Prison Rape Elimination Act (PREA) Audit Report
Juvenile Facilities

☐ **Interim** ☒ **Final**

Date of Report 11/20/2019

Auditor Information

Name: James L. Roland Jr.	**Email:** james.roland@nakamotogroup.com
Company Name: The Nakamoto Group, Inc.	
Mailing Address: 11820 Parklawn Drive, Suite 240	**City, State, Zip:** Rockville, MD. 20852
Telephone: 302-468-6535	**Date of Facility Visit:** 10/24-25/2019

Agency Information

Name of Agency Michigan Department of Health		**Governing Authority or Parent Agency** *(If Applicable)*	
Physical Address: 235 South Grand Avenue		**City, State, Zip:** Lansing, Michigan, 48933	
Mailing Address:		**City, State, Zip:**	
The Agency Is:	☐ Military	☐ Private for Profit	☐ Private not for Profit
☐ Municipal	☐ County	☒ State	☐ Federal

Agency Website with PREA Information: https://www.michigan.gov/mdhhs/0,5885,7-339-73971_34044_93169---,00.html

Agency Chief Executive Officer

Name: Joo Yeun Chang	
Email: Changj4@michigan.gov	**Telephone:** 517-241-3990

Agency-Wide PREA Coordinator

Name: Soleil Campbell	
Email: CampbellS6@michigan.gov	**Telephone:**
PREA Coordinator Reports to: Deborah Buchanan	**Number of Compliance Managers who report to the PREA Coordinator:** 2

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Facility Information

Name of Facility: Shawono Center			
Physical Address: 10 North Howes Lake Road		**City, State, Zip:** Grayling, Michigan, 49738	
Mailing Address (if different from above):		**City, State, Zip:**	
The Facility Is:	☐ Military	☐ Private for Profit	☐ Private not for Profit
☐ Municipal	☐ County	☒ State	☐ Federal

Facility Website with PREA Information: https://www.michigan.gov/mdhhs/0,5885,7-339-73971_34044_34049-109166--,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:

☒ N/A

If the facility has completed any internal or external audits other than those that resulted in accreditation, please describe:
External Audit was completed by James Roland on 11/23/2016. Shawono Center successfully completed the audit.

Facility Administrator/Director/Director

Name:	Todd Serby		
Email:	SerbyT@michigan.gov	**Telephone:**	989-344-5000

Facility PREA Compliance Manager

Name:	John Junttila		
Email:	junttila@michigan.gov	**Telephone:**	989-344-5000

Facility Health Service Administrator ☒ N/A

Name:	
Email:	**Telephone:**

Facility Characteristics

Designated Facility Capacity:	40
Current Population of Facility:	40
Average daily population for the past 12 months:	40
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:	12-20
Average length of stay or time under supervision	316 Days
Facility security levels/resident custody levels	High Security

Number of residents admitted to facility during the past 12 months	26
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for *72 hours or more*:	26
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for *10 days or more:*	26
Does the audited facility hold residents 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 residents: Select all that apply (N/A if the audited facility does not hold residents 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: ☐ N/A

Number of staff currently employed by the facility who may have contact with residents:	44
Number of staff hired by the facility during the past 12 months who may have contact with residents:	5
Number of contracts in the past 12 months for services with contractors who may have contact with residents:	7
Number of individual contractors who have contact with residents, currently authorized to enter the facility:	7
Number of volunteers who have contact with residents, currently authorized to enter the facility:	2
Physical Plant	
Number of buildings: **Auditors should count all buildings that are part of the facility, whether residents 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 residents, 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.**	1
Number of resident 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 residents 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 residents 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.**	4
Number of single resident cells, rooms, or other enclosures:	40
Number of multiple occupancy cells, rooms, or other enclosures:	0
Number of open bay/dorm housing units:	4
Number of segregation or isolation cells or rooms (for example, administrative, disciplinary, protective custody, etc.):	2

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:

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:	0
When the facility received allegations of sexual abuse or sexual harassment (whether staff-on-resident or resident-on-resident), 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: ☐ 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?	6
When the facility receives allegations of sexual abuse or sexual harassment (whether staff-on-resident or resident-on-resident), 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: ☐ 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.

Overview

The on-site Prison Rape Elimination Act (PREA) compliance audit of the Shawono Center (SC), located in Grayling, Michigan was conducted on October 24-25, 2019 by the U.S. Department of Justice (DOJ) certified PREA Auditor, James L. Roland Jr. from The Nakamoto Group, Inc. The standards used for this audit became effective on August 20, 2012. The Auditor conducted an opening meeting, toured the entire facility, interviewed a randomized sample of staff and residents and reviewed PREA related staff and resident documentation. Upon completion of the audit process, a closing meeting was held with the administrative staff to discuss the audit process, preliminary findings and the post-audit process. Employees at the facility were found to be extremely courteous, cooperative and professional. All areas of the facility were clean and well maintained. During the closing meeting, the Auditor thanked the staff for their hard work and dedication to the PREA process.

Pre-Audit Phase

On September 4, 2019, PREA Audit Notices in English and Spanish were provided to the facility to be posted. The Auditor observed the notices posted in the living units, at the main entrance, and in the visitation area. The notices were posted for six weeks pre-audit and the Auditor did not receive any correspondence from residents prior to the on-site visit.

SC staff members were asked to complete the Pre-Audit Questionnaire (PAQ) also provided to the facility on July 7, 2019. The completed PAQ and supporting documentation were received by the Auditor on July 20, 2019, via the PREA Resource Center OAS System.

On-Site Audit Phase

The Auditor held an opening meeting on the morning of October 24, 2019, at the SC facility with administrative staff. The audit schedule and process were discussed during the meeting. Including the Auditor, those present at the meeting were:

- Director
- Program Manager

- PREA Analyst (x2)

The Auditor was provided a private conference room in which to conduct business and confidential interviews. All requested files and rosters of both staff and residents were made available to the Auditor for review.

Site Review

Immediately following the opening meeting, a tour of the facility was completed. The Auditor was escorted by the Director. During the tour, the Auditor reviewed PREA related documentation and materials located on bulletin boards and other locations. The Auditor assessed camera surveillance, physical supervision, and electronic monitoring capabilities. Other areas of focus during the facility tour included, but were not limited to, levels of staff supervision and limits to cross-gender viewing. All signs and postings were in both English and Spanish. Informal and formal conversations with employees and residents regarding the PREA standards were conducted. Postings regarding PREA violation reporting and the agency's zero-tolerance policy for sexual abuse and sexual harassment were prominently displayed in all living units, meeting areas and throughout the facility. Audit notice postings with the PREA Auditor's contact information were posted in the same areas. The Auditor notice postings were posted eight weeks prior to the on-site visit. Unimpeded access to all areas of the facility was provided to the Auditor.

Interviews

At the time of the audit, there were 40 male residents housed at the Shawono Center. A total of 10 residents were interviewed. The facility indicated that they had no residents who were Limited English Proficient (LEP), three residents who self-identified as being members of the LGBTI community, two residents who reported sexual victimization during risk screening and one resident with cognitive disabilities. No residents were identified with physical disabilities. No residents refused to be interviewed. Interviews were conducted using the Department of Justice (DOJ) protocols to determine residents' knowledge of the PREA and the reporting mechanisms available to them.

The Shawono Center employs a staff of 44 individuals. Twenty-three staff members were interviewed, including nine random staff (from all three shifts) and 14 administrative/specialized staff. The administrative staff included the Director, PREA Compliance Manager (PCM), PREA Compliance Coordinator (PCC), and an Agency Contract Administrator. The specialized staff interviewed included a Clinical Social Worker, Human Resource Administrator, Registered Nurse, Shift Supervisor, Youth Group Leader, Youth Specialist, Investigator, and a Group Leader. Additionally, a Sexual Assault Nurse Examiner representative from Mercy Hospital and a contractor were interviewed. All staff members have been trained to act as first responders when a PREA related incident occurs. All staff members are considered first responders.

The Auditor reviewed the Memorandum of Understanding (MOU) that exists between River House, Inc. and the facility. It was confirmed that River House, Inc. will provide services to SC including, but not limited to, a 24 hour per day, seven days per week Sexual Assault Hotline,

medical accompaniment and advocacy services for a resident victim of sexual assault. The Auditor connected telephonically with an emergency room representative at Mercy Hospital and confirmed that forensic examinations by a Sexual Assault Nurse Examiner (SANE) are available 24/7.

File Review

Following the interviews, the Auditor reviewed the files requested during the pre-audit phase. The Auditor reviewed five personnel files to establish compliance with PREA training mandates and background checks. The Auditor also reviewed two facility contractor's files to ensure training mandates and background check requirements were in compliance. Screening and intake procedures were evaluated by reviewing five random resident files which included a vulnerability assessment instrument and resident education verification documentation.

Investigations

During the current auditing period, there were five cases reported allegations of sexual harassment and/or sexual abuse. Administrative investigations were completed. Three cases were ruled to be substantiated and two cases were determined to be unfounded. This documentation was reviewed by the Auditor.

All administrative investigations are conducted by the Investigator. In the event an investigation reveals potentially criminal evidence, the case is referred to as the Michigan State Police (MSP). The Investigator is responsible for receiving verbal and telephonic referrals 24 hours a day, seven days a week. Additionally, abuse investigation outcomes and general protective services assessment outcomes are submitted to, reviewed by and finalized by the Director and forwarded to the agency PREA Compliance Coordinator (PCC).

Closeout

A closing meeting was held with the Auditor and the administrative staff. Discussions centered on the audit process, preliminary findings and the post-audit process. The Auditor thanked the staff for their hard work and dedication to the PREA process.

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.

Shawono Center, located in Grayling, MI, is a publicly operated, secure 40-bed treatment facility for male juveniles between the ages of 12 and 21 years who have been adjudicated for one or more felony counts. The Center offers specialized treatment programs for sex offenders, to include addictions/substance abuse; and for delinquents with co-occurring mental health issues. All services are provided in a secure environment where treatment can take place while assuring the community a high level of security.

The facility's mission is to “Improve the quality of life in Michigan by providing services to vulnerable children that will enable families and individuals to move toward independence.” The mission of the parent organization, the Michigan Department of Health and Human Services (MDHHS), is to ensure “Child welfare professionals will demonstrate an unwavering commitment to engage and partner with families they serve to ensure safety, permanency, and well-being."

Facility outdoor recreation areas are fenced and exterior doors and selected interior doors in the building are locked and can only be opened by using a staff key. The housing consists of four living units with individual cells. Each living unit contains 10 cells each. These cells contain individual beds and a clothing storage unit for each resident. Each unit also contains showers and restrooms to accommodate the population of the unit. Showers are taken individually, and shower doors are locked by staff when occupied by youth to prevent intrusion. The facility includes classrooms for education and group therapy, a food service area with a cafeteria, a gymnasium and an administration area. All areas of the building are connected by enclosed hallways.

Shawono Center offers three distinct treatment opportunities. Substance Abuse Treatment is designated for the treatment of chronic substance users, where substance use contributed to or caused offender criminal behavior. Treatment includes daily treatment groups, a full school schedule including special education services, high school credit recovery and/or GED completion, college, psychological services, family work, community service, and enhanced transition services.

General Offender Treatment is provided for delinquents with both generalized criminogenic behavior and mental health issues. Treatment services include the same milieu as described above, with additional emphasis on psychological services and interventions. Likewise, treatment for sexual offenders includes the services provided to all residents, plus the additional specific programming for the rehabilitation of sexual offenders. There are two groups (of the four in the program) that are designated as sexual offender groups. These groups are housed in one area of the building and the other two groups are housed in a different area of the building. The facility historically reserved several beds for short-term detention; however, that is not occurring at this time because of the current state-wide need for treatment beds.

Group counselors /treatment leaders are master's degree level counselors. The program requires them to be trained in and be able to administer a valid criminogenic risk assessment system, in addition to specific PREA screening and other assessments. All staff, regardless of title or position, must attend PREA training at least annually. Other required training includes CPR/First Aid, crisis intervention and physical restraint training and program-specific training.

Youth can be placed at Shawono Center through the MDHHS assignment unit or can be directly ordered into the facility by the courts. The court determines the length of stay at the facility, which is generally based on the completion of program treatment goals. The average length of stay at the facility is 13 months. Shawono Center utilizes the evidence-supported Boys Town Treatment Model as one component of its behavior modification modality and the facility participates fully in the Michigan Youth Re-Entry Initiative. Full medical, dental and immunization services are provided at no charge to residents.

Summary of Audit Findings

The summary should include the number and list of standards exceeded, number of standards met, and number and list of standards not met.

Overview

During the auditing period, SC reported five incidents of sexual abuse/sexual harassment. There is a well-established zero-tolerance culture throughout, with documentation addressing all areas of the PREA. The agency, Michigan Department of Health and Human Services (MDHHS), maintains a Central Administration set of PREA policies, as well as specific, detailed policies for the facility. A random review of five personnel background checks and 15 employee training files established facility compliance with PREA training mandates and revealed that hiring and promotion practices are consistent with sexual abuse safety measures.

The Auditor found the facility administration maintaining a strong commitment to the PREA and the zero-tolerance policy. Significant time and resources have been employed to ensure a sexually safe environment for the residents and staff of Shawono Center.

Interviews

Interviews with staff revealed a good understanding of PREA policies. Staff members were knowledgeable about their roles in prevention, reporting, as well as their responsibilities in the event of a PREA related incident, particularly first responder duties. Staff members were able to verbalize the steps mandated in the event they were the first responder to a PREA related incident. Reporting mechanisms were displayed in a conspicuous manner and residents and staff members were aware of all reporting methods available to them. A review of the SC staff training curriculum was completed by the Auditor and records support the finding that all employees have received comprehensive PREA training. Staff appeared truly interested and vested in the residents and expressed a desire to see them succeed.

Interviews with residents revealed a good understanding of the PREA safeguards and the zero-tolerance policy. Comprehensive resident PREA education is provided in written form (i.e. Youth Handbook, entrance packet), personal instruction and posters. Ten vulnerability assessment instruments reviewed by the Auditor indicated that intake and classification assessments are efficient and seamless in addressing referrals based on victimization or abusiveness screening data. Residents acknowledged the admissions screening process included questions regarding any history of sexual abuse or victimization and whether they would like to identify a sexual preference. Residents expressed, during interviews, that they were aware of how to report abuse internally and externally. Residents verbalized trust in the SC staff and a willingness to report abuse to them. The residents demonstrated an understanding that the facility has appropriate medical and victim advocacy networks in place. Residents also affirmed they felt safe in the facility. Staff and resident interactions were observed by the Auditor and appeared to be respectful and positive.

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

Standards Exceeded

Number of Standards Exceeded: 0
List of Standards Exceeded:

Standards Met

Number of Standards Met: 43

Standards Not Met

Number of Standards Not Met: 0
List of Standards Not Met:

PREVENTION PLANNING

Standard 115.311: Zero tolerance of sexual abuse and sexual harassment; PREA coordinator

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

115.311 (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

115.311 (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

115.311 (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.

Evidence Reviewed (on-site visit, documentation, staff and inmate interviews):

1. SC Pre-Audit Questionnaire
2. Policy 560 Michigan Department of Health (MDH) Prevention of Resident Sexual Assault/Rape: Page 1
3. Policy 560 Michigan Department of Health (MDH) Prevention of Resident Sexual Assault/Rape: Definitions; Page 3
4. Policy 560 Michigan Department of Health (MDH) Prevention of Resident Sexual Assault/Rape: Definitions; Page 10
5. Shawono Center PREA Refresher: Juvenile Detention PREA Basics
6. Facility Organizational Chart
7. Youth Handbook
8. Staffing Plan
9. Interviews with the following:
10. a. Specialized and Random Staff

The agency's zero-tolerance policy against sexual abuse was clearly established in the above documentation and via interviews. The policy also outlines the agency's approach to preventing, detecting and responding to sexual abuse and sexual harassment allegations. The Director serves as the PCM. In addition to the PCM, there is a designated agency PREA Compliance Coordinator to ensure adherence to the PREA. The PCM reports to the agency PREA Compliance Coordinator (PCC). Zero-tolerance posters are displayed throughout every area of the facility. Agency and facility directives outline a zero-tolerance policy for all forms of sexual abuse and sexual harassment. Residents are informed orally about the zero-tolerance policy and the PREA program during in-processing and are required to view a video during admission and orientation presentations. Additional program information is contained in the Resident Handbook and is posted throughout the facility, as observed during the tour by this Auditor. PREA information is given to the resident in the intake packet. All PREA information, both video and written, is available in English and Spanish. Interpretive services are available for residents who do not speak or read English or Spanish. Both Center staff and residents are provided with multiple opportunities to become informed of PREA policies and procedures. All employees receive initial training and Annual Refresher Training (ART), as well as updates throughout the year.

Corrective action: None required

Standard 115.312: Contracting with other entities for the confinement of residents

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

115.312 (a)

- If this agency is public and it contracts for the confinement of its residents with private agencies or other entities including other government agencies, has the agency included the entity's obligation to adopt and 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 residents.) ☒ Yes ☐ No ☐ NA

115.312 (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 residents.) ☒ 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.

Evidence Reviewed (on-site visit, documentation, staff and inmate interviews):

1. SC Pre-Audit Questionnaire
2. Interviews with the following:
   a. Specialized Staff

The SC does not contract with other entities for the confinement of its residents.

Corrective action: None required

Standard 115.313: Supervision and monitoring

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

115.313 (a)

- Does the facility have a documented staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse?

- ☒ Yes ☐ No

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Generally accepted juvenile detention and correctional/secure residential practices? ☒ Yes ☐ No

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Any judicial findings of inadequacy? ☒ Yes ☐ No

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Any findings of inadequacy from Federal investigative agencies? ☒ Yes ☐ No

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Any findings of inadequacy from internal or external oversight bodies? ☒ Yes ☐ No

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: All components of the facility's physical plant (including "blind-spots" or areas where staff or residents may be isolated)? ☒ Yes ☐ No

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: The composition of the resident population? ☒ Yes ☐ No

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: The number and placement of supervisory staff? ☒ Yes ☐ No

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Institution programs occurring on a particular shift? ☒ Yes ☐ No

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Any applicable State or local laws, regulations, or standards? ☒ Yes ☐ No

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration the prevalence of substantiated and unsubstantiated incidents of sexual abuse? ☒ Yes ☐ No

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Any other relevant factors? ☒ Yes ☐ No

115.313 (b)

- Does the agency comply with the staffing plan except during limited and discrete exigent circumstances? ☒ Yes ☐ No

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

115.313 (c)

- Does the facility maintain staff ratios of a minimum of 1:8 during resident waking hours, except during limited and discrete exigent circumstances? (N/A if the facility is not a secure juvenile facility per the PREA standards definition of "secure".)
  ☒ Yes ☐ No ☐ NA

- Does the facility maintain staff ratios of a minimum of 1:16 during resident sleeping hours, except during limited and discrete exigent circumstances? (N/A if the facility is not a secure juvenile facility per the PREA standards definition of "secure".) ☒ Yes ☐ No ☐ NA

- Does the facility fully document any limited and discrete exigent circumstances during which the facility did not maintain staff ratios? (N/A if the facility is not a secure juvenile facility per the PREA standards definition of "secure".) ☒ Yes ☐ No ☐ NA

- Does the facility ensure only security staff are included when calculating these ratios? (N/A if the facility is not a secure juvenile facility per the PREA standards definition of "secure".)
  ☒ Yes ☐ No ☐ NA

- Is the facility obligated by law, regulation, or judicial consent decree to maintain the staffing ratios set forth in this paragraph? ☒ Yes ☐ No

115.313 (d)

- 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: Prevailing staffing patterns? ☒ 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

115.313 (e)

- Has the facility 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? (N/A for non-secure facilities) ☒ Yes ☐ No ☐ NA

- Is this policy and practice implemented for night shifts as well as day shifts? (N/A for non-secure facilities) ☒ Yes ☐ No ☐ NA

- Does the facility 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? (N/A for non-secure facilities) ☒ 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.

Evidence Reviewed (on-site visit, documentation, staff and inmate interviews):

1. SC Pre-Audit Questionnaire
2. Policy 560 Michigan Department of Health (MDH) Prevention of Resident Sexual Assault/Rape: Page 12
3. Staffing Plan Assessment SC 2019
4. Interviews with the following:
    a. Specialized and Random Staff

Agency policy requires each facility to review the staffing plans on an annual basis. Interviews with the Director revealed compliance with the PREA, and that other safety and security issues are always a primary focus when considering and reviewing respective staffing plans. The Director (also the PCM) meets weekly with his administrative staff to address staffing issues as it relates to the PREA. The facility has been provided with all necessary resources to support the programs and procedures to ensure compliance with PREA standards. The audit included an examination of all video monitoring systems, resident access to grievance forms, staff interviews and rosters. Supervisory and administrative staff members routinely make unannounced rounds covering all shifts and these rounds are documented. Interviews with staff confirmed unannounced rounds occur in all areas of the facility and are conducted on a weekly basis, with no warning to employees. The SC utilizes a number of video cameras to monitor the facility. The auditor observed these cameras during the facility tour. The facility also utilizes convex mirrors to supplement security in areas where there are numerous corners or potential blind spots.

Corrective action: None required

Standard 115.315: Limits to cross-gender viewing and searches

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

115.315 (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

115.315 (b)

- Does the facility always refrain from conducting cross-gender pat-down searches in non-exigent circumstances? ☒ Yes ☐ No ☐ NA

115.315 (c)

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

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

115.315 (d)

- Does the facility have policies that enable residents 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 have procedures that enable residents 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 a resident housing unit? ☒ Yes ☐ No

- In facilities (such as group homes) that do not contain discrete housing units, does the facility require staff of the opposite gender to announce their presence when entering an area where residents are likely to be showering, performing bodily functions, or changing clothing? (N/A for facilities with discrete housing units) ☒ Yes ☐ No ☐ NA

115.315 (e)

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

- If a resident's genital status is unknown, does the facility determine genital status during conversations with the resident, 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

115.315 (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 residents 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.

Evidence Reviewed (on-site visit, documentation, staff and inmate interviews):

1. SC Pre-Audit Questionnaire
2. Policy 560 Michigan Department of Health (MDH) Prevention of Resident Sexual Assault/Rape: Page 5
3. Policy 560 Michigan Department of Health (MDH) Prevention of Resident Sexual Assault/Rape: Page 6
4. PREA PowerPoint Training Slides
5. https://vimeo.com/183649683
6. https://vimeo.com/183649668
7. Interviews with the following:

a. Specialized and Random Staff

Policies and documentation address this standard. Cross-gender strip or cross-gender body cavity searches are prohibited, except in emergency situations or when performed and documented by a medical practitioner. Staff interviewed indicated they received cross-gender pat search training during initial and annual training. The Auditor observed that each unit has individual shower stalls and residents must shower one at a time. The scheduling of showers is monitored by staff. The facility has implemented a policy that all staff working the unit will announce themselves prior to entering the unit to allow residents the opportunity to prepare themselves from a privacy perspective. The residents interviewed acknowledged they can shower, dress and use the toilet privately, without being viewed by the staff of the opposite gender. Staff members were aware of the policy prohibiting the search of a transgender or intersex resident for the sole purpose of determining their genital status. During the past 12 months, there were no exigent circumstances that required cross-gender viewing of a resident by a staff member at the SC.

Corrective action: None

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

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

115.316 (a)

- Does the agency take appropriate steps to ensure that residents 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: Residents who are deaf or hard of hearing? ☒ Yes ☐ No

- Does the agency take appropriate steps to ensure that residents 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: Residents who are blind or have low vision? ☒ Yes ☐ No

- Does the agency take appropriate steps to ensure that residents 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: Residents who have intellectual disabilities? ☒ Yes ☐ No

- Does the agency take appropriate steps to ensure that residents 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: Residents who have psychiatric disabilities? ☒ Yes ☐ No

- Does the agency take appropriate steps to ensure that residents 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: Residents who have speech disabilities? ☒ Yes ☐ No

- Does the agency take appropriate steps to ensure that residents 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 residents 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 residents with disabilities including residents 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 residents with disabilities including residents 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 residents with disabilities including residents who: Are blind or have low vision? ☒ Yes ☐ No

115.316 (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 residents 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

115.316 (c)

- Does the agency always refrain from relying on resident interpreters, resident readers, or other types of resident assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the resident's safety, the performance of first-response duties under §115.364, or the investigation of the resident'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.

Evidence Reviewed (on-site visit, documentation, staff and inmate interviews):

1. SC Pre-Audit Questionnaire
2. Policy 560 Michigan Department of Health (MDH) Prevention of Resident Sexual Assault/Rape: Page 3; Section A2
3. Bromberg & Associates (Translation Services)
4. Linguistica International Contract # 171180000001163
5. Screening tool - Arabic.pdf
6. Screening tool - Spanish.pdf
7. Youth Orientation Packet - Arabic.pdf
8. Youth Orientation Packet - Spanish.pdf
9. Employee Training Acknowledgements
10. Youth Orientation Manual
11. 2019 Annual Training Curriculum
12. Interviews with the following:
    Specialized and Random Staff

SC takes appropriate steps to ensure residents with disabilities and residents with Limited English Proficiency (LEP) have an opportunity to participate in and benefit from the facility's efforts to prevent, detect and respond to sexual abuse and sexual harassment. PREA handouts, bulletin board postings and resident handbooks are in both English and Spanish. The above-mentioned documents were submitted to and reviewed by the Auditor. Interviewed staff members were aware of the policy that, under no circumstances, is any resident interpreter or assistant to be used when dealing with PREA issues. Translation services are provided by Linguistica International and are available to residents who do not have a basic command of the English language. There were no LEP residents at the facility at the time of the audit. The review of documentation and staff and resident interviews support a finding that the facility is in compliance with this standard.

Corrective action: None required

Standard 115.317: Hiring and promotion decisions

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

115.317 (a)

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

115.317 (b)

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

- Does the agency consider any incidents of sexual harassment in determining whether to enlist the services of any contractor who may have contact with residents? ☒ Yes ☐ No

115.317 (c)

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

- Before hiring new employees, who may have contact with residents, does the agency consult any child abuse registry maintained by the State or locality in which the employee would work? ☒ Yes ☐ No

- Before hiring new employees who may have contact with residents, 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

115.317 (d)

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

- Does the agency consult applicable child abuse registries before enlisting the services of any contractor who may have contact with residents? ☒ Yes ☐ No

115.317 (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 residents or have in place a system for otherwise capturing such information for current employees? ☒ Yes ☐ No

115.317 (f)

- Does the agency ask all applicants and employees who may have contact with residents 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 residents 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

115.317 (g)

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

115.317 (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.

Evidence Reviewed (on-site visit, documentation, staff and inmate interviews):

1. SC Pre-Audit Questionnaire
2. Policy 560 Michigan Department of Health (MDH) Prevention of Resident Sexual Assault/Rape
3. Policy JR1 100: Screening & Ongoing Checks for Staff
4. Review of Employee, Contractor, and Volunteer Background Checks (5 Examples)
5. JJ Residential Glossary
6. Interviews with the following:
    a. Specialized and Random Staff

Policies and interviews confirm compliance with this standard. Five employee files were randomly selected for review regarding this standard. A Human Resource Representative was interviewed, stating that all components of this standard have been met. Background checks have been completed on all employees, contractors, and volunteers. The MDHHS conducts background checks. Background checks must be cleared before an individual's hiring/promotion status will be approved. The State of Michigan requires that background checks on all employees are conducted every year. The policy clearly states the submission of false information by any applicant is grounds for termination. The agency makes its best efforts to contact all prior institution employers for information regarding substantiated allegations of sexual abuse or resignations occurring during a pending investigation of sexual abuse. The agency also provides information on substantiated allegations of sexual abuse/sexual harassment involving former employees, when requested by a potential institutional employer, unless prohibited by law. Appropriate licensing and certifying agencies are notified when professional employees are terminated for substantiated allegations of sexual abuse/sexual harassment. Documentation on file supports a finding that the facility is in compliance with this standard.

Corrective action: None required

Standard 115.318: Upgrades to facilities and technologies

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

115.318 (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 residents 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

115.318 (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 residents 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.

Evidence Reviewed (on-site visit, documentation, staff and inmate interviews):

1. Interviews with the following:
   a. Director

Policies and interviews confirm compliance with this standard. There were no facility upgrades, but there were technology modifications and/or upgrades during the auditing period. SC utilizes a video camera system for video surveillance. Cameras are placed strategically

throughout the facility to ensure the safety and security of both residents and staff. The facility has purchased numerous cameras and/or implemented camera upgrades. Presently the facility has 180 cameras to provide security to the facility.

Corrective action: None required

RESPONSIVE PLANNING

Standard 115.321: Evidence protocol and forensic medical examinations

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

115.321 (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

115.321 (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

115.321 (c)

- Does the agency offer all residents who experience 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

115.321 (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? (N/A if the agency *always* makes a victim advocate from a rape crisis center available to victims.) ☐ Yes ☐ No ☒ NA

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

115.321 (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

115.321 (f)

- If the agency itself is not responsible for investigating allegations of sexual abuse, has the agency requested that the investigating agency 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

115.321 (g)

- Auditor is not required to audit this provision.

115.321 (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 *always* makes a victim advocate from a rape crisis center available to victims.) ☐ 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.

Evidence Reviewed (on-site visit, documentation, staff and inmate interviews):

1. SC Pre-Audit Questionnaire
2. Policy 560 Michigan Department of Health (MDH) Prevention of Resident Sexual Assault/Rape
3. Michigan Model Policy: The Law Enforcement Response to Sexual Assault
4. Memorandum of Understanding (MOU) with River House, Inc.
5. Memorandum of Understanding (MOU) with Michigan State Police (MSP)
6. PREA Response Plan SC
7. Interviews with the following:
    a. Specialized and Random Staff

Policies and interviews confirm compliance with this standard. The facility has a fulltime infirmary for medical services. Forensic medical examinations are conducted off-grounds at Mercy Hospital (MH), located in Grayling, Michigan. All staff members have been trained in evidence protocol. In the event of a sexual assault, the Shift Supervisor is notified, followed by the Director. The Director determines when the resident should be transported to the hospital for a Sexual Assault Nurse Examiner (SANE) examination, or other medical treatment. The facility has a MOU with River House, Inc. for the provision of quality and comprehensive services for victims of sexual assault. The Hotline number is posted in each housing unit. All criminal investigations are conducted by the Michigan State Police (MSP). Administrative investigations are conducted by a trained investigator on-site.

Corrective action: None required

Standard 115.322: Policies to ensure referrals of allegations for investigations

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

115.322 (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

115.322 (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

115.322 (c)

- If a separate entity is responsible for conducting criminal investigations, does the policy describe the responsibilities of both the agency and the investigating entity? (N/A if the agency/facility is responsible for criminal investigations. See 115.321(a).) ☒ Yes ☐ No ☐ NA

115.322 (d)

- Auditor is not required to audit this provision.

115.322 (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.

Evidence Reviewed (on-site visit, documentation, staff and inmate interviews):

1. SC Pre-Audit Questionnaire
2. Memorandum of Understanding (MOU) with River House, Inc.
3. Policy 560 Michigan Department of Health (MDH) Prevention of Resident Sexual Assault/Rape
4. Policy JR1 173 Investigation Protocol
5. PREA Response Plan
6. Interviews with the following:
    a. Random and Specialized Staff

Staff members, including medical personnel, were interviewed concerning this standard and all were knowledgeable of the procedures required to secure and obtain usable physical evidence when sexual abuse is alleged. Staff members were also aware that either the Investigator or the Michigan State Police (MSP) investigates all sexual abuse allegations. All forensic medical examinations are conducted by SANE staff at Mercy Hospital (MH). A telephonic interview with the SANE representative at MH was conducted and the contract provider is aware of the provisions of the PREA standards. The representative indicated that a SANE is available 24 hours a day, seven days a week. There were no SANE examinations conducted during the past 12 months. The Rape, Abuse and Incest National Network (RAINN) and Justice Detention International (JDI), both national victim advocacy agencies, were contacted by this Auditor. Neither had information related to SC. River House, Inc. was contacted regarding advocacy services for residents at Shawono Center. The Memorandum of Understanding (MOU) was reviewed for compliance with the standard. The MOU was confirmed to be in effect at the time of the on-site audit.

Corrective action: None required

TRAINING AND EDUCATION

Standard 115.331: Employee training

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

115.331 (a)

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

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

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

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

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

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

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

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

- Does the agency train all employees who may have contact with residents on relevant laws regarding the applicable age of consent? ☒ Yes ☐ No

115.331 (b)

- Is such training tailored to the unique needs and attributes of residents of juvenile facilities? ☒ Yes ☐ No

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

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

115.331 (c)

- Have all current employees who may have contact with residents 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

115.331 (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.

Evidence Reviewed (on-site visit, documentation, staff and inmate interviews):

1. SC Pre-Audit Questionnaire
2. Policy JR1 170 Staff Development and Training
3. Policy 560 Michigan Department of Health (MDH) Prevention of Resident Sexual Assault/Rape
4. SC Schematic-Surveillance Camera Locations
5. SC Residential Module Layout
6. Shawono Center PREA Refresher: Juvenile Detention PREA Basics
7. Shawono Center PREA Refresher: Juvenile Detention Handling Disclosures of Abuse
8. Shawano Center PREA Refresher: Juvenile Detention Professional Communication and Boundaries
9. Shawono Center PREA Refresher: Juvenile Detention Resident Privacy
10. Shawono Center PREA Refresher: Juvenile Detention Ways Residents Can Report
11. Shawono Center PREA Refresher: Juvenile Detention Resident Support Services
12. Shawono Center PREA Refresher: Juvenile Detention Helping Residents Who Primarily Speak Another Language
13. Shawono Center PREA Refresher: Juvenile Detention Duty to Report: Knowledge, Suspicion, or Information
14. Shawono Center PREA Refresher: Juvenile Detention First Responder Duties

15. Shawono Center PREA Refresher: Juvenile Detention Completing a PREA Incident Report
16. Shawono Center PREA Refresher: Juvenile Detention Investigations
17. Shawono Center PREA Refresher: Juvenile Detention Encouraging Residents to Report Sexual Abuse
18. Shawono Center PREA Refresher: Juvenile Detention Monitoring for Safety and Security
19. Yearly Cycle Training Verification Form
20. Yearly Cycle Training Verification Form (examples)
21. SC Coordinated Response Plan
22. Interviews with the following:
    a. Specialized and Random Staff

Shawono Center provides extensive PREA training at this facility. All newly hired employees must attend and successfully complete the course curriculum. All employees were aware of PREA First Responder's responsibilities in the event of a reported PREA concern. All staff members are mandated to receive training annually and the curriculum includes an extensive review of PREA requirements. The training curriculum, training sign-in sheets, and other related training documentation were reviewed by the Auditor. Interviewed staff verified the requirement to acknowledge, in writing, not only that they received PREA training, but that they understood it.

Corrective action: None required

Standard 115.332: Volunteer and contractor training

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

115.332 (a)

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

115.332 (b)

- Have all volunteers and contractors who have contact with residents 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 residents)? ☒ Yes ☐ No

115.332 (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.

Evidence Reviewed (on-site visit, documentation, staff and inmate interviews):

1. SC Pre-Audit Questionnaire
2. Policy 560 Michigan Department of Health (MDH) Prevention of Resident Sexual Assault/Rape
3. Policy JR1 170 Staff Development and Training
4. Current and Active Volunteer and Contactor Roster
5. PREA Volunteer and Contractor Sign-off Sheet
6. PREA Volunteer and Contractor Sign-off Sheet (examples)
7. PREA Training Sign-in Sheets
8. Interviews with the following:
    a. Specialized and Random Staff

Policies, Annual Training 2019 Lesson Plan and Annual Training 2019 Agenda/Presentation address the mandates of this standard. All contractors and volunteers received the PREA training, including the zero-tolerance policy, reporting and responding requirements. The training is documented and maintained on file. Copies of training sign-in sheets and other related documents were reviewed by the Auditor at the facility. At the time of the audit, there were no volunteers available to be interviewed. The Auditor interviewed one contractor.

Corrective action: None required

Standard 115.333: Resident education

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

115.333 (a)

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

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

- Is this information presented in an age-appropriate fashion? ☒ Yes ☐ No

115.333 (b)

- Within 10 days of intake, does the agency provide age-appropriate comprehensive education to residents either in person or through video regarding: Their rights to be free from sexual abuse and sexual harassment? ☒ Yes ☐ No

- Within 10 days of intake, does the agency provide age-appropriate comprehensive education to residents either in person or through video regarding: Their rights to be free from retaliation for reporting such incidents? ☒ Yes ☐ No

- Within 10 days of intake, does the agency provide age-appropriate comprehensive education to residents either in person or through video regarding: Agency policies and procedures for responding to such incidents? ☒ Yes ☐ No

115.333 (c)

- Have all residents received the comprehensive education referenced in 115.333(b)? ☒ Yes ☐ No

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

115.333 (d)

- Does the agency provide resident education in formats accessible to all residents including those who: Are limited English proficient? ☒ Yes ☐ No

- Does the agency provide resident education in formats accessible to all residents including those who: Are deaf? ☒ Yes ☐ No

- Does the agency provide resident education in formats accessible to all residents including those who: Are visually impaired? ☒ Yes ☐ No

- Does the agency provide resident education in formats accessible to all residents including those who: Are otherwise disabled? ☒ Yes ☐ No
- Does the agency provide resident education in formats accessible to all residents including those who: Have limited reading skills? ☒ Yes ☐ No

115.333 (e)

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

115.333 (f)

- In addition to providing such education, does the agency ensure that key information is continuously and readily available or visible to residents through posters, resident 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.

Evidence Reviewed (on-site visit, documentation, staff and inmate interviews):

1. SC Pre-Audit Questionnaire
2. PREA PowerPoint Training Presentation
3. Policy 560 Michigan Department of Health (MDH) Prevention of Resident Sexual Assault/Rape
4. Youth Handbook
5. PREA Youth Curriculum with Videos
6. MDHHS - 5605 Juvenile Justice Residential Youth Orientation Checklist/Signature Sheets
7. Youth Training Signature Acknowledgement Sheets
8. Youth Orientation Manual
9. Receipt of PREA Training (examples)
10. Screening Tool: Risk of Victimization
11. Treatment Team Minutes
12. Updated Youth Treatment Plans (5 examples)
13. Interviews with the following:
    a. Specialized and Random Staff
    b. Residents

Policies, training curriculum, signed acknowledgments, and Orientation Checklist/Signature Sheets address the mandates of this standard. The facility puts forth its best efforts to educate the residents regarding the PREA. Residents receive information during the intake process including a Youth Handbook, printed in English and Spanish. A staff member conducts an education program regarding the PREA for all residents within 30 days of their arrival at the facility. The program includes definitions of sexually abusive behavior and sexual harassment, prevention strategies, and reporting modalities. Residents also view a comprehensive orientation video that explains the facility's zero-tolerance policy and covers the resident's right to be free from sexual abuse, sexual harassment, and retaliation. There are PREA posters displayed throughout the facility and in each housing unit. These posters offer a "Hotline" telephone number, which may be called to report sexual abuse or sexual harassment. Since the "Hotline" telephone number is an 800-toll-free number, residents are advised that they can contact any staff member to place the call. PREA information is posted in the Resident Handbook and posted in each housing unit for resident correspondence concerning any sexual abuse or sexual harassment allegation. There is also a translation language line available to LEP residents. The Auditor was provided a random sampling of PREA Checklists/Signature Sheets to verify that residents, admitted during the auditing period, received education and relevant written materials. All residents are required to acknowledge, in writing, completion of PREA education. During the interview process, randomly selected residents indicated they received information about the facility's rules against sexual abuse/sexual harassment when they arrived at the facility. They further indicated they were advised about their right not to be sexually abused/sexually harassed, how to report sexual abuse/sexual harassment and their right not be punished for reporting sexual abuse/sexual harassment. Residents were aware of available services outside of the facility for dealing with sexual abuse.

Corrective action: None required

Standard 115.334: Specialized training: Investigations

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

115.334 (a)

- In addition to the general training provided to all employees pursuant to §115.331, 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 115.321(a).)
  ☒ Yes ☐ No ☐ NA

115.334 (b)

- Does this specialized training include techniques for interviewing juvenile sexual abuse victims? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(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 115.321(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 115.321(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 115.321(a).) ☒ Yes ☐ No ☐ NA

115.334 (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 115.321(a).) ☒ Yes ☐ No ☐ NA

115.334 (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.

Evidence Reviewed (on-site visit, documentation, staff and inmate interviews):

1. SC Pre-Audit Questionnaire
2. Investigator Certification
3. Policy 560 Michigan Department of Health (MDH) Prevention of Resident Sexual Assault/Rape
4. Interviews with the following:
   a. Specialized and Random Staff

Preliminary gathering of information in suspected PREA related incidents is conducted by the Investigator. Criminal investigations are conducted outside of the facility by the MSP. There were five allegations of sexual abuse/sexual harassment in the past twelve months. A comprehensive review of documentation in all five cases was conducted by the Auditor and revealed the investigative rulings as follows: three allegations were found to be substantiated and two allegations were determined to be unfounded. Investigative documentation indicates that the facility took appropriate action based on policies and procedures outlined by the MDHHS.

Corrective action: None required

Standard 115.335: Specialized training: Medical and mental health care

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

115.335 (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? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)
  ☒ Yes ☐ No ☐ NA

- 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? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.) ☒ Yes ☐ No ☐ NA

- 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 juvenile victims of sexual abuse and sexual harassment? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.) ☒ Yes ☐ No ☐ NA

- 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? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)
  ☒ Yes ☐ No ☐ NA

115.335 (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 *or* the agency does not employ medical staff.)
  ☐ Yes ☐ No ☒ NA

115.335 (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? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.) ☒ Yes ☐ No ☐ NA

115.335 (d)

- Do medical and mental health care practitioners employed by the agency also receive training mandated for employees by §115.331? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)
  ☒ Yes ☐ No ☐ NA

- Do medical and mental health care practitioners contracted by or volunteering for the agency also receive training mandated for contractors and volunteers by §115.332? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners contracted by or volunteering for the agency.) ☒ 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.

Evidence Reviewed (on-site visit, documentation, staff and inmate interviews):

1. SC Pre-Audit Questionnaire
2. Policy 560 Michigan Department of Health (MDH) Prevention of Resident Sexual Assault/Rape
3. Training Verification Report
4. Risk of Screening Victimization Tool
5. Interviews with the following:
   a. Specialized and Random Staff

Policies, Annual Training Lesson Plan and PowerPoint Presentation address the mandates of this standard. Other training includes online specialized training for psychologists and victim advocacy training. The agency ensures all full and part-time medical and mental health

practitioners, who work regularly in its facilities, have been trained according to the practitioner's status in the organization. All mental health and medical staff have received the required specialized training on victim identification, interviewing, reporting and clinical interventions. Employees receive training annually and support documentation is on file. Medical and mental health care staff acknowledged, in writing, that they both received and understood the training, as it relates to the PREA. Interviews with medical and mental health staff confirmed awareness of their responsibilities regarding the PREA. All cases requiring the processing of sexual assault evidence collection kits are transported to Mercy Hospital where a SANE is available at all times (a SANE at MH was interviewed and confirmed access to these services). A review of the training documentation and policy confirm compliance with this standard.

Corrective action: None required

SCREENING FOR RISK OF SEXUAL VICTIMIZATION AND ABUSIVENESS

Standard 115.341: Screening for risk of victimization and abusiveness

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

115.341 (a)

- Within 72 hours of the resident's arrival at the facility, does the agency obtain and use information about each resident's personal history and behavior to reduce risk of sexual abuse by or upon a resident? ☒ Yes ☐ No

- Does the agency also obtain this information periodically throughout a resident's confinement? ☒ Yes ☐ No

115.341 (b)

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

115.341 (c)

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (1) Prior sexual victimization or abusiveness? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (2) Any gender nonconforming appearance or manner or identification as lesbian, gay, bisexual, transgender, or intersex, and whether the resident may therefore be vulnerable to sexual abuse? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (3) Current charges and offense history? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (4) Age? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (5) Level of emotional and cognitive development? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (6) Physical size and stature? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (7) Mental illness or mental disabilities? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (8) Intellectual or developmental disabilities? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (9) Physical disabilities? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (10) The residents' own perception of vulnerability? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (11) Any other specific information about individual residents that may indicate heightened needs for supervision, additional safety precautions, or separation from certain other residents? ☒ Yes ☐ No

115.341 (d)

- Is this information ascertained through conversations with the resident during the intake process and medical mental health screenings? ☒ Yes ☐ No

- Is this information ascertained during classification assessments? ☒ Yes ☐ No

- Is this information ascertained by reviewing court records, case files, facility behavioral records, and other relevant documentation from the resident's files? ☒ Yes ☐ No

115.341 (e)

- 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 resident's detriment by staff or other residents? ☒ 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.

Evidence Reviewed (on-site visit, documentation, staff and inmate interviews):

1. SC Pre-Audit Questionnaire
2. Policy 560 Michigan Department of Health (MDH) Prevention of Resident Sexual Assault/Rape
3. Policy JR5 503 Suicide Prevention
4. PREA Screening Tool (form MDHHS - 5606)
5. Staff Training Agenda 2019 Annual Refresher Training
6. Training Logs/Records for Medical and Mental Health Practitioners
7. Interviews with the following:
    a. Specialized and Random Staff

The policy addresses the requirements of this standard. Agency and facility policy require the use of a screening instrument to determine proper housing, bed assignment, work assignment, education, and other program assignments, with the goal of keeping residents at a high risk of being sexually abused/sexually harassed separate from those residents who are at a high risk of being sexually abusive. Facility policy also requires all residents to be screened within 72 hours of arrival; however, they are routinely screened on the day of arrival. Risk management staff review all relevant pre-sentence documentation and information from other confinement facilities and reassess a resident's risk level, as necessary, within 30 days of arrival. Agency policy prohibits residents from being disciplined for refusing to answer, or for not disclosing complete information in response to questions regarding their mental/physical health, developmental disability, sexual preferences, sexual victimization history and perception of vulnerability. Housing and program assignments are made on a case-by-case basis and residents are not placed in housing units based solely on their sexual identification or status. Interviews with risk management staff and a random review of risk screening assessments support the finding that the facility is in compliance with this standard.

Corrective action: None required

Standard 115.342: Use of screening information

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

115.342 (a)

- Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Housing Assignments? ☒ Yes ☐ No

- Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Bed assignments? ☒ Yes ☐ No

- Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Work Assignments? ☒ Yes ☐ No

- Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Education Assignments? ☒ Yes ☐ No

- Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Program Assignments? ☒ Yes ☐ No

115.342 (b)

- Are residents isolated from others only as a last resort when less restrictive measures are inadequate to keep them and other residents safe, and then only until an alternative means of keeping all residents safe can be arranged? (N/A if the facility *never* places residents in isolation for any reason.) ☒ Yes ☐ No ☐ NA

- During any period of isolation, does the agency always refrain from denying residents daily large-muscle exercise? (N/A if the facility *never* places residents in isolation for any reason.) ☒ Yes ☐ No ☐ NA

- During any period of isolation, does the agency always refrain from denying residents any legally required educational programming or special education services? (N/A if the facility *never* places residents in isolation for any reason.) ☒ Yes ☐ No ☐ NA

- Do residents in isolation receive daily visits from a medical or mental health care clinician? (N/A if the facility *never* places residents in isolation for any reason.) ☒ Yes ☐ No ☐ NA

- Do residents in isolation also have access to other programs and work opportunities to the extent possible? (N/A if the facility *never* places residents in isolation for any reason.) ☒ Yes ☐ No ☐ NA

115.342 (c)

- Does the agency always refrain from placing lesbian, gay, and bisexual (LGB) residents in particular housing, bed, or other assignments solely on the basis of such identification or status? ☒ Yes ☐ No

- Does the agency always refrain from placing transgender residents in particular housing, bed, or other assignments solely on the basis of such identification or status? ☒ Yes ☐ No

- Does the agency always refrain from placing intersex residents in particular housing, bed, or other assignments solely on the basis of such identification or status? ☒ Yes ☐ No

- Does the agency always refrain from considering lesbian, gay, bisexual, transgender, or intersex (LGBTI) identification or status as an indicator or likelihood of being sexually abusive? ☒ Yes ☐ No

115.342 (d)

- When deciding whether to assign a transgender or intersex resident to a facility for male or female residents, does the agency consider, on a case-by-case basis, whether a placement would ensure the resident's health and safety, and whether a placement would present management or security problems (NOTE: if an agency by policy or practice assigns residents 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 residents, does the agency consider, on a case-by-case basis, whether a placement would ensure the resident's health and safety, and whether a placement would present management or security problems? ☒ Yes ☐ No

115.342 (e)

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

115.342 (f)

- Are each transgender or intersex resident'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

115.342 (g)

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

115.342 (h)

- If a resident is isolated pursuant to provision (b) of this section, does the facility clearly document: The basis for the facility's concern for the resident's safety? (N/A if the facility *never* places residents in isolation for any reason.) ☒ Yes ☐ No ☐ NA

- If a resident is isolated pursuant to provision (b) of this section, does the facility clearly document: The reason why no alternative means of separation can be arranged? (N/A if the facility *never* places residents in isolation for any reason.) ☒ Yes ☐ No ☐ NA

115.342 (i)

- In the case of each resident who is isolated as a last resort when less restrictive measures are inadequate to keep them and other residents safe, does the facility afford a review to determine whether there is a continuing need for separation from the general population EVERY 30 DAYS? (N/A if the facility *never* places residents in isolation for any reason.)
  ☒ 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.

Evidence Reviewed (on-site visit, documentation, staff and inmate interviews):

1. SC Pre-Audit Questionnaire
2. Policy 560 Michigan Department of Health (MDH) Prevention of Resident Sexual Assault/Rape: Page 4; Section B; Subsection 3
3. Policy 560 Michigan Department of Health (MDH) Prevention of Resident Sexual Assault/Rape: Page 4; Section B; Subsection 5
4. Policy 560 Michigan Department of Health (MDH) Prevention of Resident Sexual Assault/Rape: Page 4; Section B; Subsection 4d
5. Policy JR5 503 Suicide Prevention
6. PREA Screening Tool
7. Staff Training Agenda 2019 Annual Refresher Training
8. Interviews with the following:
   a. Specialized and Random Staff

Policy, documentation, and interviews support compliance with this standard. Agency and facility policy require the use of a screening instrument to determine proper housing, bed assignment, work assignment, education, and other program assignments, with the goal of keeping inmates at a high risk of being sexually abused/sexually harassed separate from those inmates who are at a high risk of being sexually abusive. Housing and program assignments are made on a case-by-case basis and residents are not placed in housing units based solely on their sexual identification or status. From the information provided by the facility, there were three residents who self-identified as being bisexual, gay, transgender or intersex. Additionally, two residents indicated sexual victimization or abusiveness during risk screening. All residents were interviewed in those categories in support of this standard.

During the audit, risk management staff indicated transgender and intersex residents are reassessed monthly and their own views with respect to their own safety are given serious consideration. Additionally, they are given the opportunity to shower separately from other residents. Seclusion is only used in an emergency, when the resident, due to his current behavior, poses an imminent risk of harm to himself and/or others. Seclusion is not used as a means of punishment, discipline, coercion, convenience or retaliation, nor is it used to supplement the lack of staff presence or competency. The Director shall ensure that seclusion is implemented only as authorized and in accordance with the provisions set forth in MDHHS. The Director is responsible for ensuring that abusive and arbitrary use of seclusion does not occur in the program. The Director ensures that program staff members are sufficiently trained in the proper implementation and subsequent documentation. Per an interview with the Director, residents cannot be kept in seclusion for longer than 72 hours. During that time, the resident is monitored every ten minutes. Residents may be released from seclusion anytime before the 72 hours expires if they demonstrate control of their emotional state. Staff and resident interviews, the review of supporting documentation and the Auditor's observations support the facility being in compliance with the standard.

Corrective action: None required

REPORTING

Standard 115.351: Resident reporting

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

115.351 (a)

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

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

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

115.351 (b)

- Does the agency also provide at least one way for residents 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 resident reports of sexual abuse and sexual harassment to agency officials? ☒ Yes ☐ No

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

- Are residents detained solely for civil immigration purposes provided information on how to contact relevant consular officials and relevant officials at the Department of Homeland Security to report sexual abuse or harassment? (N/A if the facility *never* houses residents detained solely for civil immigration purposes.) ☐ Yes ☐ No ☒ NA

115.351 (c)

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

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

115.351 (d)

- Does the facility provide residents with access to tools necessary to make a written report? ☒ Yes ☐ No

- Does the agency provide a method for staff to privately report sexual abuse and sexual harassment of residents? ☒ 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.

Evidence Reviewed (on-site visit, documentation, staff and inmate interviews):

1. SC Pre-Audit Questionnaire
2. Policy 560 Michigan Department of Health (MDH) Prevention of Resident Sexual Assault/Rape: Page 6-7; Section E
3. Policy 560 Michigan Department of Health (MDH) Prevention of Resident Sexual Assault/Rape: Page 6; Section E; Subsection 1
4. Policy 560 Michigan Department of Health (MDH) Prevention of Resident Sexual Assault/Rape: Page 7; Section F; Subsection 1
5. Policy 560 Michigan Department of Health (MDH) Prevention of Resident Sexual Assault/Rape: Page 8; Section F; Subsection 2
6. Policy 560 Michigan Department of Health (MDH) Prevention of Resident Sexual Assault/Rape: Page 5; Section C: Staff Training; Subsections 1 and 2
7. SC PREA Response Plan
8. Signage - Children's Protective Services Sexual Abuse Hotline Number
9. Signage: River House, Inc. Hotline Number
10. Risk of Victimization Screening Tool
11. Grievance Form
12. Youth Orientation Packet
13. Juvenile Justice Residential Youth Orientation Checklist (Form MDHHS-5605)
14. Interviews with the following:
    a. Specialized and Random Staff
    b. Residents

Policies, the PREA Notices, and Youth Handbook address the requirements of the standard. A review of supporting documentation and staff/resident interviews indicates that there are multiple ways (verbally, in writing, anonymously, privately and from a third party) for inmates to report sexual abuse/sexual harassment. The facility has procedures in place for staff to document all allegations. There are posters and other documents on display throughout the facility which also explain reporting methods. Staff members promptly accept and document all verbal, written, anonymous, private and third-party reports of the alleged abuse. Family and friends of residents may report sexual abuse/sexual harassment by contacting facility staff, calling the PREA Hotline, or other third-party personnel. All interviewed residents confirmed awareness of the multiple methods of reporting sexual abuse/assault allegations. Interviews with staff and residents, observations of posters addressing reporting methods and an examination of policy/documentation confirm the facility's compliance with this standard.

Corrective action: None required

Standard 115.352: Exhaustion of administrative remedies

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

115.352 (a)

- Is the agency exempt from this standard? NOTE: The agency is exempt ONLY if it does not have administrative procedures to address resident grievances regarding sexual abuse. This does not mean the agency is exempt simply because a resident 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

115.352 (b)

- Does the agency permit residents 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 a resident 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

115.352 (c)

- Does the agency ensure that: A resident 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

115.352 (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 residents in preparing any administrative appeal.) (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- If the agency determines that the 90-day timeframe is insufficient to make an appropriate decision and claims an extension of time [the maximum allowable extension of time to respond is 70 days per 115.352(d)(3)], does the agency notify the resident 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 resident does not receive a response within the time allotted for reply, including any properly noticed extension, may a resident 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

115.352 (e)

- Are third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, permitted to assist residents 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 residents? (If a third party, other than a parent or legal guardian, files such a request on behalf of a resident, the facility may require as a condition of processing the request that the alleged victim agree to have the request filed on his or her behalf, and may also require the alleged victim to personally pursue any subsequent steps in the administrative remedy process.) (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

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

- Is a parent or legal guardian of a juvenile allowed to file a grievance regarding allegations of sexual abuse, including appeals, on behalf of such juvenile? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- If a parent or legal guardian of a juvenile files a grievance (or an appeal) on behalf of a juvenile regarding allegations of sexual abuse, is it the case that those grievances are not conditioned upon the juvenile agreeing to have the request filed on his or her behalf? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

115.352 (f)

- Has the agency established procedures for the filing of an emergency grievance alleging that a resident 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 a resident 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 resident 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

115.352 (g)

- If the agency disciplines a resident for filing a grievance related to alleged sexual abuse, does it do so ONLY where the agency demonstrates that the resident 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.

Evidence Reviewed (on-site visit, documentation, staff and inmate interviews):

1. SC Pre-Audit Questionnaire
2. Policy 560 Michigan Department of Health (MDH) Prevention of Resident Sexual Assault/Rape: Page 12-13; Section J
3. Policy 560 Michigan Department of Health (MDH) Prevention of Resident Sexual Assault/Rape: Page 7; Section E; Subsection 5
4. Policy 560 Michigan Department of Health (MDH) Prevention of Resident Sexual Assault/Rape: Page 13; Section J; Subsection 1
5. Policy 560 Michigan Department of Health (MDH) Prevention of Resident Sexual Assault/Rape: Page 13; Section J; Subsection 4
6. Policy 560 Michigan Department of Health (MDH) Prevention of Resident Sexual Assault/Rape: Page 3; Section A; Subsection 1g
7. SC Youth Grievance Form

8. Youth Handbook
9. Interviews with the following:
    a. Specialized and Random Staff
    b. Residents

Policies and interviews address the requirements of this standard. The policy requires that all PREA grievances be processed in accordance with 115.52a-f. Residents may file a grievance; however, all allegations of sexual abuse/sexual harassment, when received by staff, will immediately be referred for investigation. Residents are not required to use an informal grievance process and procedures also allow a resident to submit a grievance alleging sexual abuse without submitting it to the staff member who is the subject of the complaint. Additionally, the policy prohibits the investigation of the allegation by either staff alleged to be involved in the incident or any staff who may be under their supervision. The policy states that there is no time frame for filing a grievance relating to sexual abuse or sexual harassment. Allegations of physical abuse by staff shall be referred to the MSP, in accordance with procedures established for such referrals. The policy addresses the filing of emergency grievance requests. If a resident files the emergency grievance with the institution and believes he is under a substantial risk of imminent sexual abuse, an expedited response is required to be provided within 48 hours. There is no prohibition that limits third parties, including fellow residents, staff members, family members, attorneys and outside victim advocates in assisting residents in filing requests for grievances relating to allegations of sexual abuse or filing such requests on behalf of residents. There were no grievances filed involving PREA related issues during the past 12 months. There were no grievances alleging sexual abuse that involved an extension due to the final decision not being reached within 90 days. Additionally, there were no grievances alleging sexual abuse filed by residents in which the resident declined third-party assistance. Residents are held accountable for manipulative behavior and false allegations. Generally, disciplinary action would be taken if a grievance was filed in bad faith.

Corrective action: None required

Standard 115.353: Resident access to outside confidential support services and legal representation

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

115.353 (a)

- Does the facility provide residents with access to outside victim advocates for emotional support services related to sexual abuse by providing, posting, or otherwise making assessible 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? (N/A if the facility *never* has persons detained solely for civil immigration purposes.) ☐ Yes ☐ No ☒ NA

- Does the facility enable reasonable communication between residents and these organizations and agencies, in as confidential a manner as possible? ☒ Yes ☐ No

115.353 (b)

- Does the facility inform residents, prior to giving them access, of the extent to which such communications will be monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws? ☒ Yes ☐ No

115.353 (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 residents 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

115.353 (d)

- Does the facility provide residents with reasonable and confidential access to their attorneys or other legal representation? ☒ Yes ☐ No

- Does the facility provide residents with reasonable access to parents or legal guardians? ☒ 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.

Evidence Reviewed (on-site visit, documentation, staff and inmate interviews):

1. SC Pre-Audit Questionnaire

2. Policy 560 Michigan Department of Health (MDH) Prevention of Resident Sexual Assault/Rape: Page 6-7; Section E; Subsection 2
3. Policy 560 Michigan Department of Health (MDH) Prevention of Resident Sexual Assault/Rape: Page 3; Section A; Subsection 7
4. Youth Handbook
5. MOU with River House, Inc.
6. PREA Screening Tool
9. Interviews with the following:
    a. Specialized and Random Staff
    b. Residents

Policies and the Resident Handbook address the requirements of this standard. The facility has a MOU with River House, Inc., a local victim advocacy group. The Auditor reviewed the signed MOU documents. The Youth Handbook provides the contact information for alternate services and the information is also posted in the housing units. Psychology Services staff members have all received victim advocacy support training.

Corrective action: None required

Standard 115.354: Third-party reporting

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

115.354 (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 a resident? ☒ 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.

Evidence Reviewed (on-site visit, documentation, staff and inmate interviews):

1. SC Pre-Audit Questionnaire
2. https://www.michigan.gov/mdhhs/0,5885,7-339-73971_34044_34049-109166--,00.html
3. PREA Screening Tool
4. Youth Handbook
5. Interviews with the following:
    a. Specialized and Random Staff
    b. Residents

Policies, Youth Handbook, PREA Posters, PREA Brochure and Child Protective Services (CPS) Hotline number meet the mandates of this standard. The posters, telephone numbers, and the Website https://www.michigan.gov/mdhhs/0,5885,7-339-73971_34044_34049-109166--,00.html assist third party reporters in reporting allegations of sexual abuse/sexual harassment. The residents interviewed indicated they were aware of third-party reporting and would probably feel more comfortable reporting an incident of sexual abuse to someone inside the facility. Calls to toll-free telephone numbers must be coordinated with a member of the unit team. SC maintains hotline reporting numbers for residents and staff.

Corrective action: None required

OFFICIAL RESPONSE FOLLOWING A RESIDENT REPORT

Standard 115.361: Staff and agency reporting duties

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

115.361 (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 residents 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

115.361 (b)

- Does the agency require all staff to comply with any applicable mandatory child abuse reporting laws? ☒ Yes ☐ No

115.361 (c)

- Apart from reporting to designated supervisors or officials and designated State or local services agencies, are staff prohibited from revealing any information related to a sexual abuse report to anyone other than to the extent necessary, as specified in agency policy, to make treatment, investigation, and other security and management decisions? ☒ Yes ☐ No

115.361 (d)

- Are medical and mental health practitioners required to report sexual abuse to designated supervisors and officials pursuant to paragraph (a) of this section as well as to the designated State or local services agency where required by mandatory reporting laws? ☒ Yes ☐ No

- Are medical and mental health practitioners required to inform residents of their duty to report, and the limitations of confidentiality, at the initiation of services? ☒ Yes ☐ No

115.361 (e)

- Upon receiving any allegation of sexual abuse, does the facility head or his or her designee promptly report the allegation to the appropriate office? ☒ Yes ☐ No

- Upon receiving any allegation of sexual abuse, does the facility head or his or her designee promptly report the allegation to the alleged victim's parents or legal guardians unless the facility has official documentation showing the parents or legal guardians should not be notified? ☒ Yes ☐ No

- If an alleged victim is under the guardianship of the child welfare system, does the facility head or his or her designee promptly report the allegation to the alleged victim's caseworker instead of the parents or legal guardians? ☒ Yes ☐ No

- If a juvenile court retains jurisdiction over the alleged victim, does the facility head or designee also report the allegation to the juvenile's attorney or other legal representative of record within 14 days of receiving the allegation? ☒ Yes ☐ No

115.361 (f)

- 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.

Evidence Reviewed (on-site visit, documentation, staff and inmate interviews):

1. SC Pre-Audit Questionnaire
2. Policy 560 Michigan Department of Health (MDH) Prevention of Resident Sexual Assault/Rape: Page 7-8; Section F; Subsection 1
3. Policy 560 Michigan Department of Health (MDH) Prevention of Resident Sexual Assault/Rape: Page 7-8; Section F; Subsection 2
4. Policy 560 Michigan Department of Health (MDH) Prevention of Resident Sexual Assault/Rape: Page 10; Section H; Subsection 1i
5. PREA Response Plan
6. PREA Screening Tool
7. Interviews with the following:
    a. Specialized and Random Staff
    b. Residents

Policies and interviews address the requirements of this standard. Staff, contractors, and volunteers must report and respond to allegations of sexually abusive behavior, regardless of the source of the report. Interviewed staff members were aware of their duty to immediately report all allegations of sexual abuse, sexual harassment and retaliation relevant to the PREA standards. The reporting is ordinarily made to a Shift Supervisor but could be made privately or to a third party. The policy requires the information concerning the identity of the alleged resident victim and the specific facts of the case be shared with staff on a need-to-know basis, due to their involvement with the victim's welfare and/or the investigation of the incident. If a resident was at risk of sexual victimization, the staff could temporarily place him in another unit. There have been no residents placed in another unit due to a risk of sexual victimization during the past twelve months. This was verified through interviews with random staff. Safety plans would be established to ensure that the resident was safe. A review of policy and interviews with staff support the finding that the facility is in compliance with this standard.

Corrective action: None required

Standard 115.362: Agency protection duties

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

115.362 (a)

- When the agency learns that a resident is subject to a substantial risk of imminent sexual abuse, does it take immediate action to protect the resident? ☒ 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.

Evidence Reviewed (on-site visit, documentation, staff and inmate interviews):

1. SC Pre-Audit Questionnaire
2. Policy 560 Michigan Department of Health (MDH) Prevention of Resident Sexual Assault/Rape: Page 9; Section G
3. PREA RESPONSE PLAN
4. Interviews with the following:
    a. Specialized and Random Staff

Policy and interviews address the requirements of this standard. Interviewed staff members were aware of their duties and responsibilities when they become aware or suspect that a resident is being sexually abused or sexually harassed. All staff indicated they would act immediately to protect the resident, including separating the victim/predator, securing the scene to protect possible evidence, preventing the destruction of potential evidence and contacting the Shift Supervisor and medical staff. In the past 12 months, there were no instances in which SC staff determined that a resident was subject to a substantial risk of imminent sexual abuse. There have been no residents placed in this status in the past twelve months. This was also verified through interviews with random staff. Safety plans would be established to ensure that the resident was safe.

Standard 115.363: Reporting to other confinement facilities

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

115.363 (a)

- Upon receiving an allegation that a resident 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

- Does the head of the facility that received the allegation also notify the appropriate investigative agency? ☒ Yes ☐ No

115.363 (b)

- Is such notification provided as soon as possible, but no later than 72 hours after receiving the allegation? ☒ Yes ☐ No

115.363 (c)

- Does the agency document that it has provided such notification? ☒ Yes ☐ No

115.363 (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.

Evidence Reviewed (on-site visit, documentation, staff and inmate interviews):

1. SC Pre-Audit Questionnaire
2. Policy 560 Michigan Department of Health (MDH) Prevention of Resident Sexual Assault/Rape: Page 9; Section F; Subsection 9
3. Policy 560 Michigan Department of Health (MDH) Prevention of Resident Sexual Assault/Rape: Page 8; Section F; Subsection 1

4. Policy 560 Michigan Department of Health (MDH) Prevention of Resident Sexual Assault/Rape: Page 8; Section F; Subsection 2
5. Policy 560 Michigan Department of Health (MDH) Prevention of Resident Sexual Assault/Rape: Page 9-11; Section H; Investigation Protocols
6. PREA Screening Tool
3. Interviews with the following:
    a. Specialized and Random Staff

The policy addresses the requirements of this standard. The policy requires that any resident allegation of sexual abuse occurring while confined at another facility be reported to the Director where the alleged abuse occurred within 72 hours of receipt of the allegation. Established procedures require the Director to immediately notify the other confinement facility, in writing, of the nature of the sexual abuse allegation.

Corrective action: None required

Standard 115.364: Staff first responder duties

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

115.364 (a)

- Upon learning of an allegation that a resident 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 a resident 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 a resident 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 a resident 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

115.364 (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.

Evidence Reviewed (on-site visit, documentation, staff and inmate interviews):

1. SC Pre-Audit Questionnaire
2. PREA Training Curriculum
3. SC PREA Response Plan Policy 560 Michigan Department of Health (MDH) Prevention of Resident Sexual Assault/Rape: Page 2
4. Policy 560 Michigan Department of Health (MDH) Prevention of Resident Sexual Assault/Rape: Page 9-10; Section H; Subsections 1 d-f
5. Policy 560 Michigan Department of Health (MDH) Prevention of Resident Sexual Assault/Rape: Page 10; Section H; Subsection 1f
6. Interviews with the following:
    a. Specialized and Random Staff

Policies and interviews address the requirements of this standard. All interviewed staff members were extremely knowledgeable concerning their first responder duties and responsibilities upon learning of an allegation of sexual abuse/sexual harassment. Staff indicated they would separate the residents, secure the scene, prevent the destruction of any evidence and contact their supervisor and medical staff. The supervisor would continue to protect the resident and notify medical, mental health and administrative/executive staff. In the past 12 months, there were no allegations that a resident was sexually abused, and a first responder was required to separate the victim and the abuser.

Corrective action: None required

Standard 115.365: Coordinated response

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

115.365 (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.

Evidence Reviewed (on-site visit, documentation, staff and inmate interviews):

1. SC Pre-Audit Questionnaire
2. SC PREA RESPONSE PLAN
3. PREA Training Curriculum
4. Interviews with the following:
    a. Specialized and Random Staff

Policy and the SC PREA RESPONSE PLAN document address the requirements of this standard. The policies were reviewed by the Auditor. The local policy specifies the guidelines and procedures that prevent sexual abuse/sexual assault and provides for prompt and effective intervention, in the event abuse or an assault occurs. The local policy also includes procedures for the investigation, discipline, and prosecution of the assailant or abuser. The SC PREA RESPONSE PLAN details first responder duties, reporting procedures, physical evidence collection/preservation, and medical/mental health care responsibilities. The Plan was developed to assist staff in responding to allegations of prohibited and/or illegal sexually abusive behavior.

Corrective action: None required

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

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

115.366 (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 residents pending the outcome of an investigation or of a determination of whether and to what extent discipline is warranted? ☒ Yes ☐ No

115.366 (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.

Evidence Reviewed (on-site visit, documentation, staff and inmate interviews):

1. SC Pre-Audit Questionnaire
2. Union Agreement with the State of Michigan
3. Interviews with the following:
    a. Specialized and Random Staff

The facility has a Collective Bargaining Agreement with the State of Michigan and the United Auto Workers (UAW), Local 6000 (Administrative Support Unit, Human Services Unit). The Collective Bargaining Agreement does not prohibit the facility from removing alleged staff sexual abusers from contact with any residents pending the outcome of an investigation or of a determination of whether and to what extent discipline is warranted. Staff interviews confirmed compliance with this standard.

Corrective action: None required

Standard 115.367: Agency protection against retaliation

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

115.367 (a)

- Has the agency established a policy to protect all residents and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other residents or staff? ☒ Yes ☐ No

- Has the agency designated which staff members or departments are charged with monitoring retaliation? ☒ Yes ☐ No

115.367 (b)

- Does the agency employ multiple protection measures, such as housing changes or transfers for resident victims or abusers, removal of alleged staff or resident abusers from contact with victims, and emotional support services, for residents or staff who fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations,? ☒ Yes ☐ No

115.367 (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 residents or staff who reported the sexual abuse to see if there are changes that may suggest possible retaliation by residents 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 residents who were reported to have suffered sexual abuse to see if there are changes that may suggest possible retaliation by residents 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 resident 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: Resident 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: Resident 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

115.367 (d)

- In the case of residents, does such monitoring also include periodic status checks? ☒ Yes ☐ No

115.367 (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

115.367 (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.

Evidence Reviewed (on-site visit, documentation, staff and inmate interviews):

1. SC Pre-Audit Questionnaire
2. SC PREA Response Plan Policy 560 Michigan Department of Health (MDH) Prevention of Resident Sexual Assault/Rape: Page 6; Section E; Subsection 1

3. SC PREA Response Plan Policy 560 Michigan Department of Health (MDH) Prevention of Resident Sexual Assault/Rape: Page 9; Section F; Subsection 10
4. SC PREA Response Plan Policy 560 Michigan Department of Health (MDH) Prevention of Resident Sexual Assault/Rape: Page 9; Section F; Subsection 10 and Section G
5. Interviews with the following:
    a. Specialized Staff

The policy addresses the requirements of this standard. The policy prohibits any type of retaliation against any staff person or resident who reports sexual abuse, sexual harassment or cooperates in related investigations. The first shift Supervisor is responsible for monitoring retaliation. During the interview, he indicated that he follows up on all 30, 60 and 90-day reviews to ensure the policy is being enforced and conducts periodic status checks on the frequency of incident reports, housing reassignments, and negative performance reviews/staff job reassignments, as required in 115.67c. In the event of possible retaliation, the first shift Supervisor indicated he would monitor the situation indefinitely. There have been no incidents of retaliation in the past 12 months. Compliance with this standard was determined by a review of policy/documentation and staff interviews.

Corrective action: None required

Standard 115.368: Post-allegation protective custody

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

115.368 (a)

- Is any and all use of segregated housing to protect a resident who is alleged to have suffered sexual abuse subject to the requirements of § 115.342? ☒ 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.

Evidence Reviewed (on-site visit, documentation, staff and inmate interviews):

1. SC Pre-Audit Questionnaire
2. SC PREA Response Plan Policy 560 Michigan Department of Health (MDH) Prevention of Resident Sexual Assault/Rape: Page 4; Section B; Subsection 5
5. Interviews with the following:
    a. Specialized Staff

The policy addresses the requirements of the standard. The policy requires staff to assess and consider all appropriate alternatives for safeguarding alleged resident victims of sexual abuse/sexual harassment. The facility does not use seclusion as an alternative after an allegation has been reported. Residents or staff may be re-assigned to another unit or building pending the outcome of the investigation. Compliance with this standard was determined by a review of policy, as well as a tour of the facility and staff interviews.

Corrective action: None required

INVESTIGATIONS

Standard 115.371: Criminal and administrative agency investigations

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

115.371 (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 115.321(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 115.321(a).] ☒ Yes ☐ No ☐ NA

115.371 (b)

- Where sexual abuse is alleged, does the agency use investigators who have received specialized training in sexual abuse investigations involving juvenile victims as required by 115.334? ☒ Yes ☐ No

115.371 (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

115.371 (d)

- Does the agency always refrain from terminating an investigation solely because the source of the allegation recants the allegation? ☒ Yes ☐ No

115.371 (e)

- 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

115.371 (f)

- 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 resident or staff? ☒ Yes ☐ No

- Does the agency investigate allegations of sexual abuse without requiring a resident who alleges sexual abuse to submit to a polygraph examination or other truth-telling device as a condition for proceeding? ☒ Yes ☐ No

115.371 (g)

- 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

115.371 (h)

- 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

115.371 (i)

- Are all substantiated allegations of conduct that appears to be criminal referred for prosecution? ☒ Yes ☐ No

115.371 (j)

- Does the agency retain all written reports referenced in 115.371(g) and (h) for as long as the alleged abuser is incarcerated or employed by the agency, plus five years unless the abuse was committed by a juvenile resident and applicable law requires a shorter period of retention?
  ☒ Yes ☐ No

115.371 (k)

- 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

115.371 (l)

- Auditor is not required to audit this provision.

115.371 (m)

- When an outside agency 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 115.321(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.

Evidence Reviewed (on-site visit, documentation, staff and inmate interviews):

1. SC Pre-Audit Questionnaire
2. Policy 560 Michigan Department of Health (MDH) Prevention of Resident Sexual Assault/Rape: Page 9-12; Section H; Investigation Protocol

3. Policy 560 Michigan Department of Health (MDH) Prevention of Resident Sexual Assault/Rape: Page 9-12; Section F; Subsection 8
4. Investigator Training Certificates
5. Interviews with the following:
    a. Investigator
    b. Specialized and Random Staff

Policies and interviews address the components of this standard. According to the Director, the facility fully cooperates with any outside agency that initiates an investigation. The Director serves as the facility liaison and provides requested information to outside investigative agencies, as well as access to the resident. The credibility of an alleged victim, suspect or witness is assessed on an individual basis and is not determined by the person's status as resident or staff. The agency does not require a resident who alleges sexual abuse to submit to a polygraph examination or other truth assessment device as a condition for proceeding with the investigation. During the last 12 months, there were five allegations of sexual harassment and/or sexual abuse. Three allegations were found to be substantiated and two were determined to be unfounded. The MSP conducts all criminal investigations. Internal investigations are initiated by the Director and then forwarded to the Investigator for additional investigation. Compliance with this standard was determined by a review of policy and documentation, as well as staff interviews.

Corrective action: None required

Standard 115.372: Evidentiary standard for administrative investigations

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

115.372 (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.

Evidence Reviewed (on-site visit, documentation, staff and inmate interviews):

1. SC Pre-Audit Questionnaire
2. Policy 560 Michigan Department of Health (MDH) Prevention of Resident Sexual Assault/Rape: Page 9-12; Section H
3. Interviews with the following:
   a. Investigator

Policy and interviews address the requirement of this standard. The evidence standard is a preponderance of the evidence in determining whether allegations of sexual abuse/sexual harassment are substantiated. When interviewed, the Investigator confirmed that he was aware of the evidence standard.

Corrective action: None required

Standard 115.373: Reporting to residents

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

115.373 (a)

- Following an investigation into a resident's allegation that he or she suffered sexual abuse in an agency facility, does the agency inform the resident as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded? ☒ Yes ☐ No

115.373 (b)

- If the agency did not conduct the investigation into a resident's allegation of sexual abuse in the agency's facility, does the agency request the relevant information from the investigative agency in order to inform the resident? (N/A if the agency/facility is responsible for conducting administrative and criminal investigations.) ☒ Yes ☐ No ☐ NA

115.373 (c)

- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The staff member is no longer posted within the resident's unit? ☒ Yes ☐ No

- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The staff member is no longer employed at the facility? ☒ Yes ☐ No

- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The agency learns that the staff member has been indicted on a charge related to sexual abuse in the facility? ☒ Yes ☐ No

- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility? ☒ Yes ☐ No

115.373 (d)

- Following a resident's allegation that he or she has been sexually abused by another resident, 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 a resident's allegation that he or she has been sexually abused by another resident, 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

115.373 (e)

- Does the agency document all such notifications or attempted notifications? ☒ Yes ☐ No

115.373 (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.

Evidence Reviewed (on-site visit, documentation, staff and inmate interviews):

1. SC Pre-Audit Questionnaire
2. Investigation Case Review (reviewed all 5 cases)
3. Notification of Completed Investigation
4. Notification of Completed Investigation (5 examples)
5. Investigation Report (8 examples)
6. Administrative Outcome (5 examples)
7. Policy 560 Michigan Department of Health (MDH) Prevention of Resident Sexual Assault/Rape: Page 7; Section F; Subsection 3
8. Policy 560 Michigan Department of Health (MDH) Prevention of Resident Sexual Assault/Rape: Page 7; Section F; Subsection 4
9. Youth Grievance Form

Interviews with the following:

a. Specialized and Random Staff

Policy and interviews address the components of this standard. During the last 12 months, there were eight allegations of sexual harassment and/or sexual abuse. The facility uses the MSP for all criminal investigative services. Residents are informed of the investigative process. All investigative decisions require a written response, including the rationale for the decision. This written documentation is made available to the youth and/or family members. Copies of all investigative decisions are maintained. Decisions are available to the victim's family, the administration and the Michigan Department of Children's Services.

Corrective action: None required

DISCIPLINE

Standard 115.376: Disciplinary sanctions for staff

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

115.376 (a)

- Are staff subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies? ☒ Yes ☐ No

115.376 (b)

- Is termination the presumptive disciplinary sanction for staff who have engaged in sexual abuse? ☒ Yes ☐ No

115.376 (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

115.376 (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.

Evidence Reviewed (on-site visit, documentation, staff and inmate interviews):

1. SC Pre-Audit Questionnaire
2. Policy 560 Michigan Department of Health (MDH) Prevention of Resident Sexual Assault/Rape: Page 10; Section H; Subsection 2
3. Policy 560 Michigan Department of Health (MDH) Prevention of Resident Sexual Assault/Rape: Page 10-11; Section H; Subsection 2
4. Policy 560 Michigan Department of Health (MDH) Prevention of Resident Sexual Assault/Rape: Page 11; Section H; Subsection 2g
5. Interviews with the following:
    a. Specialized and Random Staff

Policy and interviews address the requirements of this standard. Employees are subject to disciplinary sanctions for violating agency sexual abuse or sexual harassment policies. All terminations for violations of agency sexual abuse or sexual harassment policies, or

resignations by staff that would have been terminated, if not for their resignation, may be reported to criminal investigators and to any law enforcement or relevant professional/certifying/licensing agencies by the facility, unless the activity was clearly not criminal. Compliance with this standard was determined by a review of policy/documentation and staff interviews.

Corrective action: None required

Standard 115.377: Corrective action for contractors and volunteers

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

115.377 (a)

- Is any contractor or volunteer who engages in sexual abuse prohibited from contact with residents? ☒ 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

115.377 (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 residents? ☒ 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.

Evidence Reviewed (on-site visit, documentation, staff and inmate interviews):

1. SC Pre-Audit Questionnaire
2. Training Curriculum
3. Policy 560 Michigan Department of Health (MDH) Prevention of Resident Sexual Assault/Rape: Page 3; Section A; Subsection 1g
4. Policy 560 Michigan Department of Health (MDH) Prevention of Resident Sexual Assault/Rape: Page 4; Section B; Subsection 5
5. Policy 560 Michigan Department of Health (MDH) Prevention of Resident Sexual Assault/Rape: Page 1
6. Interviews with the following:
    a. Specialized and Random Staff

Policy and interviews address the requirements of the standard. Any contractor or volunteer who engages in sexual abuse/sexual harassment would be prohibited from contact with residents and would be reported to the appropriate investigating agency, law enforcement, or relevant professional/licensing/certifying bodies, unless the activity was clearly not criminal in nature. In non-criminal cases, the SC would take appropriate remedial measures and consider whether to prohibit further contact with residents. During the past 12 months, there were no incidents where a contractor or volunteer was accused or found guilty of sexual abuse or sexual harassment. Compliance with this standard was determined by a review of policy and volunteer/contractor training files and contractor (one) and staff interviews. At the time of the audit, no volunteers were available for interviews.

Corrective action: None required

Standard 115.378: Interventions and disciplinary sanctions for residents

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

115.378 (a)

- Following an administrative finding that a resident engaged in resident-on-resident sexual abuse, or following a criminal finding of guilt for resident-on-resident sexual abuse, may residents be subject to disciplinary sanctions only pursuant to a formal disciplinary process? ☒ Yes ☐ No

115.378 (b)

- Are disciplinary sanctions commensurate with the nature and circumstances of the abuse committed, the resident's disciplinary history, and the sanctions imposed for comparable offenses by other residents with similar histories? ☒ Yes ☐ No

- In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident is not denied daily large-muscle exercise? ☒ Yes ☐ No

- In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident is not denied access to any legally required educational programming or special education services? ☒ Yes ☐ No

- In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident receives daily visits from a medical or mental health care clinician? ☒ Yes ☐ No

- In the event a disciplinary sanction results in the isolation of a resident, does the resident also have access to other programs and work opportunities to the extent possible? ☒ Yes ☐ No

115.378 (c)

- When determining what types of sanction, if any, should be imposed, does the disciplinary process consider whether a resident's mental disabilities or mental illness contributed to his or her behavior? ☒ Yes ☐ No

115.378 (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 offer the offending resident participation in such interventions? ☒ Yes ☐ No

- If the agency requires participation in such interventions as a condition of access to any rewards-based behavior management system or other behavior-based incentives, does it always refrain from requiring such participation as a condition to accessing general programming or education? ☒ Yes ☐ No

115.378 (e)

- Does the agency discipline a resident for sexual contact with staff only upon a finding that the staff member did not consent to such contact? ☒ Yes ☐ No

115.378 (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

115.378 (g)

- If the agency prohibits all sexual activity between residents, does the agency always refrain from considering non-coercive sexual activity between residents to be sexual abuse? (N/A if the agency does not prohibit all sexual activity between residents.) ☒ 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.

Evidence Reviewed (on-site visit, documentation, staff and inmate interviews):

1. SC Pre-Audit Questionnaire
2. Policy 560 Michigan Department of Health (MDH) Prevention of Resident Sexual Assault/Rape: Page 4; Section B; Subsection 5
3. Policy JR6 610 Isolation and/or Confinement
4. Policy JR6 610 Physical Restraint
5. Youth Handbook
6. Interviews with the following:
    a. Specialized and Random Staff

Policy and interviews address the components of this standard. Appropriate measures must be taken to protect the due process rights of residents who are, or who may be, subject to discipline. This policy ensures residents are treated fairly under a consistent system of discipline that teaches and encourages appropriate behaviors and discourages inappropriate behaviors. The Youth Handbook packet addresses all disciplinary sanctions for juvenile residents. The facility does not use seclusion in cases of alleged sexual abuse or sexual harassment. Consensual sex of any nature is prohibited. Residents that sexually abuse or harass staff (not consensual) will be disciplined. The Shawono Center program does not discipline residents who make an allegation in good faith, even if an investigation does not establish evidence sufficient to substantiate the allegation.

Corrective action: None required

MEDICAL AND MENTAL CARE

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

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

115.381 (a)

- If the screening pursuant to § 115.341 indicates that a resident has experienced prior sexual victimization, whether it occurred in an institutional setting or in the community, do staff ensure that the resident is offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening? ☒ Yes ☐ No

115.381 (b)

- If the screening pursuant to § 115.341 indicates that a resident has previously perpetrated sexual abuse, whether it occurred in an institutional setting or in the community, do staff ensure that the resident is offered a follow-up meeting with a mental health practitioner within 14 days of the intake screening? ☒ Yes ☐ No

115.381 (c)

- 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

115.381 (d)

- Do medical and mental health practitioners obtain informed consent from residents before reporting information about prior sexual victimization that did not occur in an institutional setting, unless the resident is under the age of 18? ☒ 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.

Evidence Reviewed (on-site visit, documentation, staff and inmate interviews):

1. SC Pre-Audit Questionnaire

2. Policy 560 Michigan Department of Health (MDH) Prevention of Resident Sexual Assault/Rape: Page 4; Section B; Subsection 2d
3. Policy 560 Michigan Department of Health (MDH) Prevention of Resident Sexual Assault/Rape: Page 7; Section E; Subsection 2
4. Treatment Team Minutes
5. Updated Treatment Plan (5 examples reviewed)
6. PREA Screening Tool
7. Interviews with the following:
    a. Specialized and Random Staff
    b. Residents

Policy and interviews address the requirements of this standard. Interviews with health and psychology services staff confirm the institution has a very thorough system for collecting medical and mental health information which allows the staff to provide continued re-assessment and follow up services to the residents. In the past 12 months, 100% of residents who disclosed prior victimization during screening were offered a follow-up meeting with a medical or mental health practitioner. Additionally, 100% of the residents who have previously perpetrated sexual abuse, as indicated during the screening, were offered a follow-up meeting with a mental health practitioner. Treatment services are offered without financial cost to the resident, as confirmed by observation and a review of intake screening documents. Screening for prior sexual victimization in any setting is conducted by unit team staff during in-processing procedures. In-processing procedures also include screening for previous sexually abusive behavior in an institutional setting or in the community. When indicated, staff members ensure that the resident is offered a follow-up meeting with a mental health practitioner within 14 days of the intake screening. Information related to sexual victimization or abusiveness is limited to medical and mental health practitioners and other staff with a need-to-know for the purpose of determining treatment plans, security, housing, work, program assignments, and other management decisions. Signed and dated informed consent are obtained from residents before reporting prior sexual victimization which did not occur in an institutional setting. All information is handled confidentially. Interviews with the intake screening staff support a finding that the facility is in compliance with this standard.

Corrective action: None required

Standard 115.382: Access to emergency medical and mental health services

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

115.382 (a)

- Do resident 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

115.382 (b)

- If no qualified medical or mental health practitioners are on duty at the time a report of recent sexual abuse is made, do staff first responders take preliminary steps to protect the victim pursuant to § 115.362? ☒ Yes ☐ No

- Do staff first responders immediately notify the appropriate medical and mental health practitioners? ☒ Yes ☐ No

115.382 (c)

- Are resident 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

115.382 (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.

Evidence Reviewed (on-site visit, documentation, staff and inmate interviews):

1. SC Pre-Audit Questionnaire
2. Policy 560 Michigan Department of Health (MDH) Prevention of Resident Sexual Assault/Rape: Page 9; Section H; Subsection 1c
3. Policy 560 Michigan Department of Health (MDH) Prevention of Resident Sexual Assault/Rape: Page 8; Section F; Subsection 6
4. Policy JR3 381 Medication Administration
5. Updated Treatment Plans (5 examples)
6. PREA Screening Tool

7. MOU with River House, Inc.
8. Interviews with the following:
    a. Specialized and Random Staff

Policy and interviews address the requirements of this standard. All services are provided to residents at no cost. Resident victims are provided timely, unimpeded access to emergency medical treatment and crisis intervention services. Referrals are made to Mercy Hospital and River House, Inc. for medical and victim advocacy services, respectively.

Corrective action: None required

Standard 115.383: 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

115.383 (a)

- Does the facility offer medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility? ☒ Yes ☐ No

115.383 (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

115.383 (c)

- Does the facility provide such victims with medical and mental health services consistent with the community level of care? ☒ Yes ☐ No

115.383 (d)

- Are resident victims of sexually abusive vaginal penetration while incarcerated offered pregnancy tests? (N/A if "all-male" facility. *Note: in "all-male" facilities, there may be residents who identify as transgender men who may have female genitalia. Auditors should be sure to know whether such individuals may be in the population and whether this provision may apply in specific circumstances.*) ☒ Yes ☐ No ☐ NA

115.383 (e)

- If pregnancy results from the conduct described in paragraph § 115.383(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. *Note: in "all-male" facilities, there may be residents who identify as transgender men who may have female genitalia. Auditors should be*

sure to know whether such individuals may be in the population and whether this provision may apply in specific circumstances.) ☒ Yes ☐ No ☐ NA

115.383 (f)

- Are resident victims of sexual abuse while incarcerated offered tests for sexually transmitted infections as medically appropriate? ☒ Yes ☐ No

115.383 (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

115.383 (h)

- Does the facility attempt to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners? ☒ 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.

Evidence Reviewed (on-site visit, documentation, staff and inmate interviews):

1. SC Pre-Audit Questionnaire
2. Policy 560 Michigan Department of Health (MDH) Prevention of Resident Sexual Assault/Rape: Page 8; Section F; Subsection 6
3. PREA Screening Tool (SA0002)
4. MOU with River House, Inc.
5. Interviews with the following:
    a. Specialized and Random Staff

Policies and interviews address the requirements of this standard. The facility medical and mental health personnel provide services to the entire SC resident population. Medical personnel is available for consultation or call-back on off-duty hours. Mental health providers are also available for call-back during off-duty hours. Information and access to care are offered to all resident victims, as clinically indicated. Victim advocacy services are offered through trained staff members and River House, Inc… Agency policy prohibits resident co-pays for medical treatment in cases of sexual abuse. All treatment is offered at no financial cost to the resident. Resident victims of sexual abuse are offered information about, and timely access to, information regarding sexually transmitted infection prophylaxis. This information is provided in accordance with professionally accepted standards of care, when medically appropriate. There were no allegations of sexual abuse that required referral for forensic evidence collection by a SANE provider in the past year. Compliance with this standard was determined by a review of policy/documentation and interviews with a SANE and facility medical staff. Secondary materials documenting compliance are on file.

Corrective action: None required

DATA COLLECTION AND REVIEW

Standard 115.386: Sexual abuse incident reviews

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

115.386 (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

115.386 (b)

- Does such review ordinarily occur within 30 days of the conclusion of the investigation? ☒ Yes ☐ No

115.386 (c)

- Does the review team include upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners? ☒ Yes ☐ No

115.386 (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 §§ 115.386(d)(1) - (d)(5), and any recommendations for improvement and submit such report to the facility head and PREA compliance manager? ☒ Yes ☐ No

115.386 (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.

Evidence Reviewed (on-site visit, documentation, staff and inmate interviews):

1. SC Pre-Audit Questionnaire
2. Policy 560 Michigan Department of Health (MDH) Prevention of Resident Sexual Assault/Rape: Page 11-12; Section H; Subsection 5
3. Policy 560 Michigan Department of Health (MDH) Prevention of Resident Sexual Assault/Rape: Page 1; Definitions
4. Policy 560 Michigan Department of Health (MDH) Prevention of Resident Sexual Assault/Rape: Page 12; Section I; Subsection 6

5. U.S. Department of Justice: Survey of Sexual Victimization, 2018, State Juvenile Systems Summary Form
6. PREA Retaliation Monitor - Youth (2 examples)
7. PREA Sexual Abuse Incident Review (4 examples)
8. Interviews with the following:
    a. Director

The policy addresses the requirements of this standard. Administrative and criminal investigations are completed on all allegations of sexual abuse/sexual harassment. The Michigan State Police conduct all criminal investigations. The SC conducts a sexual abuse incident review at the conclusion of every sexual abuse investigation unless the allegation was proven to be unfounded. Based on interviews with members of the facility incident review team, the review is conducted within 30 days of the conclusion of the investigation and consideration is given as to whether the incident was motivated by race, ethnicity, gender identity, status, perceived status, or gang affiliation. The team also makes a determination as to whether additional monitoring technology should be added to enhance staff supervision. The review team is comprised of upper-level management officials, including the Director, Shift Supervisor and the Program Administrator. Per policy, all required reviews by the incident review team are completed within 30 days of the conclusion of all investigations. Additionally, per policy, the findings are thoroughly documented. An annual review of all incidents is also completed. The incident review team seeks additional information from other staff, as needed, to ensure a thorough review has been completed.

Corrective action: None required

Standard 115.387: Data collection

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

115.387 (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

115.387 (b)

- Does the agency aggregate the incident-based sexual abuse data at least annually? ☒ Yes ☐ No

115.387 (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

115.387 (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

115.387 (e)

- Does the agency also obtain incident-based and aggregated data from every private facility with which it contracts for the confinement of its residents? (N/A if agency does not contract for the confinement of its residents.) ☒ Yes ☐ No ☐ NA

115.387 (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.

Evidence Reviewed (on-site visit, documentation, staff and inmate interviews):

1. SC Pre-Audit Questionnaire
2. Policy 560 Michigan Department of Health (MDH) Prevention of Resident Sexual Assault/Rape: Page 12; Section I; Subsection 6
3. Interviews with the following:
   a. Director
   b. Incident Review Team Member

Policy and interviews address the components of this standard. The data collected is captured with a computer program; it includes the information necessary to answer all questions from the most recent version of the Survey of Sexual Violence, conducted by the Department of Justice. MDHHS aggregates and reviews all incident-based sexual abuse

data annually. Upon request, MDHHS provides all data from the previous calendar year to the Department of Justice.

Corrective action: None required

Standard 115.388: Data review for corrective action

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

115.388 (a)

- Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Identifying problem areas? ☒ Yes ☐ No

- Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Taking corrective action on an ongoing basis? ☒ Yes ☐ No

- Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Preparing an annual report of its findings and corrective actions for each facility, as well as the agency as a whole? ☒ Yes ☐ No

115.388 (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

115.388 (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

115.388 (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.

Evidence Reviewed (on-site visit, documentation, staff and inmate interviews):

1. SC Pre-Audit Questionnaire
2. Michigan Department of Health and Human Services Juvenile Justice Programs: *PREA, 2018 Annual Data, and Annual Report*
3. https://www.michigan.gov/mdhhs/0.5885,7-339-73971_34044_93169---,00.htmi
4. Interviews with the following:
    a. Director

The policy addresses the requirements of this standard. As confirmed by a review of supporting documentation, the MDHHS collects accurate, uniform data for every allegation of sexual abuse/sexual harassment by using a standardized instrument. The information can be found on their website: https://www.michigan.gov/mdhhs/0.5885,7-339-73971_34044_93169---,00.htmi. The agency tracks information concerning sexual abuse via Youth 360. The data collected includes the information necessary to answer all questions from the most recent version of the Survey of Sexual Violence, conducted by the Department of Justice. The report includes a comparison of the current year's data and corrective actions with data from previous years and provides an assessment of the agency's progress. The agency aggregates and reviews all data annually.

Corrective action: None required

Standard 115.389: Data storage, publication, and destruction

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

115.389 (a)

- Does the agency ensure that data collected pursuant to § 115.387 are securely retained? ☒ Yes ☐ No

115.389 (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

115.389 (c)

- Does the agency remove all personal identifiers before making aggregated sexual abuse data publicly available? ☒ Yes ☐ No

115.389 (d)

- Does the agency maintain sexual abuse data collected pursuant to § 115.387 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.

Evidence Reviewed (on-site visit, documentation, staff and inmate interviews):

1. SC Pre-Audit Questionnaire
2. MDHHS Umbrella Policy 560: Page 6-7
3. MDHHS Website: https://www.michigan.gov/mdhhs/0.5885,7-339-73971_34044_93169---,00.htmi
4. Interviews with the following:
    a. Director

Policy and interviews address the components of this standard. MDHHS maintains sexual abuse data collected for at least ten years after the date of its initial collection. MDHHS monitors and makes available aggregated sexual abuse data from its facilities and contracted agency facilities on its website. That data can be found at MDHHS Website: https://www.michigan.gov/mdhhs/0.5885,7-339-73971_34044_93169---,00.htmi. All personal identifiers are removed before the information is posted.

Corrective action: None required

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 residents? ☒ Yes ☐ No

115.401 (n)

- Were residents 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.

This was the second PREA audit of this facility. The Auditor was allowed access to all areas of the facility and had access to all required supporting documentation. The Auditor was able to conduct private interviews with both residents and staff. All MDHHS facilities have received at least one PREA audit since August 20, 2012. At least one-third of all agency facilities were audited during the one-year period after August 20, 2012. The Auditor was provided supporting documentation before and during the audit. Notifications of the audit posted throughout the Shawono Center allowed residents to correspond confidentially with the Auditor prior to the audit. No confidential correspondence was received by the Auditor as a result of the audit postings at the facility.

Corrective action: None required

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. The review period is for prior audits completed during the past three years PRECEDING THIS AGENCY AUDIT. 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 Shawono Center has fully implemented all policies, practices, and procedures outlined in the PREA standards. The Auditor reviewed applicable standards and, through the review of supporting documentation, interviews with staff, residents and the observation of physical evidence, concluded that this facility fully meets and substantially complies in all material ways with the PREA standards for the relevant review period. MDHHS policies are directly tied to the PREA standards and staff expectations. The facility's leadership is fully committed to eliminating sexual abuse/sexual harassment, as evidenced in the realistic staffing analysis and the recommendations for enhanced supervision techniques. PREA training for staff and residents is documented and all stakeholders receive the appropriate level of training and are knowledgeable of the intent of the PREA and the tools available to ensure prevention, detection, reporting and response to sexual abuse incidents. Sexual abuse and victimization propensity screening is well established and tracked in an organized fashion. Referrals for mental health counseling are integrated into the intake and allegations of sexual abuse processes. Medical networks for the residents are established in the community. The public has access to reporting mechanisms and agency PREA trends data via the agency website. The Shawono Center currently complies with all applicable PREA standards and no corrective actions are required.

Corrective action: None required

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 resident 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.

James L. Roland, Jr. 11/20/2019

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.