporting documentation prior to the due date of the interim report. Upon the return of the facility's PREA Coordinator, requested supporting documentation was provided to resolve several standards. Other standards, relative to physical plant changes were delayed due to vendor issues with the manufacturing of necessary doors. Once doors were delivered and installed in late November 2019, the facility provided appropriate photographic verification that required barriers were installed to protect from cross gender viewing and to eliminate the vulnerable blind spot in the fire exit corridor from the auditorium area of the facility.

Other standards required time for the development of documentation and evidence of practice. Risk screening was sampled in August 2019 and was found to be compliant at that time. Due to the time required for the development and completion of investigations, the auditor requested samples in November 2019 to verify that in-person interviews were being conducted with both alleged subjects and alleged victims during investigations. All requested documentation was exchanged via email between the facility PREA Coordinator, agency PREA Analyst and the auditor to verify compliance.

Through the facility's efforts during the corrective action period to rectify the auditor's concerns, the agency's efforts to implement contract monitoring, and the supplied evidence of compliance; the auditor finds that there is sufficient evidence that the facility is in full compliance with the standards.

Specific Corrective Action Recommendations:

115.12
Corrective Action Recommendation:
The MDOC will be required to establish a formal and documented means of ensuring the agency's contracted entities comply with each of the PREA standards, including audit obligations established under §115.401. Should the contracted entities not comply with its obligations to demonstrate compliance through an audit each cycle pursuant to 115.401; the agency will need to demonstrate its compliance by not renewing such contracts consistent with provision (b) of the standard.

POST INTERIM REPORT CORRECTIVE ACTIONS TAKEN

Following the issuing of the interim report, a discussion was held in conjunction with a debriefing from the agency's Richard A. Handlon audit on June 27, 2019. During that discussion with one of the agency's PREA Analysts, it was suggested that a facilitated discussion between the PA DOC audit teams, the MDOC and the PREA Resource Center could be helpful in advancing the discussion. The audit team sent a request to the PREA Resource Center (PRC), requesting the phone conference and potential dates of availability. On July 18, 2019, a request for a phone conference and potential dates of availability was sent to the MDOC PREA Coordinator and Analysts and the discussion was ultimately scheduled for August 8, 2019.

During the phone conference, the audit team, MDOC PREA staff, and a representative of the PRC discussed the viewpoints of the audit team and the agency. Due to continued disagreement between the agency and the audit team over the applicability of the standard to MDOC prison audits; the PRC representative agreed to draft a summary of the conversation for review by the agency PREA Coordinator and the audit teams for submission to the PREA Management Office (PMO) for interpretive guidance. Between August 9, 2019 and August 13, 2019, the drafts circulated between the audit team and MDOC, before submission to the PMO.

On August 23, 2019, the PRC provided the PMO's interpretive guidance on the applicability of 115.12 to the two identified agency contracts. The following guidance was issued:

Based on the information provided and in light of current guidance, it appears that the FAQ that MIDOC relies on for its argument does not apply to this situation. The FAQ envisions temporary transfer/housing situations that arise with facilities that are **not already contracted** and based on reasons outside the control of the agency. The circumstances described seem to indicate that the IDRP is a detention facility used by the MIDOC to hold inmates who have been adjudicated as parole violators until they are released or transferred to a DOC facility. In other words, it appears that this involves a standard contract to hold to MIDOC inmates and therefore MIDOC needs to ensure that the IDRP complies with the standards. It doesn't matter that they are there temporarily—the vast majority of inmates are only held temporarily, but they are still entitled to the protections offered by the Standards, and so the requirements of 115.12 apply.

On August 26, 2019, the MDOC again asserted its reservations with the interpretive guidance and requested the original direction from the DOJ staff for their use and support moving forward within the agency.

On September 3, 2019, the audit team requested a phone conference to discuss potential resolution to 115.12. The audit team advised the agency of approximate dates when corrective action periods could be anticipated to expire and stressed the urgency of formulating a plan, even if the MDOC continued to

pursue its objection to the applicability of the standard. A phone conference was ultimately scheduled for September 23, 2019.

During the phone conference, the audit team, the MDOC PREA staff, and MDOC contract monitoring staff discussed the steps necessary to demonstrate evidence of contract monitoring. Through the discussion, the audit team learned that the contracts are legislatively earmarked and would be renewing automatically October 1, 2019. The audit team discussed the August 2, 2019 FAQ, which updated the previous February 19, 2014 FAQ, to require that any entity under contract for 3 years or more must be audited as PREA compliant by August 20, 2022. Within the FAQs, even though the contracted entity need not be required to be immediately compliant, the contracting agency is required to document its monitoring of the contracted entity's progress towards compliance.

The audit team learned that the contracted entities have no infrastructure to comply with PREA at this time, and have yet to develop so much as policy provisions to govern how they will implement the standards. Given the starting point of the contracted entities, the audit team and the MDOC mutually agreed upon a monitoring tactic that would begin with the issuance of a formal contractual corrective action plan issued to the contracted entities, citing their failure to adhere to their contractual obligation to comply with the PREA standards. The corrective action plan must outline achievable and measurable milestones for the contracted entity to meet during various intervals throughout the one-year period of the October 1, 2019 contract. The audit team suggested that the corrective action plan include that the contracted entities be held accountable to implement the most critical components of developing compliance within that initial year, such as development of a policy within three months, completion of staff, contractor, volunteer, and inmate training and education requirements within six months, and implementation of risk screening procedures prior to the end of the contractual year so that the contracted entities would be on target to achieve full compliance and be prepared for audit by the August 20, 2022 date established within the FAQ. To fulfill their portion of contract monitoring required by the standards, the MDOC would be responsible to gather tangible evidence of compliance through documentation exchanges, hold the contracted facility accountable to the deadlines imposed within the corrective action plan, and to enforce compliance with the plan through its available contractual remedies. The MDOC's PREA staff would be consulted by the agency's contract monitors to assess whether the contracted entity's evidence of compliance was consistent with the PREA standards.

The audit team and the MDOC mutually agreed that the provision of the corrective action plan to the contracted entities, and an acknowledgement of the obligations of the corrective action plan requirement by the contracted entities would suffice as evidence that the MDOC has engaged in contract monitoring as required by provision (b) of the standard. The MDOC's enforcement of the contractual corrective action plan is deemed to be most appropriately assessed during future third cycle audits to ensure the MDOC has continued with those obligations initiated through the second cycle audits where the issue was first identified.

On September 24, 2019, the MDOC provided the audit team with the contractual corrective action plans developed for each of the contracted entities and provided email correspondence verifying that each had been formally sent to each of the contracted facilities. The corrective action plans included the following milestones:

1. No later than 12/26/2019, your organization must have PREA policies in place, and provide to Contract Monitor, that will bring your organization into compliance with the following sections of the Prison Rape Elimination Act, Prisons and Jail Standards:
   a. 115.11 Zero tolerance of sexual abuse and sexual harassment; PREA coordinator.

b. 115.13 Supervision and monitoring.
c. 115.15 Limits to cross-gender viewing and searches.
d. 115.22 Policies to ensure referrals of allegations for investigations.
e. 115.61 Staff and agency reporting duties.
f. 115.67 Agency protection against retaliation.

2. No later than 3/24/2020, your organization must develop, and provide to Contract Monitor, PREA training for employees, volunteers, contractors, and offenders, that will bring your organization into compliance with the following sections of the Prison Rape Elimination Act, Prisons and Jail Standards:
   a. 115.31 Employee training.
   b. 115.32 Volunteer and contractor training.
   c. 115.33 Inmate education.
   d. 115.34 Specialized training: Investigations.
   e. 115.35 Specialized training: Medical and mental health care
3. No later than 6/24/2020, your organization must develop, and provide to Contract Monitor, a risk screening process that will bring your organization into compliance with the following sections of the Prison Rape Elimination Act, Prisons and Jail Standards:
   a. 115.41 Screening for risk of victimization and abusiveness.
   b. 115.42 Use of risk of victimization and abusiveness

4. You must have a certified PREA audit completed on your organization no later than 8/19/2022, and once within each three-year PREA cycle thereafter. Subsequent contract renewals will require continued PREA implementation.
   a. 115.93 Audits of standards
   b. 115.401-115.405 Auditing and Corrective Action

The contracted entities were given until October 8, 2019 to respond to the corrective action plan.

The audit team was provided with the contracted entity response on October 8, 2019. Both contracted entities agreed to abide by the corrective action plan and agreed to the deadlines the MDOC imposed via the contract corrective action plan. The audit team finds this formal demand for compliance by the MDOC and acknowledgement of the need for corrective action by the contracted entities to satisfy provision (b)'s requirements for the agency to monitor and enforce compliance with PREA provisions of its contracts.

115.13
CORRECTIVE ACTION RECOMMENDATION:
To be fully compliant with provision (a)’s consideration of blind spots, the auditor will require verification that the doors to the fire exit corridor within the facility’s auditorium have been installed. Verification can be in the form of photographs of the location.
To be fully compliant with provision (d), the facility will be required to submit the additional request for round reader reports requested. Upon receipt of compliant documentation, the auditor may find full compliance with the provision.

POST INTERIM REPORT CORRECTIVE ACTIONS TAKEN

Following the submission of the interim report, the requested round reader documentation was provided to the auditor to confirm that administrative rounds are occurring in accordance with provision (d) of the standards. There was a technological issue with some of the round readers for the facility PREA Coordinator registering under his name and appearing as “not specified” along with the Deputy

Warden's rounds only being specifically labeled under his name in four of the six housing units, again, with some of those rounds appearing as "not specified." Nevertheless, the rounds were specified as a supervisory round in the system; however, not associated with a specific name.

Round reader reports verified that daily rounds were occurring in the housing units at irregular interviews. While each shift may not have been covered each day, there was evidence that there were then times where multiple supervisory rounds occurred the same shift in one day. Again, this irregularity of rounds appears to support the standard's intent to deter sexual abuse through unannounced oversight consistent with provision (d) of the standard.

With respect to provision (a) of the standard, the facility experienced several delays with the manufacturer producing and delivering the fire exit doors for the auditorium area. The facility's PREA Coordinator provided email correspondence from the vendor to verify the delays. Ultimate, on November 19, 2019, the facility received and were able to provide verification of the installation of the doors via photographs to eliminate the blind spot, consistent with provision (a) of the standard.

Following the provision of requested documentation of supervisory rounds and the installation of doors in the auditorium area that eliminate blind spots; the auditor finds that the facility has taken the necessary actions to be fully compliant with the standard.

115.15
CORRECTIVE ACTION RECOMMENDATIONS:
Due to the absence of doors on the upper restrooms of housing units 5 and 3 and the potential for cross-gender viewing of the extreme ends of the urinals in the restrooms; the facility will be required to install the saloon style doors the facility previously ordered to be fully compliant with provision (d) of the standard. Upon completion of the work, the facility may send photographic evidence that the doors will be installed as verification.

POST INTERIM REPORT CORRECTIVE ACTIONS TAKEN

The facility experienced delays with the manufacturer of the doors for the restrooms. The PREA Coordinator provided verification from the vendor to explain the nature of the delays. Ultimately, on November 18, 2019, the facility was able to provide photographic verification that the doors were received and installed to provide inmates sufficient privacy to toilet in accordance with provision (d) of the standard.

Based upon the evidence provided, the auditor finds that the facility has provided sufficient protections against cross-gender viewing and is in full compliance with the standard.

115.35
CORRECTIVE ACTION RECOMMENDATION:
The facility provided documentation of 18 of 21 medical and mental health practitioners completion of the specialized training modules that was reviewed by the auditor. The auditor later made a request for the remaining three records. Due to the timing of the request and the PREA Coordinator's absence, this request was unable to be satisfied prior to the issuing of this interim report. Upon receipt of records to confirm the facility's three mental health practitioners have received specialized training, the auditor will find compliance.

POST INTERIM REPORT CORRECTIVE ACTIONS TAKEN

115.41
CORRECTIVE ACTION RECOMMENDATION:
Given the opportunity for misleading information to be available to staff via its outdated 2015 version of the PREA Risk Assessment Manual, the auditor requires that the agency's PREA Risk Assessment Manual, containing updates reflective of the agency's revised risk screening procedures from 2017 and requiring affirmative responses to the subjective components of the assessment which can only be ascertained from the inmate themselves be formally approved by the agency and available to staff on the agency's policy management system.

The Muskegon Correctional Facility is also required to continue with its risk screening procedures and demonstrate that it consistently assesses inmates within the timeframes prescribed by the standards. Compliance will be measured by the facility providing the auditor with a copy of the facility's tracking sheet. The auditor will then select a random sample of those inmates and request applicable computerized risk screening records to verify the accuracy of the tracking log, thus ensuring that risk screenings are completed as required in accordance with provisions (a) (b) and (f) of the standard. If compliance is demonstrated during the initial 90-day period, the auditor will be satisfied that the matter has been corrected.

POST INTERIM REPORT CORRECTIVE ACTIONS TAKEN

In late August 2019, the facility's PREA Coordinator provided the auditor a copy of the facility's risk screening tracker. Similar to the initial analysis, the auditor utilized the DATEDIF function within Excel to analyze the timeliness of risk screening. The auditor analyzed the spreadsheet for the completed assessments between May and August that were due for both 72 hour and 30 day assessments. The auditor found continued progressive improvement in the facility's timeliness of assessments, with sample sizes averaging over 70 samples per month. The auditor found that the facility's established process for 72 hour assessments continued to successfully produce timely assessments in accordance with provision (b) of the standard. Specifically, the facility demonstrated greater than 95% compliance in each month of the review period.

With respect to 30 day assessments, the auditor found that during the month of May, the facility demonstrated greater than 90% compliance with timely assessments. In the remaining sample period, the auditor found that the facility demonstrated greater than 95% compliance with reassessments. Based upon the facility's efforts to conduct screenings within the timelines of the standards; the auditor now finds that the facility is in full compliance with the standard.

115.42
CORRECTIVE ACTION RECOMMENDATION:
The Muskegon Correctional Facility is substantially compliant with the practices required by the provisions of 115.42; however, based on the absence of a well-established reassessment process; the facility may be relying on incomplete information to make such decisions. This standard will naturally be considered compliant upon satisfaction of the reassessment procedures mandated by 115.41.

POST INTERIM REPORT CORRECTIVE ACTIONS TAKEN

As noted within 115.41, the facility has established a consistent risk screening process to ensure that assessments are completed within the timeframes noted within the standard. Therefore, the facility is equipped with timely and accurate information upon with to base decisions required by 115.42. The auditor now finds full compliance with the standard.

115.52
CORRECTIVE ACTION RECOMMENDATION:
As noted under provision (d), the auditor requested evidence that an inmate was notified of a grievance extension under MCF/18/08/00001. The facility's investigation tracking log indicates the investigation was initiated on August 16, 2018 and concluded December 17, 2018, a period of 122 days. Upon receipt of compliant documentation confirming that the inmate was notified of the grievance extension when the grievance exceeded 90 days; the auditor shall find compliance.

POST INTERIM REPORT CORRECTIVE ACTIONS TAKEN

Following the submission of the interim report and the return of the facility's PREA Coordinator, the auditor was provided a copy of the investigative file for grievance MCF 18/08/00001. The investigative file contains documentation within to verify that the inmate was informed of the need for additional time to complete the investigation of the grievance in accordance with provision (d) of the standard. Based upon this documentation, the auditor now finds full compliance with the standard.

115.71
CORRECTIVE ACTION RECOMMENDATIONS:
To become compliant with this standard, the facility will be required to implement procedures to physically interview pertinent parties to each allegation to augment any written statements obtained during the investigation. Investigatory reports will need to thoroughly describe testimonial evidence gathered during the investigatory process, describe a review of prior allegations involving suspected perpetrators, thoroughly describe all evidence gathered and attempted to be gathered during the investigation. The auditor finds that with a successful implementation of the facility's procedures to route all sexual abuse and sexual harassment investigations through the facility's PREA Coordinator for a quality assurance review should provide an opportunity to ensure compliant investigatory practices are adhered to prior to submission to the Warden for completion.
The auditor will measure compliance through a review of all facility investigations in the 90 days following the implementation of the corrective action plan. The auditor will expect to see interview summaries within each facility investigation and a thorough description of investigatory efforts. Should the facility not have sufficient evidence of investigatory practice during that 90-day period where the facility can demonstrate its commitment to the thorough pursuit of an investigation; corrective action will continue until such time as investigative reports demonstrating compliance are received or 180 days have been exhausted.

POST INTERIM REPORT CORRECTIVE ACTIONS TAKEN

During the corrective action period, the auditor requested and received the facility's investigatory log in November 2019. The auditor sampled three random investigations from the investigation log on November 10, 2019 and received the requested reports on November 12, 2019. The three investigations involved allegations of prisoner on prisoner sexual harassment. The auditor reviewed

the investigatory files and found evidence that applicable parties were interviewed during the course of the investigation.
Through a review of the first investigation, the auditor found that alleged victim had transferred to another facility since the allegation had been made and a request for an investigatory interview by the current housing facility was made. Within the investigation, the alleged victim was unable to provide sufficient details to identify the subject. An interview was conducted with the alleged victim's former cell mate in an attempt to develop a subject; however, this proved unsuccessful.
Through a review of the second investigation, the auditor found that there was an attempt to interview the alleged victim; however, the alleged victim was uncooperative. Despite the lack of cooperation, the investigator followed through with the available information and conducted an interview with the subject named in the original complaint.
Through a review of the third investigation, the auditor found that the investigator interviewed both applicable parties to the allegation. Based upon the nature of the allegation and the location where it was alleged to have occurred, there was no opportunity for additional witnesses to be identified or interviewed.
The auditor finds, through a sampling of investigations, that the facility has taken the necessary steps to correct the thoroughness element of provision (a) of the standard. There is now sufficient evidence that interviews are conducted and that efforts are made to advance the investigation when there is either a lack of cooperation or minimal initial leads to the complaint.
The auditor also found that the facility implemented a quality control process to ensure that all allegations are reviewed by the facility PREA Coordinator for review prior to submission for final approval. Each predication contained internal affairs instruction to ensure the investigation was reviewed by the facility PREA Coordinator prior to submission. In later investigations, the auditor noticed that the investigatory template had a section for review of prior allegations, as required by provision (c) of the standard.
As described in the review of investigations, the auditor finds evidence that the facility is documenting its findings in a manner consistent with provision (f) of the standard; specifically, there is evidence that testimonial evidence is being gathered for inclusion in the report and that testimonial evidence is adequately described.
Based upon a review of sampled investigations during the corrective action period, the auditor found evidence that the facility has implemented procedures to ensure a greater level of quality in its investigations consistent with provisions (a),(c), and (f) of the standard and therefore finds that the facility is now in full compliance with the standard.

115.73
CORRECTIVE ACTION RECOMMENDATION:
The facility will be required to establish procedures to ensure it notifies an alleged victim of sexual abuse when any of the triggering elements of provision (c) exist. Specifically, the auditor finds that the facility did not document notification that a contract staff member was barred from entering the facility pending investigation. During the corrective action period, the facility will be required to provide evidence that it notifies alleged inmate victims of those elements identified under provision (c) or has established procedures to do so, should triggering events not occur within the corrective action period.

POST INTERIM REPORT CORRECTIVE ACTIONS TAKEN

In November 2019, the auditor sampled the facility's investigatory log and requested sample investigations. Within those sampled investigations, the auditor found sufficient evidence that the involved inmates were notified of the triggering events in accordance with the standard. Although there

was no specific triggering event to measure compliance with provision (c), the auditor finds that with the quality assurance procedures implemented to enhance investigatory compliance, there is sufficient infrastructure to ensure that such notifications are made when necessary. Therefore, the auditor finds compliance with the standard.

115.81
CORRECTIVE ACTION RECOMMENDATION:
To fulfill compliance with provision (a) of the standard, records to confirm that the requested sampled inmate was seen by a mental health practitioner in relation to disclosed abuse is necessary. Upon receipt of the requested sample document that demonstrates compliance, the auditor will find compliance with provision (a) of the standard.

POST INTERIM REPORT CORRECTIVE ACTIONS TAKEN

Following the issuance of the interim report, the auditor was provided records to confirm that the sampled inmate was seen by a mental health practitioner in relation to disclosed sexual abuse. The evaluation confirms that disclosed sexual abuse was affirmatively addressed during the interview. Based upon the receipt of requested sample documentation, the auditor finds full compliance with the standard.

115.87
Corrective Action Recommendation:
It is recommended that the agency establish procedures for contract monitoring, which includes data collection to capture incident based and aggregate data for its contracted facilities.

POST INTERIM REPORT CORRECTIVE ACTIONS TAKEN

As described in 115.12, the agency's contracted entities have significant ground to cover in achieving PREA compliance. Therefore, the contracted entities did not have data collection procedures in place to capture the requisite data for the MDOC to aggregate in accordance with provision (e) of the standard. The MDOC issued a corrective action plan to its contracted entities to develop compliant policies and as part of its contract monitoring, the MDOC will be collecting incident based and aggregate data from the contracted entities once methods have been established by the contracted entities. Until then, the MDOC will track incident based data for its populations housed within the facility through its AIM system that it uses to track all allegations for inmates confined in the MDOC. Specifically, any allegations involving MDOC inmates will be entered into the AIM system for statistical reporting. Consistent with the August 2, 2019 and February 19, 2014 contract monitoring FAQs, the contracting agency will not be held in non-compliance, so long as the contracting agency is documenting the contracted agency's progress towards achieving compliance, which would include the development of procedures to collect data consistent with the standard.

The agency issued a formal corrective action plan to its contracted facilities and received responses on October 8, 2019, that both will be implementing procedures to comply with the PREA standards, which will eventually bring the agency into compliance with this standard's obligation to collect incident based and aggregate data from its contracted facilities.

115.89
CORRECTIVE ACTION RECOMMENDATION:
It is recommended that the agency establish procedures for contract monitoring, which includes data collection to capture incident based and aggregate data for its contracted facilities, which is subsequently published as part of the agency's annual statistical report on its website.

POST INTERIM REPORT CORRECTIVE ACTIONS TAKEN

As described in 115.12, the agency's contracted entities have significant ground to cover in achieving PREA compliance. Therefore, the contracted entities did not have data collection procedures in place to capture the requisite data for the MDOC to aggregate in accordance with provision (e) of 115.87, therefore, such information is not included in the MDOC's annual report consistent with provision (b) of the standard. The MDOC issued a corrective action plan to its contracted entities to develop compliant policies and as part of its contract monitoring, the MDOC will be collecting incident based and aggregate data from the contracted entities once methods have been established by the contracted entities. Until then, the MDOC will track incident based data for its populations housed within the facility through its AIM system that it uses to track all allegations for inmates confined in the MDOC. Specifically, any allegations involving MDOC inmates will be entered into the AIM system for statistical reporting and inclusion in future annual reports. Consistent with the August 2, 2019 and February 19, 2014 contract monitoring FAQs, the contracting agency will not be held in non-compliance, so long as the contracting agency is documenting the contracted agency's progress towards achieving compliance, which would include the development of procedures to collect data for publication within an annual report consistent with the standard.

The agency issued a formal corrective action plan to its contracted facilities and received responses on October 8, 2019, that both will be implementing procedures to comply with the PREA standards, which will eventually bring the agency into compliance with this standard's obligation to collect incident based and aggregate data from its contracted facilities.

PREVENTION PLANNING

Standard 115.11: Zero tolerance of sexual abuse and sexual harassment; PREA coordinator

All Yes/No Questions Must Be Answered by The Auditor to Complete the Report

115.11 (a)

- Does the agency have a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment? ☒ Yes ☐ No

- Does the written policy outline the agency's approach to preventing, detecting, and responding to sexual abuse and sexual harassment? ☒ Yes ☐ No

115.11 (b)

- Has the agency employed or designated an agency-wide PREA Coordinator? ☒ Yes ☐ No
- Is the PREA Coordinator position in the upper-level of the agency hierarchy? ☒ Yes ☐ No
- Does the PREA Coordinator have sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards in all of its facilities? ☒ Yes ☐ No

115.11 (c)

- If this agency operates more than one facility, has each facility designated a PREA compliance manager? (N/A if agency operates only one facility.) ☒ Yes ☐ No ☐ NA
- Does the PREA compliance manager have sufficient time and authority to coordinate the facility's efforts to comply with the PREA standards? (N/A if agency operates only one facility.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

(a) An agency shall have a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment and outlining the agency's approach to preventing, detecting, and responding to such conduct.

Agency policy 03.03.140 and the PREA Manual were reissued by the agency in March 2017 and became effective throughout the agency on 04/24/2017. These policies 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. The auditor reviewed these documents in their entirety. Following a correction to the local operating procedures to clarify opposite gender announcement procedures during the overnight sleeping hours on the facility's second shift; the auditor was able to determine that the existence of such policies demonstrates compliance with provision (a) as described below.

Agency policy 03.03.140 PRISON RAPE ELIMINATION ACT (PREA) AND PROHIBITED SEXUAL CONDUCT INVOLVING PRISONERS serves to establish the agency's zero-tolerance policy and outline the agency's approach to implementing the PREA standards. This policy outlines definitions, sets forth the zero-tolerance standard, describes responsibilities of staff, outlines preventative measures, reporting mechanisms, investigation practices, medical and mental health provider responsibilities and access to victim advocacy. Although the description of the zero-tolerance standard does not precisely match that of the standard language, consisting with the FAQ from March 2018; literal verbiage from the standard is not required to be recited.

The MDOC is in the process of establishing initial determinations of compliance at each of its facilities during the second audit cycle. With the knowledge that there is a wide array of policies issued prior to the effective date of the PREA Standards and the need to cover those areas where previous policy may have been inadequate to meet the PREA standards; the agency created its PREA manual. The agency PREA Manual is a document that serves to unify the agency's approach to implementing the PREA standards, in detail, that were previously covered by a network policies relative to such areas as segregation, employee
training, prisoner placement, health care, etc. Under the authority of a Director's Office Memorandum (DOM), the agency PREA Manual supersedes all policies that were issued prior to its initial issue in September 2015 and supersedes any conflicting policies at the time of its reissue in April 2017. Specifically, in DOM 2017-12 effective January 1, 2017, "The Manual shall control where in conflict with any current policy requirements, including requirements set forth in PD03.03.140."

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.
The facility developed its local operating procedures, OP 03.03.140, which clarifies the specific roles of staff within the facility to execute the agency's PD 03.03.140 and duties prescribed by the PREA Manual. Specifically, the local policy covers agency definitions, risk screening procedures, facility PREA Coordinator and their authority, training, background checks, prohibited conduct, reporting procedures, grievances, mental health referrals required by the standards, investigations, advocacy services, discipline, gender dysphoric inmates, prevention and response duties of staff by staff classification.

(b) An agency shall employ or designate an upper-level, agency-wide PREA coordinator with sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards in all of its facilities.

According to 03.03.140 and the PREA Manual, the position of PREA Manager 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. At the onset of the circular auditing consortium and Pennsylvania's first audits in Michigan in November 2016, it was explained that the title of PREA Manager, is used to accommodate existing Michigan Civil Service title rules. Through

an interview with the PREA Manager, he has sufficient time and authority to implement PREA standards throughout the agency. The PREA Manager is assisted by three agency PREA Analysts, who act in a capacity similar to a PREA Coordinator for facilities in their designated geographic zones throughout the state. These agency PREA Analysts are responsible for onsite contact, provision of technical assistance to the facility, and assistance during audit preparation activities.

(c) Where an agency operates more than one facility, each facility shall designate a PREA compliance manager with sufficient time and authority to coordinate the facility's efforts to comply with the PREA standards.

According to the PREA Manual, the position of PREA Coordinator at the facility oversees the duties of a facility PREA Compliance Manager. This auditor was informed during a previous interview with the agency PREA Manager that the agency titles were modified to accommodate existing Civil Service title rules within the state of Michigan. The PREA Coordinator for the Muskegon Correctional Facility is also one of the facility's two Inspectors. The position of Inspector within the MDOC is an upper-level management position who reports directly to the Warden. The position of Inspector is responsible for the facility's security and investigations. The auditor notes that the facility PREA Coordinator was placed into his position, approximately one year prior to the audit and has made strides during that time to implement the PREA standards at the facility. Through an interview with the PREA Coordinator, the position provides adequate time and authority to coordinate the facility's efforts to comply with PREA standards.

Based on a review of the PREA Manual and interviews with the PREA Manager and facility PREA Coordinator, the auditor determined compliance with provision (c).

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

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.12 (a)

- If this agency is public and it contracts for the confinement of its inmates with private agencies or other entities including other government agencies, has the agency included the entity's obligation to comply with the PREA standards in any new contract or contract renewal signed on or after August 20, 2012? (N/A if the agency does not contract with private agencies or other entities for the confinement of inmates.) ☒ Yes ☐ No ☐ NA

115.12 (b)

- Does any new contract or contract renewal signed on or after August 20, 2012 provide for agency contract monitoring to ensure that the contractor is complying with the PREA standards? (N/A if the agency does not contract with private agencies or other entities for the confinement of inmates OR the response to 115.12(a)-1 is "NO".) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

(a) A public agency that contracts for the confinement of its inmates with private agencies or other entities, including other government agencies, shall include in any new contract or contract renewal the entity's obligation to adopt and comply with the PREA standards.

(b) Any new contract or contract renewal shall provide for agency contract monitoring to ensure that the contractor is complying with the PREA standards.

Based upon a review of the Pre-Audit Questionnaire (PAQ), the PREA Manual, the interviews of the PREA Manager and PREA Coordinator, it initially appeared that neither the agency nor the facility currently contract with other entities or agencies for the confinement of its inmates. The absence of any contracts for the confinement of its inmates within pre-audit materials and policy provisions with the PREA Manual demonstrate the agency's intended compliance with provisions (a) and (b) should it contract for confinement of its inmates.

However, during the formation of the interim report, this auditor researched the Michigan state contract repository and discovered that the agency has two active contracts with the Ingham and Clinton County Jails for the housing of parole violators under the auspice of the Intensive Detention Program. Following the request for evidence of compliance, the audit teams were advised that the agency contends these contracts are applicable to the community confinement standards and thus not subject to audit under §115.12 and §115.87(e) as the contracts are not for the housing of what the agency considers to be its "inmates". Specifically, the agency states the individuals are parole violators who are pending decision for return to an MDOC facility; thus, not officially an MDOC "inmate." The agency claimed to have received verbal guidance from the PREA Resource Center; stating their position of defining the contracts as community confinement was appropriate and that as such, the auditing of the standards would not be applicable to its prison audits. The audit team requested that the agency provide written direction from the PRC to affirm this guidance. As of the date of this interim report, the audit team has not received such written direction provided to the agency.

The audit team researched the agency's description of the program, which states that the individuals are housed pursuant to the program are likely to be returned to the community and are placed for technical violations of parole and arrests for new misdemeanor and felony charges. Thus, the audit

teams contend that the individuals housed pursuant to the contract are detained in a jail, have no "non-residential time", and may be pending disposition for new criminal offenses to differentiate them from an individual who would otherwise be in a pre-trial detention status pursuant to an arrest in the community and unable to post bail in a similar jail scenario. Therefore, the audit team contends the individuals housed pursuant to the contract would be considered "inmates" who are subject to both the provisions of §115.12 and §115.87(e). In furtherance, the auditor submitted an auditor help request through the auditor portal for standards interpretation guidance.

A response to the auditor helpline request was received June 4, 2019. The guidance was that "the fact that people confined in Community Confinement Facilities are referred to as 'residents' does not exempt a jail or prison from any responsibilities in §115.12 because the Prison & Jail Standards say 'inmate'." This information was communicated to the agency on June 4, 2019 and a request for a phone conference on how to resolve the issues was requested. The agency later responded with the FAQ dated April 18, 2018, on June 13, 2019, apparently claiming exception to the standard. The auditor's review of the contracts reveals that the contract is for a set period of time (45 days), provides for programming to those housed pursuant to the contract, and is conducted under the auspice of a specific Intensive Detention Reentry Program created by the agency for a specified per diem rate; thus, is not exempt from the provisions of 115.12 via the April 18, 2018 FAQ insomuch as the contract is not for a "temporary transfer" to effectuate a legal process. As of the date of this interim report, the agency has not responded to a request for a phone conference to resolve the issue.

When evaluating compliance with the provisions enumerated within the standard. The audit teams find compliance with provision (a) of the standard. Specifically, the agency has included in its contracts that the facilities adopt and comply with the PREA standards. However, the agency has no established contract monitoring system to ensure the contracted agencies are compliant with the PREA standards as required under provision (b) of the standard.

Although the contract has language for the PREA standards as a requirement; neither contracted facility has any publicly posted evidence of PREA compliance (i.e. an audit report or policies pertaining to PREA), with one facility's website simply stating they will strive to be PREA compliant. Considering that said contracts were entered into as of October 1, 2017 and remain in effect through September 30, 2019; each contracted facility has had ample time to establish PREA policies pursuant to its contract obligations and to generate sufficient evidence of compliance through an audit, with MDOC oversight and contract monitoring as required by the standard.

Due to the absence of contract monitoring and an established documented procedure to ensure the contracted entities are adhering to the PREA standards; the audit team finds that the agency has not met its obligations under provision (b) of the standard to effectively monitor its contracted agencies nor compelled compliance with the PREA standards.

Corrective Action Recommendation:

The MDOC will be required to establish a formal and documented means of ensuring the agency's contracted entities comply with each of the PREA standards, including audit obligations established under §115.401. Should the contracted entities not comply with its obligations to demonstrate compliance through an audit each cycle pursuant to 115.401; the agency will need to demonstrate its compliance by not renewing such contracts consistent with provision (b) of the standard.

Post Interim Report Corrective Action:

Following the issuing of the interim report, a discussion was held in conjunction with a debriefing from the agency's Richard A. Handlon audit on June 27, 2019. During that discussion with one of the agency's PREA Analysts, it was suggested that a facilitated discussion between the PA DOC audit teams, the MDOC and the PREA Resource Center could be helpful in advancing the discussion. The audit team sent a request to the PREA Resource Center (PRC), requesting the phone conference and potential dates of availability. On July 18, 2019, a request for a phone conference and potential dates of availability was sent to the MDOC PREA Coordinator and Analysts and the discussion was ultimately scheduled for August 8, 2019.

During the phone conference, the audit team, MDOC PREA staff, and a representative of the PRC discussed the viewpoints of the audit team and the agency. Due to continued disagreement between the agency and the audit team over the applicability of the standard to MDOC prison audits; the PRC representative agreed to draft a summary of the conversation for review by the agency PREA Coordinator and the audit teams for submission to the PREA Management Office (PMO) for interpretive guidance. Between August 9, 2019 and August 13, 2019, the drafts circulated between the audit team and MDOC, before submission to the PMO.

On August 23, 2019, the PRC provided the PMO's interpretive guidance on the applicability of 115.12 to the two identified agency contracts. The following guidance was issued:

Based on the information provided and in light of current guidance, it appears that the FAQ that MIDOC relies on for its argument does not apply to this situation. The FAQ envisions temporary transfer/housing situations that arise with facilities that are **not already contracted** and based on reasons outside the control of the agency. The circumstances described seem to indicate that the IDRP is a detention facility used by the MIDOC to hold inmates who have been adjudicated as parole violators until they are released or transferred to a DOC facility. In other words, it appears that this involves a standard contract to hold to MIDOC inmates and therefore MIDOC needs to ensure that the IDRP complies with the standards. It doesn't matter that they are there temporarily—the vast majority of inmates are only held temporarily, but they are still entitled to the protections offered by the Standards, and so the requirements of 115.12 apply.

On August 26, 2019, the MDOC again asserted its reservations with the interpretive guidance and requested the original direction from the DOJ staff for their use and support moving forward within the agency.

On September 3, 2019, the audit team requested a phone conference to discuss potential resolution to 115.12. The audit team advised the agency of approximate dates when corrective action periods could be anticipated to expire and stressed the urgency of formulating a plan, even if the MDOC continued to pursue its objection to the applicability of the standard. A phone conference was ultimately scheduled for September 23, 2019.

During the phone conference, the audit team, the MDOC PREA staff, and MDOC contract monitoring staff discussed the steps necessary to demonstrate evidence of contract monitoring. Through the discussion, the audit team learned that the contracts are legislatively earmarked and would be renewing automatically October 1, 2019. The audit team discussed the August 2, 2019 FAQ, which updated the previous February 19, 2014 FAQ, to require that any entity under contract for 3 years or more must be audited as PREA compliant by August 20, 2022. Within the FAQs, even though the contracted entity need not be required to be immediately compliant, the contracting agency is required to document its monitoring of the contracted entity's progress towards compliance.

The audit team learned that the contracted entities have no infrastructure to comply with PREA at this time and have yet to develop so much as policy provisions to govern how they will implement the standards. Given the starting point of the contracted entities, the audit team and the MDOC mutually agreed upon a monitoring tactic that would begin with the issuance of a formal contractual corrective action plan issued to the contracted entities, citing their failure to adhere to their contractual obligation to comply with the PREA standards. The corrective action plan must outline achievable and measurable milestones for the contracted entity to meet during various intervals throughout the one-year period of the October 1, 2019 contract. The audit team suggested that the corrective action plan include that the contracted entities be held accountable to implement the most critical components of developing compliance within that initial year, such as development of a policy within three months, completion of staff, contractor, volunteer, and inmate training and education requirements within six months, and implementation of risk screening procedures prior to the end of the contractual year so that the contracted entities would be on target to achieve full compliance and be prepared for audit by the August 20, 2022 date established within the FAQ. To fulfill their portion of contract monitoring required by the standards, the MDOC would be responsible to gather tangible evidence of compliance through documentation exchanges, hold the contracted facility accountable to the deadlines imposed within the corrective action plan, and to enforce compliance with the plan through its available contractual remedies. The MDOC's PREA staff would be consulted by the agency's contract monitors to assess whether the contracted entity's evidence of compliance was consistent with the PREA standards.

The audit team and the MDOC mutually agreed that the provision of the corrective action plan to the contracted entities, and an acknowledgement of the obligations of the corrective action plan requirement by the contracted entities would suffice as evidence that the MDOC has engaged in contract monitoring as required by provision (b) of the standard. The MDOC's enforcement of the contractual corrective action plan is deemed to be most appropriately assessed during future third cycle audits to ensure the MDOC has continued with those obligations initiated through the second cycle audits where the issue was first identified.

On September 24, 2019, the MDOC provided the audit team with the contractual corrective action plans developed for each of the contracted entities and provided email correspondence verifying that each had been formally sent to each of the contracted facilities. The corrective action plans included the following milestones:

5. No later than 12/26/2019, your organization must have PREA policies in place, and provide to Contract Monitor, that will bring your organization into compliance with the following sections of the Prison Rape Elimination Act, Prisons and Jail Standards:
   g. 115.11 Zero tolerance of sexual abuse and sexual harassment; PREA coordinator.
   h. 115.13 Supervision and monitoring.
   i. 115.15 Limits to cross-gender viewing and searches.
   j. 115.22 Policies to ensure referrals of allegations for investigations.
   k. 115.61 Staff and agency reporting duties.
   l. 115.67 Agency protection against retaliation.

6. No later than 3/24/2020, your organization must develop, and provide to Contract Monitor, PREA training for employees, volunteers, contractors, and offenders, that will bring your organization into compliance with the following sections of the Prison Rape Elimination Act, Prisons and Jail Standards:
   f. 115.31 Employee training.

g. 115.32 Volunteer and contractor training.
h. 115.33 Inmate education.
i. 115.34 Specialized training: Investigations.
j. 115.35 Specialized training: Medical and mental health care

7. No later than 6/24/2020, your organization must develop, and provide to Contract Monitor, a risk screening process that will bring your organization into compliance with the following sections of the Prison Rape Elimination Act, Prisons and Jail Standards:
   c. 115.41 Screening for risk of victimization and abusiveness.
   d. 115.42 Use of risk of victimization and abusiveness

8. You must have a certified PREA audit completed on your organization no later than 8/19/2022, and once within each three-year PREA cycle thereafter. Subsequent contract renewals will require continued PREA implementation.
   c. 115.93 Audits of standards
   d. 115.401-115.405 Auditing and Corrective Action

The contracted entities were given until October 8, 2019 to respond to the corrective action plan.

The audit team was provided with the contracted entity response on October 8, 2019. Both contracted entities agreed to abide by the corrective action plan and agreed to the deadlines the MDOC imposed via the contract corrective action plan. The audit team finds this formal demand for compliance by the MDOC and acknowledgement of the need for corrective action by the contracted entities to satisfy provision (b)'s requirements for the agency to monitor and enforce compliance with PREA provisions of its contracts.

Standard 115.13: Supervision and monitoring

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.13 (a)

- Does the agency ensure that each facility has developed a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect inmates against sexual abuse? ☒ Yes ☐ No

- Does the agency ensure that each facility has documented a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect inmates against sexual abuse? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the generally accepted detention and correctional practices in calculating adequate staffing levels and determining the need for video monitoring? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration any judicial

findings of inadequacy in calculating adequate staffing levels and determining the need for video monitoring? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration any findings of inadequacy from Federal investigative agencies in calculating adequate staffing levels and determining the need for video monitoring? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration any findings of inadequacy from internal or external oversight bodies in calculating adequate staffing levels and determining the need for video monitoring? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration all components of the facility's physical plant (including "blind-spots" or areas where staff or inmates may be isolated) in calculating adequate staffing levels and determining the need for video monitoring? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the composition of the inmate population in calculating adequate staffing levels and determining the need for video monitoring? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the number and placement of supervisory staff in calculating adequate staffing levels and determining the need for video monitoring? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the institution programs occurring on a particular shift in calculating adequate staffing levels and determining the need for video monitoring? ☒ Yes ☐ No ☐ NA

- Does the agency ensure that each facility's staffing plan takes into consideration any applicable State or local laws, regulations, or standards in calculating adequate staffing levels and determining the need for video monitoring? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the prevalence of substantiated and unsubstantiated incidents of sexual abuse in calculating adequate staffing levels and determining the need for video monitoring? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration any other relevant factors in calculating adequate staffing levels and determining the need for video monitoring? ☒ Yes ☐ No

115.13 (b)

- In circumstances where the staffing plan is not complied with, does the facility document and justify all deviations from the plan? (N/A if no deviations from staffing plan.) ☒ Yes ☐ No ☐ NA

115.13 (c)

- In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: The staffing plan established pursuant to paragraph (a) of this section? ☒ Yes ☐ No

- In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: The facility's deployment of video monitoring systems and other monitoring technologies? ☒ Yes ☐ No

- In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: The resources the facility has available to commit to ensure adherence to the staffing plan? ☒ Yes ☐ No

115.13 (d)

- Has the facility/agency implemented a policy and practice of having intermediate-level or higher-level supervisors conduct and document unannounced rounds to identify and deter staff sexual abuse and sexual harassment? ☒ Yes ☐ No

- Is this policy and practice implemented for night shifts as well as day shifts? ☒ Yes ☐ No

- Does the facility/agency have a policy prohibiting staff from alerting other staff members that these supervisory rounds are occurring, unless such announcement is related to the legitimate operational functions of the facility? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

(a) The agency shall ensure that each facility it operates shall develop, document, and make its best efforts to comply on a regular basis with a staffing plan that provides for adequate levels of staffing, and, where applicable, video monitoring, to protect inmates against sexual abuse. In calculating adequate staffing levels and determining the need for video monitoring, facilities shall take into consideration:
(1) Generally accepted detention and correctional practices;
(2) Any judicial findings of inadequacy;

(3) Any findings of inadequacy from Federal investigative agencies;
(4) Any findings of inadequacy from internal or external oversight bodies;
(5) All components of the facility's physical plant (including "blind-spots" or areas where staff or inmates may be isolated);
(6) The composition of the inmate population;
(7) The number and placement of supervisory staff;
(8) Institution programs occurring on a particular shift;
(9) Any applicable State or local laws, regulations, or standards;
(10) The prevalence of substantiated and unsubstantiated incidents of sexual abuse; and
(11) Any other relevant factors.

The PREA Manual specifies the eleven factors enumerated within provision (a) of the standard are considered when developing the staffing plan for MDOC prisons. The facility staffing plan, which was reviewed by the facility on September 20, 2018 and approved on September 23, 2018, coupled with an interview of the facility's Warden, verifies that all eleven factors within provision (a) of the standard were used to formulate the facility staffing plan. The plan contains a narrative description relative to each of the eleven enumerated factors and the facility's findings, except for how it complies with generally accepted correctional practices, which was explained through interview with the Warden.

The facility evaluates its staffing needs through analysis of similar size facilities with comparable programming to ensure that it's staffing levels are meeting generally accepted correctional practices. During the audit tour, the auditor observed that the facility provides for direct supervision on the housing units, with officer staff conducting rounds and being accessible to the inmate population; consistent with best correctional practices. The auditor notes that neither the agency nor the facility are subject to any findings of inadequacy from the Courts or Federal investigative agencies. There are no state or local laws governing staffing. The facility is subject to audit by the state's Auditor General and is subject to internal audits, which were included as part of the staffing plan's formulation documentation. Internal findings of inadequacy were noted in a 2017 inspection with respect to rounds conducted by the facility's Inspector and Resident Unit Manager (RUM) the fire and safety inspections; however, none were with respect to manpower resources required under the staffing plan. The population is composed of "general population" (inmates with a designated custody level of medium), "incentive based unit", "GOALS/PAWS unit" (Growth, Opportunity, and Life Skills – a unique management style program, aimed at engaging Offenders in programs and providing a positive living environment through increased staff and volunteer programming, along with the facility's canine program, aimed at training dogs for a career) and the "faith based unit" (Prison Fellowship program within the facility) populations.

All six housing units are identically constructed in the shape of a "Y" style celled environment, with an upper and lower tier, an officer station is located on the first floor strategically placed in front of the unit's 3 day room/recreation areas where inmates may congregate during out of cell time. From the station, the officers have the vantage point of viewing each wing. Through the open tier system, they can also monitor traffic on the second floor of the unit, while maintaining access to monitor activity in those day rooms behind them. The only unique structural change between the housing units is that Housing Unit 6 was constructed several years after the facility was opened and incorporated more of the agency's modernized approach to increasing visibility by placing the officer's station at an elevated vantage point, allowing greater view of the upper tier. Additionally, this unit does not have the group shower configuration of the remaining five units and houses 70 less inmates. It is noted that housing units can hold the following maximum populations:

Unit 1: 226

Unit 2: 238
Unit 3: 238
Unit 4: 238
Unit 5: 238
Unit 6: 160

With the aforementioned inmate populations, and the incentive based nature of two of the units; the facility's staffing plan accounts for these differences in the composition of the inmate population by placing a third officer on its "traditional" housing units, and allowing for two officers to staff the faith based unit during its first shift of 0600-1800. When the facility is required to collapse posts due to staffing issues, it has determined that the composition of its incentive-based units may permit for the reduction down to two officers. During the second shift of 1800-0600, the staffing for each Unit 2 through 6 reduces to two staff. Unit 1 maintains its third officer due to the 27 "temporary segregation" beds being located on the lower tier of one of its wings.

The facility operates on a 12-hour shift schedule for its custody staff. Shifts run from 0600-1800 and 1800-0600. There is a small overlapping shift of five officers who work an eight-hour shift from 1400-2200 hours to supplement with security relative to programming occurring before inmates are required to lock-in for the night. This shift has one officer assigned to the visiting room and four individuals assigned as "rovers" who may provide relief, escorts, assist with line movements of inmates, or other functions. With respect to the number and placement of supervisory staff, each 12-hour shift is overseen by one Captain, three Lieutenants and two Sergeants. In addition to security chain of command, a total of two Resident Unit Managers (RUM) and ten Prison Counselors to assist in the oversight of the housing units during the facility's first shift.

As noted above, officer assignment varies by housing unit and shift; however, each has staff assigned to monitor both wings and the lobby area of the housing unit. Additional staff are assigned to randomly rove throughout the facility and supervise yard activities, food service, visiting, the facility's education building, healthcare, and administrative areas. The auditors observed officers stationed on each housing unit, consistent with the staffing plan as the tour progressed, along with additionally roving staff outside the housing units, who were observed supervising recreation and directing inmate movements for feeding. Moreover, the audit team observed that staff roved the education and programming areas to ensure safety and deter prohibited activity. Two officers are allocated to the programming building during its first shift operational hours to provide additional security for those programs directly overseen by MDOC instructors. All programs facilitated by instructors, prison counselors and mental health staff are subject to checks during officer rounds. Moreover, the programming area of the facility has clear lines of visibility, via a window, into each area to ensure maximum accountability with minimum staffing. There were no substantiated reports to sway the staffing plan and the unsubstantiated reports were not influenced by staffing levels. The auditor's review of investigations finds the facility's assessment that reported incidents were not influenced by staffing levels to be in accordance with provision (a). The auditor notes that the facility has a robust camera system, which provides facility staff with an exceptional support tool to augment existing officer presence.

Interviews with the Warden reveal that no recent modifications were made to the staffing plan. While not a specific violation of the standard, based on the facility's ability to either collapse non-essential posts or mandate overtime to fulfill staffing needs; the Warden did indicate in an interview that an additional officer to assist with evening activities after the conclusion of the 0600-1800 shift would be helpful to reduce overtime burdens and reduce the frequency of collapsing non-essential activity related posts. According to the facility's population spreadsheet provided pre-audit, the operational staffing

plan was originally predicated on 1338 inmates and the facility generally operates just shy of capacity at 1321.

Although compliance with the literal standard is achieved (specifically referring to the facility generically and the agency PREA Manager [Coordinator] as required parties to a staffing plan review), a recommendation, the facility should incorporate the facility's PREA Coordinator (PREA Compliance Manager according to the standards) in its staffing plan formulation when the staffing plan is subject to creation and not simply review. Although there is documented proof of his involvement in the review process in April 2019; he disclosed in an interview that he was not involved in the development of the staffing plan in September 2018.

While not directly related to the staffing plan itself, the auditor does note that during the tour of the facility's auditorium area, there is a fire exit of to the right of stage that creates a blind-spot of significant concern. The doors are solid and open inwards towards an isolated corridor. There are two access points to the corridor, one from the stage itself and the second from the floor of the auditorium. The exit to the corridor is another set of solid doors that open outward. The doors cannot be opened from the other directions without a key, meaning that if an individual were taken into this area, and the corridor exit were blocked; that individual would be trapped within and vulnerable to sexual abuse. Because the doors are fire doors, they cannot be locked from the auditorium access point to prevent entry into the emergency exit corridor.

When discussing the issue with facility staff during the audit tour, the facility's PREA Coordinator and the agency PREA Analyst stated that they had self-identified that area of concern. The facility provided a copy of a purchase order for replacement fire proof doors with a window that can be utilized for inward viewing into the corridor from all three access points. With such doors installed, there is ample opportunity for viewing into this area from all vantage points, including the exit doors into a busy hallway within the facility's school building. To be fully compliant with provision (a)'s consideration of blind spots, the auditor will require verification that the doors noted in the purchase order have been installed. Verification can be in the form of photographs of the location.

(b) In circumstances where the staffing plan is not complied with, the facility shall document and justify all deviations from the plan.

According to an interview with the PREA Manager, the agency does not ordinarily deviate from its staffing plan. The PREA Manager reported that all posts are filled either through voluntary overtime or mandated overtime. An interview with the Warden revealed that staff either volunteer or are mandated to remain at their posts on overtime to fulfill the facility's staffing plan. When the facility does not have staff it can mandate for overtime, non-essential posts can be collapsed, and facility activities cancelled to ensure adequate staffing on each of the facility's housing units. The Warden states that daily shift rosters document facility absences and how posts are filled, collapsed or reconciled. During the audit tour, the auditor observed the use of overtime to ensure posts were filled, interviewing random staff who reported that they were working overtime, covering shifts vacated by absences. The facility's primary reasons for employing deviations from its staffing plan include unanticipated emergency inclement weather, sick leave, unscheduled emergency transportation of inmates to outside hospitals for medical care.

Pre-audit, the facility provided its Daily Personnel Reconciliation sheets and overtime summaries for three dates during the audit period to demonstrate how any deviations from the staffing plan would be documented. The worksheet documents the total staff reporting for duty, essential posts that are required to be filled and the number of officers remaining to staff non-essential posts. The form also

includes a space to document any assignments/posts closed, in compliance with provision (b) of the standard. The auditor requested documentation for additional dates of June 3, 2018, September 10, 2018, December 26, 2018, and February 3, 2019 to confirm consistent practice. The auditor's review of these documents confirms that practice was consistent with the documentation observed pre-audit for those randomly selected dates. Moreover, the overtime summary worksheets, which document the necessity for the use of overtime, confirms that the facility utilized overtime to cover absences created by sick/unscheduled leave.

Interviews with the Warden and the auditor's observation and interviews with staff who worked overtime, and the facility's documentation consisting of the Daily Personnel Reconciliation sheets and overtime summaries confirm the facility makes its best efforts to comply with its staffing plan and documents any deviations (i.e. collapsing of non-essential activity posts) to demonstrate compliance with provision (b).

(c) Whenever necessary, but no less frequently than once each year, for each facility the agency operates, in consultation with the PREA coordinator required by § 115.11, the agency shall assess, determine, and document whether adjustments are needed to:
(1) The staffing plan established pursuant to paragraph (a) of this section;
(2) The facility's deployment of video monitoring systems and other monitoring technologies; and
(3) The resources the facility has available to commit to ensure adherence to the staffing plan.

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 Manager for review. The PREA Manager reports involvement in the staffing plan process for each facility within the agency. The auditor notes that this is the initial PREA audit for this facility and its formal staffing plan was just officially formulated in September 2018. There was a review for April 2019, with evidence of the PREA Manager's review; following facility review by the facility PREA Coordinator and Warden.

While agency policy specifies that the staffing plan is to be reviewed annually by the facility and the agency PREA Manager, the auditor notes that the Muskegon Correctional Facility's staffing plan was just developed September 2018, and this is the facility initial efforts to demonstrate compliance with the PREA standards through an audit; therefore, additional pre-audit period annual staffing plan reviews were determined irrelevant to this audit. From this auditor's observations during his participations in twelve audits throughout the agency, Muskegon Correctional Facility and the agency as a whole, have taken action to upgrade camera technology to demonstrate compliance with provision (c).

(d) Each agency operating a facility shall implement a policy and practice of having intermediate-level or higher-level supervisors conduct and document unannounced rounds to identify and deter staff sexual abuse and sexual harassment. Such policy and practice shall be implemented for night shifts as well as day shifts. Each agency shall have a policy to prohibit staff from alerting other staff members that these supervisory rounds are occurring, unless such announcement is related to the legitimate operational functions of the facility.

PD 04.04.100 Custody, Security and Safety Systems and the PREA Manual 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 electronic round reading device printouts from the Deputy Warden, shift Captains, Lieutenants, RUM and Sergeants during the month of December to demonstrate unannounced supervisory rounds taking place within the facility during all

three shifts; covering all areas of operations on those shifts. During the on-site portion of the audit, this auditor observed log book entries on the housing units to demonstrate compliance with provision (d) of the standard with sufficient rounds in each unit to cover each shift. Additionally, during the audit tour, the auditor asked to see each camera, excluding perimeter cameras, to verify compliance with cross-gender viewing limitations. During this time, the auditor observed that rounds were taking place throughout the facility by officers in the housing units.

Through interviews with the PREA Coordinator and review of log book activity on the housing units during the audit tour, 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. One of the facility Resident Unit Managers (RUM) was interviewed and reported that rounds are conducted regularly, staff are not permitted to notify others of occurring rounds and that she routinely changes his patterns, such as skipping some units, to ensure rounds are not predictable. She states that she is required to visit each of her housing units at least once per day to deter prohibited activity. A Deputy Warden was also interviewed for this purpose and confirmed that he makes efforts to ensure his rounds are not conducted in sequence to ensure they are not predictable. Radio traffic is not permitted to ensure rounds are not announced. Rounds are documented in the unit log books in green ink and via the use of a round reader. 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 supervisors during each shift on the housing units.

A review of agency policy, interviews with the facility administration, informal interviews with line staff and a review of log book entries indicate compliance with provision (d). Post audit, the auditor made a request for additional round reader print outs for the facility's Deputy Warden and the PREA Coordinator. Due the timing of the request and the PREA Coordinator's absence from the facility, the request was unable to be satisfied prior to the issuing of this interim report. Upon receipt of compliant sample documentation requested by the auditor; the auditor will be able find full compliance with provision (d).

CORRECTIVE ACTION RECOMMENDATION:

To be fully compliant with provision (a)'s consideration of blind spots, the auditor will require verification that the doors to the fire exit corridor within the facility's auditorium have been installed. Verification can be in the form of photographs of the location.

To be fully compliant with provision (d), the facility will be required to submit the additional request for round reader reports requested. Upon receipt of compliant documentation, the auditor may find full compliance with the provision.

POST INTERIM REPORT CORRECTIVE ACTIONS TAKEN:

Following the submission of the interim report, the requested round reader documentation was provided to the auditor to confirm that administrative rounds are occurring in accordance with provision (d) of the standards. There was a technological issue with some of the round readers for the facility PREA Coordinator registering under his name and appearing as "not specified" along with the Deputy Warden's rounds only being specifically labeled under his name in four of the six housing units, again, with some of those rounds appearing as "not specified." Nevertheless, the rounds were specified as a supervisory round in the system; however, not associated with a specific name.

Round reader reports verified that daily rounds were occurring in the housing units at irregular interviews. While each shift may not have been covered each day, there was evidence that there were then times where multiple supervisory rounds occurred the same shift in one day. Again, this irregularity of rounds appears to support the standard's intent to deter sexual abuse through unannounced oversight consistent with provision (d) of the standard.

With respect to provision (a) of the standard, the facility experienced several delays with the manufacturer producing and delivering the fire exit doors for the auditorium area. The facility's PREA Coordinator provided email correspondence from the vendor to verify the delays. Ultimate, on November 19, 2019, the facility received and were able to provide verification of the installation of the doors via photographs to eliminate the blind spot, consistent with provision (a) of the standard.

Following the provision of requested documentation of supervisory rounds and the installation of doors in the auditorium area that eliminate blind spots; the auditor finds that the facility has taken the necessary actions to be fully compliant with the standard.

Standard 115.14: Youthful inmates

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.14 (a)

- Does the facility place all youthful inmates in housing units that separate them from sight, sound, and physical contact with any adult inmates through use of a shared dayroom or other common space, shower area, or sleeping quarters? (N/A if facility does not have youthful inmates [inmates <18 years old].) ☐ Yes ☐ No ☒ NA

115.14 (b)

- In areas outside of housing units does the agency maintain sight and sound separation between youthful inmates and adult inmates? (N/A if facility does not have youthful inmates [inmates <18 years old].) ☐ Yes ☐ No ☒ NA

- In areas outside of housing units does the agency provide direct staff supervision when youthful inmates and adult inmates have sight, sound, or physical contact? (N/A if facility does not have youthful inmates [inmates <18 years old].) ☐ Yes ☐ No ☒ NA

115.14 (c)

- Does the agency make its best efforts to avoid placing youthful inmates in isolation to comply with this provision? (N/A if facility does not have youthful inmates [inmates <18 years old].) ☐ Yes ☐ No ☒ NA

- Does the agency, while complying with this provision, allow youthful inmates daily large-muscle exercise and legally required special education services, except in exigent circumstances? (N/A if facility does not have youthful inmates [inmates <18 years old].) ☐ Yes ☐ No ☒ NA

- Do youthful inmates have access to other programs and work opportunities to the extent possible? (N/A if facility does not have youthful inmates [inmates <18 years old].)
  ☐ Yes ☐ No ☒ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

(a) A youthful inmate shall not be placed in a housing unit in which the youthful inmate will have sight, sound, or physical contact with any adult inmate through use of a shared dayroom or other common space, shower area, or sleeping quarters.

(b) In areas outside of housing units, agencies shall either:
(1) maintain sight and sound separation between youthful inmates and adult inmates, or
(2) provide direct staff supervision when youthful inmates and adult inmates have sight, sound, or physical contact.

(c) Agencies shall make best efforts to avoid placing youthful inmates in isolation to comply with this provision. Absent exigent circumstances, agencies shall not deny youthful inmates daily large-muscle exercise and any legally required special education services to comply with this provision. Youthful inmates shall also have access to other programs and work opportunities to the extent possible.

Agency policy 05.01.140, Prisoner Placement and Transfer, outlines that agency's approach to housing youthful inmates and were reviewed in determining compliance. Agency policy dictates that male youthful inmates are 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. Additionally, the PREA manual and facility narrative reinforce the agency's assertion that youthful inmates are not housed at Muskegon Correctional Facility. The agency provided operational procedures from TCF and WHV to demonstrate that said facilities due have procedures in place to manage youthful offenders.

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

Standard 115.15: Limits to cross-gender viewing and searches

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.15 (a)

- Does the facility always refrain from conducting any cross-gender strip or cross-gender visual body cavity searches, except in exigent circumstances or by medical practitioners?
  ☒ Yes ☐ No

115.15 (b)

- Does the facility always refrain from conducting cross-gender pat-down searches of female inmates in non-exigent circumstances? (N/A here for facilities with less than 50 inmates before August 20,2017.) ☒ Yes ☐ No ☐ NA

- Does the facility always refrain from restricting female inmates' access to regularly available programming or other out-of-cell opportunities in order to comply with this provision? (N/A here for facilities with less than 50 inmates before August 20, 2017.) ☒ Yes ☐ No ☐ NA

115.15 (c)

- Does the facility document all cross-gender strip searches and cross-gender visual body cavity searches? ☒ Yes ☐ No

- Does the facility document all cross-gender pat-down searches of female inmates?
  ☒ Yes ☐ No

115.15 (d)

- Does the facility implement a policy and practice that enables inmates to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks? ☒ Yes ☐ No

- Does the facility require staff of the opposite gender to announce their presence when entering an inmate housing unit? ☒ Yes ☐ No

115.15 (e)

- Does the facility always refrain from searching or physically examining transgender or intersex inmates for the sole purpose of determining the inmate's genital status? ☒ Yes ☐ No

- If an inmate's genital status is unknown, does the facility determine genital status during conversations with the inmate, by reviewing medical records, or, if necessary, by learning that information as part of a broader medical examination conducted in private by a medical practitioner? ☒ Yes ☐ No

115.15 (f)

- Does the facility/agency train security staff in how to conduct cross-gender pat down searches in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs? ☒ Yes ☐ No

- Does the facility/agency train security staff in how to conduct searches of transgender and intersex inmates in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

(a) The facility shall not conduct cross-gender strip searches or cross-gender visual body cavity searches (meaning a search of the anal or genital opening) except in exigent circumstances or when performed by medical practitioners.

04.04.140 SEARCH AND ARREST IN CORRECTIONAL FACILITIES and the PREA Manual establish procedures to limit cross gender viewing and were reviewed in determining compliance with provision (a) of the standard. As part of its pre-audit questionnaire, the facility indicates that no cross-gender strip searches or visual body cavity searches were conducted during this audit period. The auditor notes that, while the facility provided the outdated version of the agency policy in its pre-audit materials; the auditor was able to find the most recent reissue (March 1, 2019) on the agency's website. There are no standard conflicts noted in the updated version.

Policy 04.04.110 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 and a supervisor is required. Readily available is not consistent with exigent circumstances as defined in the standards. Policy 04.04.110 also does not specify who may view recorded body cavity searches (Z-4), only noting that the Warden

or his/her supervisors may authorize release or viewing of the recording. According to the PREA Resource Center's FAQ's, a facility should use a privacy screen or other similar device to obstruct viewing of inmate breast, buttocks or genitalia in cases where supervisors of the opposite gender are present with the inmate being strip searched. A previous interview with the agency PREA Manager confirms that privacy screens are to be used if or when an opposite gender supervisor must be present during a strip/body cavity search; however, there is an adequate number of male staff supervisory staff within the facility's staffing compliment that such measures would not be necessary. Auditor observation of the staffing composition affirms an adequate number of male supervisory staff are available when supervision is required. It was clarified that any recorded strip searches or body cavity searches, as described in policy, could only be utilized for investigatory purposes.

The facility identified one of its intake strip search area as an empty room adjacent to the control center in the administration building, which contains the sally port in and out of the facility. Inmates on transports process in and out of the facility via the same pathway as staff. Moreover, the visiting area is near the sally port; thus, the location of this strip room is ideal for conducting routine strip searches. The identified room has a cover on the window that permits inward viewing. Staff performing the strip search enter the room with the inmate, close the door, and conduct the search. Sexual abuse of the inmate would be deterred by the ability to hear through the door, the volume of traffic passing through the area, and the control center being able to observe the use of this area. During the audit, the audit team observed inmates being processed in and out of the facility and this strip search area being utilized by male staff. The facility also has a secondary strip search area in the School/LTA building where the facility's Quarter Master is located. New commits to the facility are searched at this location upon reception and issue of facility clothing. Strip searches are performed in an inmate restroom, which would be cleared out for the purposes of the search. There is a barrier inside the doorway to this restroom to prevent cross-gender viewing. The inmate being searched would stand at the far end of the restroom and would be shielded from viewing by any individual traveling the hallway the barrier. The auditor also notes that all inmates arriving at Muskegon Correctional Facility will have processed through the agency's Reception and Guidance Center or will have transferred in from another MDOC facility, where an inmate's gender or any special privacy considerations for transgender inmates would have been pre-determined.

The facility PREA Coordinator confirms that no cross-gender strip searches or visual body cavity searches were conducted, and the facility's strip search areas have adequate privacy from cross-gender viewing to demonstrate compliance with provision (a) of the standard and clarification of practice that eliminates the ambiguity in agency policy.

(b) As of August 20, 2015, or August 20, 2017 for a facility whose rated capacity does not exceed 50 inmates, the facility shall not permit cross-gender pat-down searches of female inmates, absent exigent circumstances. Facilities shall not restrict female inmates' access to regularly available programming or other out-of-cell opportunities in order to comply with this provision.

Policy 04.04.110, which was reviewed in determining compliance with provision (b) of the 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.

Although agency policy 04.04.110 is provides an exception to cross-gender pat-search procedures for female inmates that are not clearly defined to specify what type of contraband could be considered an

exigent circumstance that could trigger the permission of a cross- gender pat search of a female inmate; the auditor also notes that Muskegon Correctional Facility does not house female inmates.

Through the PAQ, a review of agency policy 05.01.140, Prisoner Placement and Transfer, the PREA Manual, the facility tour and interviews with the PREA Manager, PREA Coordinator and Warden, the 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).

(c) The facility shall document all cross-gender strip searches and cross-gender visual body cavity searches, and shall document all cross-gender pat-down searches of female inmates.

Policy 04.04.110 and the PREA Manual establish policy for provision (c) of the standard and was reviewed in determining compliance. Agency policy 04.04.110 requires that a report be authored to the Warden of the facility by the end of shift when a 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 additional staff be present during the course of such a search for safety/accountability and that additional staff person must be of the same gender as the person receiving the visual body cavity search. Search training materials confirm that staff are trained that females are to be pat-searched by female staff only and that if a male staff must do so in an emergency; staff are trained that it must be documented through the submission of a written report to the on-duty administrator. As previously noted, Muskegon Correctional Facility does not house female inmates to require such documentation of female inmates being searched by male staff. As previously noted, there is an adequate number of male staff employed at the facility on both shifts to avoid the necessity for cross-gender strip searches.

The facility PREA Coordinator and the PAQ confirmed there were no reported cross gender strip, visual body cavity or pat-searches of female inmates conducted by the facility. Random staff interviews confirmed that line staff are aware of the prohibition against cross-gender strip searches and the auditor notes that the facility does not house female inmates. Moreover, the auditor's observation of the strip search area confirms that adequate privacy from outside the area viewing exists, allowing this auditor to determine compliance with provision (c) of the standard.

(d) The facility shall implement policies and procedures that enable inmates to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks. Such policies and procedures shall require staff of the opposite gender to announce their presence when entering an inmate housing unit.

03.03.140 PRISON RAPE ELIMINATION ACT (PREA) AND PROHIBITED SEXUAL CONDUCT INVOLVING PRISONERS, the PREA Manual, Privacy Notice Signs, Knock and Announce and photographs of showering facilities signs were reviewed pre-audit in determining compliance with provision (d) of the standard.

During the audit tour, this auditor observed that the facility has numerous Privacy Notice Signs, Knock and Announce signs displayed at entrances to the housing units, officer desks and in the bathroom areas of the housing units. Opposite gender staff announcements were made on all housing unit tours and staff waited 10 seconds after making the announcement prior to entering the unit to afford time to ensure privacy.

A total of 46 inmates were formally interviewed during the course of the audit (including specialized populations); however, the random protocol of questions was used for each. The audit team ensured that an inmate from each of the housing unit wings, both upper and lower tiers in each housing unit were randomly selected for interview, with a consistent selection on each unit by selecting the same cell numbers in each. Of those interviewed 11 affirmatively stated that opposite gender announcements were not made when females staff entered the units. 23 affirmatively identified that opposite gender announcements were made consistently. The remainder of the inmates stated that such announcements occurred most of the time or that they could not tell how frequently the announcements were made, with inmates admitting to the fact that they do not pay attention to or routinely listen for these announcements.

The auditor attempted to identify a pattern by housing unit and found conflicting inmate reports from inmates within the same housing units. Several inmates who stated they did not hear the announcements stated that they lived close to a fan posted at the end of the tiers, further explaining that they cannot hear even routine messages relayed over the facility's intercom system. Given the layout of each housing unit and the fact that inmates are required to wear headphones to watch their personal televisions and listen to music on their tablets, there is considerable opportunity for the routine noise of those routine living requirements to drown out any announcement that is made. The auditor notes that the configuration of the housing units is such that the restrooms and showers are located in close proximity to the entryway to the housing unit; thus, when inmates are in the process of either of these two functions, they are in greatest proximity to hear the announcements taking place.

While the facility may be practicing the concept of opposite gender announcements, as all staff confirmed such a practice in interviews and the audit team observed announcements being made during the three days onsite; the inconsistency in the effectiveness of this announcement practice is evident among a portion of the inmate population that may be living in proximity of the fans used to cool the housing unit. In speaking with these inmates, they stated that the fan even drowns out the housing unit intercom system; negating that or any other audible signal as a more effective alternative. However, the auditor does note that the only authorized opportunity for cross-gender viewing occurs in the bathroom area, which is located near the entry way, where the observed practice has the greatest opportunity to fulfill its intent of limiting cross-gender viewing. The facility is literally compliant with the opposite gender announcement element of provision (d) of the standard with its actions.

During the course of the audit tour, the auditor observed that each housing unit has two communal bathroom facilities (one on each tier), located near the entryway in each housing unit, in proximity to the officer post/office space and counselor office. The restrooms are located on one wing of the unit and the showers would be located on the opposite wing. The restrooms consist of several toilets in individual stalls. Next to the toilets is a row of urinals without individual dividers. Next to the urinals were a row of sinks. While on the audit tour, the audit team noticed that the extreme ends of the urinal rows could be subject to opposite gender viewing. The facility installed doors on most of the restroom doors prior to the audit to rectify this situation and removed the window from the upper portion of the doors to allow for audible detection of sexual abuse or other violence. While well intentioned, these doors were observed to be routinely propped open by the inmates during the audit tour; negating the intended effect. The facility stated that they had ordered automatic closing devices to solve this issue; however, they had not arrived by the time of the audit. The auditor also notes that there are port-hole style windows that look into the restroom area and provide an opportunity for staff to ensure safety. These windows were frosted in such a manner to prevent cross-gender viewing by obscuring to a height sufficient to block viewing of inmate's toileting. The auditor notes; however, that doors were not present on the upper floor restroom on housing unit 5 and housing unit 3 at the time of the onsite audit.

During interviews with the inmates, they raised concerns that, although the doors to the restroom afforded them greater privacy; the fact that the doors swung inwards allowed for them to be trapped behind the doors in the toilet stall area with no means of escape. The facility, having already recognized this could be an area for sexual safety to be compromised by its efforts to provide privacy required by the provision had submitted a purchase order to place 30 inch “saloon style” doors, which swing in both directions, on the entryway to the restrooms. The auditor observed the purchase order to confirm materials were ordered and affirms this would address the need to limit cross-gender viewing in this area and satisfy the safety concerns relative to being trapped in the toileting stall area.

The shower area is designated as the formal changing area for all inmates and if an inmate is to be completely unclothed (exposing their genitalia), it is to be done in the shower area. In units one through five, the showers consist of a rectangular room with multiple shower heads (approximately 12) protruding from each of the shower walls. The shower room has a door and port-style windows to view inward to ensure safety. The door and windows are obscured to a sufficient height as to block viewing of the genitals, compliant with the provision of the standard.

During interviews with the inmates, they raised concerns that the absence of individual shower dividers created a safety concern. The inmates asserted that predatory inmates could watch another inmate in the nude and become aroused. Others expressed prejudicial concerns that gay inmates were viewing them for gratification. The audit team explained to inmates that the standards do not require individual shower stalls during audit interviews. However, the audit team relayed the inmate’s concerns with safety from perceived predatory inmates to the facility’s administration during the exit meeting. The facility, was agreeable to consider and would begin exploring the possibility of installing toilet style divider stalls between the shower heads to address inmate safety and privacy concerns.

All 46 randomly interviewed inmates confirmed that they are not subject to unclothed viewing by opposite gender staff in a routine manner, outside of cell checks or other forms of unintentional viewing consistent with the standard.

Formal random interviews and numerous informal interviews during the audit tour with both staff and inmates confirm the auditor’s observation that inmates were able to dress, shower or toilet without being viewed by staff of the opposite gender, consistent with provision (d) of the standard. However, due to the absence of doors on the upper restrooms of housing units 5 and 3; the facility will be required to install the saloon style doors the facility previously ordered to be fully compliant with provision (d) of the standard.

(e) The facility shall not search or physically examine a transgender or intersex inmate for the sole purpose of determining the inmate’s genital status. If the inmate’s genital status is unknown, it may be determined during conversations with the inmate, by reviewing medical records, or, if necessary, by learning that information as part of a broader medical examination conducted in private by a medical practitioner.

The PREA Manual and 04.06.184 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 the 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. All fifteen randomly interviewed security staff could clearly articulate their knowledge that it is not part of their duties to search an inmate to determine genital status, furthering that such determinations are made

prior to their interactions with the inmates, with a majority noting that this would be a healthcare determination. The only identified transgender inmate housed at the facility was scheduled for formal interview and confirmed that they have not been searched for the sole purpose of determining their genital status. Through formal and informal interviews with multiple ranks of staff and a transgender inmate, the auditor is confident that transgender and intersex inmates are not examined, or strip searched for the sole purpose of determining genital status to find compliance with provision (e) of the standard.

(f) The agency shall train security staff in how to conduct cross-gender pat-down searches, and searches of transgender and intersex inmates, in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs.

Custody and Security in Corrections Part 2, Personal 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). Staff were able to articulate proper cross gender search techniques during random interviews and stated that they received this training through the MDOC training academy and as part of their annual training. Through past audits in the MDOC, this auditor is aware that it has been a long-standing practice for cross-gender search training to be delivered to staff through the training academy process. The facility reported that 100% of security staff have been provided training to conduct professional cross-gender and transgender pat searches. The facility provided documentation, in the form of 136 staff training records of computer based training record receipts of training being completed between October 1, 2017 and October 1, 2018 as part of its pre-audit sample training records relative to transgender/intersex searches. This total of 136 coincides with the total number of officer staff identified on the staffing plan. Although the staff training records identify the work location of some of the employees as the Earnest C. Brooks Correctional Facility, the auditor notes that these facilities are on the same compound and share resources, including training and hiring functions being conducted at the Earnest C. Brooks facility. Random interviews with all 15 staff indicate that search training is part of the training academy process and computer based modules are completed annually; however, staff also mentioned that in-person training occurs periodically during what is referred to as PA-415 training blocks. When interviewed, all 15 staff affirmatively identified that they would search an inmate either consistent with a female search process or identified the “praying hands” technique. A review of the training materials, random interviews with staff and a review of training records demonstrates compliance with provision (f) of the standard.

CORRECTIVE ACTION RECOMMENDATIONS:

Due to the absence of doors on the upper restrooms of housing units 5 and 3 and the potential for cross-gender viewing of the extreme ends of the urinals in the restrooms; the facility will be required to install the saloon style doors the facility previously ordered to be fully compliant with provision (d) of the standard. Upon completion of the work, the facility may send photographic evidence that the doors have been installed as verification.

POST INTERIM REPORT CORRECTIVE ACTIONS TAKEN:

The facility experienced delays with the manufacturer of the doors for the restrooms. The PREA Coordinator provided verification from the vendor to explain the nature of the delays. Ultimately, on November 18, 2019, the facility was able to provide photographic verification that the doors were received and installed to provide inmates sufficient privacy to toilet in accordance with provision (d) of the standard.

Based upon the evidence provided, the auditor finds that the facility has provided sufficient protections against cross-gender viewing and is in full compliance with the standard.

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

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.16 (a)

- Does the agency take appropriate steps to ensure that inmates with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: inmates who are deaf or hard of hearing? ☒ Yes ☐ No

- Does the agency take appropriate steps to ensure that inmates with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: inmates who are blind or have low vision? ☒ Yes ☐ No

- Does the agency take appropriate steps to ensure that inmates with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: inmates who have intellectual disabilities? ☒ Yes ☐ No

- Does the agency take appropriate steps to ensure that inmates with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: inmates who have psychiatric disabilities? ☒ Yes ☐ No

- Does the agency take appropriate steps to ensure that inmates with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: inmates who have speech disabilities? ☒ Yes ☐ No

- Does the agency take appropriate steps to ensure that inmates with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Other (if "other," please explain in overall determination notes)? ☒ Yes ☐ No

- Do such steps include, when necessary, ensuring effective communication with inmates who are deaf or hard of hearing? ☒ Yes ☐ No

- Do such steps include, when necessary, providing access to interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary? ☒ Yes ☐ No

- Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with inmates with disabilities including inmates who: Have intellectual disabilities? ☒ Yes ☐ No

- Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with inmates with disabilities including inmates who: Have limited reading skills? ☒ Yes ☐ No

- Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with inmates with disabilities including inmates who: Are blind or have low vision? ☒ Yes ☐ No

115.16 (b)

- Does the agency take reasonable steps to ensure meaningful access to all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment to inmates who are limited English proficient? ☒ Yes ☐ No

- Do these steps include providing interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary? ☒ Yes ☐ No

115.16 (c)

- Does the agency always refrain from relying on inmate interpreters, inmate readers, or other types of inmate assistance except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the inmate's safety, the performance of first-response duties under §115.64, or the investigation of the inmate's allegations? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

(a) The agency shall take appropriate steps to ensure that inmates with disabilities (including, for example, inmates who are deaf or hard of hearing, those who are blind or have low vision, or those who

have intellectual, psychiatric, or speech disabilities), have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment. Such steps shall include, when necessary to ensure effective communication with inmates who are deaf or hard of hearing, providing access to interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary. In addition, the agency shall ensure that written materials are provided in formats or through methods that ensure effective communication with inmates with disabilities, including inmates who have intellectual disabilities, limited reading skills, or who are blind or have low vision. An agency is not required to take actions that it can demonstrate would result in a fundamental alteration in the nature of a service, program, or activity, or in undue financial and administrative burdens, as those terms are used in regulations promulgated under title II of the Americans With Disabilities Act, 28 CFR 35.164.

The agency PREA Manual requires that the Department provide prisoner education in formats understandable by the entire prisoner population. Policy 03.03.140 specifies that the agency PREA Manager 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 inmates. The PREA Manual, along with training materials, were reviewed by this auditor in determining compliance with provision (a) of the 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. The agency also produces a PREA specific brochure in Spanish, as well as publishing its Prisoner Guidebooks in Spanish.

A braille version of the PREA pamphlet was created for blind inmates and a sign language interpreting service is available on an as needed basis for those inmates who are deaf. 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 English and Spanish.

During an interview with the Warden, she noted that Muskegon Correctional Facility has a significant elderly population and a greater concentration of life sentenced inmates in its population; however, the facility does not specialize in housing any noteworthy disabled populations. During the onsite portion of the audit, the audit team was unable to identify Limited English Proficiency (LEP) inmates who were onsite. With this auditor having audited in the state of Michigan ten times prior to this audit, it has consistently been observed that the facilities have a limited number of LEP inmates at most locations. While the auditor was unable to confirm practice in person, the auditor was provided with correspondence between the facility and its interpretation service, PALLERO TRANSLATIONS, who provide onsite interpretation services to the facility. The facility provided confirmation that translation services were made available for inmates to effectuate parole hearings in November 2018 and July 2018, when it did house two separate Spanish speaking individuals. Moreover, through previous audits, the auditor is aware that there is access to a phone interpretation services as well throughout the agency. Based upon documentation that the facility provides translation services as necessary, the auditor is satisfied that the facility has access to interpreter services should it be required to process an allegation of sexual abuse or sexual harassment.

A total of five individuals with disabilities, including cognitive, hearing impairments, and physical disabilities were interviewed during the onsite audit. Those inmates who were identified with cognitive impairments also reported that they understood the educational materials that the agency provides, with one individual confirming that the facility provides them with assistance to help understand anything he has trouble comprehending. The hearing-impaired individual stated that he can read anything he may not have heard. Physically disabled individuals confirmed they are able to access and understand available materials. As another step to reach all inmates, the institution broadcasts the agency's PREA video on the inmate movie channel of the inmate cable system on a recurrent schedule between movies. Furthermore, the agency sends weekly emails to each of the inmate accounts on its kiosk/tablet system where the inmates are exposed to reporting mechanisms and the availability of the JDI inside line advocacy services.

The auditor does note that the comprehensive educational process is completed at the agency's Reception and Guidance Center (RGC) prior to transfer to Muskegon Correctional Facility and the agency's reporting methods are universal; thus, the need for additional comprehensive PREA education upon arrival at Muskegon is minimal; however, PREA is covered with each inmate during the facility's orientation.

(b) The agency shall take reasonable steps to ensure meaningful access to all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment to inmates who are limited English proficient, including steps to provide interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary.

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. The auditor reviewed translation invoices from the facility to confirm that the facility has an active interpretation services account to reach LEP inmates. During the onsite portion of the audit, the audit team was unable to identify Limited English Proficiency (LEP) inmates who were onsite. With this auditor having audited in the state of Michigan ten times prior to this audit, it has consistently been observed that the facilities have a limited number of LEP inmates at most locations. While the auditor was unable to confirm practice in person, the auditor was provided with correspondence between the facility and its interpretation service, PALLERO TRANSLATIONS, who provide onsite interpretation services to the facility. The facility provided confirmation that translation services were made available for inmates to effectuate parole hearings in November 2018 and July 2018, when it did house two separate Spanish speaking individuals. The auditor notes that the contract with Pallero translation services requires in-person translation. When the auditor questioned how the facility reacts in crisis situations where an emergency does not permit the coordination of an onsite interpreter; the facility responded that it will use a staff interpreter to gather any necessary preliminary information to effectuate a response. However, if needed, the interpreter can be called in, albeit at a higher emergency rate. Based upon the facility's ability to provide routine and crisis interpretation services, the auditor finds compliance with provision (b) of the standard.

(c) The agency shall not rely on inmate interpreters, inmate readers, or other types of inmate assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the inmate's safety, the performance of first-response duties under § 115.64, or the investigation of the inmate's allegations.

Agency policy 03.03.140 and PREA Manual prohibit the use of inmate interpreters and were reviewed in deterring compliance with provision (c). 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. Fourteen of fifteen randomly interviewed staff were able to affirmatively articulate that inmate interpreters could either not be used under any circumstances or 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. Staff consistently related that they would find an interpreter to assist in such situations to aid in determination of compliance with provision (c).

Standard 115.17: Hiring and promotion decisions

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.17 (a)

- Does the agency prohibit the hiring or promotion of anyone who may have contact with inmates who has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997)? ☒ Yes ☐ No

- Does the agency prohibit the hiring or promotion of anyone who may have contact with inmates who has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse? ☒ Yes ☐ No

- Does the agency prohibit the hiring or promotion of anyone who may have contact with inmates who has been civilly or administratively adjudicated to have engaged in the activity described in the question immediately above? ☒ Yes ☐ No

- Does the agency prohibit the enlistment of services of any contractor who may have contact with inmates who has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997)? ☒ Yes ☐ No

- Does the agency prohibit the enlistment of services of any contractor who may have contact with inmates who has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse? ☒ Yes ☐ No

- Does the agency prohibit the enlistment of services of any contractor who may have contact with inmates who has been civilly or administratively adjudicated to have engaged in the activity described in the question immediately above? ☒ Yes ☐ No

115.17 (b)

- Does the agency consider any incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any contractor, who may have contact with inmates? ☒ Yes ☐ No

115.17 (c)

- Before hiring new employees, who may have contact with inmates, does the agency: perform a criminal background records check? ☒ Yes ☐ No

- Before hiring new employees, who may have contact with inmates, does the agency: consistent with Federal, State, and local law, make its best efforts to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse? ☒ Yes ☐ No

115.17 (d)

- Does the agency perform a criminal background records check before enlisting the services of any contractor who may have contact with inmates? ☒ Yes ☐ No

115.17 (e)

- Does the agency either conduct criminal background records checks at least every five years of current employees and contractors who may have contact with inmates or have in place a system for otherwise capturing such information for current employees? ☒ Yes ☐ No

115.17 (f)

- Does the agency ask all applicants and employees who may have contact with inmates directly about previous misconduct described in paragraph (a) of this section in written applications or interviews for hiring or promotions? ☒ Yes ☐ No

- Does the agency ask all applicants and employees who may have contact with inmates directly about previous misconduct described in paragraph (a) of this section in any interviews or written self-evaluations conducted as part of reviews of current employees? ☒ Yes ☐ No

- Does the agency impose upon employees a continuing affirmative duty to disclose any such misconduct? ☒ Yes ☐ No

115.17 (g)

- Does the agency consider material omissions regarding such misconduct, or the provision of materially false information, grounds for termination? ☒ Yes ☐ No

115.17 (h)

- Does the agency provide information on substantiated allegations of sexual abuse or sexual harassment involving a former employee upon receiving a request from an institutional employer for whom such employee has applied to work? (N/A if providing information on

substantiated allegations of sexual abuse or sexual harassment involving a former employee is prohibited by law.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

(a) The agency shall not hire or promote anyone who may have contact with inmates, and shall not enlist the services of any contractor who may have contact with inmates, who—
(1) Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997);
(2) Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or
(3) Has been civilly or administratively adjudicated to have engaged in the activity described in paragraph (a)(2) of this section.

02.06.111 EMPLOYMENT SCREENING (updated effective 05/20/2019) and the PREA Manual establish procedures for hiring and were reviewed in determining compliance with provision (a). 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 the standard. It is noted that the auditor reviewed the agency's website and found that an updated version of this policy was issued between the provision of the pre-audit materials and the actual audit. The most recent version adds a provision relative to the prohibition against searching a candidate's prior salary history and maintains the prohibitions noted above.

Corrections Officer job postings, application questions 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. These application materials were part of its NEOGOV online application materials that are universal throughout the agency. The facility is not responsible for conducting background checks of correctional officer staff, which are hired by the agency and disbursed to individual locations. These background screenings are conducted by the agency central office. The facility is, however, responsible for directly hiring non-officer personnel. The facility conducts checks on those staff directly hired and those staff transferring into the facility.

The facility reports on the PAQ that 15 staff were hired at the facility in the preceding year. An interview with the Human Resource officer, (who is located within the Earnest C. Brook Correctional Facility, as the facility is next to Muskegon and the two share resources) confirms that all candidates considered for hire or promotion by the facility are subject to background checks, that not only come in the form of criminal history checks, but also in the review of personnel records, contacts with all former employers, and letters to former institutional employers soliciting whether the candidate engaged in or resigned during investigation for sexual abuse or sexual harassment. Any individual convicted or adjudicated of the enumerated behaviors would be rejected as a candidate for employment. The Human Resource representative also stated that individuals who have engaged in sexual abuse or sexual harassment would not be considered for promotion.

Prior to meeting with the HR representative, the auditor made a request for evidence of background checks for five auditor selected individuals who were hired during the previous year to confirm practice of background checks being conducted. Upon arriving at the HR office, the auditor was provided with evidence of LEIN (Law Enforcement Information Network) checks to confirm that criminal background checks, where such information prohibited by the standard provision would be discovered. The auditor was also provided evidence where the facility contacted a prior institutional employer for a candidate during the audit period for the discovery of information prohibited by the standard. While with the HR representative, she accessed the NEOGOV site and reviewed the stored records for new hires within the electronic system. The auditor was able to observe where the criminal background verification information was stored, along with verification of contacting prior employers, warrant checks, domestic violence checks, and other pre-hiring functions. While meeting with the HR representative, the auditor learned that the state's recently elected Governor banned the use of criminal history questions on the NEOGOV online application for all state agencies in 2019. She provided this auditor with a form that the agency utilizes to capture this prohibited information on new hires and promotional candidates since this change went into effect. This form captures those factors enumerated in provision (a) and captures incidents of sexual harassment noted within provision (b).

A review of facility hiring records, agency application materials, interviews with the agency PREA Manager and Human Resource staff confirm that the Muskegon Correctional Facility is compliance with provision (a) of the standard.

(b) The agency shall consider any incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any contractor, who may have contact with inmates.

Policy 02.06.111 and applications for employment were reviewed in determining compliance with provision (b). Adequate screening for incidents of sexual harassment are present within the materials. Sample applications for a new hire and promotion were reviewed. Both employment application materials demonstrate consideration of incidents of sexual harassment in the hiring process. While meeting with the HR representative, the auditor learned that the state's recently elected Governor banned the use of criminal history questions on the NEOGOV online application for all state agencies in 2019. She provided this auditor with a form that the agency utilizes to capture this prohibited information on new hires and promotional candidates since this change went into effect. Under both hiring practices, the agency had mechanisms for eliciting prohibited behavior in its application materials. Policy states that any candidate for a job change or promotion with a history of engaging in misconduct, such as sexual harassment
can be blocked by the agency Director. The HR officer explained in an interview that any candidate for a job change or promotion with a history of engaging in sexual harassment would not be hired or promoted.

A review of policy and the interview with Human Resource staff confirms that the facility is not responsible for conducting background checks of newly hired custody staff. This function in completed at the agency level by central office staff where candidates are centrally hired and allocated to facilities. However, the facility is responsible for review and selections of promotions, transfers of custody staff. Sample applications for a new hire and promotion were reviewed, along with the newly created form for capturing information recently removed from NEOGOV applications. Both employment processes demonstrate consideration of incidents of sexual harassment in the hiring process to find compliance with provision (b).

(c) Before hiring new employees who may have contact with inmates, the agency shall:
(1) Perform a criminal background records check; and
(2) Consistent with Federal, State, and local law, make its best efforts to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse.

02.06.111 EMPLOYMENT SCREENING and the PREA Manual establish procedures for hiring and were reviewed in determining compliance with provision (c). A review of policy and the interview with Human Resource staff confirms that the facility is not responsible for conducting background checks of custody staff. This function in completed at the agency level by central office staff. However, the facility is responsible for review and selections of promotions and transfers of custody staff. Within pre-audit sample documentation, this auditor found evidence in support of this claim via sample documentation of two prospective candidates cleared background checks.

The facility reports on the PAQ that 15 staff were hired at the facility in the preceding year. An interview with the Human Resource officer, (who is located within the Earnest C. Brook Correctional Facility, as the facility is next to Muskegon and the two share resources) confirms that all candidates considered for hire or promotion by the facility are subject to background checks, that not only come in the form of criminal history checks, but also in the review of personnel records, contacts with all former employers, and letters to former institutional employers soliciting whether the candidate engaged in or resigned during investigation for sexual abuse or sexual harassment. Any individual convicted or adjudicated of the enumerated behaviors would be rejected as a candidate for employment. The Human Resource representative also stated that individuals who have engaged in sexual abuse or sexual harassment would not be considered for promotion.

Prior to meeting with the HR representative, the auditor made a request for evidence of background checks for five auditor selected individuals who were hired during the previous year to confirm practice of background checks being conducted. Upon arriving at the HR office, the auditor was provided with evidence of LEIN checks to confirm that criminal background checks, where such information prohibited by the standard provision would be discovered. The auditor was also provided evidence where the facility contacted a prior institutional employer for a candidate during the audit period for the discovery of information prohibited by the standard. While with the HR representative, she accessed the NEOGOV site and reviewed the stored records for new hires within the electronic system. The auditor was able to observe where the criminal background verification information was stored, along with verification of contacting prior employers, warrant checks, domestic violence checks, and other pre-hiring functions.

Based upon the auditors interview with HR, observation of the NEOGOV repository, receipt of records confirming that selected background checks were completed, a review of application materials, a review of the new form for gathering information about prohibited conduct, and evidence of receiving information from a former institutional employer; the auditor is able to find substantial compliance that

the facility conducts criminal background checks and contacts prior institutional employers to determine whether a candidate has engaged in sexual abuse or sexual harassment consistent with provision (c) of the standard.

(d) The agency shall also perform a criminal background records check before enlisting the services of any contractor who may have contact with inmates.

Agency policy 02.06.111 and the PREA Manual were reviewed in determining compliance with provision (d). An interview with HR staff revealed that background checks for contractors are conducted by the facility's records department. The facility provided a volunteer and contractor roster that documented LEIN check information for contractors and volunteers that listed the date on which individual clearances were conducted. HR staff and the agency PREA Analyst, who was onsite, confirmed that all background checks for contractors expire and must be completed each year. The facility provided a spreadsheet print out listing all authorized contractors and volunteers for the facility as sample documentation of background checks for contractors as proof of this provision of the standard. This list included information on 179 individuals who were cleared by background check and currently authorized to enter the facility as contractors or volunteers at the facility in support of finding compliance for provision (d).

(e) The agency shall either conduct criminal background records checks at least every five years of current employees and contractors who may have contact with inmates or have in place a system for otherwise capturing such information for current employees.

According to policy 02.06.111 EMPLOYMENT SCREENING (updated 05/20/2019), the PREA Manual and staff interviews, LEIN checks are completed through the records office in June of designated years for agency employees. There are two layers of LEIN checks that are completed. There is an annual screening required for all staff that have inmate contact which scans for domestic violence, protection orders and arrests. Then, an in-depth criminal history check will be completed every three years for all employees.

Agency policy dictates that background checks be conducted in June of specified years; the facility's formal documentation of its three-year background checks demonstrates these screenings were conducted in June of 2018 and are due again in June of 2021. 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. Each log documents when the clearance was run to identify the annual expiration date.

(f) The agency shall ask all applicants and employees who may have contact with inmates directly about previous misconduct described in paragraph (a) of this section in written applications or interviews for hiring or promotions and in any interviews or written self-evaluations conducted as part of reviews of current employees. The agency shall also impose upon employees a continuing affirmative duty to disclose any such misconduct.

The facility provided, and the 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 the standard when applying for employment or promotion and during any self-evaluations. While meeting with the HR representative, the auditor learned that the state's recently elected Governor banned the use of criminal history questions on the NEOGOV online application for all state agencies in 2019. She provided this auditor

with a form that the agency utilizes to capture this prohibited information on new hires and promotional candidates since this change went into effect. Under both hiring practices, the agency had mechanisms for eliciting prohibited behavior in its application materials. 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 and consistent with the FAQ; none need be established to demonstrate compliance with the standards. An interview with HR staff confirm that any falsification of this information on written applications would be grounds for immediate termination. Based upon the existence of mechanisms to elicit past acts of sexual abuse in hiring and promotional activities, work rules establishing an affirmative duty to disclose prohibited conduct, policy provisions, and the absence of self-evaluations, there is sufficient evidence that the facility demonstrates compliance with provision (f) of the standard.

(g) Material omissions regarding such misconduct, or the provision of materially false information, shall be grounds for termination.

Agency policy 02.06.111 and the PREA Manual, which were reviewed by this auditor, affirmatively states that material omissions regarding such misconduct or the provision of materially false information are grounds for termination. An interview with HR staff confirms that falsifying this information on written application materials would lead to termination. The agency policy and work rules within the employee handbook sufficiently cover provision (g) of the standard. The facility indicates that there have been no instances where such material omissions have been noted.

(h) Unless prohibited by law, the agency shall provide information on substantiated allegations of sexual abuse or sexual harassment involving a former employee upon receiving a request from an institutional employer for whom such employee has applied to work.

02.01.140 HUMAN RESOURCE FILES, 02.06.111 EMPLOYMENT SCREENING and the PREA Manual establish procedures for provision (h) of the standard and were reviewed by this auditor. The facility had one direct examples of the facility responding to a request from the GEO group for such information on a former employee to establish compliance with provision (h).

Standard 115.18: Upgrades to facilities and technologies

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.18 (a)

- If the agency designed or acquired any new facility or planned any substantial expansion or modification of existing facilities, did the agency consider the effect of the design, acquisition, expansion, or modification upon the agency's ability to protect inmates from sexual abuse? (N/A if agency/facility has not acquired a new facility or made a substantial expansion to existing facilities since August 20, 2012, or since the last PREA audit, whichever is later.)
  ☐ Yes ☐ No ☒ NA

115.18 (b)

- If the agency installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology, did the agency consider how such technology may enhance the agency's ability to protect inmates from sexual abuse? (N/A if agency/facility has not installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology since August 20, 2012, or since the last PREA audit, whichever is later.)
  ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

(a) When designing or acquiring any new facility and in planning any substantial expansion or modification of existing facilities, the agency shall consider the effect of the design, acquisition, expansion, or modification upon the agency's ability to protect inmates from sexual abuse.

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 nor the facility have substantially expanded or altered existing facilities since August 20, 2012. No new facilities were reportedly acquired by the agency; rather, the agency has been closing facilities. 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 since 2012. Additional cameras with audio capabilities were added to that facility to ensure inmate safety and PREA compliance. The warden confirmed that there has been no expansion or modifications to the Muskegon Correctional Facility. During the tour, there were no areas of the facility that appear to have undergone significant expansion or modification since the construction of housing unit 6, which was built prior to 2012, to substantiate compliance with provision (a) of the standard. The only observed modifications during the tour were the placement of doors on the restrooms which were aimed at enhancing compliance with 115.15's limitations on the potential for cross-gender viewing.

(b) When installing or updating a video monitoring system, electronic surveillance system, or other monitoring technology, the agency shall consider how such technology may enhance the agency's ability to protect inmates from sexual abuse.

From previous audits within the agency, the auditor is aware that, beginning at the start of the 2nd audit cycle, 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 camera system was expanded with the intent of identifying blind spots and attempting to strategically place those cameras in such a manner as to provide the greatest degree of coverage. The facility's camera system consists of 239 cameras and incorporates the capability an advanced digital screening technology to digitally block viewing of toileting, showering and strip search areas throughout the facility as necessary to prevent cross-gender viewing. The auditor reviewed facility camera maps and observed during the audit tour that the placement of cameras was strategically aimed to enhance sexual safety within the facility, while still affording privacy to dwelling, showering and toileting facilities within the housing units. The facility also installed an electronic tour scan verification system that was observed during the tour. The reader points are located throughout each housing area to verify that security rounds are conducted at all points within the housing unit at required intervals.

The facility provided two examples where the facility updated video monitoring technology in its educational and administration buildings during the audit period; specifically, by moving and adding cameras to compensate for blind spots. Additionally, the facility provided documentation of a viewing station being added in the Deputy Warden's administration complex, to allow more expedient incident review by key facility figures. The consideration to enhance coverage and eliminate blind spots ultimately demonstrates that the facility considers its blind spots relative to 115.13 and 115.18. This strategic deployment of video monitoring technology and round reading technology demonstrates the agency and facility dedication to compliance with provision (b) of the standard.

RESPONSIVE PLANNING

Standard 115.21: Evidence protocol and forensic medical examinations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.21 (a)

- If the agency is responsible for investigating allegations of sexual abuse, does the agency follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.) ☒ Yes ☐ No ☐ NA

115.21 (b)

- Is this protocol developmentally appropriate for youth where applicable? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.) ☒ Yes ☐ No ☐ NA

- Is this protocol, as appropriate, adapted from or otherwise based on the most recent edition of the U.S. Department of Justice's Office on Violence Against Women publication, "A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents," or similarly comprehensive and authoritative protocols developed after 2011? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.) ☒ Yes ☐ No ☐ NA

115.21 (c)

- Does the agency offer all victims of sexual abuse access to forensic medical examinations, whether on-site or at an outside facility, without financial cost, where evidentiarily or medically appropriate? ☒ Yes ☐ No

- Are such examinations performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) where possible? ☒ Yes ☐ No

- If SAFEs or SANEs cannot be made available, is the examination performed by other qualified medical practitioners (they must have been specifically trained to conduct sexual assault forensic exams)? ☒ Yes ☐ No

- Has the agency documented its efforts to provide SAFEs or SANEs? ☒ Yes ☐ No

115.21 (d)

- Does the agency attempt to make available to the victim a victim advocate from a rape crisis center? ☒ Yes ☐ No

- If a rape crisis center is not available to provide victim advocate services, does the agency make available to provide these services a qualified staff member from a community-based organization, or a qualified agency staff member? ☒ Yes ☐ No

- Has the agency documented its efforts to secure services from rape crisis centers? ☒ Yes ☐ No

115.21 (e)

- As requested by the victim, does the victim advocate, qualified agency staff member, or qualified community-based organization staff member accompany and support the victim through the forensic medical examination process and investigatory interviews? ☒ Yes ☐ No

- As requested by the victim, does this person provide emotional support, crisis intervention, information, and referrals? ☒ Yes ☐ No

115.21 (f)

- If the agency itself is not responsible for investigating allegations of sexual abuse, has the agency requested that the investigating entity follow the requirements of paragraphs (a) through

(e) of this section? (N/A if the agency/facility is responsible for conducting criminal AND administrative sexual abuse investigations.) ☒ Yes ☐ No ☐ NA

115.21 (g)

- Auditor is not required to audit this provision.

115.21 (h)

- If the agency uses a qualified agency staff member or a qualified community-based staff member for the purposes of this section, has the individual been screened for appropriateness to serve in this role and received education concerning sexual assault and forensic examination issues in general? [N/A if agency attempts to make a victim advocate from a rape crisis center available to victims per 115.21(d) above.] ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

(a) To the extent the agency is responsible for investigating allegations of sexual abuse; the agency shall follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions.

According to the agency's Crime Scene Management and Preservation training manual and an interview with the agency PREA Manager, the agency's crime scene preservation is predicated upon the United States Army Criminal Investigation Command and Michigan State Police training materials.

During interviews with facility medical staff and investigators, the facility is not responsible for collecting forensic evidence from those involved in criminal sexual abuse investigations. Inmates are transported to SAFE/SANE examiners at the Mercy Hospital in the any clothing worn during an alleged incident of sexual abuse. The agency's protocol, which is outlined in the PREA Manual and Crime Scene Management and Preservation training manual, demonstrates that 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.

The auditor observed demonstration of practice within one facility investigation of alleged forced oral penetration. The initial report was one of sexual harassment. Once the alleged victim was removed from the alleged abuser's presence and was located within a safe space, the alleged victim disclosed the additional details pertaining to sexual abuse. By that time, the staff had gathered the alleged victim's clothing under the assumption that this was simply a cell move for protective purposes; however, once the extent of the allegation was known, clothing was returned to the cell and the cell sealed for evidentiary purposes. The alleged victim purportedly discarded a tissue with the alleged abuser's semen in a communal trashcan, which was subsequently secured during the initial response. Following the report, the alleged victim was transported to Mercy Hospital for a SANE examination. One flaw in the process, however, is that the Michigan State Police report indicates the trashcan in question was errantly returned to service by a subsequent shift of staff who were unaware of why it had been secured. The auditor recommends that the facility secure any potential evidence from outside a cell in a more secure evidence location pending retrieval by MSP.

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, such as washing, performing bodily functions and changing clothes. 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 the standard.

(b) The protocol shall be developmentally appropriate for youth where applicable, and, as appropriate, shall be adapted from or otherwise based on the most recent edition of the U.S. Department of Justice's Office on Violence Against Women publication, "A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents," or similarly comprehensive and authoritative protocols developed after 2011.

The auditor notes that the facility does not conduct forensic examinations. Those examinations are conducted at Mercy Hospital. Uniform evidence protocol is covered in Crime Scene Preservation and Basic Investigator's Training. Both training manuals were reviewed by this auditor in determining compliance with provision (b) of the standard. Training materials cover the necessary technical detail to aid first responders in preserving available evidence for later collection by the Michigan State Police (MSP). 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. 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 until collected by MSP. According to the agency's Crime Scene Management and Preservation training manual and an interview with the agency PREA Manager, the agency's crime scene preservation is predicated upon the United States Army Criminal Investigation Command and Michigan State Police training materials, which demonstrates compliance with provision (b) of the standard.

(c) The agency shall offer all victims of sexual abuse access to forensic medical examinations, whether on-site or at an outside facility, without financial cost, where evidentiary or medically appropriate. Such examinations shall be performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) where possible. If SAFEs or SANEs cannot be made available, the examination can be performed by other qualified medical practitioners. The agency shall document its efforts to provide SAFEs or SANEs.

Policy 03.04.100 and the PREA Manual, reviewed by this auditor in determining compliance with provision (c) of the standard, specify that forensic examinations are provided without cost to victims of sexual abuse. The PAQ indicates that no inmates were sent to Mercy Hospital for a forensic examination during the audit period; however, the auditor also notes that the facility provided pre-audit sample documentation to demonstrate practice of an inmate being sent to Mercy Hospital for a forensic examination. During the onsite audit, the auditor learned that the facility received an allegation, following the exchange of pre-audit materials, where a forensic examination was offered. That individual was transported to the outside hospital; however, once there, declined to undergo the examination.

Through an interview of a staff member at Mercy Hospital; it was confirmed that inmates at the Muskegon Correctional Facility are provided with SANE services when transported to the location. While no formal agreement for SAFE/SANE services is in place, an interview with Mercy Hospital confirms that a pool of three SANE staff are employed and available on an “on-call” basis to ensure coverage on all shifts when this service is necessary. Moreover, if there is some problem with connecting with one of the “on-call” staff at the Muskegon location, the facility can reach out and access the “on-call” SANE staff at the Holland campus outside of the Grand Rapids area. In the rare circumstance that a SANE would not be available, a physician would be responsible for the forensic evidence collection kit processing and applicable paperwork.

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

(d) The agency shall attempt to make available to the victim a victim advocate from a rape crisis center. If a rape crisis center is not available to provide victim advocate services, the agency shall make available to provide these services a qualified staff member from a community-based organization, or a qualified agency staff member. Agencies shall document efforts to secure services from rape crisis centers. For the purpose of this standard, a rape crisis center refers to an entity that provides intervention and related assistance, such as the services specified in 42 U.S.C. 14043g(b)(2)(C), to victims of sexual assault of all ages. The agency may utilize a rape crisis center that is part of a governmental unit as long as the center is not part of the criminal justice system (such as a law enforcement agency) and offers a comparable level of confidentiality as a nongovernmental entity that provides similar victim services.

Through previous audits within the agency, the auditor is aware of documented agency attempts to reach an agreement with the Detroit Rescue Mission Ministries and the Michigan Coalition to End Domestic and Sexual Violence at the agency level were provided and reviewed by the auditor in determining compliance with provision (d). Since the last time the auditor conducted an audit within the agency, the MDOC entered into an agreement with Just Detention International (JDI) to provide victim advocacy services via telephone. Furthermore, within the JDI agreement, there is a provision where JDI will assist the agency with bridging those service gaps for local rape crisis center agreements for in-person advocacy service deliver.

While the JDI service does not fully address the needs of those inmates who require accompaniment during a forensic examination; the auditor notes that the agency trains all of its medical and mental health practitioners to serve as qualified agency staff members to fulfill this need. Staff are required to complete the 14 online modules created by the Office for Victims of Crime Training and Technical Assistance Center (OVCTTAC). The facility provided records to verify completion of this training by medical and mental health staff within its training records under 115.35 during the pre-audit

documentation exchange. During discussions with Mercy Hospital's SANE program that Muskegon Correctional Facility uses for forensic examinations, the auditor learned that the hospital ordinarily has internal victim advocates to assist during forensic examinations. The facility also provides access to "An End to Silence" for state organizational contact information within the facility library.

The facility PREA Coordinator confirms in an interview that rape crisis services are provided by JDI and that qualified facility staff members have been identified and trained to provide advocacy services to those during forensic examinations in the absence of a formal rape crisis service agreement. Specifically, to ensure the availability of a qualified staff member on all shifts, the facility has designated and trained all medical and mental health providers to serve as victim advocates.

Four inmates who were identified as having reported sexual abuse were interviewed onsite. Two reported sexual abuse occurring at other facilities in the past. One reported an incident of sexual harassment occurring, and the final individual reported an allegation that did not involve penetration. None of the inmates reported allegations that would have been consistent with requiring a forensic examination, where accompaniment by a rape crisis advocate would have been appropriate. While all four of the individuals denied that the facility arranged for contact with a victim advocate or provided them with the contact information for victim advocacy services; the auditor notes that the JDI hotline is prominently posted throughout housing units and is emailed to all inmates weekly via the kiosk/tablet system.

Interviews with the PREA Coordinator, PREA Manager, a review of agency MOU with JDI, documentation of correspondence with the Henry Ford Allegiance Hospital and the facility's documented training of 20 staff members to serve as a qualified agency staff member under this standard, demonstrates that the facility is in compliance with provision (d).

(e) As requested by the victim, the victim advocate, qualified agency staff member, or qualified community-based organization staff member shall accompany and support the victim through the forensic medical examination process and investigatory interviews and shall provide emotional support, crisis intervention, information, and referrals.

The PREA Manual and Memo with Michigan State Police, which were reviewed by the auditor, confirm that both the agency, the criminal investigative unit and the facility will permit a victim advocate to accompany a victim through the forensic medical examination and investigatory interviews.

The facility and agency have identified medical and mental health staff to serve as qualified staff members 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 Mercy Hospital. Through previous audits, this auditor was provided the series of training materials that the agency adopted from the Office for Victims of Crime Training and Technical Assistance Center (a component of the US Department of Justice) to train its staff to act in the capacity of a qualified staff member and found the curriculum to be sufficient. Specifically, the advocacy training consists of 14 modules addressing Advocacy, Assessing Victims' Needs, Basic Communication Skills, Collaboration, Confidentiality, Conflict Management/Negotiation, Crisis Intervention, Culture, Diversity, Inclusivity, Documentation, Problem Solving, Referrals, Self-Care, Trauma-Informed Care and a specialized module for Incarcerated Victims of Sexual Violence. The facility provided documentation of 15 active staff having completed this training. The MSP memorandum confirms that the investigative agency has agreed to allow these individuals 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, upon request of the victim, to demonstrate compliance with provision (e) of the standard; however, has not had to exercise these plans.

(f) To the extent the agency itself is not responsible for investigating allegations of sexual abuse, the agency shall request that the investigating agency follow the requirements of paragraphs (a) through (e) of this section.

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 the standard.

(g) The requirements of paragraphs (a) through (f) of this section shall also apply to:
(1) Any State entity outside of the agency that is responsible for investigating allegations of sexual abuse in prisons or jails; and
(2) Any Department of Justice component that is responsible for investigating allegations of sexual abuse in prisons or jails.

Provision (g) of the standard is not required to be audited by the auditor.

(h) For the purposes of this section, a qualified agency staff member or a qualified community-based staff member shall be an individual who has been screened for appropriateness to serve in this role and has received education concerning sexual assault and forensic examination issues in general.

The facility attempts to make a rape crisis advocate available; however, has yet to enter into a formal agreement. In the event, such services are necessary, the facility uses qualified medical or mental health from the facility who have received training in trauma informed care and are generally educated in the forensic examination procedures. Through previous audits, this auditor was provided the series of training materials that the agency adopted from the Office for Victims of Crime Training and Technical Assistance Center (a component of the US Department of Justice) to train its staff to act in the capacity of a qualified staff member and found the curriculum to be sufficient. Specifically, the advocacy training consists of 14 modules addressing Advocacy, Assessing Victims' Needs, Basic Communication Skills, Collaboration, Confidentiality, Conflict Management/Negotiation, Crisis Intervention, Culture, Diversity, Inclusivity, Documentation, Problem Solving, Referrals, Self-Care, Trauma-Informed Care and a specialized module for Incarcerated Victims of Sexual Violence. The facility provided documentation of 15 active staff having completed this training, consistent with provision (h) of the standard.

Standard 115.22: Policies to ensure referrals of allegations for investigations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.22 (a)

- Does the agency ensure an administrative or criminal investigation is completed for all allegations of sexual abuse? ☒ Yes ☐ No

- Does the agency ensure an administrative or criminal investigation is completed for all allegations of sexual harassment? ☒ Yes ☐ No

115.22 (b)

- Does the agency have a policy and practice in place to ensure that allegations of sexual abuse or sexual harassment are referred for investigation to an agency with the legal authority to conduct criminal investigations, unless the allegation does not involve potentially criminal behavior? ☒ Yes ☐ No

- Has the agency published such policy on its website or, if it does not have one, made the policy available through other means? ☒ Yes ☐ No

- Does the agency document all such referrals? ☒ Yes ☐ No

115.22 (c)

- If a separate entity is responsible for conducting criminal investigations, does such publication describe the responsibilities of both the agency and the investigating entity? [N/A if the agency/facility is responsible for criminal investigations. See 115.21(a).] ☒ Yes ☐ No ☐ NA

115.22 (d)

- Auditor is not required to audit this provision.

115.22 (e)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

(a) The agency shall ensure that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment.

The auditor reviewed agency policies 03.03.140, 01.01.140 and the PREA Manual when assessing compliance with provision (a) of the standard. The auditor notes that the pre-audit materials contained outdated policy samples for agency policy 01.01.140. When reviewing the new version of the policy from the agency's website, the auditor noted that formerly problematic section G of 01.01.140, which required that the allegations must contain facts, rather than mere assertions or rumor to be entered into the internal affairs division investigation database, was removed and revised under the new section of I to designate that all allegations of work rule violations, including Prison Rape Elimination Act allegations must be entered into AIM within two business days. The PREA Manual confirms that all allegations are entered into the agency's database for investigation.

An interview with the agency head's designee confirms that all allegations of sexual abuse and sexual harassment are investigated. A review of agency policy and interviews with the agency head's designee and agency PREA Manager confirm that a referral process is in place to both notify and receive allegations of sexual abuse reported at or from other facilities. The auditor reviewed the facility's investigatory log and took a cursory review of all investigations onsite. The facility provided robust pre-audit sample documentation of investigations. Between pre-audit samples and those taken for in-depth analysis onsite, the auditor had a total of 16 complete investigatory files for review.

Multiple examples of investigation referrals existed within pre-audit sample documentation and reviewed, to include referrals from verbal reports to staff members of security, psychology, counseling, and medical ranks, grievance referrals, and incidents reported to other confinement facilities. The MSP are responsible for conducting criminal investigations should criminal behavior be observed during the facility's administrative response. Within the investigatory files for sexual abuse allegations, there was evidence of referral to the Michigan State Police (MSP), with the MSP electing to conduct a criminal investigation of an alleged incident of forced oral penetration. Agency policies, interviews and a review of facility investigations demonstrates that the facility is in compliance with provision (a) of the standard.

(b) The agency shall have in place a policy to ensure that allegations of sexual abuse or sexual harassment are referred for investigation to an agency with the legal authority to conduct criminal investigations, unless the allegation does not involve potentially criminal behavior. The agency shall publish such policy on its website or, if it does not have one, make the policy available through other means. The agency shall document all such referrals.

Michigan State Police (MSP) investigate criminal allegations involving staff as specified under the reviewed policy, 01.01.140. The investigation is monitored and coordinated by the Internal Affairs Division. Policy 03.03.140, which was reviewed by this auditor addresses referrals of prisoner on prisoner sexual abuse to MSP. 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 the standard. Interviews with facility investigators confirmed they are aware of their obligations to refer allegations of a criminal nature to MSP. During a review of facility investigations, there was evidence of referrals to support that the facility refers all potential criminal allegations to MSP, either in the form of MSP reports or email correspondence between the facility's Inspector and the assigned MSP trooper for the facility. MSP elected to conduct one investigation of alleged forced oral penetration as further evidence that the facility refers potentially criminal behavior to an entity with the legal authority to conduct criminal investigations.

(c) If a separate entity is responsible for conducting criminal investigations, such publication shall describe the responsibilities of both the agency and the investigating entity.

This auditor reviewed and verified that policies 01.01.014 and 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 the standard.

(d) Any State entity responsible for conducting administrative or criminal investigations of sexual abuse or sexual harassment in prisons or jails shall have in place a policy governing the conduct of such investigations.

(e) Any Department of Justice component responsible for conducting administrative or criminal investigations of sexual abuse or sexual harassment in prisons or jails shall have in place a policy governing the conduct of such investigations.

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

TRAINING AND EDUCATION

Standard 115.31: Employee training

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.31 (a)

- Does the agency train all employees who may have contact with inmates on its zero-tolerance policy for sexual abuse and sexual harassment? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with inmates on how to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with inmates on inmates' right to be free from sexual abuse and sexual harassment ☒ Yes ☐ No

- Does the agency train all employees who may have contact with inmates on the right of inmates and employees to be free from retaliation for reporting sexual abuse and sexual harassment? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with inmates on the dynamics of sexual abuse and sexual harassment in confinement? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with inmates on the common reactions of sexual abuse and sexual harassment victims? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with inmates on how to detect and respond to signs of threatened and actual sexual abuse? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with inmates on how to avoid inappropriate relationships with inmates? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with inmates on how to communicate effectively and professionally with inmates, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming inmates? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with inmates on how to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities? ☒ Yes ☐ No

115.31 (b)

- Is such training tailored to the gender of the inmates at the employee's facility? ☒ Yes ☐ No

- Have employees received additional training if reassigned from a facility that houses only male inmates to a facility that houses only female inmates, or vice versa? ☒ Yes ☐ No

115.31 (c)

- Have all current employees who may have contact with inmates received such training? ☒ Yes ☐ No

- Does the agency provide each employee with refresher training every two years to ensure that all employees know the agency's current sexual abuse and sexual harassment policies and procedures? ☒ Yes ☐ No

- In years in which an employee does not receive refresher training, does the agency provide refresher information on current sexual abuse and sexual harassment policies? ☒ Yes ☐ No

115.31 (d)

- Does the agency document, through employee signature or electronic verification, that employees understand the training they have received? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

(a) The agency shall train all employees who may have contact with inmates on:
(1) Its zero-tolerance policy for sexual abuse and sexual harassment;
(2) How to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures;
(3) Inmates' right to be free from sexual abuse and sexual harassment;
(4) The right of inmates and employees to be free from retaliation for reporting sexual abuse and sexual harassment;
(5) The dynamics of sexual abuse and sexual harassment in confinement;
(6) The common reactions of sexual abuse and sexual harassment victims;
(7) How to detect and respond to signs of threatened and actual sexual abuse;
(8) How to avoid inappropriate relationships with inmates;
(9) How to communicate effectively and professionally with inmates, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming inmates; and
(10) How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities.

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 the standard. A review of these materials provides a robust explanation of all 10 points required by the standards. 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, scheduled to last approximately 1 hour each. This training is also repeated annually as part of the facility's in-service training requirements. Pre-audit, the facility provided training records of 180 of 239 staff having completed its PREA computer-based courses during its last training year of October 2017 through October 2018. It is noted that the current training year remains open; thus, more recent records are not applicable at this time. While onsite, the auditor was provided with the additional records, which consisted of the training records for those medical and mental health care staff working in the facility. Their training records are coded under a different name within the agency's computerized training program; thus, did not appear on the initial report. Facility training record reports verify that 249 facility staff have completed the annually required training modules during the facility's most recent training year. When the auditor inquired how records exceeded the facility's current staffing compliment, the auditor was informed that training records also identified those employees who left employment since the training year. The auditor notes that there was a column on the training report to identify and reconcile those inactive employees to verify training for the current compliment. 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 15 staff who were randomly interviewed were able to clearly describe elements from the training to demonstrate knowledge of the factors required by the standards in compliance with provision (a).

(b) Such training shall be tailored to the gender of the inmates at the employee's facility. The employee shall receive additional training if the employee is reassigned from a facility that houses only male inmates to a facility that houses only female inmates, or vice versa.

Based upon the PAQ and the auditor's observations during the tour, Muskegon Correctional Facility 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 the standard. From a previous audit at another MDOC facility that does house female inmates, the auditor is aware that the agency offers a specific module of training on collaborative case management for women that is not just specific to PREA, but an overall gender inclusive training. This training supplements those working with female offenders on a regular basis; however, it is again noted that female inmates are not housed at the Muskegon Correctional Facility and there are no staff noted who have transferred in from the Women's Huron Valley Correctional Facility. Based on a review of PREA training materials and a sampling of training records; the facility demonstrates compliance with provision (b).

(c) All current employees who have not received such training shall be trained within one year of the effective date of the PREA standards, and the agency shall provide each employee with refresher training every two years to ensure that all employees know the agency's current sexual abuse and sexual harassment policies and procedures. In years in which an employee does not receive refresher training, the agency shall provide refresher information on current sexual abuse and sexual harassment policies.

Muskegon Correctional Facility 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 completed annually to aid in fulfillment of annual training requirements. As part of the facility's pre-audit documentation, it provided records of 180 staff completing this training as part of its annual in-service training requirements. Additional training records provided onsite confirm that the remaining 59 staff received their version of training. Training records and the agency training plans demonstrate compliance with provision (c) of the standard.

(d) The agency shall document, through employee signature or electronic verification that employees understand the training they have received.

Pre-audit, the facility provided training records of 180 of 239 staff having completed its PREA computer-based courses during its last training year of October 2017 through October 2018. It is noted that the current training year remains open; thus, more recent records are not applicable at this time. While onsite, the auditor was provided with the additional records, which consisted of the training records for those medical and mental health care staff working in the facility. Their training records are coded under a different name within the agency's computerized training program; thus, did not appear on the initial report. Facility training record reports verify that 249 facility staff have completed the annually required training modules during the facility's most recent training year. When the auditor inquired how records exceeded the facility's current staffing compliment, the auditor was informed that training records also identified those employees who left employment since the training year. The auditor notes that there was a column on the training report to identify and reconcile those inactive employees to verify training for the current compliment. 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 15

staff who were randomly interviewed were able to clearly describe elements from the training to demonstrate knowledge of the factors required by the standards

The training module slides demonstrate that 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. Training reports come with an indication of whether or not the staff person passed or failed the training demonstrating compliance with provision (d) of the standard.

Standard 115.32: Volunteer and contractor training

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.32 (a)

- Has the agency ensured that all volunteers and contractors who have contact with inmates have been trained on their responsibilities under the agency's sexual abuse and sexual harassment prevention, detection, and response policies and procedures? ☒ Yes ☐ No

115.32 (b)

- Have all volunteers and contractors who have contact with inmates been notified of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents (the level and type of training provided to volunteers and contractors shall be based on the services they provide and level of contact they have with inmates)? ☒ Yes ☐ No

115.32 (c)

- Does the agency maintain documentation confirming that volunteers and contractors understand the training they have received? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

(a) The agency shall ensure that all volunteers and contractors who have contact with inmates have been trained on their responsibilities under the agency's sexual abuse and sexual harassment prevention, detection, and response policies and procedures.

Policy 03.02.105 addresses the need for service providers to be trained according to their level of contact with prisoners. According to policy 03.03.140 and the PREA Manual, the MDOC defines contractors and volunteers as an employee and therefore trains these individuals with the same computer based training materials available to directly hired employees when those employees have a significant level of inmate contact. The agency's training curriculum for contractors and volunteers with a less intimate level of contact, which was reviewed by the auditor, sufficiently addresses the concepts of sexual abuse, sexual harassment, reporting and response procedures. In addition to the auditor's review of the training materials, the auditor reviewed a sampling of training records across multiple contractor and volunteer disciplines to determine compliance with provision (a) of the standard. The auditor notes that training records for 27 contractors were provided pre-audit and were dated in 2018. The auditor requested additional records while onsite, via random selection from the facility's authorized (LEIN cleared) contractor and volunteer lists.

The auditor selected 5 contractors and received the requested documentation to verify training conducted by the Chaplain for two of the individuals with a limited inmate contact and two records to confirm that healthcare contractors were trained on the agency's computer-based modules. The auditor had selected additional records from other random individuals; however, based on the classification of the individual contractors selected, the nature of their contractual responsibilities did not warrant training. Specifically, those individuals were delivery truck drivers who would not have contact with inmates and individuals who had been cleared for entry; however, never reported to the facility.

Volunteer training records verify that the facility's Chaplain supervises the training and ensures it is appropriately documented at a time at the time of initial visit. Records also reflect training groups are conducted for formalized group volunteer/contractor activities. All 5 randomly selected volunteer training records were provided to the auditor to confirm that training of volunteers occurs regularly throughout the year.

Two medical contractors and two volunteers were selected by the auditor and reported during their interviews that they received training that provided them with information about sexual abuse, sexual harassment, signs thereof and individualized reporting options. The two medical contractors stated that their training consisted of a review of the agency's PREA Manual and records confirm that they completed the agency's specialized healthcare computer-based module. The two volunteers interviewed confirmed that they received their training through the prison's chaplain, as both volunteer on the facility's Prison Fellowship faith-based housing unit. Each of the contractors and volunteers were aware of their responsibility to forward allegations of sexual abuse and sexual harassment to their supervisor to ensure referral for investigation.

Based upon a review of selected training records, interviews with contractors and volunteers, and a review of the training options depending upon the level of contact with inmates; the auditor finds there is evidence in support that contractors and volunteers are trained on their responsibilities consistent with provision (a) of the standard.

(b) The level and type of training provided to volunteers and contractors shall be based on the services they provide and level of contact they have with inmates, but all volunteers and contractors who have contact with inmates shall be notified of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents.

Policy 03.02.105 addresses the need for service providers to be trained according to their level of contact with prisoners. According to policy 03.03.140 and the PREA Manual, the MDOC defines contractors and volunteers as an employee and therefore trains these individuals with the same computer-based training materials available to directly hired employees when those employees have a significant level of inmate contact. The agency's training curriculum for contractors and volunteers with a less intimate level of contact, which was reviewed by the auditor, sufficiently addresses the concepts of sexual abuse, sexual harassment, reporting and response procedures.

Two medical contractors and two volunteers were selected by the auditor and reported during their interviews that they received training that provided them with information about sexual abuse, sexual harassment, signs thereof and individualized reporting options. The two medical contractors stated that their training consisted of a review of the agency's PREA Manual and records confirm that they completed the agency's specialized healthcare computer-based module. The two volunteers interviewed confirmed that they received their training through the prison's chaplain, as both volunteer on the facility's Prison Fellowship faith-based housing unit. Each of the contractors and volunteers were aware of their responsibility to forward allegations of sexual abuse and sexual harassment to their supervisor to ensure referral for investigation.

The facility's medical wing is accessed through annex on housing unit 1. During the tour of that unit, informal interviews occurred with two contractors within the area to demonstrated that contract staff 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 the standard.

(c) The agency shall maintain documentation confirming that volunteers and contractors understand the training they have received.

The agency PREA Manual requires that the Department maintain documentation confirming that volunteers and contractors receive and understand the agency's PREA training. The facility provided training rosters for 27 staff during 2018 as part of its pre-audit documentation. While onsite, this auditor requested additional records from a total of 10 randomly selected contractors and volunteers to confirm training of contractors and volunteers is an ongoing practice. Those records reveal that contractors and volunteers are trained as they are authorized to enter the facility, under the supervision of the facility's Chaplain/volunteer coordinator when the individuals have a low level of contact with inmates. Records for healthcare contract staff confirm that those staff have completed the agency's PREA healthcare computer-based training module that is provided to directly hired agency staff. Training records demonstrate compliance with provision (c) of the standard.

Standard 115.33: Inmate education

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.33 (a)

- During intake, do inmates receive information explaining the agency's zero-tolerance policy regarding sexual abuse and sexual harassment? ☒ Yes ☐ No

- During intake, do inmates receive information explaining how to report incidents or suspicions of sexual abuse or sexual harassment? ☒ Yes ☐ No

115.33 (b)

- Within 30 days of intake, does the agency provide comprehensive education to inmates either in person or through video regarding: Their rights to be free from sexual abuse and sexual harassment? ☒ Yes ☐ No

- Within 30 days of intake, does the agency provide comprehensive education to inmates either in person or through video regarding: Their rights to be free from retaliation for reporting such incidents? ☒ Yes ☐ No

- Within 30 days of intake, does the agency provide comprehensive education to inmates either in person or through video regarding: Agency policies and procedures for responding to such incidents? ☒ Yes ☐ No

115.33 (c)

- Have all inmates received such education? ☒ Yes ☐ No

- Do inmates receive education upon transfer to a different facility to the extent that the policies and procedures of the inmate's new facility differ from those of the previous facility? ☒ Yes ☐ No

115.33 (d)

- Does the agency provide inmate education in formats accessible to all inmates including those who are limited English proficient? ☒ Yes ☐ No

- Does the agency provide inmate education in formats accessible to all inmates including those who are deaf? ☒ Yes ☐ No

- Does the agency provide inmate education in formats accessible to all inmates including those who are visually impaired? ☒ Yes ☐ No

- Does the agency provide inmate education in formats accessible to all inmates including those who are otherwise disabled? ☒ Yes ☐ No

- Does the agency provide inmate education in formats accessible to all inmates including those who have limited reading skills? ☒ Yes ☐ No

115.33 (e)

- Does the agency maintain documentation of inmate participation in these education sessions? ☒ Yes ☐ No

115.33 (f)

- In addition to providing such education, does the agency ensure that key information is continuously and readily available or visible to inmates through posters, inmate handbooks, or other written formats? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

(a) During the intake process, inmates shall receive information explaining the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and how to report incidents or suspicions of sexual abuse or sexual harassment.

Policies 03.03.140, 04.01.105, 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 the facility PREA Coordinator and random inmates, as well as observations along the audit tour, this education is reportedly completed through a video based presentation that is 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. During the audit tour, the auditor learned that the facility first provides the agency PREA brochure an inmate receives clothing and bedding from the facility's Quartermaster upon reception. This brochure and additional PREA information are provided once again during comprehensive inmate education at the facility's orientation program, which is generally conducted within seven to ten days of arrival into Muskegon. A review of these materials by the auditor, satisfies compliance with this element of provision (a).

Through informal interviews with the agency PREA Analyst, it was reported that the agency provides comprehensive inmate education at the Charles Egeler Reception and Guidance Center (RGC). All inmates that are received at Muskegon Correctional Facility will have passed through this facility for classification. Therefore, there was a basic assumption that minimal additional education would be

required upon transfer for those inmates who passed through RGC. However, during the onsite audit of the Charles Egeler Reception & Guidance Center (RGC) by consortium auditors Steven Noll and David Radziewicz, occurring May 22-24, 2019, following the conclusion of the onsite audit for Muskegon Correctional Facility; it was discovered that the assumed provision of education at RGC was facilitated by inmate peer specialists and consisted of viewing the agency's video and provision of the pamphlet without explanation or opportunity for questions. This agency level education did not address all of the specific reporting mechanisms available within the agency nor its emotional support line with Just Detention International. Therefore, the auditor relied upon the facility's education records provided through its orientation as evidence of the more comprehensive education required by provision (b).

Inmate interviews provided inconsistent information with respect to compliance with provision (a) of the standard. It is noted that only 15 of the 46 inmates interviewed arrived at the facility within the previous year to the audit. 25 of the 46 interviewed, had been at the facility for at least two years, with the remaining six arriving at the facility within the previous two years. Despite these variances in arrival dates, 31of 46 inmates were able to affirmatively identify that the facility provided some form of PREA educational information during the intake process; indicating that the facility has a long-standing practice of delivering some form of intake PREA educational information, even with several of those inmates in the facility in excess of three years. There were three of the 15 inmates who were received during the audit period who could not recall receiving PREA educational information during the intake process, with no consistent pattern of arrival dates to determine whether there was a temporary gap in procedures. During those interviews, however, inmates were consistently able to identify the posters with reporting information that are prominently displayed throughout the facility and J-Pay emails as a means to locate reporting information if necessary. Provided the evidence of compliance during the audit period and outside of the audit period, coupled with educational efforts at prior facilities, there is enough evidence that intake education is provided consistent with the standard.

During the audit tour, this auditor spoke informally with multiple housing unit counselors. As part of the intake processing, each counselor is required to complete an immediate file review to complete security and programming reviews of the received inmates. Part of the intake processing is to ensure that documentation of the PREA education session is located within the file and to subsequently note that date on the front of the inmate file. During the audit tour, this auditor randomly sampled inmate files on several housing units to verify documented evidence of PREA education prior to arrival at the facility to provide additional evidence of compliance with provision (a) of the standard.

(b) Within 30 days of intake, the agency shall provide comprehensive education to inmates either in person or through video regarding their rights to be free from sexual abuse and sexual harassment and to be free from retaliation for reporting such incidents, and regarding agency policies and procedures for responding to such incidents.

Policies 03.03.140, 04.01.105, 04.01.140 and the PREA Manual 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. This education is completed through a video based presentation that is 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 informal interviews with the PREA Analyst and Prison Counselors on the housing units, it was reported that the MDOC has an intake facility, Charles Egeler Reception & Guidance Center (RGC), where intake is completed for prisoners who are assigned to the Muskegon Correctional Facility and records of completion are

reviewed upon reception to the facility during the initial file review. As noted, during a subsequent audit of RGC immediately following the closeout of the Muskegon audit, it was discovered that the comprehensive education at RGC did not consistently address all available reporting mechanisms available within the agency, nor the available JDI resources. Therefore, the facility specific orientation records were relied upon to supplement and verify compliance with the comprehensive educational requirements.

A total of 46 inmate interviews were conducted with random and targeted inmates during the audit; however, all inmates were administered the random inmate question protocols. As previously noted, only 15 of the 46 interviewed inmates arrived at the facility within the audit period. Despite the longer-term nature of those inmates interviewed, 31 of the 46 were able to affirm that they received comprehensive PREA educational information at the facility's orientation. Going further, another nine interviewed inmates were able to affirm that they received this comprehensive education at another MDOC facility. Of the six who could not recall receipt of comprehensive education at the facility, four were received at least two and one-half years prior to the onsite audit. In addition to the facility's orientation, most inmates confirmed that education materials were provided and the PREA video (Taking Action) was shown also shown during the intake process at RGC. Interviewed inmates also report that information is continuously displayed throughout the housing units on posters, is available in handbooks, is on the inmate television network, and repeatedly appears on the J-Pay kiosks and tablets.

An interview was conducted with the facility's intake staff person, who is responsible for completing the orientation program, including comprehensive PREA education. This individual states they provide inmates with information to include their rights to be free from sexual abuse, sexual harassment, derogatory references to them or any unwanted touching. Inmates are informed of reporting mechanisms and where to locate information about reporting mechanisms if later needed. The facility has the goal of providing this education within 72 hours of reception to the facility; however, there are sometimes conflicts which delay orientation. The orientation schedule is timed to match up with normal incoming transport dates to achieve this timeliness goal.

To gauge evidence of practice for both inmate education and risk screening requirements, the auditor selected 21 inmates from the facility's PREA Risk Assessment Tracker. The auditor notes that the tracker is kept by housing unit; therefore, samples were requested from each housing unit's spreadsheets to verify consistency throughout the facility. For those inmates selected, the auditor requested both inmate education and PREA risk assessment records for each to determine compliance with the education and risk screening standards. Training records were compared against the facility entry date logged on the PREA risk screening tracker to verify that comprehensive education was provided within 30 days of arrival at the facility through the facility's orientation program. The auditor found that all 20 of 21 sampled inmates were provided comprehensive education within 30 days. One record was not dated by the inmate and excluded from the sample. Of the remaining 20 samples, 11 received education with three days of arrival and the longest an inmate waited for education was 15 days. Inmate training receipts from the facility that were randomly selected by the auditor and readily provided by the facility demonstrate compliance with provision (b) of the standard.

The auditor does note that interviews with all selected inmates demonstrated that inmates were well informed of available reporting mechanisms. 37 of the 46 interviewed were able to identify at least three reporting mechanisms or point to locations where they were able to find such information in the event they needed to make a report. 45 of 46 inmates were able to confirm that written, verbal and third-party reports were permitted. These interviews confirm that the education process and reiteration efforts described below are achieving their intended effect, consistent with the intent of the standard.

(c) Current inmates who have not received such education shall be educated within one year of the effective date of the PREA standards, and shall receive education upon transfer to a different facility to the extent that the policies and procedures of the inmate's new facility differ from those of the previous facility.

Through previous interviews with the PREA Manager and a review of agency materials, it is clear that PREA policies and reporting mechanisms are universal throughout the agency, negating the need to significantly retrain inmates upon transfer from the RGC to the Muskegon Correctional Facility; provided such training occurred in accordance with the standards. A previous interview with the agency PREA Manager 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. Through previous audits within the agency, and during this audit, the auditor observed evidence of PREA training records in inmate files preceding the agency's full efforts to engage in the audit process during the 2nd auditing cycle.

Recognizing the need to ensure that inmates are adequately refreshed, however, the facility began educating all of its incoming transfers through the facility's orientation. As noted above, two-thirds of the randomly sampled inmate interview population were transferred to the facility outside the previous 12 months of the audit period. Of those 31 inmates who were at the facility prior to this period, 27 were able to affirm that they received comprehensive education. Interviews, coupled with the observation of training records in counselor files during the audit tour, demonstrate that the facility has sufficient practices in place to assure that all inmates have received comprehensive PREA education consistent with provision (c) of the standard.

(d) The agency shall provide inmate education in formats accessible to all inmates, including those who are limited English proficient, deaf, visually impaired, or otherwise disabled, as well as to inmates who have limited reading skills.

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 Muskegon Correctional Facility submitted evidence of use of translation services through Pallero Inc as proof of its provision of interpretative services for disabled or LEP inmates during the intake education process. Additionally, the facility has staff who can act as interpreters as needed. During the onsite portion of the audit, the audit team learned through inmate interviews with cognitively disabled, physically disabled, and hearing-impaired individuals that the facility provides materials in a manner they can understand or provides an individual assistant to help them understand information. During the audit tour, the auditor observed that PREA signage was posted in both English and Spanish throughout the facility. In addition to the agency's standardized signage, the facility also generated additional signage to advertise reporting mechanisms, victim resource information and the zero-tolerance policy. The facility 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 library that are available for check-out to the inmate population. Moreover, the facility and agency also advertise reporting mechanisms and the JDI

Inside Line service through weekly J-Pay emails, in addition to replays of the agency PREA video on the inmate movie channel. The auditor reviewed these training materials, the library inventory and interpretation invoices to determine compliance with provision (d) of the standard.

(e) The agency shall maintain documentation of inmate participation in these education sessions.

The agency and facility maintain documentation of inmate education via form CAJ-1036. As part of the facility's intake and receptions procedures, each new reception's file is reviewed, and it is verified that the inmate has documented receipt of training within the file. As part of its pre-audit documentation, the facility provided completed samples of this education document. The auditor randomly selected 2 inmate files from housing unit counselor offices during the audit tour to verify that agency PREA training records existed. Additional random selections were made from the facility's PREA risk tracking worksheet to verify compliance with both education and risk screening requirements. The auditor notes that the tracker is kept by housing unit; therefore, samples were requested from each housing unit's spreadsheets to verify consistency throughout the facility. For those inmates selected, the auditor requested both inmate education and PREA risk assessment records for each to determine compliance with the education and risk screening standards. Training records were compared against the facility entry date logged on the PREA risk screening tracker to verify that comprehensive education was provided within 30 days of arrival at the facility through the facility's orientation program. The auditor found that all 20 of 21 sampled inmates were provided comprehensive education within 30 days. One record was not dated by the inmate and excluded from the sample. Of the remaining 20 samples, 11 received education with three days of arrival and the longest an inmate waited for education was 15 days. Inmate training receipts from the facility that were randomly selected by the auditor and readily provided by the facility demonstrate compliance with provision (e) of the standard. During inmate interviews, inmates also report that they were required to sign a paper to confirm they were educated.

(f) In addition to providing such education, the agency shall ensure that key information is continuously and readily available or visible to inmates through posters, inmate handbooks, or other written formats.

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 Muskegon Correctional Facility, these posters were visible throughout the housing units, common areas of the facility and programming locations. Inmates receive a tri-fold PREA brochure that is published in both English and Spanish during the intake process and orientation at the facility. 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 and the agency's training materials and prisoner guidebooks that are available for the inmate population to check out. Inmate confirm through interviews that the facility regularly broadcasts the agency's PREA video on the movie channel of the inmate cable system. Finally, as part of its ongoing efforts, the agency provided, and the inmate confirmed during interviews, that there is a weekly notification through the agency's kiosk/tablet system that provides PREA information, relative to reporting mechanisms and availability of the JDI Inside Line resource. Inmates sometimes complained during interviews that this repetitive sending of information was excessive; however, it demonstrates the facility's efforts to ensure that such information remains readily available consistent with provision (f). Based on the efforts of the facility to actively advertise and promote PREA resources throughout all areas of the facility, as well as its efforts to ensure PREA information, including its educational video, is constantly available, this auditor determines compliance with provision (f) of the standard.

Standard 115.34: Specialized training: Investigations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.34 (a)

- In addition to the general training provided to all employees pursuant to §115.31, does the agency ensure that, to the extent the agency itself conducts sexual abuse investigations, its investigators have received training in conducting such investigations in confinement settings? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.21(a).) ☒ Yes ☐ No ☐ NA

115.34 (b)

- Does this specialized training include techniques for interviewing sexual abuse victims? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.21(a).] ☒ Yes ☐ No ☐ NA

- Does this specialized training include proper use of Miranda and Garrity warnings? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.21(a).] ☒ Yes ☐ No ☐ NA

- Does this specialized training include sexual abuse evidence collection in confinement settings? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.21(a).] ☒ Yes ☐ No ☐ NA

- Does this specialized training include the criteria and evidence required to substantiate a case for administrative action or prosecution referral? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.21(a).] ☒ Yes ☐ No ☐ NA

115.34 (c)

- Does the agency maintain documentation that agency investigators have completed the required specialized training in conducting sexual abuse investigations? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.21(a).] ☒ Yes ☐ No ☐ NA

115.34 (d)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

(a) In addition to the general training provided to all employees pursuant to § 115.31, the agency shall ensure that, to the extent the agency itself conducts sexual abuse investigations, its investigators have received training in conducting such investigations in confinement settings.

The agency has a Basic Investigator Training manual that was reviewed by the 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 18 active staff at the Muskegon Correctional Facility completed the agency's basic investigator training. In addition to the agency's Basic Investigator Training, training records confirm that all 18 staff completed also completed the NIC specialized investigator's training for PREA, which covers the key investigatory standard training points in satisfaction of provision (a) of the standard. The auditor also spot-checked five of these individuals who were trained investigators to verify that they have also completed the most recent issue of the facility's PREA training required under 115.31. All five were verified as having completed regular annual PREA training in compliance with provision (a). Two investigators were interviewed onsite, one of the facility's Inspectors and one of the lower-level supervisors authorized to conduct investigations. Both affirmed they received training specific to investigations and described content consistent with the curriculum reviewed.

(b) 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 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, all 18 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 the standard. During interviews with two of the facility's investigators, both demonstrated sufficient retention of the training materials and were able to describe that the content of training was consistent with the observed curriculum. As will be noted under the investigatory standard, not all investigators within the facility have been brought up to date with agency policy for sexual abuse and sexual harassment investigations which prohibit the use of questionnaires to substitute in lieu of investigatory interviews. To remedy this deficit and others observed within investigations, the facility implemented an investigatory review process, where all sexual abuse and sexual harassment investigations will be routed through the facility PREA Coordinator/Inspector for review prior to submission to the Warden for final review.

(c) The agency shall maintain documentation that agency investigators have completed the required specialized training in conducting sexual abuse investigations.

The agency maintains documentation of investigator training in the employee's training file. The facility provided documentation that was reviewed by the auditor to verify that 18 active employees have completed the Basic Investigator Training. Training records were provided to confirm that all 18 investigators also completed the NIC specialized investigator training in satisfaction of provision (c) of the standard.

(d) Any State entity or Department of Justice component that investigates sexual abuse in confinement settings shall provide such training to its agents and investigators who conduct such investigations.

The auditor is not responsible for auditing provision (d) of the standard.

Standard 115.35: Specialized training: Medical and mental health care

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.35 (a)

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in how to detect and assess signs of sexual abuse and sexual harassment? ☒ Yes ☐ No

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in how to preserve physical evidence of sexual abuse? ☒ Yes ☐ No

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in how to respond effectively and professionally to victims of sexual abuse and sexual harassment? ☒ Yes ☐ No

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in how and to whom to report allegations or suspicions of sexual abuse and sexual harassment? ☒ Yes ☐ No

115.35 (b)

- If medical staff employed by the agency conduct forensic examinations, do such medical staff receive appropriate training to conduct such examinations? (N/A if agency medical staff at the facility do not conduct forensic exams.) ☐ Yes ☐ No ☒ NA

115.35 (c)

- Does the agency maintain documentation that medical and mental health practitioners have received the training referenced in this standard either from the agency or elsewhere? ☒ Yes ☐ No

115.35 (d)

- Do medical and mental health care practitioners employed by the agency also receive training mandated for employees by §115.31? ☒ Yes ☐ No

- Do medical and mental health care practitioners contracted by and volunteering for the agency also receive training mandated for contractors and volunteers by §115.32? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

(a) The agency shall ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in:
(1) How to detect and assess signs of sexual abuse and sexual harassment;
(2) How to preserve physical evidence of sexual abuse;
(3) How to respond effectively and professionally to victims of sexual abuse and sexual harassment; and
(4) How and to whom to report allegations or suspicions of sexual abuse and sexual harassment.

Agency policies 02.05.100 and 02.05.101establish procedures for ensuring staff, including contract staff, are adequately trained based on their positions within the agency. The agency has developed a training curriculum specific to medical and mental health staff that were reviewed by the auditor. These

materials expand upon the basic training module 2 to cover the four points required by the standards. 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. In response to a previous audit at another MDOC facility at the start of the 2nd audit cycle that this auditor participated in, the MDOC also provides training to all of its medical and mental health staff to serve as a qualified agency staff member, with respect to providing victim advocacy services in the event an individual needs such support. As such, medical and mental health practitioners with the MDOC receive training beyond the standard's minimal requirements.

The facility reported 21 regular medical and mental health care staff work regularly within the facility. Pre-audit, they provided documentation of seven records of medical and mental health practitioners having completed the training modules related to their specific disciplines that were reviewed by the auditor. While onsite, the auditor received 16 records of health care staff competing specialized training, confirmation that a 17th staff was on long-term medical leave, and one mental health staff training record. Following the audit, the auditor requested records to very that the remaining three mental health staff received training. Due to the timing of the request and the PREA Coordinator's absence, this request was unable to be satisfied prior to the issuing of this interim report. During the onsite audit, the audit team interviewed two mental health staff, who were not listed on the mental health training roster, who described completion of a training module consistent with the curriculum. 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). However, due to the need for confirmation of training for the remaining mental health staff, the auditor lists this item for corrective action. Upon receipt of records to confirm the facility's three mental health practitioners have received specialized training, the auditor will find compliance.

(b) If medical staff employed by the agency conduct forensic examinations, such medical staff shall receive the appropriate training to conduct such examinations.

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

(c) The agency shall maintain documentation that medical and mental health practitioners have received the training referenced in this standard either from the agency or elsewhere.

The facility provided documentation of 18 of 21 medical and mental health practitioners completion of the specialized training modules that was reviewed by the auditor. The auditor later made a request for the remaining three records. Due to the timing of the request and the PREA Coordinator's absence, this request was unable to be satisfied prior to the issuing of this interim report. Training records are kept in the computerized training records for employees and demonstrate compliance with provision (c) of the standard. However, due to the need for confirmation of training for the remaining mental health staff, the auditor lists this item for corrective action. Upon receipt of records to confirm the facility's three mental health practitioners have received specialized training, the auditor will find compliance.

(d) Medical and mental health care practitioners shall also receive the training mandated for employees under § 115.31 or for contractors and volunteers under § 115.32, depending upon the practitioner's status at the agency.

The agency has developed a training curriculum 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. Therefore, completion of the specialized training module for medical and mental health care staff also verifies completion of the agency's trainings required under 115.31 and 115.32. The auditor's review of these training materials and corresponding completion records demonstrates compliance with provision (d) of the standard.

CORRECTIVE ACTION RECOMMENDATION:

The facility provided documentation of 18 of 21 medical and mental health practitioners completion of the specialized training modules that was reviewed by the auditor. The auditor later made a request for the remaining three records. Due to the timing of the request and the PREA Coordinator's absence, this request was unable to be satisfied prior to the issuing of this interim report. Upon receipt of records to confirm the facility's three mental health practitioners have received specialized training, the auditor will find compliance.

POST INTERIM REPORT CORRECTIVE ACTIONS TAKEN:

Following the issuing of the interim report and upon return to the facility, the Muskegon PREA Coordinator was able to provide the auditor the remaining three training records for the facility's medical and mental health practitioners. Based upon the provision of these requested records, the auditor finds the facility is in full compliance with the standard.

SCREENING FOR RISK OF SEXUAL VICTIMIZATION AND ABUSIVENESS

Standard 115.41: Screening for risk of victimization and abusiveness

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.41 (a)

- Are all inmates assessed during an intake screening for their risk of being sexually abused by other inmates or sexually abusive toward other inmates? ☒ Yes ☐ No

- Are all inmates assessed upon transfer to another facility for their risk of being sexually abused by other inmates or sexually abusive toward other inmates? ☒ Yes ☐ No

115.41 (b)

- Do intake screenings ordinarily take place within 72 hours of arrival at the facility?
  ☒ Yes ☐ No

115.41 (c)

- Are all PREA screening assessments conducted using an objective screening instrument?
  ☒ Yes ☐ No

115.41 (d)

- Does the intake screening consider, at a minimum, the following criteria to assess inmates for risk of sexual victimization: (1) Whether the inmate has a mental, physical, or developmental disability? ☒ Yes ☐ No

- Does the intake screening consider, at a minimum, the following criteria to assess inmates for risk of sexual victimization: (2) The age of the inmate? ☒ Yes ☐ No

- Does the intake screening consider, at a minimum, the following criteria to assess inmates for risk of sexual victimization: (3) The physical build of the inmate? ☒ Yes ☐ No

- Does the intake screening consider, at a minimum, the following criteria to assess inmates for risk of sexual victimization: (4) Whether the inmate has previously been incarcerated?
  ☒ Yes ☐ No

- Does the intake screening consider, at a minimum, the following criteria to assess inmates for risk of sexual victimization: (5) Whether the inmate's criminal history is exclusively nonviolent?
  ☒ Yes ☐ No

- Does the intake screening consider, at a minimum, the following criteria to assess inmates for risk of sexual victimization: (6) Whether the inmate has prior convictions for sex offenses against an adult or child? ☒ Yes ☐ No

- Does the intake screening consider, at a minimum, the following criteria to assess inmates for risk of sexual victimization: (7) Whether the inmate is or is perceived to be gay, lesbian, bisexual, transgender, intersex, or gender nonconforming (the facility affirmatively asks the inmate about his/her sexual orientation and gender identity AND makes a subjective determination based on the screener's perception whether the inmate is gender non-conforming or otherwise may be perceived to be LGBTI)? ☒ Yes ☐ No

- Does the intake screening consider, at a minimum, the following criteria to assess inmates for risk of sexual victimization: (8) Whether the inmate has previously experienced sexual victimization? ☒ Yes ☐ No

- Does the intake screening consider, at a minimum, the following criteria to assess inmates for risk of sexual victimization: (9) The inmate's own perception of vulnerability? ☒ Yes ☐ No

- Does the intake screening consider, at a minimum, the following criteria to assess inmates for risk of sexual victimization: (10) Whether the inmate is detained solely for civil immigration purposes? ☒ Yes ☐ No

115.41 (e)

- In assessing inmates for risk of being sexually abusive, does the initial PREA risk screening consider, when known to the agency: prior acts of sexual abuse? ☒ Yes ☐ No

- In assessing inmates for risk of being sexually abusive, does the initial PREA risk screening consider, when known to the agency: prior convictions for violent offenses? ☒ Yes ☐ No

- In assessing inmates for risk of being sexually abusive, does the initial PREA risk screening consider, when known to the agency: history of prior institutional violence or sexual abuse? ☒ Yes ☐ No

115.41 (f)

- Within a set time period not more than 30 days from the inmate's arrival at the facility, does the facility reassess the inmate's risk of victimization or abusiveness based upon any additional, relevant information received by the facility since the intake screening? ☒ Yes ☐ No

115.41 (g)

- Does the facility reassess an inmate's risk level when warranted due to a: Referral? ☒ Yes ☐ No

- Does the facility reassess an inmate's risk level when warranted due to a: Request? ☒ Yes ☐ No

- Does the facility reassess an inmate's risk level when warranted due to a: Incident of sexual abuse? ☒ Yes ☐ No

- Does the facility reassess an inmate's risk level when warranted due to a: Receipt of additional information that bears on the inmate's risk of sexual victimization or abusiveness? ☒ Yes ☐ No

115.41 (h)

- Is it the case that inmates are not ever disciplined for refusing to answer, or for not disclosing complete information in response to, questions asked pursuant to paragraphs (d)(1), (d)(7), (d)(8), or (d)(9) of this section? ☒ Yes ☐ No

115.41 (i)

- Has the agency implemented appropriate controls on the dissemination within the facility of responses to questions asked pursuant to this standard in order to ensure that sensitive information is not exploited to the inmate's detriment by staff or other inmates? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

(a) All inmates shall be assessed during an intake screening and upon transfer to another facility for their risk of being sexually abused by other inmates or sexually abusive toward other inmates.

Policy 03.03.140, 05.01.140, the PREA Manual and the PREA Risk Assessment Manual, which were reviewed by the auditor, state that an intake screening shall be conducted at facilities during intake. The auditor notes that the agency policies governing risk screening 03.03.140 and the PREA Manual changed in April of 2017 due to prior audits within the MDOC, which identified non-complaint practices of simply reviewing prior assessments upon transfer. Policy changes were updated to compliantly assess all incoming transfers upon reception utilizing the initial assessment instrument and subsequently conducting reviews using the review assessment. These updated policies were effective approximately two years to the first day of the onsite audit; making agency policy compliance with provision (a) of the standard.

However, the auditor notes that the 2017 version of the agency's PREA Risk Assessment Manual, which guides staff on the practical implementation of the risk screening procedures remains in a draft format that was utilized to satisfy previous corrective action periods within the agency for this auditor's prior audits. This raises a concern, insomuch as the facility provided the 2015 version of this risk screening manual as supporting documentation in the pre-audit phase, which still directs non-compliant practices of not requiring face-to-face assessment reviews, not requiring affirmative responses to the critical question of past victimization, and not recompleting the initial assessment upon each transfer. The auditor learned through a subsequent consortium audit later that week at the agency's RGC facility, that staff can only access the 2015 version of this manual via its policy management system. Given the opportunity for misleading information to be available to staff via its outdated 2015 version of the PREA Risk Assessment Manual, the auditor requires that the agency's PREA Risk Assessment Manual, containing updates reflective of the agency's revised risk screening procedures from 2017 and requiring affirmative responses to the subjective components of the assessment which can only be

ascertained from the inmate themselves be formally approved and available to staff on the agency's policy management system.

Although the changes in agency policy were effective approximately two years prior to the onsite audit, the auditor found evidence the Muskegon Correctional Facility did not begin to consistently implement compliant risk screenings consistent with agency policy until the fall of 2018. Specifically, the auditor analyzed the facility's PREA Risk Tracker provided during the pre-audit exchange of materials. The risk tracker was designed to record the date of arrival and each inmate's assessment history. The tracking spreadsheet is organized by housing unit and further organized by cell assignment; reflective of the inmates housed in a particular cell at that moment and snapshot in time. There are separate tabs for each floor of the housing units, i.e. a separate spreadsheet tab for Housing Unit 1 Lower Level and Housing Unit 1 Upper Level. During the auditor tour, when informally interviewing the Prison Counselors responsible for completing the assessments, each affirmed that they rotate for one-week periods to conduct the initial assessments of incoming transfers, then each are responsible for conducting the review of the assessments for their designated area of coverage, specifically, the floor of the housing unit to which they are assigned as an inmate's counselor.

To verify the veracity of the information contained on the PREA Risk Tracker, the auditor selected 20 samples from the spreadsheet and requested that the facility provide the electronic records to verify entry dates and the computerized date stamp of the assessment. The auditor found that the spreadsheet was reliable, insomuch as there was only one assessment date incorrectly recorded by a single day out of the 40 (initial and review assessments). Furthermore, the auditor intentionally selected examples where the facility self-admitted its non-compliance with assessment timeliness and found those electronic records further matched the facility's spreadsheet.

With the understanding of the operational premises behind the tracking worksheet, the auditor conducted an automated filtering of the data to select those inmates who arrived at the facility between May 2018 through March of 2019, due to the spreadsheet being provided April 15, 2019. The auditor used Excel's date difference calculator to assess the difference between the arrival date and assessment dates for each housing unit and level tab to find whether those inmates were assessed within the timeframes prescribed within the standards. The auditor excluded those samples determined to be unreliable due to potential typographical errors and those who, based upon reception date, were not due for reassessment. The resulting pool of reliable records upon which to assess compliance was 387 records. The auditor found that 40 of those initial assessments (10.3%) were either completed beyond 72 hours, were not logged as completed, or were dated prior to the inmate's documented arrival date at the facility. The auditor notes that the significant number of delayed assessments or incomplete assessments on the analysis occurred more than six months prior to the audit; thus, it appears the facility self-corrected the timeliness of its initial assessments when it implemented the rotational schedule of a single staff being responsible for all incoming assessments for an assigned week.

The auditor found; however, that of the 387 samples, 100 reassessments (25.8%) were either delayed, not completed, or contained incorrect dates, i.e. dates prior to the inmate's transfer into the facility. Again, the auditor found a pattern, insomuch as that the facility appeared to improve approximately six months prior to the audit, with the rate of non-compliance for individuals arriving after November 1, 2018 to 39 of 221 records (17.6%). Regardless of the recent improvement; records are not consistent with the level of institutionalization necessary to say that compliant practice has been established for these types of reviews.

Formal interviews with inmates identified 15 inmates who were received within the past year. Of those 15, a total of 12 affirmed that they were asked intake screening questions and only three affirmed that they were rescreened. As described under provision (c), the auditor learned that the facility relies on a robust informational history that accompanies each incoming transfer for the responses to all but those assessment questions which require the subjective input of the inmate, specifically pertaining to the individual's disability status, perception of vulnerability, and history of victimization. As a result, there is significant potential for the inmates not recall the risk screening process utilizing the PREA Resource Center's standardized template of random inmate questions.

Formal interviews with three staff responsible for risk screening state in interviews that initial assessments are usually completed on the date of arrival or the next day at the facility or if not, within 72-hours. The assessors described the process of being assigned a rotational week, where they are responsible for completing assessments for all incoming transfers to the facility to avoid the complication of individuals being missed through the absence of their assigned counselor during the reception window. The auditor asked the question of what takes place when either the PC may not be available within 72 hours due to an extended weekend and the respondent indicated that there are select shift staff, who are at the facility during weekends and holidays, who have been trained to conduct the assessment to ensure timeliness. The auditor finds that there is sufficient evidence to demonstrate the facility has implemented the agency's policy to conduct intake screenings of all incoming receptions consistent with provision (a) of the standard.

(b) Intake screening shall ordinarily take place within 72 hours of arrival at the facility.

Policy 03.03.140, 05.01.140, the PREA Manual and the PREA Risk Assessment Manual, which were reviewed by the auditor, state that an intake screening shall be conducted at facilities during intake. The auditor notes that the agency policies governing risk screening 03.03.140 and the PREA Manual changed in April of 2017 due to prior audits within the MDOC, which identified non-complaint practices of simply reviewing prior assessments upon transfer. Policy changes were updated to compliantly assess all incoming transfers upon reception utilizing the initial assessment instrument and subsequently conducting reviews using the review assessment. These updated policies were effective approximately two years to the first day of the onsite audit; making agency policy compliance with provision (a) of the standard.

Although the changes in agency policy were effective approximately two years prior to the onsite audit, the auditor found evidence the Muskegon Correctional Facility did not begin to consistently implement compliant risk screenings consistent with agency policy until the fall of 2018. Specifically, through analysis of the facility's PREA Risk Tracking spreadsheet (please refer to the methodology described under provision (a) for further details), the auditor found a reliable sample pool of 387 records within the audit period and found that 40 of the assessments were either completed beyond 72 hours, were not logged as completed, or were dated prior to the inmate's documented arrival date at the facility, resulting in an overall compliance rate of 89.7% for the audit period. The auditor notes that the significant number of delayed assessments or incomplete assessments on the analysis occurred more than six months prior to the audit; thus, it appears the facility self-corrected the timeliness of its initial assessments when it implemented the rotational schedule of a single staff being responsible for all incoming assessments for an assigned week.

Formal interviews with three staff responsible for risk screening confirms that initial assessments are usually completed on the date of arrival at the facility or otherwise within 72 hours. Due to the recent level of compliance and the facility's self-corrective actions to develop procedures for compliant intake

risk screening procedures; the auditor finds there is sufficient evidence of compliance with provision (b) of the standard.

(c) Such assessments shall be conducted using an objective screening instrument.

The PREA Risk Assessment Worksheet that was reviewed by the auditor meets objective criteria as required by provision (c) of the 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. The tool is designed in such a manner as that if different individuals were to assess the same metrics and be fed the same input data; assessment scores would ultimately be the same. The auditor notes that, within the state of Michigan, a pre-sentence report is prepared for individuals convicted of a felony and when there is a referral for misdemeanor convictions. Therefore, the MDOC has the strategic advantage of objective records to confirm responses to the risk assessment without the need to rely on self-reported information from the inmate for significant items pertaining to their incarceration history and criminal history. Pre-sentence reports also contain relevant information relative to provision (d)'s requirements to assess LGBT status, disabilities, and prior history of sexual victimization. MDOC assessors are instructed to rely on these pre-sentence reports and other agency/facility generated records to affirm responses to those items on the assessment tool. Therefore, there is an even greater potential for consistency and objectivity to the assessment process based upon the sourcing of evidentiary information.

During the onsite audit, the auditors learned first-hand how the facility relied upon collateral information to complete its assessment process when attempting to identify individuals who were identified as victims of sexual abuse through the risk screening process. An additional six inmates needed to be reselected for targeted interviews based upon information uncovered through the risk screening process that the inmate's denied reporting to MDOC assessors. When probing further into the matter, it was learned that the identified victimization or other criteria was either generated through the pre-sentence report or report during MDOC intake procedures and consistently relied upon through the assessment process. The auditor finds this use of historical information in a consistent fashion to enhance compliance with the objectivity requirements of provision (c). The auditor also notes, in the same vein, to be given the designation as an Aggressor or Victim, (not potential) the tool requires documentation to confirm previous aggression or victimization; further cementing its objectivity for such designations. The subjective components of the assessment are an individualized reaffirmation of whether the individual reports a disability, whether they perceive themselves to be vulnerable, and whether the individual has experienced victimization; consistent with the standard.

(d) The intake screening shall consider, at a minimum, the following criteria to assess inmates for risk of sexual victimization:
(1) Whether the inmate has a mental, physical, or developmental disability;
(2) The age of the inmate;
(3) The physical build of the inmate;
(4) Whether the inmate has previously been incarcerated;
(5) Whether the inmate's criminal history is exclusively nonviolent;
(6) Whether the inmate has prior convictions for sex offenses against an adult or child;
(7) Whether the inmate is or is perceived to be gay, lesbian, bisexual, transgender, intersex, or gender nonconforming;
(8) Whether the inmate has previously experienced sexual victimization;
(9) The inmate's own perception of vulnerability; and
(10) Whether the inmate is detained solely for civil immigration purposes.

Based on a review of the PREA Manual and the PREA Risk Assessment Manual, as well as through a discussion with the agency PREA Manager, the auditor is satisfied that the intake screening instrument meets the 10 criteria set forth in provision (d) of the standard. While the tool does not affirmatively address criteria 10, neither the agency nor the Muskegon Correctional Facility 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 elements of the standard are affirmatively addressed within the intake screening process to demonstrate compliance with provision (d) of the standard.

(e) The initial screening shall consider prior acts of sexual abuse, prior convictions for violent offenses, and history of prior institutional violence or sexual abuse, as known to the agency, in assessing inmates for risk of being sexually abusive.

Based on a review of the PREA Manual and the PREA Risk Assessment Manual, as well as through a discussion with the agency PREA Manager, the auditor is satisfied that the intake screening instrument meets the requirements of provision (e) of the 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 the standard is adequately inclusive of both convictions and known institutional behavior.

(f) Within a set time period, not to exceed 30 days from the inmate's arrival at the facility, the facility will reassess the inmate's risk of victimization or abusiveness based upon any additional, relevant information received by the facility since the intake screening.

The PREA Manual and the PREA Risk Assessment Manual, which were reviewed by the auditor, clearly specify applicable time frames for assessment completion. 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, based upon a review of objective information contained in the individual's records. Formal interviews with inmates identified 15 inmates who were received within the past year. Of those 15, a total of three affirmed that they were asked risk screening questions for a second time. As described under provision (c), the auditor learned that the facility relies on a robust informational history that accompanies each incoming transfer for the responses to all but those assessment questions which require the subjective input of the inmate, specifically during the reassessment process, the assessing staff have objective records to verify all information except the potential variable of having suffered sexual abuse. As a result, there is significant potential for the inmates not recall the risk screening process utilizing the PREA Resource Center's standardized template of random inmate questions.

Although the changes in agency policy were effective approximately two years prior to the onsite audit, the auditor found evidence the Muskegon Correctional Facility did not begin to consistently implement compliant risk screenings consistent with agency policy until the fall of 2018. Consistent with the methodology described under provision (a), the auditor found that of the 387 samples, 100 reassessments (25.8%) were either delayed, not completed, or contained incorrect dates, i.e. dates prior to the inmate's transfer into the facility. Again, the auditor found a pattern, insomuch as that the facility appeared to improve approximately six months prior to the audit, with the rate of non-compliance for individuals arriving after November 1, 2018 to 39 of 221 records (17.6%). Regardless of the recent

improvement; records are not consistent with the level of institutionalization necessary to say that compliant practice has been established for these types of reviews under provision (f).

(g) An inmate's risk level shall be reassessed when warranted due to a referral, request, incident of sexual abuse, or receipt of additional information that bears on the inmate's risk of sexual victimization or abusiveness.

Policy 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 the standard. Staff responsible for risk screening communicate that they are aware of their responsibilities to conduct assessments as needed to demonstrate compliance with provision (g) of the standard.

(h) Inmates may not be disciplined for refusing to answer, or for not disclosing complete information in response to, questions asked pursuant to paragraphs (d)(1), (d)(7), (d)(8), or (d)(9) of this section.

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 Manager, PREA Coordinator and staff responsible for conducting assessments confirm during formal and informal interviews that the assessment is voluntary and that there are no disciplinary consequences for failing to participate, consistent with provision (h) of the standard.

(i) The agency shall implement appropriate controls on the dissemination within the facility of responses to questions asked pursuant to this standard in order to ensure that sensitive information is not exploited to the inmate's detriment by staff or other inmates.

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 the audit tour and through interviews with the PREA Manager and PREA Coordinator, only those staff with a role in the risk screening process 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 the standard.

CORRECTIVE ACTION RECOMMENDATION:

Given the opportunity for misleading information to be available to staff via its outdated 2015 version of the PREA Risk Assessment Manual, the auditor requires that the agency's PREA Risk Assessment Manual, containing updates reflective of the agency's revised risk screening procedures from 2017 and requiring affirmative responses to the subjective components of the assessment which can only be ascertained from the inmate themselves be formally approved by the agency and available to staff on the agency's policy management system.

The Muskegon Correctional Facility is required to continue with its risk screening procedures and demonstrate that it consistently assesses inmates within the timeframes prescribed by the standards.

Compliance will be measured by the facility providing the auditor with a copy of the facility's tracking sheet. The auditor will then select a random sample of those inmates and request applicable

computerized risk screening records to verify the accuracy of the tracking log, thus ensuring that risk screenings are completed as required in accordance with provisions (a) (b) and (f) of the standard. If compliance is demonstrated during the initial 90-day period, the auditor will be satisfied that the matter has been corrected.

POST INTERIM REPORT CORRECTIVE ACTIONS TAKEN:

In late August 2019, the facility's PREA Coordinator provided the auditor a copy of the facility's risk screening tracker. Similar to the initial analysis, the auditor utilized the DATEDIF function within Excel to analyze the timeliness of risk screening. The auditor analyzed the spreadsheet for the completed assessments between May and August that were due for both 72 hour and 30 day assessments. The auditor found continued progressive improvement in the facility's timeliness of assessments, with sample sizes averaging over 70 samples per month. The auditor found that the facility's established process for 72 hour assessments continued to successfully produce timely assessments in accordance with provision (b) of the standard. Specifically, the facility demonstrated greater than 95% compliance in each month of the review period.

With respect to 30 day assessments, the auditor found that during the month of May, the facility demonstrated greater than 90% compliance with timely assessments. In the remaining sample period, the auditor found that the facility demonstrated greater than 95% compliance with reassessments. Based upon the facility's efforts to conduct screenings within the timelines of the standards; the auditor now finds that the facility is in full compliance with the standard.

Standard 115.42: Use of screening information

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.42 (a)

- Does the agency use information from the risk screening required by § 115.41, with the goal of keeping separate those inmates at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Housing Assignments? ☒ Yes ☐ No

- Does the agency use information from the risk screening required by § 115.41, with the goal of keeping separate those inmates at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Bed assignments? ☒ Yes ☐ No

- Does the agency use information from the risk screening required by § 115.41, with the goal of keeping separate those inmates at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Work Assignments? ☒ Yes ☐ No

- Does the agency use information from the risk screening required by § 115.41, with the goal of keeping separate those inmates at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Education Assignments? ☒ Yes ☐ No

- Does the agency use information from the risk screening required by § 115.41, with the goal of keeping separate those inmates at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Program Assignments? ☒ Yes ☐ No

115.42 (b)

- Does the agency make individualized determinations about how to ensure the safety of each inmate? ☒ Yes ☐ No

115.42 (c)

- When deciding whether to assign a transgender or intersex inmate to a facility for male or female inmates, does the agency consider on a case-by-case basis whether a placement would ensure the inmate's health and safety, and whether a placement would present management or security problems (NOTE: if an agency by policy or practice assigns inmates to a male or female facility on the basis of anatomy alone, that agency is not in compliance with this standard)? ☒ Yes ☐ No

- When making housing or other program assignments for transgender or intersex inmates, does the agency consider on a case-by-case basis whether a placement would ensure the inmate's health and safety, and whether a placement would present management or security problems? ☒ Yes ☐ No

115.42 (d)

- Are placement and programming assignments for each transgender or intersex inmate reassessed at least twice each year to review any threats to safety experienced by the inmate? ☒ Yes ☐ No

115.42 (e)

- Are each transgender or intersex inmate's own views with respect to his or her own safety given serious consideration when making facility and housing placement decisions and programming assignments? ☒ Yes ☐ No

115.42 (f)

- Are transgender and intersex inmates given the opportunity to shower separately from other inmates? ☒ Yes ☐ No

115.42 (g)

- Unless placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting lesbian, gay, bisexual, transgender, or intersex inmates, does the agency always refrain from placing: lesbian, gay, and bisexual inmates in dedicated facilities, units, or wings solely on the basis of such identification or status? ☒ Yes ☐ No

- Unless placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting lesbian, gay, bisexual, transgender, or intersex inmates, does the agency always refrain from placing: transgender inmates in dedicated facilities, units, or wings solely on the basis of such identification or status? ☒ Yes ☐ No

- Unless placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting lesbian, gay, bisexual, transgender, or intersex inmates, does the agency always refrain from placing: intersex inmates in dedicated facilities, units, or wings solely on the basis of such identification or status? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

(a) The agency shall use information from the risk screening required by § 115.41 to inform housing, bed, work, education, and program assignments with the goal of keeping separate those inmates at high risk of being sexually victimized from those at high risk of being sexually abusive.

The auditor reviewed the PREA Manual and policy 05.01.140 and found that the agency policies are compliant and mirror the language set forth in provision (a) of the standard. The agency uses a computerized assessment process to arrive at an inmate classification for risk. The results generated from the assessment feed into the facility's bed management program and 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 the auditor believed was great tool to demonstrate use of the screening information for housing decisions. Following previous MDOC audits by this auditor, the agency also issued an agency-wide memorandum to prohibit the pairing of identified Aggressors and Potential Aggressors with Victims or Potential Victims in isolated work assignments or those work areas with any blind spots that could enable sexual abuse. In addition to review of the bed management score sheets, the auditor requested the facility's identified vulnerable areas and resulting risk screening scores for inmates working in those assignments. The facility identified the POA Room, Music Clerks, Property and the Food Service Dish Tank areas as vulnerable areas where high risk individuals should nor work together. When reviewing the risk assessment scores, the auditor found that no Victims, Potential Victims, Abusers, or Potential Abusers were assigned together in those locations, consistent with provision (a) of the 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 and concurrent placement of these inmates in vulnerable work assignments identified in the aforementioned paragraph. The auditor is satisfied with the high level of supervision and camera coverage in the housing units, programming, education and most work site buildings to ensure that any risk identified by the screening tool is mitigated by the staff to inmate ratio, direct supervision, and monitoring technology.

(b) The agency shall make individualized determinations about how to ensure the safety of each inmate.

05.01.140 Prisoner Placement and Transfer and the PREA Manual, which were reviewed by the auditor, establish agency policy regarding individualized safety determinations. Policy and a formal interview with the only transgender inmate at the facility provides support to the facility's claim that it makes individualized determinations to ensure the safety of each inmate, consistent with provision (b) of the standard. Specifically, an interview with a transgender inmate indicated that the facility did ask questions pertaining to their individual safety and developed a plan to have this individual shower at count time on another wing of the housing unit with access to a private shower where other inmates are precluded from being able to watch or harass her. The transgender inmate, however, did voice concern that she wished to be housed in the facility's honor/incentive based unit. During an interview with the inmate's counselor, who was interviewed for risk screening purposes, she explained, in its individualized determinations for the inmate's safety, her placement on the general population section of housing unit one allowed for her to have access to the medical annex on that unit and a private shower that is typically reserved for inmates on the segregation wing of the housing unit, ensuring she is not placed at undue risk of vulnerability the shower areas may present on the facility's other housing units. Moreover, this shower affords a greater degree of blocking to prevent viewing of her breasts that would not be available via the group showers. Those showers have port-holes, which allow staff to view inward and see the upper torso of inmates for safety purposes. Consistent with random and informal inmate interviews, the inmates consistently identified the shower areas as a potential soft spot, where inmates have free access to use the showers during out-of-cell time. Therefore, the auditor finds that the facility's decisions with respect to housing the transgender inmate within the facility were made in such a manner that demonstrates consistency with provision (b) of the standard.

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. During the audit tour, housing unit staff stated that they have the ability to move those individuals they perceive to be vulnerable or aggressive within the housing units to cells closer to the officers' station for an increased level of monitoring. 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. An interview with the facility PREA Coordinator reveals that he is aware of the need to ensure individualized safety determinations are made for each inmate, not only for housing, but for all assignments for work, education and programming. As noted under provision (a), the auditor requested risk screening data for individuals in identified vulnerable worksites and found that practice of using risk scores is in place. The facility demonstrates that it has procedures in place to meet the requirements of provision (b) and with consistent application of the requirements of the risk screening procedures within standard 115.41, it will fulfill its obligations with this provision.

(c) In deciding whether to assign a transgender or intersex inmate to a facility for male or female inmates, and in making other housing and programming assignments, the agency shall consider on a

case-by-case basis whether a placement would ensure the inmate's health and safety, and whether the placement would present management or security problems.

At the time of the initial audit, the PREA Manual and policy 04.06.184 GENDER DYSPHORIA, were reviewed by this auditor. Both contained 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). The facility provided a pre-audit sample of the facility's health care services review of a transgender inmate's placement via a medical progress note completed by an agency Physician resulting from the October 17, 2018 committee meeting. This was the inmate's initial review prior to placement at Muskegon in February 2019. The PREA Coordinator at the facility states that transgender inmates are reviewed for initial placement at a male or female facility when they pass through the MDOC's Charles Edgar Reception and Guidance Center (RGC), where all inmates complete classification. A formal interview with a transgender inmate confirmed this report, insomuch as she stated that accommodations were made for her prior to arrival at Muskegon Correctional Facility, consistent with provision (c).

(d) Placement and programming assignments for each transgender or intersex inmate shall be reassessed at least twice each year to review any threats to safety experienced by the inmate.

Policy 04.06.184 and the PREA Manual were reviewed by the auditor. Policy indicates that placement and programming assignments for transgender, intersex and Gender Dysphoric inmates will be reassessed twice yearly by facility medical or mental health staff. The facility notes that its only transgender inmate arrived in February 2019 and was not due for a semi-annual or annual review. Through information discussions during the audit, the auditor learned that Muskegon Correctional Facility is one of two facilities within the MDOC that does not have individualized shower configurations. Thus, the facility tends not to receive significant numbers of transgender inmates due to the physical plant challenges associated with accommodating privacy needs.

Based upon policy provisions and the facility's understanding that it must review any transgender inmates who remain in the facility semi-annually; the auditor finds there is sufficient evidence to determine compliance.

(e) A transgender or intersex inmate's own views with respect to his or her own safety shall be given serious consideration.

The PREA Manual and the recently updated 04.06.184 GENDER DYSPHORIA policy were reviewed by the auditor. Both documents provide for a transgender or intersex inmate's own views to be considered in the placement and accommodation provision process. Policies indicate that these decisions are made by the Gender Dysphoria Collaborative Review Committee, chaired by the agency's chief medical and psychiatric directors.

Case management documentation supports the process outlined in policy is executed as described. A formal interview with the facility's only transgender inmate confirms that the facility asked specific questions regarding safety. As cited under provision (b), although the facility considered the transgender inmate's own views with respect to their safety and placement within the facility and the inmate contends she could be safely housed on the facility's honor unit; the auditor finds compelling evidence that the decisions made by the facility to house the inmate where they were housed during the audit is substantially rooted in the assurance of that individual's safety.

Based upon the formal interview with the transgender inmate, the facility PREA Coordinator and policy, it appears that the transgender inmate's views were considered when making determinations for housing and other programming determinations consistent with provision (e) of the standard.

(f) Transgender and intersex inmates shall be given the opportunity to shower separately from other inmates.

Policy 04.06.184 and the PREA Manual, reviewed by the auditor, specify that transgender inmates are given the opportunity to shower separately. During the audit, formal interviews with the counselor on housing unit one and a formal interview with the facility PREA Coordinator indicate that transgender inmates can shower during count time when all other inmates are locked in their cells. The facility goes further, insomuch as it allows the transgender inmate to access a private shower on specialty wing of the unit to ensure she has access to a shower capable of affording greater privacy. An interview with the transgender inmate at the facility confirms that they were approved for private showering; demonstrating compliance with provision (f).

(g) The agency shall not place lesbian, gay, bisexual, transgender, or intersex inmates in dedicated facilities, units, or wings solely on the basis of such identification or status, unless such placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting such inmates.

Policy 05.01.140 and the PREA Manual, reviewed by the auditor, address provision (g) of the 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 in collection with a consent decree, legal settlement, or court order.

The PREA Manager stated in an interview that the agency does not have dedicated facilities or housing units that are specific to LGBT populations and is not subject to a legal settlement for such. There are facilities within the agency that are not conducive to the safety and privacy needs of transgender and intersex inmates, such as those with open bay or dormitory housing, that the agency attempts to avoid placing such inmates within to ensure safety and privacy. An interview with the PREA Coordinator at the Muskegon Correctional Facility confirmed the facility takes no steps to house LGBT inmates in dedicated units or facilities; however, they typically will house any transgender inmates on housing unit one or housing unit six due to the availability of private showering facilities conducive to the inmate’s safety. An interview with a transgender inmate revealed that they have not been placed in a dedicated unit by the agency during her incarceration. Four gay and bisexual inmates were interviewed, and inmates were interviewed and indicated they were not housed in dedicated units, wings or facilities consistent with the standard.

The facility and the agency practice demonstrate compliance with provision (g) of the standard and the auditor makes the determination that the Muskegon Correctional Facility is in compliance with this provision of the standard.

CORRECTIVE ACTION RECOMMENDATION:

The Muskegon Correctional Facility is substantially compliant with the practices required by the provisions of 115.42; however, based on the absence of a well-established reassessment process; the facility may be relying on incomplete information to make such decisions. This standard will naturally be considered compliant upon satisfaction of the reassessment procedures mandated by 115.41.

POST INTERIM REPORT CORRECTIVE ACTIONS TAKEN:

As noted within 115.41, the facility has established a consistent risk screening process to ensure that assessments are completed within the timeframes noted within the standard. Therefore, the facility is equipped with timely and accurate information upon with to base decisions required by 115.42. The auditor now finds full compliance with the standard.

Standard 115.43: Protective Custody

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.43 (a)

- Does the facility always refrain from placing inmates at high risk for sexual victimization in involuntary segregated housing unless an assessment of all available alternatives has been made, and a determination has been made that there is no available alternative means of separation from likely abusers? ☒ Yes ☐ No

- If a facility cannot conduct such an assessment immediately, does the facility hold the inmate in involuntary segregated housing for less than 24 hours while completing the assessment? ☒ Yes ☐ No

115.43 (b)

- Do inmates who are placed in segregated housing because they are at high risk of sexual victimization have access to: Programs to the extent possible? ☒ Yes ☐ No

- Do inmates who are placed in segregated housing because they are at high risk of sexual victimization have access to: Privileges to the extent possible? ☒ Yes ☐ No

- Do inmates who are placed in segregated housing because they are at high risk of sexual victimization have access to: Education to the extent possible? ☒ Yes ☐ No

- Do inmates who are placed in segregated housing because they are at high risk of sexual victimization have access to: Work opportunities to the extent possible? ☒ Yes ☐ No

- If the facility restricts access to programs, privileges, education, or work opportunities, does the facility document: The opportunities that have been limited? ☒ Yes ☐ No

- If the facility restricts access to programs, privileges, education, or work opportunities, does the facility document: The duration of the limitation? ☒ Yes ☐ No

- If the facility restricts access to programs, privileges, education, or work opportunities, does the facility document: The reasons for such limitations? ☒ Yes ☐ No

115.43 (c)

- Does the facility assign inmates at high risk of sexual victimization to involuntary segregated housing only until an alternative means of separation from likely abusers can be arranged? ☒ Yes ☐ No

- Does such an assignment not ordinarily exceed a period of 30 days? ☒ Yes ☐ No

115.43 (d)

- If an involuntary segregated housing assignment is made pursuant to paragraph (a) of this section, does the facility clearly document: The basis for the facility's concern for the inmate's safety? ☒ Yes ☐ No

- If an involuntary segregated housing assignment is made pursuant to paragraph (a) of this section, does the facility clearly document: The reason why no alternative means of separation can be arranged? ☒ Yes ☐ No

115.43 (e)

- In the case of each inmate who is placed in involuntary segregation because he/she is at high risk of sexual victimization, does the facility afford a review to determine whether there is a continuing need for separation from the general population EVERY 30 DAYS? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

(a) Inmates at high risk for sexual victimization shall not be placed in involuntary segregated housing unless an assessment of all available alternatives has been made, and a determination has been made that there is no available alternative means of separation from likely abusers. If a facility cannot conduct such an assessment immediately, the facility may hold the inmate in involuntary segregated housing for less than 24 hours while completing the assessment.

The agency PREA Manual and policy 04.05.120 were reviewed by the auditor in determining compliance with provision (a) of the standard. The PREA Manual contains language that mirrors provision (a) of the standard. The 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.

During the audit tour, the facility was observed to have a designated row of cells on the lower wing of housing unit one designated as segregation. There is a gate and wall that separates this portion of the housing unit from the remainder of the general population housed on the unit. The facility reports that no inmates have been placed into involuntary segregation for risk of victimization during the audit period, which is consistent with the auditor's review of investigation records. The auditor does note, however, that following an allegation of sexual abuse or indicators of a threat of sexual victimization, the facility does exercise the exemption within the standard to temporarily move the individual to the segregation unit to debrief and conduct an assessment within 24 hours to ensure that subsequent placement is assures safety. This assessment period generally occurs within hours on the same date the safety threat is identified.

The Warden stated in an interview that segregation is not used to protect inmates at high risk of sexual victimization unless all other alternatives have been exhausted. If there were an incident, the aggressor would likely be housed in segregation. Moreover, the facility is immediately adjacent to Earnest C. Brooks Correctional Facility and an immediate transfer could be arranged as necessary.

During the audit tour, the auditor noticed that the facility has multiple housing options where individuals can be separated by housing unit within the facility if necessary. Although the auditor notes the facility does utilize the temporary use of its segregation unit to conduct safety assessments, the auditor is satisfied that the evidence that the facility refrains from placing inmates at high risk of victimization in involuntary segregated housing in excess of 24 hours while it completes its assessments to ensure safety, consistent with provision (a) of the standard.

(b) Inmates placed in segregated housing for this purpose shall have access to programs, privileges, education, and work opportunities to the extent possible. If the facility restricts access to programs, privileges, education, or work opportunities, the facility shall document:
(1) The opportunities that have been limited;
(2) The duration of the limitation; and
(3) The reasons for such limitations.

Agency policy 04.05.120 and the PREA Manual, which were reviewed by the 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. During the audit period, the auditor did not find evidence that any individual was housed in involuntary segregation in excess of the authorized assessment period to trigger documentation of those factors enumerated under provision (b). Based on policy provisions and absent evidence of non-compliance specific to inmates segregated due to high risk of victimization, the facility will be considered compliant with provision (b) of standard.

(c) The facility shall assign such inmates to involuntary segregated housing only until an alternative means of separation from likely abusers can be arranged, and such an assignment shall not ordinarily exceed a period of 30 days.

The facility reports, through interviews with the Warden and PREA Coordinator that no inmates have been placed into involuntary segregation due to risk of victimization. During the audit period, the auditor did not find evidence that any individual was housed in involuntary segregation in excess of the authorized assessment period to trigger documentation of those factors enumerated under provision (c). Based on policy provisions and absent evidence of non-compliance specific to inmates segregated due to high risk of victimization, the facility will be considered compliant with provision (c) of standard.

(d) If an involuntary segregated housing assignment is made pursuant to paragraph (a) of this section, the facility shall clearly document:
(1) The basis for the facility's concern for the inmate's safety; and
(2) The reason why no alternative means of separation can be arranged.

The facility reports through interviews with the Warden and PREA Coordinator that no inmates have been placed into involuntary segregation due to risk of victimization. During the audit period, the auditor did not find evidence that any individual was housed in involuntary segregation in excess of the authorized assessment period to trigger documentation of those factors enumerated under provision (d). Based on policy provisions and absent evidence of non-compliance specific to inmates segregated due to high risk of victimization, the facility will be considered compliant with provision (d) of standard.

(e) Every 30 days, the facility shall afford each such inmate a review to determine whether there is a continuing need for separation from the general population.

The facility reports that 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 provision (e) of the standard. Due to the absence of specific non-compliance with provision (e) of the standard, the auditor determines compliance.

REPORTING

Standard 115.51: Inmate reporting

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.51 (a)

- Does the agency provide multiple internal ways for inmates to privately report: Sexual abuse and sexual harassment? ☒ Yes ☐ No

- Does the agency provide multiple internal ways for inmates to privately report: Retaliation by other inmates or staff for reporting sexual abuse and sexual harassment? ☒ Yes ☐ No

- Does the agency provide multiple internal ways for inmates to privately report: Staff neglect or violation of responsibilities that may have contributed to such incidents? ☒ Yes ☐ No

115.51 (b)

- Does the agency also provide at least one way for inmates to report sexual abuse or sexual harassment to a public or private entity or office that is not part of the agency? ☒ Yes ☐ No

- Is that private entity or office able to receive and immediately forward inmate reports of sexual abuse and sexual harassment to agency officials? ☒ Yes ☐ No

- Does that private entity or office allow the inmate to remain anonymous upon request? ☒ Yes ☐ No

- Are inmates detained solely for civil immigration purposes provided information on how to contact relevant consular officials and relevant officials at the Department of Homeland Security? ☒ Yes ☐ No

115.51 (c)

- Does staff accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously, and from third parties? ☒ Yes ☐ No

- Does staff promptly document any verbal reports of sexual abuse and sexual harassment? ☒ Yes ☐ No

115.51 (d)

- Does the agency provide a method for staff to privately report sexual abuse and sexual harassment of inmates? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

(a) The agency shall provide multiple internal ways for inmates to privately report sexual abuse and sexual harassment, retaliation by other inmates or staff for reporting sexual abuse and sexual harassment, and staff neglect or violation of responsibilities that may have contributed to such incidents.

Policy 03.03.140, the PREA Manual, Prisoner Guidebook, Sexual Abuse Poster (advertising the sexual abuse hot-line), the PREA brochure, and the facility's weekly email notifications to inmates via the kiosk/tablet system were reviewed by the auditor in determining compliance with provision (a). All provide information to advise inmates of reporting options. The agency permits PREA allegations to be reported verbally to staff, reported via message to the PREA hot-line, in writing via grievance, in writing to the Correctional Legislative Ombudsman, in writing via the kite system and directly to the Michigan State Police.

The facility's pre-audit sample documentation included the facility's investigation tracking spreadsheet, which indicates how an allegation was first reported. The spreadsheet verifies that reports were received via the PREA Hotline, JPAY message (email), a kite to the PREA Coordinator, a kite to mental health staff, grievance, through a request for self-confinement in protective custody, a healthcare request, a notification from another facility pursuant to 115.63, and staff reports during the audit period. During a review of facility investigations, the auditor found evidence to corroborate the reporting mechanisms identified on the investigation tracker.

During formal and informal interviews during the audit tour, staff were able to identify both private and in-person means of reporting, such as the hot- line, the kite and grievance system. Of the 46 inmates interviewed, 37 were able to identify at least three methods or sources of information where reporting information was available to them. The inmates who were formally interviewed most frequently identified reporting to staff, the PREA Hotline posters, and the kiosk/tablet email systems as a source for reporting or locating available reporting methods as necessary. All but one of the 46 inmates interviewed were aware that they could make written, anonymous, or third-party reports via friends/family or fellow inmates.

During the tour, adequate reporting hot-line posters were prominently displayed throughout the facility. The auditor spot-checked the functionality of the line by utilizing the inmate phones to make calls as instructed by the poster; utilizing the anonymous PIN that the agency established for confidential calls. The auditor found the hotline to be functional and the call reaching its intended destination by following the poster's instructions. During the audit tour informal interviews, staff were aware of their obligations to accept reports from inmates. Inmates who were informally interviewed during the audit tour stated they were comfortable making a report to a staff member, but indicated there was no need to make reports at the facility. The auditor inquired why, and the inmates consistently stated that nobody is forced to have sexual relationships at the facility and that sexual activity they are aware of is consensual.

Based upon a review of policy provisions, the investigatory tracking log, and interviews with both staff and inmates, the auditor finds the agency provides multiple means of reporting consistent with provision (a) of the standard.

(b) The agency shall also provide at least one way for inmates to report abuse or harassment to a public or private entity or office that is not part of the agency, and that is able to receive and immediately forward inmate reports of sexual abuse and sexual harassment to agency officials, allowing the inmate to remain anonymous upon request. Inmates detained solely for civil immigration purposes shall be provided information on how to contact relevant consular officials and relevant officials at the Department of Homeland Security.

Policy 03.03.140, the PREA manual and the Prisoner Guidebook, which were reviewed by the 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 the standard. The facility did not have an example where a report was received from the Legislative Corrections Ombudsman during the audit period, which was consistent with the investigation tracking spreadsheet and the auditor's review of sampled investigations. During formal interviews with inmates, the Legislative Ombudsman was sparingly identified as a reporting mechanism.

The agency uses the Legislative Ombudsman to take and forward reports of sexual abuse and sexual harassment at the facility. The majority of randomly sampled inmates demonstrated difficulty identifying the Legislative Ombudsman as a reporting mechanism; however, it is clearly noted within the prisoner guidebook that this resource is available. During the tour, inmates who were informally interviewed were 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 and on the agency's PREA brochure, which inmates receive through intake procedures to sufficiently demonstrate compliance with provision (b) of the standard.

(c) Staff shall accept reports made verbally, in writing, anonymously, and from third parties and shall promptly document any verbal reports.

Policy 03.03.140 and the PREA Manual, which were reviewed by the 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. During the onsite portion of the audit, facility investigations were reviewed and demonstrated that the facility accepts reports that were made verbally, in writing (via grievance or other written notice) and from third parties. The auditor notes that an incident reported approximately three weeks prior to the onsite audit contained evidence of the facility accepting a report from an inmate's mother, initiating investigation, and transporting the alleged victim to an outside hospital for a forensic examination which was later declined by the victim. Because of the recent allegation, the investigation was not complete at the time of the onsite audit.

During formal interviews with randomly selected staff, all 15 security staff interviewed were well aware of their obligation to accept all forms of reports required by the standards and immediately document verbal reports. Medical and mental health staff were also aware of their obligations to report allegations received. All 46 inmates that were formally interviewed were aware of their ability to make reports to staff and most were confident that action would be taken on said reports. All but one of 46 interviewed inmates were able to affirmatively state their knowledge that family members or other third parties could make reports on their behalf, consistent with provision (c) of the standard,

(d) The agency shall provide a method for staff to privately report sexual abuse and sexual harassment of inmates.

Policy 03.03.140, the PREA Manual and Module 2 of the PREA training educates staff on their reporting options. These materials were reviewed by the 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 to educate staff on the means for making private reports, most staff reported during formal and informal interviews that they were comfortable making reports

directly to through the chain of command and considered their chain of command to sufficient to protect their privacy.

During a review of facility investigations, the auditor noted ample documentation to confirm that staff did act upon reports received from inmates and reported PREA allegations through the facility's chain of command. Random interviews of staff, 12 of 15 confirmed they were aware of private means to report, by skipping the chain of command and identified the hot-line, direct reports to the PREA Coordinator, administrative staff at the facility, or other supervisors as their methods to privately report sexual abuse and harassment of inmates, with 7 of 15 identifying multiple means of private reporting, consistent with provision (d) of the standard.

Standard 115.52: Exhaustion of administrative remedies

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.52 (a)

- Is the agency exempt from this standard? NOTE: The agency is exempt ONLY if it does not have administrative procedures to address inmate grievances regarding sexual abuse. This does not mean the agency is exempt simply because an inmate does not have to or is not ordinarily expected to submit a grievance to report sexual abuse. This means that as a matter of explicit policy, the agency does not have an administrative remedies process to address sexual abuse. ☐ Yes ☒ No ☐ NA

115.52 (b)

- Does the agency permit inmates to submit a grievance regarding an allegation of sexual abuse without any type of time limits? (The agency may apply otherwise-applicable time limits to any portion of a grievance that does not allege an incident of sexual abuse.) (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- Does the agency always refrain from requiring an inmate to use any informal grievance process, or to otherwise attempt to resolve with staff, an alleged incident of sexual abuse? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

115.52 (c)

- Does the agency ensure that: An inmate who alleges sexual abuse may submit a grievance without submitting it to a staff member who is the subject of the complaint? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- Does the agency ensure that: Such grievance is not referred to a staff member who is the subject of the complaint? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

115.52 (d)

- Does the agency issue a final agency decision on the merits of any portion of a grievance alleging sexual abuse within 90 days of the initial filing of the grievance? (Computation of the 90-day time period does not include time consumed by inmates in preparing any administrative appeal.) (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- If the agency claims the maximum allowable extension of time to respond of up to 70 days per 115.52(d)(3) when the normal time period for response is insufficient to make an appropriate decision, does the agency notify the inmate in writing of any such extension and provide a date by which a decision will be made? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- At any level of the administrative process, including the final level, if the inmate does not receive a response within the time allotted for reply, including any properly noticed extension, may an inmate consider the absence of a response to be a denial at that level? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

115.52 (e)

- Are third parties, including fellow inmates, staff members, family members, attorneys, and outside advocates, permitted to assist inmates in filing requests for administrative remedies relating to allegations of sexual abuse? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- Are those third parties also permitted to file such requests on behalf of inmates? (If a third-party files such a request on behalf of an inmate, the facility may require as a condition of processing the request that the alleged victim agree to have the request filed on his or her behalf, and may also require the alleged victim to personally pursue any subsequent steps in the administrative remedy process.) (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- If the inmate declines to have the request processed on his or her behalf, does the agency document the inmate's decision? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

115.52 (f)

- Has the agency established procedures for the filing of an emergency grievance alleging that an inmate is subject to a substantial risk of imminent sexual abuse? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- After receiving an emergency grievance alleging an inmate is subject to a substantial risk of imminent sexual abuse, does the agency immediately forward the grievance (or any portion thereof that alleges the substantial risk of imminent sexual abuse) to a level of review at which immediate corrective action may be taken? (N/A if agency is exempt from this standard.). ☒ Yes ☐ No ☐ NA

- After receiving an emergency grievance described above, does the agency provide an initial response within 48 hours? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- After receiving an emergency grievance described above, does the agency issue a final agency decision within 5 calendar days? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- Does the initial response and final agency decision document the agency's determination whether the inmate is in substantial risk of imminent sexual abuse? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- Does the initial response document the agency's action(s) taken in response to the emergency grievance? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- Does the agency's final decision document the agency's action(s) taken in response to the emergency grievance? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

115.52 (g)

- If the agency disciplines an inmate for filing a grievance related to alleged sexual abuse, does it do so ONLY where the agency demonstrates that the inmate filed the grievance in bad faith? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

(a) An agency shall be exempt from this standard if it does not have administrative procedures to address inmate grievances regarding sexual abuse.

The agency utilizes administrative procedures to address sexual abuse and is not exempt as specified in provision (a) of the standard. According to the PAQ, the facility received seven sexual abuse and sexual harassment allegations via grievance procedures during the previous year. The auditor's review of pre-audit documentation, investigatory tracking logs and facility investigations confirmed seven investigations predicated upon inmate grievances, with an eighth retaliation claim being initiated for investigation via grievance.

(b)

(1) The agency shall not impose a time limit on when an inmate may submit a grievance regarding an allegation of sexual abuse.
(2) The agency may apply otherwise-applicable time limits to any portion of a grievance that does not allege an incident of sexual abuse.
(3) The agency shall not require an inmate to use any informal grievance process, or to otherwise attempt to resolve with staff, an alleged incident of sexual abuse.
(4) Nothing in this section shall restrict the agency's ability to defend against an inmate lawsuit on the ground that the applicable statute of limitations has expired.

Agency policy 03.03.140 and the PREA Manual were reviewed by the auditor in determining compliance with provision (b). Policies allow for an inmate's grievance to be submitted at any time to the staff the Warden designates at the facility to receive such grievances. The PREA Coordinator/Inspector is designated to receive and answer PREA grievances at Muskegon Correctional Facility. 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 03.02.130 Prisoner/Parolee Grievances. The auditor notes that policy 03.03.140 and the PREA Manual contain procedures unique to PREA and are therefore housed outside existing grievance policy 03.02.130 which governs non-sexual abuse and sexual harassment grievances. Reviewed allegations filed within the grievance process confirm that informal grievance resolution procedures are not required, nor were there time limits imposed on the submission of allegations. Based upon provisions within policy 03.03.140 and the PREA Manual and evidence of investigatory practice through allegations filed via grievance, the auditor finds that the practice of the grievance process is consistent with provision (b) of the standard.

(c) The agency shall ensure that—
(1) An inmate who alleges sexual abuse may submit a grievance without submitting it to a staff member who is the subject of the complaint, and
(2) Such grievance is not referred to a staff member who is the subject of the complaint.

Agency policy 03.03.140, and the PREA Manual were reviewed by the auditor in determining compliance with provision (c). Agency policy allows for an inmate's grievance to be submitted directly to the facility staff designated by the Warden and not the subject of the grievance. The facility's local policy, 03.03.140, identifies the PREA Coordinator as the responsible party for answering PREA grievances. Agency policy 03.03.140, and the PREA Manual specifies that the grievances will not be referred to the staff member subject to the complaint within. The reviewed investigations originating via grievance did not produce evidence that the subject of the grievance received or processed the grievance. Grievances may be submitted in locked boxes throughout the facility, consistent with provision (c) of the standard.

(d)(1) The agency shall issue a final agency decision on the merits of any portion of a grievance alleging sexual abuse within 90 days of the initial filing of the grievance.
(2) Computation of the 90-day time period shall not include time consumed by inmates in preparing any administrative appeal.
(3) The agency may claim an extension of time to respond, of up to 70 days, if the normal time period for response is insufficient to make an appropriate decision. The agency shall notify the inmate in writing of any such extension and provide a date by which a decision will be made.
(4) At any level of the administrative process, including the final level, if the inmate does not receive a response within the time allotted for reply, including any properly noticed extension, the inmate may consider the absence of a response to be a denial at that level.

Agency and facility policy 03.03.140 and the PREA Manual which were reviewed by the auditor in determining compliance with provision (d), states the PREA Coordinator/Inspector shall ensure a written response is provided to the prisoner within 60 calendar days of receipt of the Step I PREA grievance 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 Manager 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.

The facility reports seven grievances alleging sexual abuse or sexual harassment throughout the audit year. The auditor reviewed the investigation tracking log and found that six of the seven were answered within 10 weeks or less. One was answered reportedly 4 months (122 days) following submission. Post audit, the auditor requested evidence that the investigation extension notice was provided to the inmate as required by the standard. Due to the timing of the auditor's request coinciding with the absence of the facility's PREA Coordinator, this request for documentation was unable to be satisfied prior to the issuing of the interim report. Through email correspondence with the facility's PREA Coordinator, he was informed that the facility's audit will be in corrective action for agency standard 115.12 and 115.41, and this request for additional documentation can be resolved during the corrective action period.

Pending submission of compliant documentation of notification of a grievance extension noted in the preceding paragraph, the auditor's review of facility investigations filed via grievance appear to be compliant with the timelines prescribed by provision (d).

(e)(1) Third parties, including fellow inmates, staff members, family members, attorneys, and outside advocates, shall be permitted to assist inmates in filing requests for administrative remedies relating to allegations of sexual abuse, and shall also be permitted to file such requests on behalf of inmates.
(2) If a third-party files such a request on behalf of an inmate, the facility may require as a condition of processing the request that the alleged victim agree to have the request filed on his or her behalf, and may also require the alleged victim to personally pursue any subsequent steps in the administrative remedy process.
(3) If the inmate declines to have the request processed on his or her behalf, the agency shall document the inmate's decision.

Agency policy 03.03.140 and the PREA Manual which were reviewed by the auditor in determining compliance with provision (e) of the standard, permits that third parties, including fellow prisoners, staff members, family members, attorneys, and outside advocates, may file a PREA grievance 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. A review of investigations demonstrated that both investigations predicated upon a grievance were directly filed by the involved individuals. Through review of agency policy 03.03.140 and the PREA Manual the auditor is satisfied that the agency and facility have adequate procedures in place to ensure compliance with provision (e) of the standard if a third-party grievance is filed on behalf of another inmate.

(f)(1) The agency shall establish procedures for the filing of an emergency grievance alleging that an inmate is subject to a substantial risk of imminent sexual abuse.
(2) 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. The initial response and final agency decision shall document the agency's determination whether the inmate is in substantial risk of imminent sexual abuse and the action taken in response to the emergency grievance.

Agency policy 03.03.140 and the PREA Manual, which were reviewed by the auditor in determining compliance with provision (f), establishes procedure for the processing of any emergency grievance in accordance with the standards requirements. The aforementioned policies state 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 Manager 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 auditor reviewed facility investigations and found that one of the sexual harassment nor the sexual abuse investigations predicated upon a grievance was classified as an emergency grievance by the prisoner requiring a response as outlined by provision (f) of the standard. The auditor found that the facility responded within the same day the grievance was received and the agency also responded later that afternoon with a determination that the inmate's allegation was not an indicator of imminent danger/risk of sexual abuse. Specifically, the inmate's allegation consisted of an allegation that a female staff member looked at his penis while conducting rounds; which was not an indicator of imminent risk of sexual abuse. The auditor does note that there were two additional grievances that appeared to indicate an emergency filing; however, upon review during the onsite audit, both inmates initialed the original forms within the investigatory packet to verify that the allegations were not an emergency declaration that they were at imminent risk of sexual abuse, which was not as readily visible on scanned copies of the forms. Facility practice indicates the facility is compliant with provision (f) of the standard when necessary.

(g) The agency may discipline an inmate for filing a grievance related to alleged sexual abuse only where the agency demonstrates that the inmate filed the grievance in bad faith.

Agency policy 03.03.140 and the PREA Manual which were reviewed by this auditor in determining compliance with provision (g), directs that staff shall not retaliate against a prisoner for using the PREA grievance process. 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. Pre-audit documentation states that the facility has not had an instance where discipline was issued for a bad-faith grievance related to sexual abuse or sexual harassment. The auditor reviewed investigations predicated upon a report received via grievance and found no evidence that the facility disciplined an inmate for filing a grievance. Through a sample of investigations predicated by grievance, the facility demonstrates that it has not issued discipline for grievances alleging sexual abuse. Observed practice and policy provisions supports that the facility disciplines inmates in accordance with the requirements of provision (g) of the standard, when necessary.

CORRECTIVE ACTION RECOMMENDATION:

As noted under provision (d), the auditor requested evidence that an inmate was notified of a grievance extension under MCF/18/08/00001. The facility's investigation tracking log indicates the investigation was initiated on August 16, 2018 and concluded December 17, 2018, a period of 122 days. Upon receipt of compliant documentation confirming that the inmate was notified of the grievance extension when the grievance exceeded 90 days; the auditor shall find compliance.

POST INTERIM REPORT CORRECTIVE ACTIONS TAKEN:

Following the submission of the interim report and the return of the facility's PREA Coordinator, the auditor was provided a copy of the investigative file for grievance MCF 18/08/00001. The investigative file contains documentation within to verify that the inmate was informed of the need for additional time to complete the investigation of the grievance in accordance with provision (d) of the standard. Based upon this documentation, the auditor now finds full compliance with the standard.

Standard 115.53: Inmate access to outside confidential support services

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.53 (a)

- Does the facility provide inmates with access to outside victim advocates for emotional support services related to sexual abuse by giving inmates mailing addresses and telephone numbers, including toll-free hotline numbers where available, of local, State, or national victim advocacy or rape crisis organizations? ☒ Yes ☐ No

- Does the facility provide persons detained solely for civil immigration purposes mailing addresses and telephone numbers, including toll-free hotline numbers where available of local, State, or national immigrant services agencies? ☒ Yes ☐ No

- Does the facility enable reasonable communication between inmates and these organizations and agencies, in as confidential a manner as possible? ☒ Yes ☐ No

115.53 (b)

- Does the facility inform inmates, prior to giving them access, of the extent to which such communications will be monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws? ☒ Yes ☐ No

115.53 (c)

- Does the agency maintain or attempt to enter into memoranda of understanding or other agreements with community service providers that are able to provide inmates with confidential emotional support services related to sexual abuse? ☒ Yes ☐ No

- Does the agency maintain copies of agreements or documentation showing attempts to enter into such agreements? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

(a) The facility shall provide inmates with access to outside victim advocates for emotional support services related to sexual abuse by giving inmates mailing addresses and telephone numbers, including toll-free hotline numbers where available, of local, State, or national victim advocacy or rape crisis organizations, and, for persons detained solely for civil immigration purposes, immigrant services agencies. The facility shall enable reasonable communication between inmates and these organizations and agencies, in as confidential a manner as possible.

Through discussion with the agency PREA Analyst, the facility PREA Coordinator, and an interview with a representative from Just Detention International's (JDI) "An Inside Line", it was determined by the auditor that the agency and facility have established a formal agreement to provide inmates with access to outside victim advocates for emotional support services related to sexual abuse consistent with provision (a).

Pre-audit, the facility provided the auditor with a copy of the agency's Memorandum of Understanding (MOU) with JDI. The MOU establishes an agreement through September 30, 2020, utilizing OVC grant funding, to staff the support line with a JDI staff. In addition to provision of hotline services, the MOU also establishes an outreach effort by JDI to advocate on behalf of the MDOC to establish relationships with local rape crisis advocacy centers. From previous audits within the agency, the auditor is aware of the challenges the MDOC has faced when attempting to establish local agreements for in-person services, which generally is associated with a prohibition of funding services to perpetrators of violence or a lack of local resources in proximity to MDOC facilities.

As previously noted, this audit was performed within the context of a circular auditing consortium and there were eight overlapping audits between April 1 and May 20, where lead auditors collaborated to execute audit functions. On March 27, 2019, a collective call among the auditors was placed to JDI to discuss the particulars of the support hotline. During that call, the audit teams learned that the hotline was initially launched in August of 2018 and were given a detailed description of the program as follows.

MDOC facilities were provided a telephone number and a pin, via posters and J-pay messaging, in order for inmates to receive emotional support services from JDI. These services are provided during normal work hours between 8:00 a.m.to 6:00 p.m. Pacific Time. If an inmate telephones during non-regular business hours, an answering service instructs callers to telephone during normal business hours. JDI's outreach program with survivors extends to mail correspondence and providing survivor work packets when appropriate.

Telephone calls to the hotline are not recorded. Callers are advised at the onset of the call that disclosures are confidential unless the inmate is at risk to self or others. The JDI representative indicated there is a policy in place, depending on the situation, that enables JDI to breach confidentiality (i.e., if the inmate is suicidal). If an inmate's safety is at risk or threatened, JDI counselors contact MDOC to refer the incident and follow up with the agency PREA Manager or Analysts. The JDI representative indicated they have received "suicidal calls."

The pin number provided to inmates ensures confidentiality as an outside caller and enables them to remain anonymous if they choose not to identify themselves. The JDI representative indicated that MDOC has a separate reporting line for sexual abuse complaints. JDI is not a third-party reporting agency and if the individuals are attempting to make a report, they are directed to access one of the agency's reporting mechanisms, unless there is a clear safety threat. Calls are limited to 15 minutes per day.

When describing the emotional support service provided by JDI, the representative said counselors are trained to provide trauma informed counseling services and provide coping mechanisms to "talk them down and help them to process trauma in a calm way." The JDI representative also added, "we provide crisis intervention in that immediate moment," and if they are looking for legal referrals JDI provides that information.

During the onsite audit, the auditor observed multiple posters advertising the availability of the JDI service. The auditor utilized the inmate telephones to call the JDI support hotline, utilizing the instructions as displayed on the facility's posters advertising the service. The auditor called the hotline and spoke to a representative from JDI to confirm that the use of the universal anonymous PIN successfully connected the caller to a representative from JDI.

In addition to the hotline, the agency maintains multiple copies of “An End to Silence” resource guide within the facility’s library, consistent with provision (a) of the standard. Neither the agency nor the facility house civil immigration detainees; therefore, resources under this element of provision (a) are not applicable.

Randomly sampled inmates struggled to affirmatively identify the JDI hotline as an accessible service, with only 20 of 46 inmates affirmatively identifying this service. However, the auditor observed the high visibility orange posters within the units and repeatedly received reports from inmates that kiosk/tablet emails advertising the support service hotline and PREA reporting mechanisms are routinely sent by the agency to all inmates. The auditor finds that the agency makes overwhelming efforts to familiarize its populations with information pertinent this service; however, there is no means by which the agency can achieve compulsory retention with every inmate.

Based upon a review of the JDI MOU, discussions with agency personnel, an interview with a representative from JDI, and successful use of the support services hotline during the audit; the auditor finds compliance with provision (a) of the standard.

(b) The facility shall inform inmates, prior to giving them access, of the extent to which such communications will be monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws.

Through policies 05.03.118 Prisoner Mail, 05.03.130 Prisoner Telephone Use, the PREA Manual, the Prisoner Guidebook, the JDI memorandum, dated January 15, 2019 sent to all inmates within the MDOC to inform them of the service, the JDI MOU, an interview with a JDI representative, discussions with the agency PREA Analyst, and JDI “An Inside Line” posters, which were reviewed by the auditor in determining compliance with provision (b) of the standard, inmates are adequately made aware of how communications are monitored and which lines of communication are unmonitored for confidentiality purposes. In furtherance of this effort to achieve confidentiality, the agency has established an anonymous PIN number for inmates to use to avoid any personal identifiers when accessing the phone system.

(c) The agency shall maintain or attempt to enter into memoranda of understanding or other agreements with community service providers that are able to provide inmates with confidential emotional support services related to sexual abuse. The agency shall maintain copies of agreements or documentation showing attempts to enter into such agreements.

As previously noted throughout this standard, the MDOC has entered into a formal MOU with JDI for the provision of victim advocacy services consistent with the standard. This MOU was signed by the agency on March 20, 2018 and JDI on April 11, 2018. According to an interview with the JDI representative, the hotline “launched” in August 2018 and later expanded to all MDOC facilities. The agreement runs through September 30, 2020. Based upon the auditor’s review of the MOU, the agency and facility are determined to be compliant with provision (c) of the standard.

Standard 115.54: Third-party reporting

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.54 (a)

- Has the agency established a method to receive third-party reports of sexual abuse and sexual harassment? ☒ Yes ☐ No

- Has the agency distributed publicly information on how to report sexual abuse and sexual harassment on behalf of an inmate? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The agency shall establish a method to receive third-party reports of sexual abuse and sexual harassment and shall distribute publicly information on how to report sexual abuse and sexual harassment on behalf of an inmate.

Through a review of agency policy 03.03.140, which contains reporting options, the Corrections Legislative Ombudsman MOU, the Sexual Abuse reporting poster, the online reporting form found on the MDOC's website and investigatory examples that were predicated upon a 3rd party report; the 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. 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. During formal interviews with inmates, all but one of 46 inmates affirmed that it was possible for third parties, such as family or friends, could make reports on behalf of another inmate. The auditor notes that an incident reported approximately three weeks prior to the onsite audit contained evidence of the facility accepting a report from an inmate's mother, initiating investigation, and transporting the alleged victim to an outside hospital for a forensic examination which was later declined by the victim. Because of the recent allegation, the investigation was not complete at the time of the onsite audit; however, the initial incident report documents that the facility received the outside call and followed up with the alleged victim. Based on a review of the aforementioned items and the investigations demonstrating practice, compliance with provision (a) of the standard was determined.

OFFICIAL RESPONSE FOLLOWING AN INMATE REPORT

Standard 115.61: Staff and agency reporting duties

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.61 (a)

- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency? ☒ Yes ☐ No

- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding retaliation against inmates or staff who reported an incident of sexual abuse or sexual harassment? ☒ Yes ☐ No

- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding any staff neglect or violation of responsibilities that may have contributed to an incident of sexual abuse or sexual harassment or retaliation? ☒ Yes ☐ No

115.61 (b)

- Apart from reporting to designated supervisors or officials, does staff always refrain from revealing any information related to a sexual abuse report to anyone other than to the extent necessary, as specified in agency policy, to make treatment, investigation, and other security and management decisions? ☒ Yes ☐ No

115.61 (c)

- Unless otherwise precluded by Federal, State, or local law, are medical and mental health practitioners required to report sexual abuse pursuant to paragraph (a) of this section? ☒ Yes ☐ No

- Are medical and mental health practitioners required to inform inmates of the practitioner's duty to report, and the limitations of confidentiality, at the initiation of services? ☒ Yes ☐ No

115.61 (d)

- If the alleged victim is under the age of 18 or considered a vulnerable adult under a State or local vulnerable persons statute, does the agency report the allegation to the designated State or local services agency under applicable mandatory reporting laws? ☒ Yes ☐ No

115.61 (e)

- Does the facility report all allegations of sexual abuse and sexual harassment, including third-party and anonymous reports, to the facility's designated investigators? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

(a) The agency shall require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency; retaliation against inmates or staff who reported such an incident; and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation.

Policy 03.03.140, the PREA Manual and work rules published within the Employee Handbook, which were reviewed by the auditor, confirm that staff are required to report all elements denoted within provision (a) of the standard. Local operating procedure 03.03.140 dictates that staff at Muskegon Correctional Facility are responsible for making reports to their immediate supervisor and documenting their actions as soon as possible. A review of facility investigations demonstrates practice that staff took reports of sexual abuse from an inmate to initiate an investigation and documented them in a written format, such as an email to the facility's PREA Coordinator/Inspector or other formal report. Formal and informal interviews during the audit tour indicate that all 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, and document promptly afterwards, complaint with provision (a) of the standard.

(b) Apart from reporting to designated supervisors or officials, staff shall not reveal any information related to a sexual abuse report to anyone other than to the extent necessary, as specified in agency policy, to make treatment, investigation, and other security and management decisions.

Policy 03.03.140, local procedures 03.03.140 and the PREA Manual, which were reviewed by the auditor, contain distinct prohibitions against sharing any information received from a sexual abuse report, consistent with provision (b) of the standard. The only acceptable disclosures are relative to investigative, treatment, security and management decisions. Agency policy and random interviews with all 15 randomly 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 the standard. Staff who perform risk screening, also confirm in their formal interviews that the sensitive information gathered about sexual victimization must be protected and kept as confidential as possible.

(c) Unless otherwise precluded by Federal, State, or local law, medical and mental health practitioners shall be required to report sexual abuse pursuant to paragraph (a) of this section and to inform inmates of the practitioner's duty to report, and the limitations of confidentiality, at the initiation of services.

Policy 03.03.140, local policy 03.03.140 and the PREA Manual, which were reviewed by the 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.

A total of three medical staff and two mental health staff were formally interviewed. 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 to the PREA Coordinator at the facility consistent with provision (c) of standard to demonstrate compliance. Of the five staff interviewed, four affirmed that they have personally become aware of such reports and have forwarded those reports to the facility's PREA Coordinator. Through a review of the facility's investigatory log, the auditor found evidence that 11 investigations were predicated upon report by medical or mental health staff. During a review of facility investigations, the auditor observed source documentation from medical and mental health staff used to notify the PREA Coordinator of the need for investigation.

The auditor also wishes to recognize the creative efforts of the agency to ensure that all inmates are aware of the limitations on confidentiality. Specifically, the auditor observed in each medical and mental health clinician office areas that a sign prominently displayed and advertised the limitations of confidentiality for medical and mental health providers consistent with this standard.

(d) If the alleged victim is under the age of 18 or considered a vulnerable adult under a State or local vulnerable person's statute, the agency shall report the allegation to the designated State or local services agency under applicable mandatory reporting laws.

The auditor reviewed the Michigan Department of Health and Human Services website pertaining to mandated reporters. The auditor found that Michigan law requires certain professionals, including corrections professionals are mandated to report suspicions of child abuse or neglect to the Centralized Intake at the Department of Health and Human Services.

Agency policy 03.03.140, local policy 03.03.140 and the PREA Manual, which were reviewed by the auditor, require the facility staff to report any allegation involving a victim under the age of 18 to the agency PREA Manager for forwarding to the proper state authorities under mandatory reporting laws. Through the auditor's observations during the audit tour, 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 the 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 Analyst confirms in discussions that inmates under the age of 18 are housed at Thumb Correctional Facility (males) or Women's Huron Valley Correctional Facility (females). These designated facilities are also supported by the agency's policies regarding prisoner placement. The agency PREA Manager affirms that mandatory reports are forwarded to the PREA Manager's attention and he is responsible for making the report to the Department of Health and Human Services.

Through agency policy and interviews with the PREA Manager, the agency has sufficiently demonstrated that it has procedures in place for making necessary mandatory reports in compliance

with provision (d) of the standard. Such reports have not come from the Muskegon Correctional Facility; however, the agency has experience forwarding such reports to applicable state agencies.

(e) The facility shall report all allegations of sexual abuse and sexual harassment, including third-party and anonymous reports, to the facility's designated investigators.

Policy 03.03.140 and the PREA Manual, which were reviewed by the auditor in determining compliance with provision (e), 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. While a review of the facility's investigations and investigation log did not reveal that allegations were reported by third parties as applicable to the standard; the auditor is satisfied that the facility's responses to other means of allegation reporting, including incoming notifications pursuant to 115.63, demonstrates that it is consistently investigating all allegations it receives. An interview with the Warden and investigatory staff confirm that investigations are conducted for all reports of sexual abuse and sexual harassment, regardless of how they were reported. Based on the foregoing, the auditor determined compliance with provision (e).

Standard 115.62: Agency protection duties

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.62 (a)

- When the agency learns that an inmate is subject to a substantial risk of imminent sexual abuse, does it take immediate action to protect the inmate? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

When an agency learns that an inmate is subject to a substantial risk of imminent sexual abuse, it shall take immediate action to protect the inmate.

Policy 05.01.140, and the PREA Manual, which were reviewed by the auditor in determining compliance with provision (a), 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. In the event that an inmate makes a claim that they are at imminent risk of sexual abuse, 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 to determine what measures are required to ensure the safety of each inmate, which would start with an investigation into the potential threat and could include actions such as transferring potential abusers or victims to another location. She stated that segregation may be necessary; however, if utilized, they would begin looking for immediate alternatives, such as transfer. All 15-random staff interviewed recognized their need to take immediate action to protect inmates from victimization, indicating that they would separate the potential victim from the immediate threat, notify a supervisor and look for alternative means to keep the individuals safe, such as a housing unit change. If necessary, the inmate could be escorted to the segregation area to be removed from a threat if time was necessary for further assessment.

During an in-depth review of sampled investigations, the auditor found evidence that a contract staff member, who was found to have retaliated against an inmate who made a sexual abuse allegation against him was prohibited from the facility once there was sufficient evidence the alleged retaliation occurred, consistent with provision (a) of the standard. During a review of another sampled investigation, upon an initial report that an individual was being sexually harassed, the facility removed the individual and was in the process of effectuating a cell change, until such time as he later alleged that he was sexually abused. This act of removing an individual from a potential source of danger is again, consistent demonstration of practice of the standard.

Based on interviews and supporting documentation of action take to protect potential sexual abuse victims, the auditor determines compliance with the standard.

Standard 115.63: Reporting to other confinement facilities

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.63 (a)

- Upon receiving an allegation that an inmate was sexually abused while confined at another facility, does the head of the facility that received the allegation notify the head of the facility or appropriate office of the agency where the alleged abuse occurred? ☒ Yes ☐ No

115.63 (b)

- Is such notification provided as soon as possible, but no later than 72 hours after receiving the allegation? ☒ Yes ☐ No

115.63 (c)

- Does the agency document that it has provided such notification? ☒ Yes ☐ No

115.63 (d)

- Does the facility head or agency office that receives such notification ensure that the allegation is investigated in accordance with these standards? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

(a) Upon receiving an allegation that an inmate was sexually abused while confined at another facility, the head of the facility that received the allegation shall notify the head of the facility or appropriate office of the agency where the alleged abuse occurred.

Policy 03.03.140 and the PREA Manual, which were reviewed by the auditor, establish procedures for notifying other facilities of allegations of sexual abuse that did not occur in the receiving institution. Policies indicate that notifications must be made from facility head to facility head, consistent with provision (a) of the standard. Pre-audit sample documentation provided evidence of practice, with the receipt and forwarding of an allegation occurring at Oaks Correctional Facility via email in February 2019. The facility's correspondence between facility heads, document that the report was made within 24 hours of receipt and described the facility's responses to provide mental health services and begin retaliation monitoring. During an interview with the Warden, she stated that interfacility allegations would be addressed just the same is if the incident or report were made within her facility. If the allegation were incoming, the facility would conduct the investigation or if the allegation was outgoing the facility would provide the follow-up medical/mental health care.

(b) Such notification shall be provided as soon as possible, but no later than 72 hours after receiving the allegation.

Policy 03.03.140 and the PREA Manual, which were reviewed by the auditor, establish procedures for notifying other facilities of allegations of sexual abuse that did not occur in the receiving institution within 72 hours. Pre-audit sample documentation provided evidence of practice, with the receipt and forwarding of an allegation occurring at Oaks Correctional Facility via email in February 2019. The

facility's correspondence between facility heads, document that the report was made within 24 hours of receipt and described the facility's responses to provide mental health services and begin retaliation monitoring demonstrating compliance with provision (b) of the standard.

(c) The agency shall document that it has provided such notification.

The PREA Manual and agency policy 03.03.140, which were reviewed by the auditor, require that such notifications are made within 72 hours. Pre-audit sample documentation provided evidence of practice, with the receipt and forwarding of an allegation occurring at Oaks Correctional Facility via email in February 2019. The facility's correspondence between facility heads, document that the report was made within 24 hours of receipt and described the facility's responses to provide mental health services and begin retaliation monitoring demonstrating compliance with provision (c) of the standard.

(d) The facility head or agency office that receives such notification shall ensure that the allegation is investigated in accordance with these standards.

Policy 03.03.140 and the PREA Manual, which were reviewed in determining compliance with provision (d) of the 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 both confirm that allegations received from other confinement facilities are properly investigated. On the pre-audit questionnaire, the facility reported that four allegations of sexual abuse were reported to the facility during the audit period. The facility provided the AIM case numbers and synopsis for each of the allegations to confirm that each were assigned for investigation. During the in-depth review of sampled investigations, the auditor found evidence that the facility made its best efforts to investigate an allegation of sexual abuse, with the reporting inmate only being able to recall the year and generic location (shower) area where the incident alleged occurred. A second investigation was conducted on an alleged incident occurring 2 years in the past, following a previous confirmed assault within the facility. While the auditor has concerns about the quality of this investigation that is addressed in 115.71; the facility demonstrates evidence of compliance with conducting the investigation following notification.

Standard 115.64: Staff first responder duties

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.64 (a)

- Upon learning of an allegation that an inmate was sexually abused, is the first security staff member to respond to the report required to: Separate the alleged victim and abuser? ☒ Yes ☐ No

- Upon learning of an allegation that an inmate was sexually abused, is the first security staff member to respond to the report required to: Preserve and protect any crime scene until appropriate steps can be taken to collect any evidence? ☒ Yes ☐ No

- Upon learning of an allegation that an inmate was sexually abused, is the first security staff member to respond to the report required to: Request that the alleged victim not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating, if the abuse occurred within a time period that still allows for the collection of physical evidence? ☒ Yes ☐ No

- Upon learning of an allegation that an inmate was sexually abused, is the first security staff member to respond to the report required to: Ensure that the alleged abuser does not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating, if the abuse occurred within a time period that still allows for the collection of physical evidence? ☒ Yes ☐ No

115.64 (b)

- If the first staff responder is not a security staff member, is the responder required to request that the alleged victim not take any actions that could destroy physical evidence, and then notify security staff? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

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

The PREA Manual, which was reviewed by the auditor, requires the first responding security staff member to take the four actions specified by provision (a) of the 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. While reviewing the agency's updated medical emergency policy, 03.04.125, from the agency's website for 115.82; the auditor also notes that first responder provisions for security and non-security staff, consistent with provisions (a) and (b) of the standard were added. The auditor notes this policy was issued and effective on the first day of the onsite audit. On the PAQ, the facility reports that one incident was reported within a timeframe that would have allowed for the collection of forensic evidence during the audit period. The auditor's onsite review of investigations supports the facility's assertion.

The auditor conducted an in-depth analysis of 17 facility investigations, prior to and following the onsite audit. During the review of investigation 25685, occurring in July 2018, the auditor found evidence that the facility attempted to execute its first responder duties. The initial report was an allegation of sexual harassment, however, once the alleged victim was removed from contact with the alleged abuser at the facility's Captain's office, the alleged victim reported that he was forced to perform oral sex. Prior to disclosure, the alleged victim's property was being packed to accompany him with a cell move; however, once the allegation was known, the cell was secured and the clothing with potential evidence was returned to the scene. The inmate also disclosed that he had spit the alleged abuser's semen into a tissue within a trashcan that was also later secured. It is noted in the MSP report; however, that the trashcan was accidentally put back into service by the next shift prior to MSP being able to look for the tissue supposedly discarded within. Although this specific item of evidence was unable to be secured, the facility did secure and protected the cell once the alleged sexual abuse was disclosed. The inmate was subsequently transported to an outside hospital for forensic examination. Based upon credibility issues with the alleged victim and witness testimony, the allegation concludes with an unsubstantiated disposition and the evidence would most likely not have added relevant to the outcome, if it existed, based on other facts uncovered during the investigation.

The auditor found that the remaining investigated allegations of sexual abuse involving alleged penetration were reported outside of the agency's 96-hour protocol to refer for forensic examination. Specifically, the allegations were made either weeks or years after the alleged abuse, negating the need for elements 2-4 of provision (a). However, additional evidence of compliance with element 1 of provision (a) is found in investigations 24646 and 24921, where the alleged victim and alleged abuser were separated and kept separate following the reported allegation.

The auditor notes, however, there was an incident reported approximately three weeks prior to the onsite audit contained evidence of the facility accepting a report from an inmate's mother, initiating investigation, and transporting the alleged victim to an outside hospital for a forensic examination which was later declined by the victim. Because of the recent allegation, the investigation was not complete at the time of the onsite audit. The initial incident report reveals that the alleged victim did not wish to provide specific details pertaining to the allegation, including when and where it allegedly occurred so that the area could be secured for evidence gathering consistent with the standard. However, the incident report does reveal that the facility executed its emergency plan to coordinate responses with healthcare based upon what information was known at the time.

An interview with a first responder revealed their duty to separate involved participants, preserve the scene, ask the victim to take no actions to destroy evidence and alert both shift command, as well as medical/mental health practitioners. During formal interviews, the auditor notes that when staff were asked to respond to question 11, regarding their obligations upon receipt of the report of sexual abuse,

staff consistently responded with their duty to separate involved parties, notify the chain of command and preserve evidence.

During the audit tour, the auditor informally interviewed staff and questioned them about their first responder responsibilities should an incident of sexual abuse be reported to them. All staff understood their responsibility to ensure safety by separating victims and abusers and the need to preserve and protect evidence.

Based on a formal interview with a first responder, a review of policies, observation of practice within facility investigations and informal interviews with staff during the audit tour, this auditor was satisfied that Muskegon Correctional staff are well aware of their first responder obligations under provision (a) of the standard and has executed these obligations when necessary.

(b) If the first staff responder is not a security staff member, the responder shall be required to request that the alleged victim not take any actions that could destroy physical evidence, and then notify security staff.

The PREA Manual, which was reviewed by the 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. While reviewing the agency's updated medical emergency policy, 03.04.125, from the agency's website for 115.82; the auditor also notes that first responder provisions for security and non-security staff, consistent with provisions (a) and (b) of the standard were added. The auditor notes this policy was issued and effective on the first day of the onsite audit.

Although psychology staff and healthcare staff at the facility frequently received allegations of sexual abuse, the auditor did not identify any instances where non-security first responders received an allegation within the timeframes where forensic evidence was able to be collected or where forensic evidence collection would have been appropriate. During the audit tour, non-custody staff, including medical and counseling 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 the standard.

Standard 115.65: Coordinated response

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.65 (a)

- Has the facility developed a written institutional plan to coordinate actions among staff first responders, medical and mental health practitioners, investigators, and facility leadership taken in response to an incident of sexual abuse? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The facility shall develop a written institutional plan to coordinate actions taken in response to an incident of sexual abuse, among staff first responders, medical and mental health practitioners, investigators, and facility leadership.

The facility has developed its own operating procedures for agency policy 03.03.140. The document titled OP 03.03.140, which was reviewed by the auditor, describes the procedures employed by the facility when responding to allegations of sexual abuse among supervisory, investigative staff and facility leadership. The interview with the Warden outlined the facility's plans to coordinate a medical evaluation, mental health evaluation and coordination with custody status to complete the investigatory process, describing response procedures from start to finish. Through a review of facility investigations, it appears that the plan has been adhered to, depending upon the nature of the allegation and what response steps would be employed in response to the allegation. Through investigations, the auditor observed that the facility coordinated local medical and mental health evaluations, and transported an alleged victim for forensic examination when necessary. Based upon the facility's local operating procedures describing who does what in response to an allegation and evidence of practicing that plan the auditor finds compliance with the standard.

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

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.66 (a)

- Are both the agency and any other governmental entities responsible for collective bargaining on the agency's behalf prohibited from entering into or renewing any collective bargaining agreement or other agreement that limits the agency's ability to remove alleged staff sexual abusers from contact with any inmates pending the outcome of an investigation or of a determination of whether and to what extent discipline is warranted? ☒ Yes ☐ No

115.66 (b)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

(a) Neither the agency nor any other governmental entity responsible for collective bargaining on the agency's behalf shall enter into or renew any collective bargaining agreement or other agreement that limits the agency's ability to remove alleged staff sexual abusers from contact with any inmates pending the outcome of an investigation or of a determination of whether and to what extent discipline is warranted.

The MDOC's PREA Manual's language, which was reviewed by the auditor, mirrors the language of provision (a) of the 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. The 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 the standard. The auditor notes that the contracts were effective January 1, 2019 and expire December 31, 2021.

Specifically, the contracts contain the phrase "It shall not be the policy of the Employer to take disciplinary action in the course of an investigation unless, in the Employer's judgment, an emergency suspension or removal from the premises is warranted."
This language within the contract allows for the employer, when warranted, to 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. 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 the standard. Moreover, through a review of facility investigations, the auditor found evidence to support that the

facility demonstrates that it exercises its ability to reassign or prohibit contact between staff and alleged victims pending investigation, specifically in the form of the Stop Order issued against a facility doctor upon discovery that the individual engaged in retaliatory actions against an inmate who alleged sexual abuse.

(b) Nothing in this standard shall restrict the entering into or renewal of agreements that govern:
(1) The conduct of the disciplinary process, as long as such agreements are not inconsistent with the provisions of §§ 115.72 and 115.76; or
(2) Whether a no-contact assignment that is imposed pending the outcome of an investigation shall be expunged from or retained in the staff member's personnel file following a determination that the allegation of sexual abuse is not substantiated.

The auditor is not required to audit provision (b) of the standard.

Standard 115.67: Agency protection against retaliation

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.67 (a)

- Has the agency established a policy to protect all inmates and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other inmates or staff? ☒ Yes ☐ No

- Has the agency designated which staff members or departments are charged with monitoring retaliation? ☒ Yes ☐ No

115.67 (b)

- Does the agency employ multiple protection measures, such as housing changes or transfers for inmate victims or abusers, removal of alleged staff or inmate abusers from contact with victims, and emotional support services for inmates or staff who fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations? ☒ Yes ☐ No

115.67 (c)

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor the conduct and treatment of inmates or staff who reported the sexual abuse to see if there are changes that may suggest possible retaliation by inmates or staff? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor the conduct and treatment of inmates who were reported to have suffered sexual abuse to see if there are changes that may suggest possible retaliation by inmates or staff? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Act promptly to remedy any such retaliation? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor any inmate disciplinary reports? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor inmate housing changes? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor inmate program changes? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor negative performance reviews of staff? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor reassignments of staff? ☒ Yes ☐ No

- Does the agency continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need? ☒ Yes ☐ No

115.67 (d)

- In the case of inmates, does such monitoring also include periodic status checks? ☒ Yes ☐ No

115.67 (e)

- If any other individual who cooperates with an investigation expresses a fear of retaliation, does the agency take appropriate measures to protect that individual against retaliation? ☒ Yes ☐ No

115.67 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

(a) The agency shall establish a policy to protect all inmates and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other inmates or staff, and shall designate which staff members or departments are charged with monitoring retaliation.

Agency policy 03.03.140 and the PREA Manual, which were reviewed by the auditor in determining compliance with provision (a) of the standard, 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 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 Muskegon Correctional Facility, one of the ten Prison Counselors (PC) are responsible for monitoring, generally with their assigned housing unit PC. During the course of the audit, the audit team interviewed three of the PCs to further understand retaliation monitoring practices at the facility. All three confirmed that they individually meet with inmates, at least once per week to review for potential evidence of retaliation. The aforementioned allow the auditor to determine compliance with provision (a) of the standard.

(b) The agency shall employ multiple protection measures, such as housing changes or transfers for inmate victims or abusers, removal of alleged staff or inmate abusers from contact with victims, and emotional support services for inmates or staff who fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations.

Through interviews with the agency head's designee, the PREA Manager, 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 the standard.

An interview with the agency head's designee confirmed that retaliation is not tolerated and there are procedures to ensure that both staff and inmates are monitored at each facility. In an interview with the Warden, she expressed that the facility separates individuals involved in allegations by housing units or facility transfers when necessary, ensure individuals receive appropriate supportive counseling, when needed, and monitors for retaliation. The facility has multiple housing units to separate individuals to another location within the compound or to transfer them to the Earnest C. Brooks Correctional Facility, which is adjacent to the facility. There was evidence within sampled investigatory files to confirm that individuals were separated by housing unit moves, a transfer to Earnest C. Brooks, transfers to Lakeland Correctional facility and voluntary requests for placement into the facility's protective custody

unit. The Warden also stated that, should retaliation be noticed, an investigation would be conducted and sanctioning if substantiated. The PREA Coordinator stated that retaliation monitoring takes place for 90 days, unless the allegation is unfounded and considers a wide array of factors, such as work assignment changes and discipline. During the audit period and through a review of investigations, the auditor found demonstration of practice. Specifically, an inmate who alleged sexual abuse by a facility contract physician subsequently had an order to have his medication crushed and his wheelchair taken from him by that contract doctor, following a report of sexual abuse. The inmate's counselor, who conducted the monitoring, and another staff that the physician made potentially incriminating comments to both reported the perceived retaliation. While the facility was unable to substantiate the sexual abuse allegation, there was sufficient evidence to support that retaliation occurred and the physician was prohibited from returning to the facility. Monitoring is conducted by a review of factors enumerated under provision (c) of the standard and face-to-face meetings.

The auditor determines compliance with provision (b) of the standard based on the cited interviews, policy provisions to ensure multiple monitoring measures are employed, facility protection measures it demonstrated within its investigatory files following allegations of sexual abuse and sexual harassment, and demonstration of practice when it substantiated an alleged act of retaliation.

(c) For at least 90 days following a report of sexual abuse, the agency shall monitor the conduct and treatment of inmates or staff who reported the sexual abuse and of inmates who were reported to have suffered sexual abuse to see if there are changes that may suggest possible retaliation by inmates or staff, and shall act promptly to remedy any such retaliation. Items the agency should monitor include any inmate disciplinary reports, housing, or program changes, or negative performance reviews or reassignments of staff. The agency shall continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need.

Agency policy 03.03.140 and the PREA Manual, which were reviewed by the 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 and action is taken to protect the involved individuals by separation or increased monitoring. Evidence of practice, as stated within provision (b), was observed. Investigation 25615 was assigned and completed following evidence of retaliation being uncovered during the inmate's retaliation monitoring session.

The facility reported the aforementioned instance of retaliation during the audit period on the PAQ; however, no other evidence of retaliation was noted. Investigatory files were reviewed for documentation of retaliation monitoring. The auditor found consistent evidence within the investigatory files that the facility monitored those individuals in its custody at the time sexual abuse allegations were made. The auditor notes that in some sexual harassment files, the alleged victim was monitored, which is beyond the requirements of the standard.

Formal interviews with the staff conducting retaliation monitoring revealed that the monitors meet with those who have made allegations on a regular basis, at least once per week. Retaliation monitoring is generally conducted by the inmate's assigned PC, who is based on the inmate's housing unit. This

assignment process provides an extra level of day-to-day monitoring and ease of access to seek assistance if necessary.

Through an in-depth review of seventeen sampled investigation files, the auditor found that one file was not complete and did not contain all documentation ordinarily available in the agency's packet. In the remaining 16, the auditor found evidence of retaliation monitoring occurring for all inmates who were housed at the facility at the time the allegations were made. Retaliation monitoring took place for the entire 90-day period, even in one instance where the allegation was determined to be unfounded during the 90-day period. The auditor found that the facility exceeded the minimum requirements of the standard by monitoring some of those inmates who made allegations of sexual harassment. Based on evidence of substantial compliance, this auditor finds sufficient practice to determine compliance with provision (c) of the standard.

(d) In the case of inmates, such monitoring shall also include periodic status checks.

The Warden at the facility stated in an interview that retaliation 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 the standard.

Investigatory files were reviewed, and it was discovered that facility practice includes documented face-to-face contacts with applicable parties during the monitoring period. The facility monitors each individual on a weekly basis for a total of thirteen weeks. The auditor notes that in one instance, the alleged victim reported to the monitoring PC in one of the documented face-to-face contacts, a potential concern for retaliation related to a facility contract physician taking his wheelchair and ordering for his medication to be crushed. The monitoring staff took appropriate action to review the claim and referred it to the facility's PREA Coordinator/Inspector for investigation. In all instances where retaliation monitoring was completed within an investigatory file, face-to-face contacts were documented on the MDOC's retaliation monitoring form. An interview with three staff members who conduct retaliation monitoring reveals that each consistently meet with the alleged victim at least once per week; however, as previously noted, the assigned retaliation monitor is generally the inmate's assigned counselor on their housing unit; thus, there is frequently more informal contact and ample access for an individual to report retaliation when necessary.

(e) If any other individual who cooperates with an investigation expresses a fear of retaliation, the agency shall take appropriate measures to protect that individual against retaliation.

The PREA Manual, which was reviewed by the 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 facility reports that no other individual, aside from the victim/complainant expressed a fear of retaliation or requested monitoring for retaliation. A review of investigatory files did not reveal evidence of any other individual expressing concern for 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. The auditor relied upon interviews, a review of investigations and policy provisions to determine compliance with provision (e) of the standard.

(f) An agency's obligation to monitor shall terminate if the agency determines that the allegation is unfounded.

The PREA Manual specifies, which was reviewed by the auditor, confirms that retaliation monitoring ceases when an allegation is unfounded. Although termination of monitoring is permissible under the standards upon a determination of unfounded, a sampled investigation revealed that retaliation monitoring continued until its natural conclusion following an allegation. Actions taken by the facility are consistent with provision (f) of the standard.

Standard 115.68: Post-allegation protective custody

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.68 (a)

- Is any and all use of segregated housing to protect an inmate who is alleged to have suffered sexual abuse subject to the requirements of § 115.43? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Any use of segregated housing to protect an inmate who is alleged to have suffered sexual abuse shall be subject to the requirements of § 115.43.

The auditor reviewed the PREA Manual in determining compliance with the standard. The PREA Manual contains language consistent with conditions with standard 115.43. According to the PAQ, the facility indicates that no inmate victims of sexual abuse have been placed into segregated housing following an allegation. The auditor does note, however, that following an allegation of sexual abuse or indicators of a threat of sexual victimization, the facility does exercise the exemption within the standard to temporarily move the individual to the segregation unit to debrief and conduct an assessment within 24 hours to ensure that subsequent placement is assures safety. This assessment period generally occurs within hours on the same date the safety threat is identified. The auditor found evidence where an inmate who was at risk was moved to the segregation unit for assessment and released to another housing unit in the facility within 30 minutes.

The Warden stated in an interview that segregation is not used to protect inmates at high risk of sexual victimization unless all other alternatives have been exhausted. If there were an incident, the aggressor would likely be housed in segregation. Moreover, the facility is immediately adjacent to Earnest C. Brooks Correctional Facility and an immediate transfer could be arranged as necessary. The auditor interviewed an inmate in the segregation unit who was on protective custody status. He stated that he was placed there due to threats from rival gang members and not relative to risk of sexual victimization or following a report of sexual abuse.

Through a review of investigations, the auditor discovered that no victims were placed into involuntary administrative segregation beyond the assessment period authorized by 115.43 following an allegation of sexual abuse. All segregation requests were voluntarily initiated by the inmate. Moreover, when an alleged victim placed themselves into voluntary administrative custody following an allegation; the facility coordinated a transfer to Earnest C. Brooks Correctional facility within 24 hours. There was evidence within investigation files that alleged victims and alleged abusers were either transferred to different housing units within the facility or to other facilities to ensure protection following an allegation to demonstrate its compliance with 115.68.

INVESTIGATIONS

Standard 115.71: Criminal and administrative agency investigations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.71 (a)

- When the agency conducts its own investigations into allegations of sexual abuse and sexual harassment, does it do so promptly, thoroughly, and objectively? [N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations. See 115.21(a).] ☒ Yes ☐ No ☐ NA

- Does the agency conduct such investigations for all allegations, including third party and anonymous reports? [N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations. See 115.21(a).] ☒ Yes ☐ No ☐ NA

115.71 (b)

- Where sexual abuse is alleged, does the agency use investigators who have received specialized training in sexual abuse investigations as required by 115.34? ☒ Yes ☐ No

115.71 (c)

- Do investigators gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data? ☒ Yes ☐ No

- Do investigators interview alleged victims, suspected perpetrators, and witnesses? ☒ Yes ☐ No

- Do investigators review prior reports and complaints of sexual abuse involving the suspected perpetrator? ☒ Yes ☐ No

115.71 (d)

- When the quality of evidence appears to support criminal prosecution, does the agency conduct compelled interviews only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution? ☒ Yes ☐ No

115.71 (e)

- Do agency investigators assess the credibility of an alleged victim, suspect, or witness on an individual basis and not on the basis of that individual's status as inmate or staff? ☒ Yes ☐ No

- Does the agency investigate allegations of sexual abuse without requiring an inmate who alleges sexual abuse to submit to a polygraph examination or other truth-telling device as a condition for proceeding? ☒ Yes ☐ No

115.71 (f)

- Do administrative investigations include an effort to determine whether staff actions or failures to act contributed to the abuse? ☒ Yes ☐ No

- Are administrative investigations documented in written reports that include a description of the physical evidence and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings? ☒ Yes ☐ No

115.71 (g)

- Are criminal investigations documented in a written report that contains a thorough description of the physical, testimonial, and documentary evidence and attaches copies of all documentary evidence where feasible? ☒ Yes ☐ No

115.71 (h)

- Are all substantiated allegations of conduct that appears to be criminal referred for prosecution? ☒ Yes ☐ No

115.71 (i)

- Does the agency retain all written reports referenced in 115.71(f) and (g) for as long as the alleged abuser is incarcerated or employed by the agency, plus five years? ☒ Yes ☐ No

115.71 (j)

- Does the agency ensure that the departure of an alleged abuser or victim from the employment or control of the agency does not provide a basis for terminating an investigation?
  ☒ Yes ☐ No

115.71 (k)

- Auditor is not required to audit this provision.

115.71 (l)

- When an outside entity investigates sexual abuse, does the facility cooperate with outside investigators and endeavor to remain informed about the progress of the investigation? (N/A if an outside agency does not conduct administrative or criminal sexual abuse investigations. See 115.21(a).) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

(a) When the agency conducts its own investigations into allegations of sexual abuse and sexual harassment, it shall do so promptly, thoroughly, and objectively for all allegations, including third-party and anonymous reports.

Agency policy 03.03.140 and the PREA Manual were reviewed by the auditor in determining compliance with provision (a). These documents indicate that when an allegation of sexual abuse or sexual harassment is received, whether reported verbally or in writing, it 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 AIM entry for each alleged incident. Agency policy requires that all reports, regardless of their source of origination, be taken and referred for investigation.

During the audit, the audit team interviewed the PREA Coordinator, who also serves as one of the facility's two Inspectors, and a facility Lieutenant, who are authorized to conduct investigations within

the facility. Interviews with two facility investigators confirm that investigations are required to be initiated immediately. Reported facility practice is that preliminary actions, such as downloading of video and securing of documentation (i.e. log books, etc.) begin immediately. 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.

The facility reported a total of 43 sexual abuse and sexual harassment allegations during the previous year. The auditor conducted an in-depth review 16 complete investigatory files (one of the 17 files requested was incomplete due to the recently of the report). The auditor also reviewed the facility's investigatory logs. The auditor found that all investigations demonstrates that the facility responds promptly to allegations and initiates investigations after an allegation is made. The facility's administrative investigations typically conclude within 60 days; however, two of the sampled investigations required longer periods of time yet were completed within three and one-half months. The auditor is satisfied that the facility promptly investigates allegations.

This auditor raised concerns over meeting the thoroughness element of provision (a) in prior audits within the agency through the use of an investigative questionnaire with suspects, victims and witnesses; leading to an update in policy 03.03.140 approximately two years prior to the audit, where physical interviews are required with all applicable parties in the investigation, including witnesses, victims, and subjects. This questionnaire is a predetermined set of questions that the investigator would ordinarily ask during the course of an investigatory interview. Employees are permitted to take the questionnaire with them and have up to 24 hours later to submit the questionnaire after conferring with union representation. The use of a questionnaire is permitted for other routine administrative investigations within the agency.

The auditor finds that a lack of an in-person interview with key participants within an investigation diminishes the potential for meaningful testimonial evidence to be obtained through a dynamic dialogue with the investigator that considers tone, body language and allows for instantaneous follow-up questioning on any inconsistencies. Closed ended questions as contained in an investigatory questionnaire do not encourage the discovery of facts relevant to a thorough investigation as required by provision (a) and provision (c) of the standard. The auditor notes that updated policy where in-person interviews are required, was effective April 24, 2017.

Notwithstanding the changes in agency policy, the facility did not demonstrate its compliance with the provision (a) of the standard or its own agency policy by sufficient practice of interviews. Although the agency PREA Analyst attempted to explain that the selection of questionnaire in the agency's AIM system to format generate the investigatory report was accidental and that the questionnaires were simply a preparatory tool to guide interview questions; the auditor found sufficient evidence to the contrary within the larger investigatory files. Specifically, the auditor found handwritten responses to questionnaires, documented statements within investigations that responses were taken from questionnaires, and documentation that an alleged victim did not respond to an investigative questionnaire. From an in-depth review of 16 complete investigatory files, the auditor found sufficient evidence that questionnaires were relied upon in lieu of formal interviews in investigation numbers 26235, 26580, 26778, 24646, 25108, 24921, and 26221.

When this issue of the use of questionnaires was identified on-site, the auditor, the PREA Coordinator and the agency PREA Analyst discussed potential solutions. The facility responded with the implementation of a formal investigatory review process, whereby the facility's PREA Coordinator must review all sexual abuse and sexual harassment investigations prior to submission to the Warden. Under previous procedures, the assigned investigator would complete the report and submit it to the

Warden for review. The facility's PREA Coordinator was not involved in the investigatory review process prior to the investigation's approval; thus, there was no formal mechanism by which to intervene when questionnaires were used prior to the investigation formally being approved. Under revised procedures, the facility's PREA Coordinator can remand investigatory reports to the investigator and require formal interviews when questionnaires were used.

While formal interviews with facility investigators confirmed that it is general practice for all parties to be interviewed, it is noted that seven out of 16 investigatory packets that were reviewed demonstrated evidence that questionnaires were utilized in lieu of formal interviews.

Although not pervasive, the auditor is also concerned about the minimal effort observed in investigations where the alleged victim either refused to cooperate or provided limited information. Specifically, 25381 and 26461 received limited information and cooperation from alleged victims. However, the auditor finds that additional evidence in the form of agency records could likely have been reviewed to provide additional context and rationale for findings. Upon the failure of the alleged victim to respond to an investigative questionnaire in 26461, the investigator did not document any additional efforts to review the allegation and thoroughly determine whether it occurred.

Based on the use of a previously identified non-compliant investigatory practice following the change in agency policy, the auditor determines that the facility will require corrective action to meet the requirements of provision (a) of the standard.

(b) Where sexual abuse is alleged, the agency shall use investigators who have received special training in sexual abuse investigations pursuant to § 115.34.

Agency policy 03.03.140 and the PREA Manual, which were reviewed by the 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.

Muskegon Correctional Facility reports that 18 staff are trained and authorized to conduct sexual abuse and sexual harassment investigations. The facility provided documentation that was reviewed by the auditor to verify that 18 active employees have completed the Basic Investigator Training. Training records were provided to confirm that all 18 investigators also completed the NIC specialized investigator training in satisfaction of provision (b) of the standard.

Interviews with facility investigators demonstrated knowledge of Miranda and Garrity warnings. Both articulated considerations for interviewing sexual abuse victims and evidence collection techniques to preserve forensic evidence. Both of the interviewed investigators demonstrated proficient understanding of the preponderance of the evidence standard, consistent with provision (b) of the standard.

(c) Investigators shall gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data; shall interview alleged victims, suspected perpetrators, and witnesses; and shall review prior complaints and reports of sexual abuse involving the suspected perpetrator.

The MDOC's basic investigator's training, which was reviewed by the auditor in determining compliance with provision (c) provides sufficient background training to enable investigators to fulfill the elements set forth within the standards. Agency policy 03.03.140 and the PREA Manual outline the agency's goal to comply with the all elements noted in provision (c). As noted under provision (a) of the standard, facility practice and a review of investigations demonstrates that the facility is not in substantial compliance with this provision of the standard. Specifically, the use of the investigative questionnaire for relevant interviews with victims, suspects, and witnesses in seven of 16 sampled investigations indicates a need for additional monitoring for all facility investigators to ensure they are familiar with the requirements outlined in policy 03.03.140. The facility elected to implement a formal review process, where all facility investigations would be routed through the facility's PREA Coordinator for quality assurance prior to submission to the Warden.

Through a review of investigations, the auditor observed that the facility demonstrates that it makes its best efforts to preserve evidence, whether that be in the form of video, shift rosters, logbooks, medical reports, etc. The facility routinely demonstrated that it reviewed video evidence. Moreover, the facility used shift rosters and logbooks to confirm the presence of staff in areas of the facility during the dates and times pertaining to alleged staff misconduct. The auditor does note, that investigatory reports do not consistently specifically mention a review for prior complaints involving the suspected perpetrator as required by provision (c) of the standard. The auditor recommends that each investigation incorporate a template line to indicate that prior reports did or did not exist for the suspected perpetrator and, when applicable, those investigations were reviewed for relevancy pertaining to the current investigation. The auditor notes that a series of allegations were made against a contract physician at the facility during a narrow window of time; however, the auditor did not find sufficient evidence that the investigations were coordinated at a higher level and that all assigned investigators were aware of the related allegations simultaneously investigated. Again, implementation of a formal quality assurance review process through the facility's PREA Coordinator should sufficiently allow for consistent application of this element of the provision and overall compliance with all elements of provision (c) of the standard, which will be monitored during the corrective action period.

(d) When the quality of evidence appears to support criminal prosecution, the agency shall conduct compelled interviews only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution.

Basic Investigator's training and the PREA Manual, which were reviewed by the 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 and multiple investigations were referred to the Michigan State Police (MSP) for appropriate criminal investigation. The auditor notes that through a review of the facility's investigations, none produced a level of evidence to support criminal prosecution. The auditor finds compliance with provision (d).

(e) The credibility of an alleged victim, suspect, or witness shall be assessed on an individual basis and shall not be determined by the person's status as inmate or staff. No agency shall require an inmate who alleges sexual abuse to submit to a polygraph examination or other truth-telling device as a condition for proceeding with the investigation of such an allegation.

The PREA Manual, which was reviewed by the auditor, states that an alleged victim's credibility will be assessed on an individual basis and not determined by the persons status as an inmate or staff member. Interviews with facility investigators confirmed that credibility is based on the facts and details

that can corroborate from their statements and available physical evidence. Both indicated that truth-telling devices are not used in the investigatory process. A review of facility investigations revealed no use of truth-telling devices and individual credibility assessments were not made based upon the person's status as a staff member or inmate, consistent with the facts elicited, allowing this auditor to find compliance with provision (e).

(f) Administrative investigations:
(1) Shall include an effort to determine whether staff actions or failures to act contributed to the abuse; and
(2) Shall be documented in written reports that include a description of the physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings.

The auditor does not find substantial compliance with provision (f) based on a review of facility investigations. The auditor notes that three of 16 investigations (26236, 26175, and 25381) did not adequately describe the testimonial evidence gathered. Moreover, the lack of investigatory interviews with all participants during administrative investigations doe not allow for adequate determinations and descriptions of testimonial evidence that is not gathered through testimony. Again, the auditor finds that upon successful implementation of a quality assurance review process as agreed upon during the exit meeting with the facility; the Muskegon Correctional Facility will have mechanisms in place to assure consistent application of provision (f) of the standard.

(g) Criminal investigations shall be documented in a written report that contains a thorough description of physical, testimonial, and documentary evidence and attaches copies of all documentary evidence where feasible.

A review of facility investigations by the auditor confirms that the facility refers allegations with potentially criminal behavior to its local MSP outpost. In facility investigation 25685, the MSP investigated an alleged sexual assault involving alleged oral penetration. The facility obtained a copy of the MSP investigatory report, which was documented in a manner consistent with provision (g) of the standard.

(h) Substantiated allegations of conduct that appears to be criminal shall be referred for prosecution.

Through interviews with the PREA Coordinator, facility investigators and a review of investigations, this auditor confirms that there were no substantiated allegations that appeared to be of a criminal nature. The auditor notes that a criminal investigation was conducted by MSP for potentially criminal behavior. According to state legal procedures, the agency does not have the ability to file criminal charges; therefore, MSP would be the entity responsible for referring for criminal prosecution arising out of the MSP investigation. The auditor reviewed agency policies 03.03.140 and the PREA Manual. A review of policy coupled with an interview with the PREA Coordinator and another facility investigator; the auditor is satisfied that Muskegon Correctional Facility has sufficient procedures in place to refer allegations of criminal conduct for prosecution consistent with provision (h) of the standard.

(i) The agency shall retain all written reports referenced in paragraphs (f) and (g) of this section for as long as the alleged abuser is incarcerated or employed by the agency, plus five years.

The PREA Manual, which was reviewed by the 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 the standard.

(j) The departure of the alleged abuser or victim from the employment or control of the facility or agency shall not provide a basis for terminating an investigation.

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. A review of facility investigations produced no evidence that investigations were terminated due to the departure of a victim or an abuser. Specifically, the auditor found evidence that the facility investigated multiple allegations referred back to it from other facilities where inmates has reported previous sexual abuse at Muskegon Correctional Facility.

(k) Any State entity or Department of Justice component that conducts such investigations shall do so pursuant to the above requirements.

The auditor is not required to audit provision (k).

(l) When outside agencies investigate sexual abuse, the facility shall cooperate with outside investigators and shall endeavor to remain informed about the progress of the investigation.

Interviews with the Warden, PREA Coordinator, PREA Manager and investigators support the fact that facility staff are required comply with outside investigators. The facility Inspector (who is also the facility's PREA Coordinator) is the responsible party for ensuring coordination with the MSP. The auditor found evidence within investigatory files that allegations of a potentially criminal nature were referred to the Michigan State Police for investigation and that a criminal investigation was completed for an alleged inmate-on-inmate allegation involving oral penetration. Within the investigation, the auditor reviewed the MSP investigation, which described the cooperative interactions between the facility and the MSP investigator. Informal interviews with the two facility Inspectors reveal that there is a significant cooperative relationship between the MSP and the facility. Both stated they have the personal contact information for their assigned investigator and can quickly exchange information as necessary. Based upon interviews and the MSP report, the auditor finds that there are sufficient procedures in place to coordinate and cooperate with outside investigations when necessary for this auditor to find compliance with provision (l).

CORRECTIVE ACTION RECOMMENDATIONS:

To become compliant with this standard, the facility will be required to implement procedures to physically interview pertinent parties to each allegation to augment any written statements obtained during the investigation. Investigatory reports will need to thoroughly describe testimonial evidence gathered during the investigatory process, describe a review of prior allegations involving suspected perpetrators, thoroughly describe all evidence gathered and attempted to be gathered during the investigation. The auditor finds that with a successful implementation of the facility's procedures to route all sexual abuse and sexual harassment investigations through the facility's PREA Coordinator for a quality assurance review should provide an opportunity to ensure compliant investigatory practices are adhered to prior to submission to the Warden for completion.

The auditor will measure compliance through a review of all facility investigations in the 90 days following the implementation of the corrective action plan. The auditor will expect to see interview summaries within each facility investigation and a thorough description of investigatory efforts. Should the facility not have sufficient evidence of investigatory practice during that 90-day period where the facility can demonstrate its commitment to the thorough pursuit of an investigation; corrective action will

continue until such time as investigative reports demonstrating compliance are received or 180 days have been exhausted.

POST INTERIM REPORT CORRECTIVE ACTIONS TAKEN:
During the corrective action period, the auditor requested and received the facility's investigatory log in November 2019. The auditor sampled three random investigations from the investigation log on November 10, 2019 and received the requested reports on November 12, 2019. The three investigations involved allegations of prisoner on prisoner sexual harassment. The auditor reviewed the investigatory files and found evidence that applicable parties were interviewed during the course of the investigation.

Through a review of the first investigation, the auditor found that alleged victim had transferred to another facility since the allegation had been made and a request for an investigatory interview by the current housing facility was made. Within the investigation, the alleged victim was unable to provide sufficient details to identify the subject. An interview was conducted with the alleged victim's former cell mate in an attempt to develop a subject; however, this proved unsuccessful.

Through a review of the second investigation, the auditor found that there was an attempt to interview the alleged victim; however, the alleged victim was uncooperative. Despite the lack of cooperation, the investigator followed through with the available information and conducted an interview with the subject named in the original complaint.

Through a review of the third investigation, the auditor found that the investigator interviewed both applicable parties to the allegation. Based upon the nature of the allegation and the location where it was alleged to have occurred, there was no opportunity for additional witnesses to be identified or interviewed.

The auditor finds, through a sampling of investigations, that the facility has taken the necessary steps to correct the thoroughness element of provision (a) of the standard. There is now sufficient evidence that interviews are conducted and that efforts are made to advance the investigation when there is either a lack of cooperation or minimal initial leads to the complaint.

The auditor also found that the facility implemented a quality control process to ensure that all allegations are reviewed by the facility PREA Coordinator for review prior to submission for final approval. Each predication contained internal affairs instruction to ensure the investigation was reviewed by the facility PREA Coordinator prior to submission. In later investigations, the auditor noticed that the investigatory template had a section for review of prior allegations, as required by provision (c) of the standard.

As described in the review of investigations, the auditor finds evidence that the facility is documenting its findings in a manner consistent with provision (f) of the standard; specifically, there is evidence that testimonial evidence is being gathered for inclusion in the report and that testimonial evidence is adequately described.

Based upon a review of sampled investigations during the corrective action period, the auditor found evidence that the facility has implemented procedures to ensure a greater level of quality in its investigations consistent with provisions (a),(c), and (f) of the standard and therefore finds that the facility is now in full compliance with the standard.

Standard 115.72: Evidentiary standard for administrative investigations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.72 (a)

- Is it true that the agency does not impose a standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The agency shall impose no standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated.

The PREA Manual and the Basic Investigator Training Manual, which were reviewed by the auditor in determining compliance, specify that the agency's standard of proof is to be the preponderance of the evidence. Interviewed investigators were clearly able to articulate the preponderance of evidence standard and describe its meaning. Although the auditor has concerns regarding the facility's investigatory practices described under 115.71, specifically impacting its thoroughness, the auditor does not see any indication where a preponderance of the evidence clearly existed in favor of the alleged act occurring and the facility did not substantiate the allegation. Perhaps the best evidence of practice can be determined in the retaliation investigation completed by the facility. Although the retaliatory actions could have been considered professional prerogatives of the physician; the facility weighed retaliatory inferences made to a witness and abrupt changes in a patient's treatment following the encounter, coupled with the physician's lack of candor during the interview process, in finding a preponderance of the evidence existed to substantiate the alleged retaliation. Based upon the auditor's review of investigations and interviews with investigators, the auditor is satisfied that the facility utilizes the preponderance of evidence standard in determining when allegations should be substantiated.

Standard 115.73: Reporting to inmates

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.73 (a)

- Following an investigation into an inmate's allegation that he or she suffered sexual abuse in an agency facility, does the agency inform the inmate as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded? ☒ Yes ☐ No

115.73 (b)

- If the agency did not conduct the investigation into an inmate's allegation of sexual abuse in an agency facility, does the agency request the relevant information from the investigative agency in order to inform the inmate? (N/A if the agency/facility is responsible for conducting administrative and criminal investigations.) ☒ Yes ☐ No ☐ NA

115.73 (c)

- Following an inmate's allegation that a staff member has committed sexual abuse against the inmate, unless the agency has determined that the allegation is unfounded, or unless the inmate has been released from custody, does the agency subsequently inform the inmate whenever: The staff member is no longer posted within the inmate's unit? ☒ Yes ☐ No

- Following an inmate's allegation that a staff member has committed sexual abuse against the inmate, unless the agency has determined that the allegation is unfounded, or unless the inmate has been released from custody, does the agency subsequently inform the inmate whenever: The staff member is no longer employed at the facility? ☒ Yes ☐ No

- Following an inmate's allegation that a staff member has committed sexual abuse against the inmate, unless the agency has determined that the allegation is unfounded, or unless the inmate has been released from custody, does the agency subsequently inform the inmate whenever: The agency learns that the staff member has been indicted on a charge related to sexual abuse in the facility? ☒ Yes ☐ No

- Following an inmate's allegation that a staff member has committed sexual abuse against the inmate, unless the agency has determined that the allegation is unfounded, or unless the inmate has been released from custody, does the agency subsequently inform the inmate whenever: The agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility? ☒ Yes ☐ No

115.73 (d)

- Following an inmate's allegation that he or she has been sexually abused by another inmate, does the agency subsequently inform the alleged victim whenever: The agency learns that the alleged abuser has been indicted on a charge related to sexual abuse within the facility? ☒ Yes ☐ No

- Following an inmate's allegation that he or she has been sexually abused by another inmate, does the agency subsequently inform the alleged victim whenever: The agency learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility? ☒ Yes ☐ No

115.73 (e)

- Does the agency document all such notifications or attempted notifications? ☒ Yes ☐ No

115.73 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

(a) Following an investigation into an inmate's allegation that he or she suffered sexual abuse in an agency facility, the agency shall inform the inmate as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded.

Agency Policy 03.03.140 and the PREA Manual, which were reviewed by the auditor, dictate that the victim in alleged incidents of sexual abuse will be notified of the investigatory outcome. Both the Warden and facility investigators confirm that inmate victims are notified of the investigatory results. Prior to the audit, Muskegon Correctional facility provided five sample documents of inmate notifications for both administrative and criminal investigations to demonstrate compliance with provision (a) of the standard. During the onsite portion of the audit, the auditor reviewed facility investigations and found evidence that the facility was in substantial compliance with its requirement to provide victims of sexual abuse notification of investigatory outcomes. The auditor found, through an in-depth review of sixteen complete investigatory packets, a notification was provided to the alleged victim in those fourteen instances where the allegation originated within the facility. One notification occurred, following the alleged victim's transfer to the neighboring facility of Earnest C. Books. The auditor found that, in two investigations where the inmate was housed at another location when the allegation was made; the investigatory packet did not contain a copy of the notice documenting inmate notification of the

investigatory results. The auditor also found evidence that the facility exceeds the standard by providing written notification to alleged victims of sexual harassment investigatory results, allowing the auditor to determine compliance with provision (a) of the standard.

(b) If the agency did not conduct the investigation, it shall request the relevant information from the investigative agency in order to inform the inmate.

Agency Policy 03.03.140 and the PREA Manual, which were reviewed by the auditor, dictate that the victim in alleged incidents of sexual abuse will be notified of the investigatory outcome. The Warden and facility investigators indicate that the Inspectors are the liaison with MSP and remain up-to-date on an investigation's status. MSP did investigate one allegation of sexual abuse at the facility. Muskegon Correctional Facility requested and received a copy of the MSP investigatory report to provide documented evidence of compliance consistent with provision (b) of the standard.

(c) Following an inmate's allegation that a staff member has committed sexual abuse against the inmate, the agency shall subsequently inform the inmate (unless the agency has determined that the allegation is unfounded) whenever:
(1) The staff member is no longer posted within the inmate's unit;
(2) The staff member is no longer employed at the facility;
(3) The agency learns that the staff member has been indicted on a charge related to sexual abuse within the facility; or
(4) The agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility.

Agency Policy 03.03.140 and the PREA Manual, which were reviewed by the auditor in determining compliance with provision (c), specifically, agency policy requires that notification of the factors enumerated in provision (c) of the standard are provided for Substantiated/Sufficient Evidence and insufficient evidence/Unsubstantiated allegations that a staff member sexually abused a prisoner. Through a review of facility investigations, the auditor found one applicable case of the triggering factors enumerated within provision (c) existed to trigger such notifications. Specifically, the alleged victim in 25108 was not notified when a STOP order was issued against his alleged abuser on 07/26/2018 during the course of the investigation. The notification, dated 09/21/2018, only contained documentation that the inmate's allegation of sexual abuse was unsubstantiated. It is further noted that a related retaliation investigation had been completed ten days prior, concluding that retaliation had occurred. Based upon the lone instance where such notification was required having gone unsatisfied, the auditor cannot find evidence of substantial compliance with provision (c) of the standard.
(d) Following an inmate's allegation that he or she has been sexually abused by another inmate, the agency shall subsequently inform the alleged victim whenever:
(1) The agency learns that the alleged abuser has been indicted on a charge related to sexual abuse within the facility; or
(2) The agency learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility.

The PREA Manual, which was reviewed by the auditor in determining compliance with provision (d), indicates that the victim in alleged incidents of sexual abuse will be notified of criminal indictments and convictions in compliance with provision (d). The facility no had such instances, thus, no facility specific examples in support of this standard were observed. There are adequate policy provisions in place to demonstrate compliance when applicable.

(e) All such notifications or attempted notifications shall be documented.

A review of facility investigations yielded ample documentation of its notification of investigatory results, as described under provision (a). Within all sampled investigations where the alleged victim was housed at the facility during the initial report, a completed CAJ-1021 notification form was located as proof of inmate notification to demonstrate compliance with provision (e) of the standard. The only two case files where such notification was not clearly present originated through notifications from other facilities and the notification obligation fell upon another holding facility.

(f) An agency's obligation to report under this standard shall terminate if the inmate is released from the agency's custody.

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 the standard.

CORRECTIVE ACTION RECOMMENDATION:
The facility will be required to establish procedures to ensure it notifies an alleged victim of sexual abuse when any of the triggering elements of provision (c) exist. Specifically, the auditor finds that the facility did not document notification that a contract staff member was barred from entering the facility pending investigation. During the corrective action period, the facility will be required to provide evidence that it notifies alleged inmate victims of those elements identified under provision (c) or has established procedures to do so, should triggering events not occur within the corrective action period.

POST INTERIM REPORT CORRECTIVE ACTIONS:

In November 2019, the auditor sampled the facility's investigatory log and requested sample investigations. Within those sampled investigations, the auditor found sufficient evidence that the involved inmates were notified of the triggering events in accordance with the standard. Although there was no specific triggering event to measure compliance with provision (c), the auditor finds that with the quality assurance procedures implemented to enhance investigatory compliance, there is sufficient infrastructure to ensure that such notifications are made when necessary. Therefore, the auditor finds compliance with the standard.

DISCIPLINE

Standard 115.76: Disciplinary sanctions for staff

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.76 (a)

- Are staff subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies? ☒ Yes ☐ No

115.76 (b)

- Is termination the presumptive disciplinary sanction for staff who have engaged in sexual abuse? ☒ Yes ☐ No

115.76 (c)

- Are disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) commensurate with the nature and circumstances of the acts committed, the staff member's disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories? ☒ Yes ☐ No

115.76 (d)

- Are all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, reported to: Law enforcement agencies (unless the activity was clearly not criminal)? ☒ Yes ☐ No

- Are all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, reported to: Relevant licensing bodies? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

(a) Staff shall be subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies.

Agency policies 02.03.100, 02.03.100A, 03.03.140, the PREA Manual and the employee handbook work rules were reviewed by the auditor in determining compliance with provision (a) of the standard. The auditor notes that these policies were updated by the agency in 2018 and the sample documentation provided pre-audit did not contain the most recent version of the polices. The auditor reviewed the updated policies on the agency's website and found that existing provisions in support of the standard's requirement from the previous version of policy remained applicable. 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 the standard.

(b) Termination shall be the presumptive disciplinary sanction for staff who have engaged in sexual abuse.

The staff sanctioning matrix provided to and reviewed by the auditor in policy 02.03.100A verifies that termination is the presumptive disciplinary action for staff who engage in sexual abuse in compliance with provision (b) of the standard. Again, the auditor was provided an outdated policy sample; however, found the most recent version on the agency's website. The identified sanctioning matrix still contains the presumptive disciplinary action of termination for sexual conduct with an offender, with lesser infractions than actually engaging in sexual abuse, such as overly-familiar, unauthorized contact, and sexual harassment being subject to disciplinary action of up to and including discharge based upon the specifics of the investigatory findings. Disciplinary sanctions for the offenses related to sexual abuse and sexual harassment, without having engaged in sexual abuse are decided upon by an agency level employment administrator. 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 the standard.

(c) Disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) shall be commensurate with the nature and circumstances of the acts committed, the staff member's disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories.

The PREA Manual and staff sanctioning matrix provided to and its update from the agency website, were reviewed by the auditor. The auditor notes that 02.03.100A verifies 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). According to 02.03.100A, the Office of Executive Affairs (OEA) Administrator is responsible in determining the sanctions for these violations that fall outside the scope of actually engaging in sexual abuse. Within 02.03.100A, the standard disciplinary sanction for enumerated infractions is specifically identified by the infraction. There can be a deviation from the presumptive sanctions if aggravating or mitigating factors arise. The policy also spells out what the progressive discipline will be issued for subsequent violations of policy if and when an infraction has been repeated. Subsequent sanctions are predicated upon the severity of the previous sanction. The PAQ indicates there were no staff from the facility who violated sexual abuse and sexual harassment policies, which is consistent with the auditor's review of the facility's investigations. 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 the standard. Based on policy provisions, the auditor determines compliance with provision (c).

(d) All terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and to any relevant licensing bodies.

Through the auditor's review of the PREA Manual, policy provisions exist to ensure 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 the standard. A review of the facility's investigations revealed no substantiated allegations of sexual abuse or sexual harassment against a staff member that were consistent with criminal behavior. There were no terminations or resignations in lieu of termination to demonstrate facility practice with respect

to provision (d) standard. Based on policy provisions, the auditor determines compliance with provision (d).

Standard 115.77: Corrective action for contractors and volunteers

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.77 (a)

- Is any contractor or volunteer who engages in sexual abuse prohibited from contact with inmates? ☒ Yes ☐ No
- Is any contractor or volunteer who engages in sexual abuse reported to: Law enforcement agencies (unless the activity was clearly not criminal)? ☒ Yes ☐ No
- Is any contractor or volunteer who engages in sexual abuse reported to: Relevant licensing bodies? ☒ Yes ☐ No

115.77 (b)

- In the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer, does the facility take appropriate remedial measures, and consider whether to prohibit further contact with inmates? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

(a) Any contractor or volunteer who engages in sexual abuse shall be prohibited from contact with inmates and shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and to relevant licensing bodies.

Under agency policy 03.03.140 and the PREA Manual, which were reviewed by the auditor in determining compliance with provision (a) of the 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 the standard. An agency memorandum dated December 27, 2016, from the manager of the Internal Affairs Section, reaffirms this direction, insomuch as any allegation of employee misconduct (including sexual abuse and sexual harassment), must be reported to the Michigan State Police (MSP) and the agency's contract monitor who oversees the specific contract. The Warden states in an interview that any contractor or volunteer who is accused of sexual abuse or sexual harassment would generally be barred from the facility pending the outcome of the investigation. There were no reported incidents involving a contractors or volunteers reported on the PAQ; however, the auditor found evidence within facility investigations that the facility acted in accordance with the Warden's interview and agency policy. Specifically, when there were allegations of sexual abuse and evidence indicative of retaliation involving a contract physician, the facility issued a STOP order to prevent the individual from entering the premises. Based upon policy provisions and observed demonstration of practice of prohibiting a contract employee from entering the facility following indicators of misconduct, the auditor determines compliance with provision (a).

(b) The facility shall take appropriate remedial measures and shall consider whether to prohibit further contact with inmates, in the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer.

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 the 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. She further commented that any contractual staff would then be placed on a "do not hire" list, maintained by the agency's contract monitors. There were no substantiated allegations of sexual abuse or sexual harassment involving contractors or volunteers upon which to gauge facility practice. However, the auditor does note that the facility did take appropriate actions and prohibited further contact with inmates for a contract employee who was found to have engaged in retaliatory behavior following a sexual abuse allegation. Based upon policy provisions, the Warden's interview, and demonstration of practice, the auditor determines compliance with provision (b).

Standard 115.78: Disciplinary sanctions for inmates

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.78 (a)

- Following an administrative finding that an inmate engaged in inmate-on-inmate sexual abuse, or following a criminal finding of guilt for inmate-on-inmate sexual abuse, are inmates subject to disciplinary sanctions pursuant to a formal disciplinary process? ☒ Yes ☐ No

115.78 (b)

- Are sanctions commensurate with the nature and circumstances of the abuse committed, the inmate's disciplinary history, and the sanctions imposed for comparable offenses by other inmates with similar histories? ☒ Yes ☐ No

115.78 (c)

- When determining what types of sanction, if any, should be imposed, does the disciplinary process consider whether an inmate's mental disabilities or mental illness contributed to his or her behavior? ☒ Yes ☐ No

115.78 (d)

- If the facility offers therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse, does the facility consider whether to require the offending inmate to participate in such interventions as a condition of access to programming and other benefits? ☒ Yes ☐ No

115.78 (e)

- Does the agency discipline an inmate for sexual contact with staff only upon a finding that the staff member did not consent to such contact? ☒ Yes ☐ No

115.78 (f)

- For the purpose of disciplinary action does a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred NOT constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation? ☒ Yes ☐ No

115.78 (g)

- Does the agency always refrain from considering non-coercive sexual activity between inmates to be sexual abuse? (N/A if the agency does not prohibit all sexual activity between inmates.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

(a) Inmates shall be subject to disciplinary sanctions pursuant to a formal disciplinary process following an administrative finding that the inmate engaged in inmate-on-inmate sexual abuse or following a criminal finding of guilt for inmate-on-inmate sexual abuse.

The auditor reviewed agency policy 03.03.105 and the PREA Manual when determining compliance with provision (a). These documents pair to 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. Again, the policy samples provided pre-audit were outdated, as agency policy was updated during 2018. The auditor found the updated agency policy on the agency's website. The updated policy remains consistent with provision (a) of the standard. Agency inmate disciplinary policy describes three potential hearing processes, depending upon the severity of the alleged misconduct; however, all three classes of sanctions occur pursuant to a formal disciplinary process. Sexual Assault and Sexual Misconduct, which are inclusive of those behaviors precluded by the standard definitions of sexual abuse and sexual harassment are considered to be Class I violations and afforded most formal disciplinary process and background investigation as permitted by agency policy. Although unrelated to the standards, the auditor does note that the agency's Sexual Misconduct charge also includes "wearing clothing of the opposite sex" and "wearing makeup by male prisoners." Given the absence of further clarification within its policy directive, there is a potential for confusion and conflict with the agency's Gender Dysphoria policy 04.06.184, insomuch as transgender inmates housed in a male facility could face disciplinary sanctions for expressing their gender and utilizing items authorized under said policy.

At the time of the audit, there were no substantiated allegations of inmate-on-inmate sexual abuse or sexual harassment upon which the auditor could gauge facility practice. Based upon policy requirements of a formal hearing process prior to the imposition of discipline for substantiated incidents of sexual abuse, the auditor determines compliance with provision (a).

(b) Sanctions shall be commensurate with the nature and circumstances of the abuse committed, the inmate's disciplinary history, and the sanctions imposed for comparable offenses by other inmates with similar histories.

The auditor reviewed agency policy 03.03.105A and 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 the standard. An interview with the Warden confirms that the facility would follow the prisoner sanctions procedure for those who violate sexual abuse and sexual harassment policies. In addition to potential discipline, inmates may have their custody levels raised (which would lead to transfer) or may be transferred to another location. There were no substantiated incidents of sexual abuse or sexual harassment during the audit period upon which the auditor could gauge facility practice at the time of the audit. Based upon the established sanctioning matrix relative to the imposition of discipline and an interview with the Warden, the auditor determines compliance with provision (b).

(c) The disciplinary process shall consider whether an inmate's mental disabilities or mental illness contributed to his or her behavior when determining what type of sanction, if any, should be imposed.

The auditor reviewed agency policy 03.03.105, and the PREA Manual which establishes procedures for the consideration of mental disabilities and mental illness when considering the appropriate type of sanction to be imposed, consistent with provision (c) of the standard. The policy contains a section specifically directed at when an inmate with a mental or cognitive impairment may not be disciplined if their mental status precludes them from understanding that the nature of their behavior was impermissible. An interview with the Warden confirms that facility hearing examiners, who are administrative law judges, are required to consider the mental status of an inmate when determining sanctions and there are alternative programming options for these inmates. There were substantiated incidents of sexual harassment during the audit period that were addressed through transfers of the harasser. There were no substantiated allegations of sexual abuse upon which the auditor could gauge facility practice at the time of the audit. 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, the auditor determines compliance with provision (c).

(d) If the facility offers therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse, the facility shall consider whether to require the offending inmate to participate in such interventions as a condition of access to programming or other benefits.

The 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 the standard. The facility's mental health unit manager described an evaluation procedure that would be employed if an inmate were found to have engaged in sexual abuse. The evaluation procedures would determine any relevant treatment need and this would likely be a condition of parole. A second mental health staff person was interviewed and described that therapy and individualized treatment would be provided to abusers; however, was uncertain whether the abuser could formally be placed in the Michigan Sex Offender Program (MSOP) absent a conviction for criminal sexual misconduct. There were no substantiated allegations of sexual abuse upon which the auditor could gauge facility practice at the time of the audit. Based upon an interview with the facility mental health manager and policy requirements, the auditor determines compliance with provision (d) of the standard.

(e) The agency may discipline an inmate for sexual contact with staff only upon a finding that the staff member did not consent to such contact.

The auditor reviewed agency policies 03.03.140, 03.03.105 and the PREA Manual in determining compliance with provision (e) of the standard. These policies contain language that is consistent with provision (e) of the standard to verify that inmates may only be disciplined for sexual contact with staff when there is a finding that staff did not consent to such contact. Less than one week prior to the onsite audit, an inmate received a misconduct report for sexual assault, for purportedly kissing a food service worker against her will. When interviewed in segregation in relation to the disciplinary report, the inmate provided information to affirm that he was previously permitted to engage in such activity with the staff member's consent. The facility immediately began reviewing the inmate's claims and once the inmate's allegations were determined credible, he was released from segregation without discipline.

The facility had no other examples of an inmate being disciplined for sexual contact with staff. A review of facility investigations supports this assertion. Based on policy provision and demonstration of practice with the incident reported a week prior to the onsite audit, the auditor finds that procedures have been established that are compliant with provision (e) of the standard.

(f) For the purpose of disciplinary action, a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred shall not constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation.

The auditor reviewed the PREA Manual when determining compliance with provision (f). 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. In sampled investigations, there was no evidence of discipline issued to inmates making allegations that could not be proven. Moreover, there was a memo following an allegation filed against a staff member that resulted in an unfounded disposition, where the facility's PREA Coordinator argued against the issue of discipline to the reporting inmate, despite the findings that the allegation did not occur, allowing the auditor to find compliance with provision (f).

(g) An agency may, in its discretion, prohibit all sexual activity between inmates and may discipline inmates for such activity. An agency may not, however, deem such activity to constitute sexual abuse if it determines that the activity is not coerced.

Through a review of the PREA Manual, the Prisoner Guidebook and interviews with the PREA Manager and PREA Coordinator, the 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. The facility reported no incidents where consensual sexual activity was addressed through disciplinary procedures. Moreover, a review of facility investigations did not reveal that any incidents of consensual sexual activity were investigated under PREA procedures for sexual abuse or sexual harassment. Based upon informal interviews during the audit, policy directives and a review of investigations, the auditor determines compliance with provision (g).

MEDICAL AND MENTAL CARE

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

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.81 (a)

- If the screening pursuant to § 115.41 indicates that a prison inmate has experienced prior sexual victimization, whether it occurred in an institutional setting or in the community, do staff ensure that the inmate is offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening? (N/A if the facility is not a prison.) ☒ Yes ☐ No ☐ NA

115.81 (b)

- If the screening pursuant to § 115.41 indicates that a prison inmate has previously perpetrated sexual abuse, whether it occurred in an institutional setting or in the community, do staff ensure that the inmate is offered a follow-up meeting with a mental health practitioner within 14 days of the intake screening? (N/A if the facility is not a prison.) ☒ Yes ☐ No ☐ NA

115.81 (c)

- If the screening pursuant to § 115.41 indicates that a jail inmate has experienced prior sexual victimization, whether it occurred in an institutional setting or in the community, do staff ensure that the inmate is offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening? ☒ Yes ☐ No

115.81 (d)

- Is any information related to sexual victimization or abusiveness that occurred in an institutional setting strictly limited to medical and mental health practitioners and other staff as necessary to inform treatment plans and security management decisions, including housing, bed, work, education, and program assignments, or as otherwise required by Federal, State, or local law? ☒ Yes ☐ No

115.81 (e)

- Do medical and mental health practitioners obtain informed consent from inmates before reporting information about prior sexual victimization that did not occur in an institutional setting, unless the inmate is under the age of 18? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

(a) If the screening pursuant to § 115.41 indicates that a prison inmate has experienced prior sexual victimization, whether it occurred in an institutional setting or in the community, staff shall ensure that the inmate is offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening.

Agency policies 03.04.140, 04.01.105, 04.06.180 and the PREA Manual, which were reviewed by the 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. While reviewing the agency's updated medical policy, 03.04.100, from the agency's website for 115.82, which was reissued on 04/01/2019; the auditor also notes that mental health evaluation requirements to ensure the timely evaluation of and provisions of services for victims and abusers, consistent with provisions (a) and (b) of the standard were added. The auditor notes this policy was issued and effective on the first day of the onsite audit. Although Muskegon Correctional Facility did not consistently implement its risk screening procedures consistent with all timeliness provisions enumerated requirements under 115.41; it did begin tracking its PREA referrals to mental health staff based on risk screening victimization disclosures on its facility PREA Risk Tracking spreadsheet. Through a letter coding system designed to identify specialized populations identified by the PREA standards, the facility tracked whether an inmate reported a history of sexually abusing, or was the victim of sexual abuse via two different letters on the spreadsheet on the offender designation column. When an individual was identified with either code for victimization or abusiveness, the spreadsheet would document whether the mental health referral was requested and the date of referral if requested. As a result, there was substantial evidence of compliance of referrals being made and individuals being seen for such reports at the time of the onsite audit.

Although the veracity of the tracking log had been verified under 115.41, with respect to receipt of electronic risk screening records to verify the accuracy of dates recorded on the spreadsheet, the auditor made additional random selection of records pertaining to risk screening to further authenticate that referral documentation on the spreadsheet was accurate. To ensure the veracity of the facility's tracking log, the auditor selected five individuals who reported prior victimization or abusiveness during risk screening. In two cases, the individuals declined the mental health meeting. In two cases where an offering for a follow-up meeting was accepted, the facility provided mental health contact notes to verify that the contact occurred within 14 days as required by provision (a) of the standard. The auditor notes that the facility did not provide one requested record when analyzing compliance for this standard. The auditor made a follow-up request for this item prior to the submission of the interim report. Due to the timing of the request and the facility's PREA Coordinator's absence, the auditor did not receive the requested materials prior to the due date of the interim report; thus, it is listed as a corrective action item until such time that the requested contact log can be provided. Upon receipt of compliant documentation that the requested mental health referral was completed, the auditor will find compliance.

During the onsite audit, the audit team encountered a noteworthy problem when attempting to interview those inmates identified as reporting victimization during risk screening. As described under 115.41, within the state of Michigan, a pre-sentence report is prepared for individuals convicted of a felony and when there is a referral for misdemeanor convictions. Therefore, the MDOC has the strategic advantage of objective records to confirm responses to the risk assessment without the need to rely on self-reported information from the inmate for significant items pertaining to their incarceration history and criminal history. Pre-sentence reports also contain relevant information relative to an individual's

LGBT status, disabilities, and prior history of sexual victimization. MDOC assessors are instructed to rely on these pre-sentence reports and other agency/facility generated records to affirm responses to those items on the assessment tool and to utilize such information in the absence of a report by the inmate.

During the onsite audit, the auditors observed first-hand how the facility relied upon collateral information to complete its assessment process when attempting to identify individuals who were identified as victims of sexual abuse through the risk screening process. An additional six inmates needed to be reselected for targeted interviews based upon information uncovered through the risk screening process that the inmate's denied reporting to MDOC assessors. When probing further into the matter, it was learned that the identified victimization or other criteria was either generated through the pre-sentence report or report during MDOC intake procedures; thus, the inmate was not fully aware of how the facility was aware of the information to make the required referrals mandated by 115.81. The auditor finds this use of historical information in a consistent with the procedures of 115.41; however, notes that it provided inconsistent and unreliable results when attempting to interview targeted inmates within this population.

Through the interview process, there were three inmates who ultimately affirmed that they had disclosed sexual victimization either at Muskegon Correctional Facility or another MDOC location during the risk screening process. These three confirmed that they received mental health evaluations and continued to access such services for their disclosed victimization at Muskegon correctional facility. Staff who perform risk screening confirmed in their interviews that they were responsible for an email notification of referral to mental health staff immediately following the assessment where victimization was disclosed.

(b) If the screening pursuant to § 115.41 indicates that a prison inmate has previously perpetrated sexual abuse, whether it occurred in an institutional setting or in the community, staff shall ensure that the inmate is offered a follow-up meeting with a mental health practitioner within 14 days of the intake screening.

Agency policies 03.04.140, 04.01.105, 04.06.180 and the PREA Manual, which were reviewed by the auditor to determine compliance with provision (b) of the standard, combine to form the agency's approach to providing the required medical and mental health services for perpetrators of sexual abuse. As described under provision (a) of this standard, the facility offered its PREA Risk Tracker and secondary contact notes as proof of compliance. The auditor was able to verify the veracity of this log through pairing of service contact notes and referral dates on the log. Records reflect that the two individuals, who were both a perpetrator and victim of sexual abuse received the initial mental health evaluation and declined further treatment.

The auditor notes from previous audits within the agency and through the content within the mental health contact notes for both selected individuals that there is a routine referral and evaluation process for all inmates received at the facility with a Criminal Sexual Conduct (CSC) offense that has been routine prior to the agency's audit activity. Based upon evidence of substantial compliance of mental health contacts with previous perpetrators of sexual abuse is evident on the mental health logs to determine compliance with provision (b) of the standard.

(c) If the screening pursuant to § 115.41 indicates that a jail inmate has experienced prior sexual victimization, whether it occurred in an institutional setting or in the community, staff shall ensure that the inmate is offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening.

Muskegon Correctional Facility operates under the definition of a prison; therefore, compliance for provision (c) is measured under provision (a).

(d) Any information related to sexual victimization or abusiveness that occurred in an institutional setting shall be strictly limited to medical and mental health practitioners and other staff, as necessary, to inform treatment plans and security and management decisions, including housing, bed, work, education, and program assignments, or as otherwise required by Federal, State, or local law.

Agency policy 03.03.140 and the PREA Manual, which were reviewed by the auditor, as well as interviews with random staff and staff who conduct risk screening, confirm that information pertaining to sexual victimization occurring in an institutional setting is treated confidentially. The agency's medical and mental health records are stored within the agency's electronic health record, NexGen, which is accessible only through a credentialed user's identity and password. 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 the standard. Moreover, within one of the sampled contact notes, the auditor observed that the mental health practitioner documented within the contact note that the inmate denied wanting the previous sexual victimization reported to outside law enforcement. Formal interviews with two of the facility's mental health staff and three of the facility's medical staff confirmed they are aware of the prohibitions on disclosing sexual victimization or abusiveness outside the purview of institutional management decisions for housing, programming, work, and education.

(e) Medical and mental health practitioners shall obtain informed consent from inmates before reporting information about prior sexual victimization that did not occur in an institutional setting, unless the inmate is under the age of 18.

The auditor reviewed agency policy 03.03.140 and the PREA Manual when determining compliance with provision (e) of the 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, allowing this auditor to determine compliance with provision (e) of the standard. One of the mental health practitioners who was formally interviewed related there were a few times where informed consent was obtained to release information pertaining to victimization that an individual wished to have further disclosed to law enforcement.
The auditor also applauds the facility for its efforts to ensure inmates are aware of the limitations on confidentiality. Specifically, the agency produced posters that explicitly explain the limitations of confidentiality, which were observed to be prominently displayed in each medical and mental health provider area of the Muskegon Correctional Facility.

CORRECTIVE ACTION RECOMMENDATION:
To fulfill compliance with provision (a) of the standard, records to confirm that the requested sampled inmate was seen by a mental health practitioner in relation to disclosed abuse is necessary. Upon

receipt of the requested sample document that demonstrates compliance, the auditor will find compliance with provision (a) of the standard.

POST INTERIM REPORT CORRECTIVE ACTIONS TAKEN:
Following the issuance of the interim report, the auditor was provided records to confirm that the sampled inmate was seen by a mental health practitioner in relation to disclosed sexual abuse. The evaluation confirms that disclosed sexual abuse was affirmatively addressed during the interview. Based upon the receipt of requested sample documentation, the auditor finds full compliance with the standard.

Standard 115.82: Access to emergency medical and mental health services

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.82 (a)

- Do inmate victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services, the nature and scope of which are determined by medical and mental health practitioners according to their professional judgment?
  ☒ Yes ☐ No

115.82 (b)

- If no qualified medical or mental health practitioners are on duty at the time a report of recent sexual abuse is made, do security staff first responders take preliminary steps to protect the victim pursuant to § 115.62? ☒ Yes ☐ No

- Do security staff first responders immediately notify the appropriate medical and mental health practitioners? ☒ Yes ☐ No

115.82 (c)

- Are inmate victims of sexual abuse offered timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate? ☒ Yes ☐ No

115.82 (d)

- Are treatment services provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident?
  ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

(a) Inmate victims of sexual abuse shall receive timely, unimpeded access to emergency medical treatment and crisis intervention services, the nature and scope of which are determined by medical and mental health practitioners according to their professional judgment.

The auditor reviewed agency policies 03.03.140, 03.04.100, 03.04.125, 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. Formal interviews with two mental health staff confirm that a response generally occurs on the same date of notification or within 24 hours of notification of an allegation of sexual abuse and that services are delivered according to the clinical judgment of the practitioner. Formal interviews with three medical staff confirmed that responses are conducted immediately. Two of the medical staff indicated that treatment is provided according to their clinical judgment and the third said that treatment is consistent with policy. When the third staff was probed for details, they described provision of emergency medical treatment at an outside hospital or internal evaluation and testing when necessary, along with provisions of mental health referrals to deliver health and mental health care consistent with a community level of care. The auditor notes that agency medical policy is consistent with the standard and formally outlines the requirements for SAFE/SANE medical evaluations within 96 hours of an allegation involving penetration, and that the medical staff was explaining that policy directs services to be delivered according to the provisions of the standard. If there were the need for emergency medical treatment beyond the facility's capability, such as a forensic examination, the individual would be transferred to the Mercy Hospital Hackley Campus for community care.

The auditor does note that within one sampled sexual abuse allegation of forced oral penetration within 96 hours, the facility transported the alleged victim to Mercy Hospital for a forensic examination. The auditor also observed in another incomplete investigatory file, an alleged victim reported that he was sexually abused by another inmate approximately three weeks prior to the onsite audit. The alleged sexual abuse involving penetration reportedly occurred the day prior. The facility's documentation confirms that the alleged victim was transported to Mercy Hospital; however, the hospital's SANE nurse documented that the forensic examination was declined by the alleged victim, after the procedure was explained.

Through a review of facility investigations and pre-audit sample documentation, it was evident that the facility has an established practice of providing timely and unimpeded access to emergency medical and crisis intervention services according to the professional judgement of clinicians when emergency responses were required. Based upon evidence of emergency services being provided according to the clinical judgement of healthcare professionals, the auditor finds compliance with provision (a) of the standard.

(b) If no qualified medical or mental health practitioners are on duty at the time a report of recent abuse is made, security staff first responders shall take preliminary steps to protect the victim pursuant to § 115.62 and shall immediately notify the appropriate medical and mental health practitioners.

The PREA Manual, which was reviewed by the auditor, contains language that mirrors the standard's language to demonstrate compliance with this provision (b) of the 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 the auditor to determine compliance with provision (b) of the standard. The auditor notes that the facility has consistent medical coverage throughout all hours of the day.
(c) Inmate victims of sexual abuse while incarcerated shall be offered timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate.

The PREA Manual and agency PREA brochure were reviewed by the auditor in determining compliance with provision (c) of the standard. The PREA Manual contains language that mirrors the standard and the brochure provides instructions for inmates to access such services. The facility also provided the MDOC's Hepatitis and HIV brochures, which provide inmates information about the potential risks associated with exposure. The auditor notes that the agency's policy is to test all inmates for HIV, Hepatitis and other STIs within 14 days of admission to receptions sites and to offer re-testing when necessary under provision (c) of the standard. Agency policy 03.04.120 further offers counseling to those who test positive for any STI or communicable disease.

The facility had two allegations involving individuals housed at the facility where sexual contact was alleged where STI testing would be appropriate and not have completed under routine admission procedures described in the preceding paragraph for reports occurring in the past and originating at other facilities. In the two instances where alleged sexual abuse was reported, both individuals were referred for a forensic examination and as part of that forensic examination were offered access to STI prophylaxis. Formal interviews with medical staff verify that testing and immunization for STIs are provided when clinically indicated for victims of sexual abuse. The auditor notes that Muskegon Correctional Facility is an all-male facility; thus, pregnancy provisions within this standard are not applicable to the facility.

Based on the review of investigations, policy provisions, and interviews with medical providers, the auditor is satisfied that the Muskegon Correctional Facility has sufficient procedures in place to ensure compliance with provision (c) of the standard and has employed such procedures as necessary through its referral of sexual abuse victims to Mercy Hospital.

(d) Treatment services shall be provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident.

The auditor reviewed agency policies 03.03.140, 03.04.125, 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. Interviews with the facility medical and mental health providers confirm that services are free of charge. Interviews with individuals who reported sexual abuse confirmed they were not charged for ensuing services from medical and mental health providers for responses in relation to alleged sexual abuse. Based on policy provisions and interviews, the auditor determines compliance with provision (d) of the standard.

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

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.83 (a)

- Does the facility offer medical and mental health evaluation and, as appropriate, treatment to all inmates who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility? ☒ Yes ☐ No

115.83 (b)

- Does the evaluation and treatment of such victims include, as appropriate, follow-up services, treatment plans, and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody? ☒ Yes ☐ No

115.83 (c)

- Does the facility provide such victims with medical and mental health services consistent with the community level of care? ☒ Yes ☐ No

115.83 (d)

- Are inmate victims of sexually abusive vaginal penetration while incarcerated offered pregnancy tests? (N/A if all-male facility.) ☒ Yes ☐ No ☐ NA

115.83 (e)

- If pregnancy results from the conduct described in paragraph § 115.83(d), do such victims receive timely and comprehensive information about and timely access to all lawful pregnancy-related medical services? (N/A if all-male facility.) ☒ Yes ☐ No ☐ NA

115.83 (f)

- Are inmate victims of sexual abuse while incarcerated offered tests for sexually transmitted infections as medically appropriate? ☒ Yes ☐ No

115.83 (g)

- Are treatment services provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident? ☒ Yes ☐ No

115.83 (h)

- If the facility is a prison, does it attempt to conduct a mental health evaluation of all known inmate-on-inmate abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners? (NA if the facility is a jail.)
  ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

(a) The facility shall offer medical and mental health evaluation and, as appropriate, treatment to all inmates who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility.

The auditor reviewed agency policies 03.04.140, 03.04.125, 04.06.180 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.

The facility provided ample pre-audit documentation of medical and mental health referrals for allegations of both sexual abuse and sexual harassment allegations. The auditor was able to compare these notes against the details known from a review of investigations and the investigatory log to determine that the facility routinely offered medical and mental health contacts as appropriate to alleged victims. In most investigatory packets viewed onsite and post audit, email correspondence between the facility's PREA Coordinator and medical or mental health staff requesting evaluation was included. The auditor also requested medical and mental health records for two recent allegations at the facility, just prior to the onsite audit, where the investigations were not yet complete. The auditor was provided medical and mental health evaluation documentation for the one instance where it was determined that a forensic examination was appropriate. In the second case, the auditor was provided mental health contact notes, which were appropriate, based on the nature of the allegation.

Formal interviews with medical and mental health staff described a process where individualized monitoring and treatment plans would be developed in conjunction with the inmate's desire for ongoing services beyond the initial evaluation.

Inmates who reported sexual abuse were interviewed; however, during those interviews, only two had reported sexual abuse for recently occurring incidents of sexual abuse at the facility. A third inmate

reported sexual abuse from 2011 occurring at another location and the fourth inmate reported sexual harassment at the facility and sexual abuse from two other MDOC locations. Through those interviews, depending on the nature of the allegation, each had seen either a medical or mental health practitioner in response to their allegations, or both medical and mental health practitioners immediately following their allegations. None reported being charged for the services received.

Through a review of sampled facility investigations, medical notes, mental health contact notes, and interviews with medical and mental health staff, evidence in favor of determining compliance with provision (a) was found.

(b) The evaluation and treatment of such victims shall include, as appropriate, follow-up services, treatment plans, and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody.

The auditor reviewed agency policies 03.04.100, 04.06.180 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. Interviews with facility medical providers confirmed that a physician would examine an alleged victim and make appropriate decisions to treat injuries, infections, STIs, etc. Interviews with facility mental health staff confirmed that an assessment would be made and applicable referrals for services the patient is willing to accept would occur following an allegation.

Medical and mental health care providers articulate what is required by provision (b) of the 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.

(c) The facility shall provide such victims with medical and mental health services consistent with the community level of care.

The auditor reviewed agency policies 03.03.140, 03.04.125, 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. The standard of care is required to be consistent with community standards and is determined by the judgment of the practitioner. All practitioners are licensed in accordance with community standards and therefore required to provide services according to those standards to maintain licensure.

Interviews with mental health staff confirm that services are delivered according to established policies and the clinical judgment of necessity as determined by the practitioner. Both, medical and mental health staff stated that their belief that services each specialty provided at the facility are comparable and consistent with community levels of care, with a level of immediate availability that is often not found within the community, allowing the auditor to determine compliance with provision (c) of the standard.

(d) Inmate victims of sexually abusive vaginal penetration while incarcerated shall be offered pregnancy tests.

The 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. Through the audit tour, the auditor observed that the Muskegon Correctional Facility does not house female inmates. Based on policy provisions and the

absence of evidence of non-compliance, the auditor determines compliance with provision (d) of the standard.

(e) If pregnancy results from the conduct described in paragraph (d) of this section, such victims shall receive timely and comprehensive information about and timely access to all lawful pregnancy-related medical services.

The 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. Through the audit tour, the auditor observed that the Muskegon Correctional Facility does not house female inmates. Based on policy provisions and the absence of evidence of non-compliance, the auditor determines compliance with provision (e) of the standard.

(f) Inmate victims of sexual abuse while incarcerated shall be offered tests for sexually transmitted infections as medically appropriate.

The auditor reviewed agency policy 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. Through a review of facility investigations, the auditor found the facility had two allegations of sexual abuse where bodily fluids were exchanged, or sexual penetration occurred to clinically indicate STI testing. Both individuals were referred for forensic examination where this testing would be completed as part of the outside hospital's procedures.

While the agency has procedures in place for intake and annual STI screenings that serve as a supplemental means to capture this information; it is recommended that it be documented on its applicable forms (CAJ-1024) that a request was made for such testing to readily demonstrate proof of its compliance. Based on the facility's provision of testing according to its policies and provision of testing as part of its forensic examination procedures, the auditor determines the facility is compliant with provision (f) of the standard.

(g) Treatment services shall be provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident.

The auditor reviewed agency policy 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. All four inmates who were interviewed following reported sexual abuse at the facility or at other facilities within the agency confirmed they were not financially charged for medical or mental health services rendered as a result of their allegations. Based on policy provisions and inmate interviews, the auditor determines compliance with provision (g) of the standard.

(h) All prisons shall attempt to conduct a mental health evaluation of all known inmate-on-inmate abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners.

The PREA Manual, which was reviewed by the 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. As of the time of the audit, there are no known instances at Muskegon

Correctional Facility where an inmate was found or known to have engaged in sexual abuse of another inmate. Based on policy provisions, the auditor determines compliance with provision (h) of the standard.

DATA COLLECTION AND REVIEW

Standard 115.86: Sexual abuse incident reviews

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.86 (a)

- Does the facility conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation, including where the allegation has not been substantiated, unless the allegation has been determined to be unfounded? ☒ Yes ☐ No

115.86 (b)

- Does such review ordinarily occur within 30 days of the conclusion of the investigation? ☒ Yes ☐ No

115.86 (c)

- Does the review team include upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners? ☒ Yes ☐ No

115.86 (d)

- Does the review team: Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse? ☒ Yes ☐ No
- Does the review team: Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; gang affiliation; or other group dynamics at the facility? ☒ Yes ☐ No
- Does the review team: Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse? ☒ Yes ☐ No
- Does the review team: Assess the adequacy of staffing levels in that area during different shifts? ☒ Yes ☐ No
- Does the review team: Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff? ☒ Yes ☐ No
- Does the review team: Prepare a report of its findings, including but not necessarily limited to determinations made pursuant to §§ 115.86(d)(1) - (d)(5), and any recommendations for

improvement and submit such report to the facility head and PREA compliance manager? ☒ Yes ☐ No

115.86 (e)

- Does the facility implement the recommendations for improvement, or document its reasons for not doing so? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

(a) The facility shall conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation, including where the allegation has not been substantiated, unless the allegation has been determined to be unfounded.

The 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. This review form includes a checklist of the five provisions which require consideration in the review process, along with a section for recommendations and approval by the PREA Coordinator, Warden and Central Office staff when recommendations require additional approval. Through interviews with the Warden, PREA Coordinator and a member of the incident review team, the audit team learned that the incident review consists of a review of the entire investigatory packet provided to the auditor. The review team consists of the Warden, Inspector/Investigator, PREA Coordinator, Deputy Warden, Heath Unit Manager, Mental Health Unit Manager, and Residential Unit Manager, depending on the nature of the allegation. The PREA Coordinator stated that the team has a standing meeting where they review the investigations, discuss concerns, or any actions that they may need to take to improve operations.

In a review of investigations at the Muskegon Correctional Facility determined to be sexual abuse and resulting in an unsubstantiated outcome, a sexual abuse incident review was completed in all but one sampled investigative file. The missing incident review was not present for an allegation investigated under case number 25326 from August of 2018, involving a report of sexual abuse that allegedly occurred in 2013, reported from another facility. It appears that the initial determination by the investigator may have been unfounded, based on the vague responses provided by the alleged victim

and the inability to provide basic details to investigate further; however, at some point the disposition was modified to unsubstantiated, which may explain the absence of a review. The auditor notes that the facility did go beyond the minimum requirements of the standard and completed an incident review for an allegation that was unfounded in investigation 26580. Based upon substantial evidence of reviews being completed following a sexual abuse investigation, the auditor finds compliance with provision (a) of the standard.

(b) Such review shall ordinarily occur within 30 days of the conclusion of the investigation.

Through the auditor's review of relevant investigations, the auditor did observe that incident reviews occurred within the 30-day period required by the standard on the CAJ-1025 form. The auditor notes, however, there were varying dates within the investigatory files, that seemed to indicate the closing date of the investigation was not always consistent. Specifically, the closing date on form CAJ-1025 did not always align with the date on the investigation or the date of the inmate notification. However, the auditor does note that these dates on these documents may not be fully reflective of the “official” closing of the investigation by the Warden or the agency’s Internal Affairs division within the agency’s AIM system used to track investigations and completion dates. Through pre-audit sample documentation and investigatory packets gathered onsite, the auditor reviewed nine sexual abuse incident reviews in total. As documented on the Eight of the nine reviews were completed within 30 days as required by provision (b) of the standard. The review for 26461 was late by approximately 1.5 months. Review of facility incident review checklists demonstrate substantial compliance with provision (b) of the standard.

(c) The review team shall include upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners.

In sampled incident reviews, the review team consists of the Warden, Inspector/Investigator, PREA Coordinator, Deputy Warden, Heath Unit Manager, Mental Health Unit Manager, and Residential Unit Manager, depending on the nature of the allegation. 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 perspectives, to include medical and mental health practitioners, the PREA Coordinator and investigators. The PREA Coordinated stated that reviews are scheduled for a standing meeting that follows another institutional meeting involving upper level management staff. The incident review form is ultimately forwarded to his attention for sign-off and approval. Any approved recommendations by the committee would be considered by him and forwarded upwards through the agency level if significant recommendations are noted. Based on interviews and incident review documentation, the auditor finds compliance with provision (c) of the standard.

(d) The review team shall:
(1) Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse;
(2) Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; or gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility;
(3) Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse;
(4) Assess the adequacy of staffing levels in that area during different shifts;

(5) Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff; and
(6) Prepare a report of its findings, including but not necessarily limited to determinations made pursuant to paragraphs (d)(1)-(d)(5) of this section, and any recommendations for improvement and submit such report to the facility head and PREA compliance manager.

Agency form CAJ-1025, which was reviewed by the auditor, mirrors the standard language to confirm that the facility must consider the six factors required by provision (d) of the standard in order to complete the agency review form. Interviews with the Warden and facility PREA Coordinator confirms that Muskegon Correctional Facility's review team considers the six factors enumerated under provision (d) of the standard in its review process. The PREA Coordinator stated that any recommendation would forwarded to his attention to be considered for implementation, citing that additional training may be recommended to address deficiencies. Once he has reviewed the report, it is forwarded to the Warden for review. The auditor notes that the form and content listed within is minimal; however, it contains the minimum content to meet the floor of the standard. While not a requirement, it is recommended that additional commentary be added to the form to help explain why the elements of the provision were or were not relevant to the specific incident review for a more comprehensive report. Based on interviews, observations within reviews and policy, the auditor determines compliance with provision (d) of the standard.

(e) The facility shall implement the recommendations for improvement or shall document its reasons for not doing so.

The auditor reviewed the agency PREA Manual and language exists that mirrors the standard. The nature of the allegations reviewed at the facility did not lead to any substantive recommendations for improvement by the facility; however, the PREA Coordinator stated that incident reviews have led to additional education and training efforts to educate staff. Based on policy provision, example documentation and an interview with the Warden, the auditor determines compliance with provision (e) of the standard.

Standard 115.87: Data collection

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.87 (a)

- Does the agency collect accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions? ☒ Yes ☐ No

115.87 (b)

- Does the agency aggregate the incident-based sexual abuse data at least annually? ☒ Yes ☐ No

115.87 (c)

- Does the incident-based data include, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice? ☒ Yes ☐ No

115.87 (d)

- Does the agency maintain, review, and collect data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews? ☒ Yes ☐ No

115.87 (e)

- Does the agency also obtain incident-based and aggregated data from every private facility with which it contracts for the confinement of its inmates? (N/A if agency does not contract for the confinement of its inmates.) ☒ Yes ☐ No ☐ NA

115.87 (f)

- Does the agency, upon request, provide all such data from the previous calendar year to the Department of Justice no later than June 30? (N/A if DOJ has not requested agency data.) ☐ Yes ☐ No ☒ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

(a) The agency shall collect accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions.

The PREA Manual states that the Department PREA Manager gathers data on each reported incident to aggregate an annual incident report. Through an interview with the PREA Manager, all allegations are entered into the Department's investigative database (AIM) so that uniform data can be obtained. The agency has a standard definition of sexual abuse and sexual harassment contained within its PREA Manual and policy 03.03.140 that guides data collection consistent with provision (a) of the standard.

(b) The agency shall aggregate the incident-based sexual abuse data at least annually.

The agency prepares an annual statistical report that is published on the agency's public website consistent with provision (b). 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. Statistical information on the agency's website exists for 2014 through 2017, consistent with provision (b) of the standard.

(c) The incident-based data collected shall include, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice.

The agency's annual PREA statistical report for 2017 and its surveys of sexual violence for 2013 through 2017 are posted on the agency's website to demonstrate compliance with provision (c) of the standard. The data collected allowed for the answering of all questions required by the Department of Justice's surveys consistent with provision (c) of the standard.

(d) The agency shall maintain, review, and collect data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews.

The agency's investigation database (AIM) is utilized to collect data. Additionally, the agency PREA Manager and regional PREA Analysist receives a courtesy copy of all facility based sexual abuse incident review packets to collect data consistent with provision (d) of the standard.

(e) The agency also shall obtain incident-based and aggregated data from every private facility with which it contracts for the confinement of its inmates.

During the formation of the interim report, this auditor discovered that the agency has two active contracts with the Ingham and Clinton County Jails for the housing of parole violators under the auspice of the Intensive Detention Program. These contracts were not reported under §115.12, nor were the facilities' incident based and aggregate data included in its 2017 annual report; despite the fact that the contracted entities were under contract in 2017.

During the evaluation of §115.12, it was determined that there is insufficient evidence that the agency completes contract monitoring required by §115.12. Without established contract monitoring, it also appears that the agency does not have documented evidence of collecting data required by §115.87(e); evidenced by the exclusion of such data in its 2017 annual report. Based upon the absence of evidence of data collection for each of its contracted entities; there is insufficient evidence to support compliance with provision (e) of the standard.

(f) Upon request, the agency shall provide all such data from the previous calendar year to the Department of Justice no later than June 30.

The auditor found no evidence that the agency was requested to provide data to the Department of Justice consistent with provision (f) and finds no evidence of non-compliance.

Corrective Action Recommendation:
It is recommended that the agency establish procedures for contract monitoring, which includes data collection to capture incident based and aggregate data for its contracted facilities.

Post Interim Report Corrective Actions Taken:

As described in 115.12, the agency's contracted entities have significant ground to cover in achieving PREA compliance. Therefore, the contracted entities did not have data collection procedures in place to capture the requisite data for the MDOC to aggregate in accordance with provision (e) of the standard. The MDOC issued a corrective action plan to its contracted entities to develop compliant policies and as part of its contract monitoring, the MDOC will be collecting incident based and aggregate data from the contracted entities once methods have been established by the contracted entities. Until then, the MDOC will track incident based data for its populations housed within the facility through its AIM system that it uses to track all allegations for inmates confined in the MDOC. Specifically, any allegations involving MDOC inmates will be entered into the AIM system for statistical reporting. Consistent with the August 2, 2019 and February 19, 2014 contract monitoring FAQs, the contracting agency will not be held in non-compliance, so long as the contracting agency is documenting the contracted agency's progress towards achieving compliance, which would include the development of procedures to collect data consistent with the standard.

The agency issued a formal corrective action plan to its contracted facilities and received responses on October 8, 2019, that both will be implementing procedures to comply with the PREA standards, which will eventually bring the agency into compliance with this standard's obligation to collect incident based and aggregate data from its contracted facilities.

Standard 115.88: Data review for corrective action

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.88 (a)

- Does the agency review data collected and aggregated pursuant to § 115.87 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Identifying problem areas? ☒ Yes ☐ No

- Does the agency review data collected and aggregated pursuant to § 115.87 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Taking corrective action on an ongoing basis? ☒ Yes ☐ No

- Does the agency review data collected and aggregated pursuant to § 115.87 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Preparing an annual report of its findings and corrective actions for each facility, as well as the agency as a whole? ☒ Yes ☐ No

115.88 (b)

- Does the agency's annual report include a comparison of the current year's data and corrective actions with those from prior years and provide an assessment of the agency's progress in addressing sexual abuse ☒ Yes ☐ No

115.88 (c)

- Is the agency's annual report approved by the agency head and made readily available to the public through its website or, if it does not have one, through other means? ☒ Yes ☐ No

115.88 (d)

- Does the agency indicate the nature of the material redacted where it redacts specific material from the reports when publication would present a clear and specific threat to the safety and security of a facility? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

(a) The agency shall review data collected and aggregated pursuant to § 115.87 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by:
(1) Identifying problem areas;
(2) Taking corrective action on an ongoing basis; and
(3) Preparing an annual report of its findings and corrective actions for each facility, as well as the agency as a whole.

The agency prepares an annual PREA statistical report to assess and improve its effectiveness of preventing and detecting sexual abuse. The agency's 2017 report identified its efforts to continue training Department investigators, Department risk screening staff, the inmate population and revisions of its policies to eliminate cross-gender viewing as several audited sites. The agency also trained its staff to fill in as qualified victim advocates in the absence of local agreements with rape crisis advocacy services. Finally, the report describes the agency's efforts to initiate access to the RAINN hotline during the reporting period to satisfy 115.53, prior to its current contract with Just Detention International (JDI) to host "An Inside Line." The report describes the agency's lessons learned since it began auditing and the enhancements it took to become compliant following corrective action periods at 11 of its 13 audited facilities, consistent with provision (a) of the standard.

(b) Such report shall include a comparison of the current year's data and corrective actions with those from prior years and shall provide an assessment of the agency's progress in addressing sexual abuse.

The agency's 2017 annual PREA report compares data from the previous three years, dating back to 2015. The agency maintains its annual reports, from 2017 through 2014 on its website for comparative purposes. The 2017 annual report does summarize the agency's progress with achieving PREA compliance at its facilities, citing its training efforts, audit progress, and corrective actions taken following corrective action periods in audits as steps to enhance compliance consistent with provision (b).

(c) The agency's report shall be approved by the agency head and made readily available to the public through its website or, if it does not have one, through other means.

The agency's annual report is approved by the agency head, which is documented through her signature on the report. The auditor confirmed that the annual report is published on the agency's website consistent with provision (c).

(d) The agency may redact specific material from the reports when publication would present a clear and specific threat to the safety and security of a facility but must indicate the nature of the material redacted.

The agency does not redact information from its annual report consistent with provision (d).

Standard 115.89: Data storage, publication, and destruction

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.89 (a)

- Does the agency ensure that data collected pursuant to § 115.87 are securely retained? ☒ Yes ☐ No

115.89 (b)

- Does the agency make all aggregated sexual abuse data, from facilities under its direct control and private facilities with which it contracts, readily available to the public at least annually through its website or, if it does not have one, through other means? ☒ Yes ☐ No

115.89 (c)

- Does the agency remove all personal identifiers before making aggregated sexual abuse data publicly available? ☒ Yes ☐ No

115.89 (d)

- Does the agency maintain sexual abuse data collected pursuant to § 115.87 for at least 10 years after the date of the initial collection, unless Federal, State, or local law requires otherwise? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

(a) The agency shall ensure that data collected pursuant to § 115.87 are securely retained.

The MDOC establishes procedures within its PREA Manual to direct that data must be securely retained. The agency PREA Manager reported that the agency's overall data pool for PREA is maintained in the agency's AIM system, which is confidential and there is limited access to the system, including a a limited number of upper agency administrators above the PREA Manager's rank who would have access to the agency investigation database. These procedures are consistent with provision (a) of the standard.

(b) The agency shall make all aggregated sexual abuse data, from facilities under its direct control and private facilities with which it contracts, readily available to the public at least annually through its website or, if it does not have one, through other means.

As noted under 115.87(e), the agency contracts with the Ingham and Clinton County Jails for the housing of parole violators under the auspice of the Intensive Detention Program. The facilities' aggregate data was not included in the agency's 2017 annual report; despite the fact that the contracted entities were under contract in 2017. Absent evidence that the agency collects and publishes aggregate data for its contracted facilities; the audit team does not find compliance with provision (b) of the standard.

(c) Before making aggregated sexual abuse data publicly available, the agency shall remove all personal identifiers.

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

(d) The agency shall maintain sexual abuse data collected pursuant to § 115.87 for at least 10 years after the date of the initial collection unless Federal, State, or local law requires otherwise.

The agency's PREA Manual specifies that data collected pursuant to 115.87 is retained for at least 10 years. The agency maintains its Surveys of Sexual Violence and annual PREA reports on its website. The SSV reports cover the five most recent years since the MDOC committed to PREA compliance and

its annual statistical reports from 2014 through 2017, leading to a finding of compliance with provision (d).

CORRECTIVE ACTION RECOMMENDATION:

It is recommended that the agency establish procedures for contract monitoring, which includes data collection to capture incident based and aggregate data for its contracted facilities, which is subsequently published as part of the agency's annual statistical report on its website.

Post Interim Report Corrective Actions Taken:

As described in 115.12, the agency's contracted entities have significant ground to cover in achieving PREA compliance. Therefore, the contracted entities did not have data collection procedures in place to capture the requisite data for the MDOC to aggregate in accordance with provision (e) of 115.87, therefore, such information is not included in the MDOC's annual report consistent with provision (b) of the standard. The MDOC issued a corrective action plan to its contracted entities to develop compliant policies and as part of its contract monitoring, the MDOC will be collecting incident based and aggregate data from the contracted entities once methods have been established by the contracted entities. Until then, the MDOC will track incident based data for its populations housed within the facility through its AIM system that it uses to track all allegations for inmates confined in the MDOC. Specifically, any allegations involving MDOC inmates will be entered into the AIM system for statistical reporting and inclusion in future annual reports. Consistent with the August 2, 2019 and February 19, 2014 contract monitoring FAQs, the contracting agency will not be held in non-compliance, so long as the contracting agency is documenting the contracted agency's progress towards achieving compliance, which would include the development of procedures to collect data for publication within an annual report consistent with the standard.

The agency issued a formal corrective action plan to its contracted facilities and received responses on October 8, 2019, that both will be implementing procedures to comply with the PREA standards, which will eventually bring the agency into compliance with this standard's obligation to collect incident based and aggregate data from its contracted facilities.

AUDITING AND CORRECTIVE ACTION

Standard 115.401: Frequency and scope of audits

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.401 (a)

- During the prior three-year audit period, did the agency ensure that each facility operated by the agency, or by a private organization on behalf of the agency, was audited at least once? (*Note: The response here is purely informational. A "no" response does not impact overall compliance with this standard.*) ☒ Yes ☐ No

115.401 (b)

- Is this the first year of the current audit cycle? (*Note: a "no" response does not impact overall compliance with this standard*.) ☐ Yes ☒ No

- If this is the second year of the current audit cycle, did the agency ensure that at least one-third of each facility type operated by the agency, or by a private organization on behalf of the agency, was audited during the first year of the current audit cycle? (N/A if this is **not** the *second* year of the current audit cycle.) ☐ Yes ☐ No ☒ NA

- If this is the third year of the current audit cycle, did the agency ensure that at least two-thirds of each facility type operated by the agency, or by a private organization on behalf of the agency, were audited during the first two years of the current audit cycle? (N/A if this is **not** the *third* year of the current audit cycle.) ☒ Yes ☐ No ☐ NA

115.401 (h)

- Did the auditor have access to, and the ability to observe, all areas of the audited facility? ☒ Yes ☐ No

115.401 (i)

- Was the auditor permitted to request and receive copies of any relevant documents (including electronically stored information)? ☒ Yes ☐ No

115.401 (m)

- Was the auditor permitted to conduct private interviews with inmates, residents, and detainees? ☒ Yes ☐ No

115.401 (n)

- Were inmates permitted to send confidential information or correspondence to the auditor in the same manner as if they were communicating with legal counsel? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The auditor was able to tour all areas of the facility, correspond with inmates and interview inmates and staff privately. The auditor was able to observe all computerized and paper records requested. Copies of requested documentation was provided as requested. Interviews were permitted to take place in a private setting. The audit is performed under a consortium, where the auditing agency conducts all audits within the audited agency. Therefore, a third of its only type of facilities (prisons) have been audited.

Standard 115.403: Audit contents and findings

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.403 (f)

- The agency has published on its agency website, if it has one, or has otherwise made publicly available, all Final Audit Reports within 90 days of issuance by auditor. The review period is for prior audits completed during the past three years PRECEDING THIS AGENCY AUDIT. In the case of single facility agencies, the auditor shall ensure that the facility's last audit report was published. The pendency of any agency appeal pursuant to 28 C.F.R. § 115.405 does not excuse noncompliance with this provision. (N/A if there have been no Final Audit Reports issued in the past three years, or in the case of single facility agencies that there has never been a Final Audit Report issued.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The auditor visited the agency website and observed final reports completed by this auditor and other consortium auditors during the second audit cycle, chronologically arranged by the audit year in which

they occurred. The auditor notes that the agency errantly listed its Marquette Branch Prison audit as occurring in the 3rd year of the audit cycle. The audit initially began in June 2018 and corrective action concluded in January 2019. Audit reports for the third year of cycle are not yet posted; however, the auditor notes that all audits occurring during the third year of the cycle had not officially concluded with a final report. Reports from the first audit cycle were also present.

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.

Auditor Instructions:

Type your full name in the text box below for Auditor Signature. This will function as your official electronic signature. Auditors must deliver their final report to the PREA Resource Center as a searchable PDF format to ensure accessibility to people with disabilities. Save this report document into a PDF format prior to submission.[1] Auditors are not permitted to submit audit reports that have been scanned.[2] See the PREA Auditor Handbook for a full discussion of audit report formatting requirements.

David Radziewicz December 5, 2019

Auditor Signature **Date**

[1] See additional instructions here: https://support.office.com/en-us/article/Save-or-convert-to-PDF-d85416c5-7d77-4fd6-a216-6f4bf7c7c110 .

[2] See *PREA Auditor Handbook*, Version 1.0, August 2017; Pages 68-69.