PREA AUDIT REPORT ☐ **INTERIM** ☒ **FINAL**

JUVENILE FACILITIES

Date of report: November 20, 2015

Auditor Information			
Auditor name: Louis A. Goodman			
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Telephone number: (602) 904-2851			
Date of facility visit: October 19-21, 2015			
Facility Information			
Facility name: Wolverine Human Services -- Pioneer Work and Learning Center (PWLC); Vassar House (VH)			
Facility physical address: 150 Enterprise Drive / 955 Commerce Drive, Vassar, Michigan 48768			
Facility mailing address: *(if different from above)*			
Facility telephone number: (989) 823-3040			
The facility is:	☐ Federal	☐ State	☐ County
	☐ Military	☐ Municipal	☒ Private for profit
	☐ Private not for profit		
Facility type:	☒ Correctional	☐ Detention	☐ Other
Name of facility's Chief Executive Officer: Paul Whitney (PWLC) Scott Forbes (VH)			
Number of staff assigned to the facility in the last 12 months: 122 Full Time, 16 Part Time			
Designed facility capacity: PWLC=90 VH=70			
Current population of facility: PWLC=31 VH=42			
Facility security levels/inmate custody levels: non-secure			
Age range of the population: 12-18			
Name of PREA Compliance Manager: Kevin Voss		**Title:** Training Coordinator / PREA Compliance Manager	
Email address: vossk@wolverinehs.org		**Telephone number:** (989) 823-3040	
Agency Information			
Name of agency: Michigan Department of Health and Human Services			
Governing authority or parent agency: *(if applicable)*			
Physical address: 235 S. Grand Ave., Lansing, MI 48909			
Mailing address: *(if different from above)*			
Telephone number: (517) 335-3489			
Agency Chief Executive Officer			
Name: Nick Lyon		**Title:** Director	
Email address: c/o Nancy Grijalva email: GrijalvaN@michigan.gov		**Telephone number:** (517) 241-1193	
Agency-Wide PREA Coordinator			
Name: Patrick Sussex		**Title:** PREA Juvenile Coordinator	
Email address: sussexp@michigan.gov		**Telephone number:** (517) 648-6503	

AUDIT FINDINGS

NARRATIVE

Wolverine Human Services (WHS) is a private, for-profit social services agency that operates several facilities in the state of Michigan. Two of its programs, located on the same campus in Vassar, Michigan, are the subject of this audit: Pioneer Work and Learning Center (PWLC) and Vassar House (VH). They are non-secure programs operated under contract to the Michigan Department of Health and Human Services (MDHHS), for the placement of adjudicated juveniles. PWLC houses male youth, and VH houses female youth. WHS's mission statement is "Helping Children to be Victors."

PWLC's program mission states "WHS Foundations Behavioral Health Program serves adolescent males with a goal of developing resiliency and maximizing strengths via a person centered approach to support adolescent recovery from mental health disorders and related behavioral challenges. The program teaches adolescent boys disorder management skills to improve personal, family, and social functioning for successful community living."

The PWLC program serves males, ages 12 to 17, who meet the following intake criteria:

- Moderate to severe Axis I and Axis II mental health disorders
- Demonstrated history of delinquency and related behaviors
- Clients served by the Department of Health and Human Services
- Special Education certifications of emotionally impaired, learning disabled, and on a case by case basis, educationally mentally impaired
- Lower than average cognitive and intellectual functioning
- A security level indicating that non-secure placement is appropriate

PWLC has 63 beds, 23 of which were occupied at the time of the site visit. Average length of stay is six months, with release being determined by program progress.

VH's program mission states "The Passages Program teaches female adolescents coping skills to regulate intense emotional responses, recovery from traumatic life events, and development of healthy life skills to improve personal, family and community functioning." The program serves females, ages 12 to 17, who meet the follwing intake criteria:

- Mental health or co-occurring disorders
- Clients served by the Department of Health and Human Services
- Temporary court wards
- Clients placed by Child Welfare Exception
- Special Education certifications of emotionally impaired, learning disabled, and on a case by case basis, educationally mentally impaired
- A security level indicating that non-secure placement is appropriate
- Mental health symptoms and problem behaviors (i.e., eating disorders, bipolar disorder, severe mood swings, self-mutilation, trauma, drug dependency issues, physically aggressive, and/or cognitive impairment)

VH has a capacity of 50 beds, 44 of which were occupied at the time of the site visit. Average length of stay is six months, with release being determined by program progress.

PWLC and VH are each administered by a Program Manager, Paul Whitney and Scott Forbes, respectively. The Facility PREA Compliance Manager is Kevin Voss, who is also the Training Officer for both programs. Wolverine Human Services has its own PREA Coordinator, Katrina Brock, who also serves as Clinical Director for both programs.

DESCRIPTION OF FACILITY CHARACTERISTICS

PWLC and VH are two of four programs that comprise a wooded, rural campus operated by Wolverine Human Services. PWLC opened in 1992 and consists of six housing units, three of which were vacant, a dining hall, a school , and a recreational building. VH opened in 2009 and consists of five housing units, a school, a dining hall and recreation facilities. Each program has its own intake area and facilities for visitation.

The PWLC housing units are open dorms. They are large rectangular spaces with open sight lines from anwhere in the builing, including staff offices along one of the walls. Residents' beds are are situated along the walls. The restrooms are located at one end of the buildings. They contain three toilet stalls with no doors and three shower stalls. Residents also change clothes in the restrooms. When they are in use, a male staff member is situated at the door, allowing him to view into the room, but not into the shower or toilet stalls. However, he can see who enters each of the stalls. No one walking past the door can see into any of the toilet or shower stalls.

The VH housing units are also open dorms, but there are half-wall partitions separating each bunk bed, affording residents a greater sense of privacy. The units are large rectangular spaces with a restroom/shower room at one end. The restroom runs most of the length of one wall, leaving a hallwy in the unit that constitutes a blind spot from portions of the unit. There are no cameras installed in the units. When a resident or residents is in the restroom/shower room, a female staff member stands at the door, which affords her a view of the room. Residents change in the restrooms. VH has its own dining hall and classroom facilities.

All of the programs on the Vassar campus share a common health unit, and there are facilities for large assembly-type gatherings, but the residents from the different programs do not attend them together.

PWLC is a clinically managed treatment program providing recovery and disorder management services for residents with moderate to severe mental health disorders. Programs and interventions include cognitive behavioral therapy, motivational interviewing, motivational enhancement therapy, trauma informed treatment, life skills, anger management, and individual and group therapy for all residents. A level system is used for behavior management.

VH is likewise clinically managed and uses a level system. Interventions include cognitive behavioral therapy, motivational interviewing, motivational incentives, trauma informed treatment, life skills, anger management, and individual and group therapy.

Education at both PWLC and VH is contractually provided under a contract with the Tuscola County Intermediate School District. Students earn credits and can participate in credit recovery. Students can also earn GEDs.

SUMMARY OF AUDIT FINDINGS

Notices of the audit were posted six weeks prior to the site visit. I received photographs of some of the audit notices at that time, and I observed them to be posted in housing units and common spaces during the on-site audit. I received the Pre-Audit Questionnaire and accompanying documents on September 28, 2015.

The on-site audit was conducted October 19-21, 2015. An initial meeting was attended by Patrick Sussex, PREA Coordinator for the Michigan Department of Health and Human Services (MDHHS) , Katrina Brock, PREA Coordinator for WHS, Kevin Voss, PREA Facility Manager at the Vassar campus, Paul Whitney, Program Manager of Pioneer Work and Learning Center (PWLC) and Investigator, and Scott Forbes, Program Manager of Vassar House (VH). I interviewed each of those individuals over the course of the site visit. The initial meeting was followed by a tour of the PWLC and VH facilities.

Also interviewed during the site visit were Derrick McCree, Senior Vice President of Residential Programs and designee for WHS's CEO, the Health Services Director for the Vassar campus, the Clinical Services Director, intake staff, the Director of Employment Services (human resources), the contract psychiatrist, a nurse, a teacher (contractor), intake staff, a therapist, two intermediate staff, five Youth Care Workers from PWLC, five Youth Care Workers from VH, five male PWLC residents and five female VH residents. Three of the interviewed residents identified as bisexual. Two of the residents were prior victims of sexual abuse.

All of the adminsistrators and staff with whom I interacted were welcoming and forthcoming. Significantly, each resident I interviewed stated unequivocally that he or she felt safe in the WHS facility. The facilities were clean and well maintained, and the programs were youth-centered and therapeutic.

It was evident that a great deal of effort has gone into implementation of the PREA standards and that WHS administrators have a productive working relationship with the MDHHS PREA Coordinator. Over the course of the audit, a few areas for improvement were identified, and WHS administrators addressed them almost immediately by revising policy, locating training modules and incorporating them into their training plan, and revising the PREA-related information posted on the WHS website. It was evident that the facility leadership viewed the audit as a learning opportunity and sought to make process improvements as a result.

At the conclusion of the site visit, a debriefing was attended by the initial meeting participants, plus Derick McCree, Senior Vice President of Residential Programs, and Carol Furbush, Director of Employment Services.

Number of standards exceeded: 1

Number of standards met: 36

Number of standards not met: 0

Number of standards not applicable: 4

Standard 115.311 Zero tolerance of sexual abuse and sexual harassment; PREA Coordinator

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The Wolverine Human Services PREA policy (PREA RTX JJR) contains a clearly stated zero tolerance policy toward all forms of sexual abuse and sexual assault. It includes the definitions of sexual assault and sexual abuse mandated by the PREA standards for juvenile facilities, and it sets out in detail that agency's approach to preventing, detecting, and responding to such conduct. Wolverine's HR policy establishes appropriate sanctions for violating the PREA policy.

The Michigan Department of Health and Human Services (MDHHS) PREA Coordinator, Patrick Sussex, oversees PREA implementation and reports to the MDHHS Director. He reports sufficient time to carry out his responsibilities. Wolverine Human Services (WHS) employs an agency PREA Coordinator, Katrina Brock, and a PREA Compliance Manager for the Pioneer Work and Learning Center (PWLC) and Vassar House (VH), Kevin Voss. Both reported in interviews that they have sufficient time for their PREA-related duties.

Standard 115.312 Contracting with other entities for the confinement of residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Not Applicable. WHS does not contract with other entities for the confinement of residents.

Standard 115.313 Supervision and monitoring

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

WHS mandates staffing ratios that exceed those this standard will impose in 2017. During waking hours their facilities maintain a 1:5 staff to resident ratio, and at night they maintain a 1:10 ratio. Supervision of residents is guided by an emphasis on direct line-of-sight, a practice VHS reportedly began

many years before the PREA standards were implemented. The importance of direct line-of-sight supervision is reenforced by posters seen throughout the facilites and was mention by most of the administrators and staff interviewed. Consistency in line-of-sight supervision is assisted by the layout of the housing units, which contain few blind spots. Both PWLC and VH have open dorm floor plans, and the housing units are large rectangles. In PWLC the view is unobstructed. VH has half-wall partitions between each bunk bed, which necessitates more movement about the unit by staff in order to observe the residents when they are in their sleeping areas.

WHS has developed a staffing plan document in response to this standard, incorporating the elements discussed above. The written plan lists out each of the 11 elements required by subparagraph (a) of this standard, but does not state that they were incorporated into the plan's development. However, interviews with the WHS PREA Coordinator and other administrators confirmed the factors' consideration.

Agency administrators and staff consistently reported in interviews that staffing plan compliance is virtually always achieved. When necessary, staff are kept over from the previous shift, or administrators work shift in order to maintain the required ratios and line-of-sight supervision. Extremely rarely, an extended snow emergency might result in an exception, which would be documented.

Unannounced rounds are conducted on all shifts by Shift Coordinators or their supervisors, Residential Care Coordinators, as required by the WHS PREA policy. They are conducted at different times so as not to be predictable. While the logs maintained satisfied the requirements of this standard, it is recommended that they be improved by adding a column for time of day, and by using the "Remarks" column to describe any issues noted on the rounds, rather than simply noting them in unit logs, which is the current practice.

Standard 115.315 Limits to cross-gender viewing and searches

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

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

WHS Policy JJR 14 prohibits strip and body cavity searches altogether. It also prohibits cross-gender pat searches, except in exigent circumstances. Although policy language suggests that a cross-gender pat search might occur in exigent circumstances, all of the staff interviewed stated that they are prohibited, and all of the residents interviewed reported never having seen or heard of a cross-gender search being conducted. Staff and managers reported that, in the absence of a same-gender staff member, a resident would be observed until an appropriate staff member was available. No cross-gender pat searches were performed in the past 12 months. The pat search training that occurs during PREA training with staff covers searches of each gender, as well as gender nonconforming youth. With all youth, staff are taught areas of the body to avoid and methods for least invasive searching with respect for the dignity and privacy of the youth regardless of gender.

The WHS PREA policy requires staff to announce their presence when entering an opposite gender housing unit. Interviewed residents reported that this occurs consistently. Because the units are open dorms, residents not only shower and use the toilet, but also change clothes in the restrooms. When a resident or residents -- never more than two -- are using the restroom for any of those three purposes, a same-gender staff member is posted at the door, affording that staff an ability to observe both the restroom and the dorm area. The restrooms are such that a person walking by the restrooms cannot see into any of the stalls where residents use the toilet, shower, or change. Residents interviewed all stated that they were unaware of any instances where an opposite-gender staff member observed an undressed resident.

The WHS PREA policy prohibits physically examining transgender or intersex residents solely to determine genital status.

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

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

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance

determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

WHS assesses youth prior to admission to determine their appropriateness for a particular program (PWLC or VH in this case). Once a resident is admitted, the facility ensures that accomodations are made for any physical disabilities as appropriate to the nature of the disability. WHS provides full academic services in partnership with the Tuscola County Intermediate School District. All special education needs are arranged through the special education department of the school or through case management of the agency. Those residents with developmenmtal disabilities are provided with one-to-one assistance via the clinical team (therapist, case manager and team manager). PREA material is summarized the for each resident in a manner appropriate for the resident's age and cognitive ability. Beginning in December, 2015, residents will also be presented quarterly refresher groups related to PREA training and education in written, verbal and video format.

WHS administrators and staff report not having housed any residents who were limited English proficient (LEP) in the past 12 months. Nonetheless, agency policy CR PREA appropriately requires that any such residents be provided materials and interpreting services. WHS also provided a document that list the interpretation services available to them, should they be needed. The same policy prohibits the use of residents to interpret for other residents who are LEP.

Standard 115.317 Hiring and promotion decisions

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

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

WHS human resources policies and practices fully satisfy this standard. Policy HR 3 governs hiring and promotion and also applies to the retention of contractors. I also reviewed the WHS Personnel Policy. The hiring process includes an application on which prospective employees are asked questions pertaining to the prohibited behaviors listed in subparagraph (a) of this standard. All applicants are screened with a criminal background check, a check of both Michigan and national sex offender registries, and a check of the Central Registry listing persons found to have been neglegent or abusive toward children. Once hired, each employee is subject to annual review of each of those databases. Engaging in any of the behaviors listed in subparagraph (a) of this standard is grounds for termination or dismissal of a contractor, and the agency imposes an affirmative duty upon employees to report all criminal violations, as well as the any of the behaviors listed in subsection (a). Material omissions regarding such misconduct or providing materially false information in the application process constitutes grounds for termination. WHS contacts prior institutional employers for references regarding potential employers, and when contacted by an institutional employer conducting a background check on one of WHS's former employees, WHS provides information on substantiated allegations of sexual abuse or sexual harassment, as required by subparagraph (h) of this standard.

During the on-site audit, I reviewed a random sample of employee personnel files and found evidence of complete pre-employment and annual backgroud checks in each of them.

Standard 115.318 Upgrades to facilities and technologies

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

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

corrective actions taken by the facility.

Not applicable. WHS has not designed or acquired a new facility or made any substantial modification to the facilities at the Vassar campus since August 20, 2012, nor have they installed or updated monitoring technology.

Standard 115.321 Evidence protocol and forensic medical examinations

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

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

WHS does not conduct criminal investigations of allegations of sexual assault or harassment. The Vassar Police Department, with which WHS maintains a memorandum of agreement, is responsible for them. WHS does conduct administration investigations of such allegations. In addition, allegations of child abuse or neglect are forwarded to the MDHHS for investigation, and WHS's licensing agency also conducts investigations of certain types of allegations, including those of sexual abuse or harassment. Administrative investigations are conducted in accordance with a uniform evidence protocol that is developmentally appropriate for adolescents. The facility's chief internal investigator is also a law enforcement officer who works part time for the Vassar Police Department. He has completed a course conducted by the National Institute of Corrections, entitled "Investigating Sexual Abuse in a Confinement Setting," as have other WHS employees involved in investigations.

According to the PREA policy and both health services and management employees, a resident who experienced sexual abuse would be transported to Saginaw Covenant Hospital, where an examination would be performed bya Sexual Assault Nurse Examiner (SANE) without cost to the resident. There were no such incidents in the past 12 months.

WHS has communicated with the Sexual Assault Center in Saganaw, MI, in an effort to establish the availability victim advocate services for any resident who is sexually abused. The director of that organization responded in writing that the Center could provide short term crisis intervention and referrals to residents, but nothing more. Thus, WHS does not have an outside advocate available to accompanmy and support the victim through the forensic examination process and investigatory interviews and to provide emotional support, crisis intervention, information and referrals, as required by subsection (e) of this standard.

Although efforts to provide an outside victim advocate service have been unsucessful, WHS employs multiple specially trained staff members who are available to accompany and support a victim of sexual abuse through the forensic examination processes and investigatory interviews and to provide emotional support, crisis intervention, information, and referrals. Both PWLC and VH have masters level limited and fully licensed mental health professionals providing services to residents. The masters level therapists participate in specific 5 module PREA training titled "PREA Medical and Mental Care Standards". All masters level therapists are trained in trauma informed and truama specific services. A resident who is victimized could request one of the therapists or case managers to serve as an advocate.

Standard 115.322 Policies to ensure referrals of allegations for investigations

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

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

The WHS PREA policy provides and the agency ensures that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment. PWLC and VHS each had one allegation of sexual abuse in the past 12 months. At the time of the audit, both of the investigations were completed.

Facility PREA policy explicitly requires that any allegation of sexual abuse be reported to "the police," as well as MDHHS (Child Protective Services) and WHS's licensing authority, for investigation. That policy is published on the WHS website and differentiates between the responsibilities of the the agency and outside investigating entities.

Standard 115.331 Employee training

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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Wolverine provides PREA training to all of its employees who may have contact with residents, as confirmed by a review of agency training records. Emplyees indicate by signature that they understand the training they have received. Refresher training is provided every six months, which exceeds the annual training required. A review of the training curriculum, together with information provided by line staff during interviews, confirmed the inclusion of the required elements for training established in subparagraph (a) of this standard. During the on-site audit, the WHS PREA Coordinator provided evidence of the adoption of a curriculum regarding communication with lesbian, gay, bisexual, transgender and intersex (LGBTI) and gender nonconforming residents. This course will be required of all employees. Training materials reviewed were tailored to the unique needs and attributes of residents of juvenile facilities. Evidence was also provided of the adoption of a module on the dynamics of sexual assault and sexual harassment in confinment, along with information specific to male residents and female residents.

Standard 115.332 Volunteer and contractor training

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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Education at VHS is delivered pursuant to a contract with the Tuscola County Intermediate School District. Additionally, some health and mental health services are delivered by contractors. Based on interviews of administrators and contractors and a review of teachers' signed acknowledgement forms, VHS has trained all contractors on their responsibilities under its sexual abuse and sexual harassment prevention, detection, and response policies and procedures. The teachers spend considerable time with residents, but never without the presence of WHS staff. Based on the the services they provide and their contact with residents, the training they received on WHS's PREA-related policies is appropriate.

Standard 115.333 Resident education

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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Interviews of a staff member responsible for providing PREA information upon intake and interviews of residents confirmed that residents are being provided the required information at intake and are able to discuss what they learned. Approximately three months prior to the audit, the facility revised its intake process so that PREA information is provided residents by a consistent staff member. Interviews of residents reflected the success of that practice. While two of the longer term residents reported that at intake they were only given copies of the facility's written PREA document for residents, all of the recently arrived residents reported that PREA was explained to them and confirmed that the information required by subsection (a) of this standard was included. The facility provided documentation of residents' participation in the PREA orientation at intake.

The written PREA information provided residents at intake is relatively comprenensive. Within one week of intake, every resident meets with his or her therapist to engage in a more comprehensive and interactive PREA assessment. During and throughout the PREA assessment, therapists inform residents of the purpose of the assessment, residents' right to be free of sexual abuse and sexual harassment, and methods of reporting sexual assault and harassment. In addtion, beginning in December, 2015, WHS will be providing video education upon intake and quarterly refresher training to all residents in group meetings that will include written, verbal and video review of PREA information.

The agency has the ability to provide residents educational materials in languages other than English, although it reported not having had to do so to date. PREA education is individually provided to residents with limited reading skills or who are intellectually challenged. The facility is accustomed to working with youth with mental, emotional, and intellectual disabilities and able to work with such residents to ensure comprehension.

In addition to the education the facility provides residents, WHS also provides continuous access to PREA-related information. Not only are PREA handbooks provided to residents at intake, but during my tour of the facilities I observed posters reminding residents of their rights and providing telephone numbers for reporting incidents to MDHHS Child Protective Services or to the National Sexual Assault Hotline.

Standard 115.334 Specialized training: Investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

WHS employs two investigators who might perform an administrative investigation of an allegation of sexual assault or sexual harassment. Each of them has completed the National Institute of Corrections (NIC) course, "Investigating Sexual Abuse in a Confinement Setting," in addition to the general PREA training provided to all employees. The NIC course includes the elements required by subsection (b) of this standard. WHS provided documentation of their investigators' completion of the course. In addition, one of the investigators is a certified law enforcement officer who also works part time for the Vassar Police Department. He reported in interview that he has received additional investigative training in that capacity.

Standard 115.335 Specialized training: Medical and mental health care

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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WHS PREA policy requires the provision of specialized training to medical and mental health care workers, to include each of the four elements prescribed by subsection (a) of this standard. The facility provided documentation of completion of that training by its medical and mental health care staff, and those interviewed during the site visit confirmed having received the specialized training. Those personnel also received the PREA training required of all WHS employees who have contact with residents.

WHS medical staff do not perform forensic examinations of residents and therefore did not receive any specialized trainings on that subject. Forensic examinations would be provided at Saginaw Covenant Hospital.

Standard 115.341 Screening for risk of victimization and abusiveness

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Each resident of PWLC and VH is subject to a screening for risk of sexual abuse, as victim or perpetrator, upon arrival. The assessment is conducted by a therapist. Residents universally reported in interviews having been asked the mandated questions their first day on site. Wolverine PREA policy explicitly mandates that each of the factors set out in subparagraph (c) of this standard be included in the assessment, and the facility provided a copy of their assessment tool, which incorporates all 11 of the required elements. The instrument does not include any additional factors, but does pose follow-up questions that seek additional detail on some of the elements. WHS ascertains information for the assessment in a review of each resident's file, usually received prior to intake, and in conversation with each resident during the intake process. Because the assessments are performed by licensed therapists, they are subject to appropriate controls to limit the dissemination of the information they adduce. The therapists who produce and maintain the information are limited by the ethical requirements of their profession. According the Katrina Brock, Clinical Director, information obtained on the assessments is provided only on a need-to-know basis to staff who work with each resident.

The assessment is objective in that it is a standardized tool used with all clients of the agency, it is gender-nonspecific and appropriate for use with all genders, and it is culturally appropriate. The assessment is conducted by therapists who are trained to interpret the outcomes and to make appropriate recommendations for each assessed resident. Clinical management provides quality control to insure the consistency of conclusions reached on the assessments.

Standard 115.342 Use of screening information

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

During intake, staff conduct PREA orientation with residents prior to their assigment to a housing unit and to specific programming. Intake staff asks about any safety concerns and notes any observable risk factors or categories. Any concerns raised are considered when making the initial housing assignment. If the subsequent, more in-depth PREA assessment identifies a concern or raises a new risk factor for abuse, the resident's assigned therapist immediately reviews the housing assignment possible for reassignment to another unit. At any point in care, if any staff member or resident becomes concerned over a resident's safety, staff will assess the circumstances and may change a resident's housing or programming assignment, if appropriate.

WHS policy prohibits placing lesbian, gay, bisexual, transgender, or intersex (LGBTI) residents in particular housing, bed or other assignments on the basis of such identification or status. Policy also precludes considering LGBTI identification or status to be an indicator of likelihood of committing acts of sexual abuse. The same policy provides that when making a housing determination for a transgender or intersex resident, the faciity will consider on a cases by case basis whether the most appropriate placement for ensuring a resident's safety and avoiding management problems is a unit for males or females. Such placement decisions are to take into consideration a resident's views with respect to his or her own safety and be reviewed at least twice a year. Policy requires that transgender and intersex residents be given the opportunity to shower separately from the other residents.

This facility prohibits the use of isolation altogether, and in doing so it exceeds this standard.

Standard 115.351 Resident reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Residents of the WHS programs have numerous ways to report sexual abuse and harassment, and interviews confirmed that they are aware of them. Residents were able to discuss the grievance process for written reports and each of them noted that they could make a report to a staff member or administrator. Residents also understood that they could use the same methods for reporting retaliation and staff neglect or violation of responsibilities that may have contributed to an incident. Residents are also aware that they can report incidents to their parents/guardians, caseworkers, or attorneys. Residents have access at all times to the grievance forms, paper, and pens or pencils necessary to make a written report.

WHS provides two outside hotlines to which residents may report incidents of sexual abuse or sexual harassment, the MDHHS hotline for reporting child abuse or neglect, and the National Center for Sexual Abuse. Both toll free numbers are posted throughout PWLC and VH. Most of the residents expressed awareness of an outside hotline for reporting. The hotlines are also available to staff who wish to report sexual abuse or sexual harassment privately, and all of the interviewed staff expressed knowledge of the hotlines in their interviews.

WHS PREA policy mandates that staff accept reports of sexual abuse or sexual harassment made verbally, in writing, anonymously, or by third parties. It requires that any report be documented promptly and reported to the receiving staff's supervisor. When interviewed, staff members consistently expressed awareness of these requirements.

Standard 115.352 Exhaustion of administrative remedies

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

WHS PREA policy imposes no time limit for filing a grievance alleging sexual abuse. A resident is not required to use any informal process or otherwise attempt to resolve an alleged incident of sexual abuse with staff. Grievances are reviewed by an admnistrator specifically assigned to Client Rights and thus would not be reviewed by a staff member who is the subject of the complaint. Should the Client Rights administrator be the subject of the grievance, a resident could use one of the other reporting mechanisms discussed above. Policy appropriately provides that a resident can be disciplined for filing a grievance related to sexual abuse only if it is established that the resident filed the grievance in bad faith. Residents interviewed understood that they could not be disciplined for alleging sexual abuse unless they intentionally fabricated the allegation.

WHS PREA policy is consistent with subsection (d) of this standard in that it requires the agency to issue a final decision on a grievance alleging sexual abuse within 90 days of its filing. The facility may clain an extension of up to 70 days, should the normal time period for response be insufficient, and in the event such an extension is climed, policy requires that both the resident and his or her parent/guardian be notified. Policy further provides that third parties are permitted to assist residents in the grievance process. Policy in that regard is consistent with subsection (e) of this standard.

WHS reports two grievances alleging sexual abuse having been filed within the past year, each of which was resolved within the initial 90 day period allowed by policy.

WHS PREA policy also provides for the filing of an emergency grievance alleging that a resident is subject to a substantial risk of imminent sexual abuse. The Client Rights administrator, who receives all grievances, has the authority to take action and is required by policy to provide an initial response "immediately." [PREA Policy at (E)(4)]. Administrators stated in interviews that in such an instance, the resident alleged to be at imminent risk would be separated from any resident(s) believed to pose the threat by moving one of them to another unit, and that in addition one-on-one monitoring could be utilized.

Standard 115.353 Resident access to outside confidential support services

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

WHS provides residents telephonic access to the National Sexual Assault Hotline. It attempted unsuccessfully to establish a memorandum of understanding with the Sexual Assault Center, a local community agency that serves victims of sexual assaults, and provided written documentation of the attempt. The toll-free number of the National Sexual Abuse Hotline is posted in the housing units and elsewhere around the facility. Staff indicated in interviews that a resident who requested to contact the hotline would be permitted to do so and that the use would be reported to supervisors. Although the call would not be monitored closely, residents are informed and expressed awareness of the implications of the mandatory reporting statute.

Residents of WHS have the right to maintain contact with their families. They are permitted one regular telephone call with their parent(s)/guardian each week and are allowed special calls when circumstances dictate. Residents are also allowed contact with their attorneys at any reasonable time, and the confidentiality of attorney-client communications is observed.

Standard 115.354 Third-party reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance

determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

WHS publishes its PREA policy on its website, which also contains it information for outside parties who wish to report allegations of sexual abuse or sexual harassment. The PREA page on WHS's website, found at www.wolverinehs.org/Services/PREA.aspx, provides the telephone numbers for the Michigan Department of Health and Human Services (MDHHS) hotline and the National Sexual Assault hotline.

Standard 115.361 Staff and agency reporting duties

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

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

WHS PREA policy requires all staff to immediately report to their supervisor any knowledge, suspicion, or information they receive regarding an incident of sexual abuse or sexual harassment that occrred in a facility, retaliation against residents or staff who reported such incidents or retaliation, and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. In addition, agency policy requires compliance with Michigan's mandatory child reporting laws. Staff are explicitly prohibited by policy from revealing any information related to a sexual assault report, except as permitted by subsection (c) of this standard.

The policy provision requiring staff to report allegations of sexual abuse and harassment applies to medical and mental health practitioners, who are required to inform residents at the initiation of services of their duty to report and the limitations of confidentiality.

Once having received an allegation of sexual abuse, the Program Manager (facility head) is required to promptly report the allegation to the appropriate WHS administrators and the victim's parents or legal guardians, unless there is documentation showing the parents or legal guardians should not be notified. Notification must also be made to the vicitim's caseworker, if the alleged victim is under the guardianship of the child welfare system. Notification of the alleged victim's attorney is also made within 14 days of receipt of the allegation. Finally, every allegation of sexual abuse and sexual harassment is required to be promptly reported to the facility's designated investigators.

Standard 115.362 Agency protection duties

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

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

Wolverine PREA policy dictates that upon learning that a resident is subject to a substantial risk of imminent sexual abuse, the Facility Director, Program Manager, or designee must "take immediate steps to protect the alleged victim . . . by separating the alleged victim from the alleged perpetrator(s) including arranging for separate housing, dining, and/or other elements of daily routine to the extent necessary to ensure protection." [PREA Policy at (G)]. In interviews, agency administrators cited that policy and also noted that a resident thought to be at imminent risk of sexual abuse could be subject

to one-on-one monitoring in addition to being physically separated from potential perpetrators, where appropriate.

Standard 115.363 Reporting to other confinement facilities

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

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

When a report of sexual abuse at another faciity is received, WHS PREA policy requires the facility director to report the allegation to the director of the facility where the abuse allegedly occurred within 72 hours. If a report alleging sexual abuse at a WHS facility is received from personnel at another facility, all of WHS's policy provisions for reporting and investigating apply.

Standard 115.364 Staff first responder duties

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

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

The WHS PREA policy addresses the responsibilities and properly includes the elements set out in subsection (a) of this standard. The policy, as recently revised, differentiates between victims of sexual assault, who are to be be requested not to take any actions that could destroy physical evidence, such as washing, brushing teeth, changing clothes, urinating, defacating, drinking, or eating, and alleged perpetrators, who are to be prohibited from taking any such actions.

Standard 115.365 Coordinated response

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

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

WHS has developed a written institutional plan to coordinate actions taken by first respnders, medical and mental health providers, investigators, and

facility administrators in the event of an incident of sexual abuse. The plan meets the requirements of this standard. However, it is recommended that the facility revise its plan by adding names of individuals and and telephone numbers where appropriate and creating a checklist of actions to be taken in such circumstances.

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

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

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

Not applicable. WHS does not engage in collective bargaining.

Standard 115.367 Agency protection against retaliation

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

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

The WHS PREA policy establishes a "designated facility monitor" to monitor both staff and residents in order to prevent retaliation after sexual abuse is reported. The policy requires that monitoring continue for a minimum of 90 days after the report of an incident. According to administrators interviewed, additional measures to prevent retaliation include separating an alleged victim or reporter from the alleged perpetrator, placing any staff alleged to have committed sexual abuse or sexual harassment on administrative leave, and providing support for any resident who is a victim of or reports sexual abuse or harassment and who expresses fear of retaliation. Monitoring for retaliation extends to any person who cooperates with an investigation and expresses a fear of retaliation.

Standard 115.368 Post-allegation protective custody

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

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

Not applicable. The facility does not use isolation.

Standard 115.371 Criminal and administrative agency investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

WHS conducts administrative investigations into allegations of sexual abuse and sexual harassment. Criminal investigations are conducted by the Vassar Police Department (VPD). WHS's primary investigator is also a police officer who works part time for the VPD, which facilitates cooperation between the two agencies. In cooperating with a criminal investigation, WHS does not compel interviews of witnesses without first consulting VPD and in fact generally would cease investigating, pending the completion of the criminal investigation. WHS's investigators have completed the National Institute of Corrections course on investigating incidents of sexual abuse in confinement, which includes a section on victims who are juveniles. All reports of sexual abuse or sexual harassment are investigated, including third-party and anonymous reports.

In instances of sexual abuse, the criminal investigation, including the gathering of evidence, is conducted by the VPD. If an incident that is not subject to criminal investigation, WHS's administrative investigation would include evidence gathering and interiewing alleged victims, suspected perpetrators, and witnesses. WHS's primary investigator reported in interview that the agency would not terminate an investigation solely because its source recants the investigation, nor because the alleged perpetrator departs employment by or control of the agency. WHS's investigator also confirmed that credibility of any person in an investigation is assessed incividually and not determined by the person's status as resident or staff. WHS does not require a resident who alleges sexual abuse to submit to a polygraph or other truth-telling device as a condition for proceeding with an investigation.

Administrative investigations include an effort to determine whether staff actions or failures to act contributed to an incident of abuse. All administrative investigations are documeted in written reports that include a description of th evidence, the reasoning behind cridibility assessments, and investigative facts and findings. A review of a sample administrative investigation report confirmed this.

WHS policy was recently revised to include languge specifying that all personnel records are to be maintained at least 7 years following termination of employment.

Standard 115.372 Evidentiary standard for administrative investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

WHS's evidentiary standard for administrative investigations, including those for sexual abuse or sexual harassment, is preponderance of the evidence, as confirmed by the agency's primary investigator in interview.

Standard 115.373 Reporting to residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

WHS PREA policy provides that after an investigation into a resident's allegation of sexual abuse in an agency facility, the agency is to inform the resident of the outcome of the investigation, regardless of whether the allegation is found to be substantiated, unsubstantiated. or unfounded. Since the agency does not conduct criminal investigations, it requests relevant information from the Vassar Police Department, in order to inform the resident. WHS PREA policy also requires that a resident who has alleged sexual abuse by a staff member be informed when the staff member is no longer posted at the resident's unit, is no longer employed at the facility, has been indicted on a charge related to sexual abuse within the facility, or has been convicted on such a charge. Similarly, policy requires informing a resident-victim when an alleged resident-abuser has been indicted on a charge related to sexual abuse within the facility and when an alleged abuser has been convicted. All notifications or attempted notifications are documented.

Standard 115.376 Disciplinary sanctions for staff

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

A review of the WHS PREA and Personnel policies, along with interviews of facility administrators, including the human resources administrator, confirms that staff who violate agency sexual abuse or sexual harassment policies are subject to disciplinary action, up to and including termination. Termination is the presumptive sanction for staff who have engaged in sexual abuse. There were no instances of staff having been found to have done so in the past 12 months. Disciplinary sanctions for violations of agency policies relating to sexual abuse or harassment, other than actually engaging in sexual abuse, are commensurate with the nature and circumstances of the incident, the staff's disciplinary history, and the sanctions imposed for comparable offenses by other staff similarly situated. Terminations for violations of sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated, are reported to law enforcement, unless there clearly was no criminal activity, and to any relevant licensing bodies. .

Standard 115.377 Corrective action for contractors and volunteers

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Based upon interviews with adminstrative staff, a contractor or volunteer who engages in sexual abuse would be removed as a contractor or volunteer and thus prhibited from contact with residents. Such a person would be reported to law enforcement unless the activity was clearly not criminal, and to relevant licensing bodies. WHS would also consider whether to prohibit further contact with residents in the case of any other violation of agency sexual abuse or harassment policies.

Explicit policy is not by this standard, and therefore the facility is in compliance. However, it is recommended that this standard be addressed in agency policy.

Standard 115.378 Disciplinary sanctions for residents

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

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

WHS has recently developed a resident discipline policy for PREA related allegations. WHS policy PREA BSM properly provides that a resident who makes a good faith allegation of sexual abuse or neglect cannot be disciplined even if the allegation is not substantiated. The policy directs that any disciplinary action or sanctions, either for false reporting or for actual abusive behavior, are to be commensorate with the the nature of the misconduct, the resident's disciplinary history, and the resident's treatment plan goals. WHS prohibits all sexual activity between residents. However, activity that between residents that is not coerced is not deemed to constitute sexual abuse.

Disciplinary sanctions at WHS are made by a treatment team and adminstered through a level system. Because they are administered through a treatment-oriented system, they inherently take into consideration the impact of any mental disabilities or illnesses.

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

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

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

Agency employees stated in interviews that a resident whose screening reflects prior sexual victimization is offered a follow-up meeting with a mental health practitioner within 14 days of the intake screening. The interviews of two such residents corroborated that subsequent meetings with mental health practitioners occurred in a timely fashion. Mental health staff also stated that a resident found to have perpetrated sexual abuse in the past would similarly be offered a follow-up with a mental health practitioner within 14 days. WHS policy addresses this requirement for both prior victims and prior perpetrators.

Interviews of medical and mental health staff affirmed that information related to sexual abuse or victimization, regardless of where it occurred, is strictly limited to medical and mental health staff and other staff who need to know in order to inform treatment, security, and management decisions.

Standard 115.382 Access to emergency medical and mental health services

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

WHS uses Saginaw Covenant Hospital for emergency and crisis intervention services. WHS also employs registered and practical nurses, who work during regular business hours. Should an emergency occur when nurses are not on site, staff first responders are trained to render first aid until the arrival of emergency medical personnel or until the victim is transported to the hospital. Interviews of medical staff confirmed that resident victims of sexual abuse would be offered timely access to emergency contraception and to sexually transmitted infection prophylaxis, where medically appropriate. All medical treatment services are provided to victims without cost.

Standard 115.383 Ongoing medical and mental health care for sexual abuse victims and abusers

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

In the event of an incident of sexual abuse, the victim would be offered medical and mental health evaluation and appropriate treatment consistent with the community level of care. All medical services are provided victims without cost. The WHS PREA policy mandates these services, and medical and mental health practitioners confirmed their provision in interviews. Treatment includes appropriate follow-up services, treatment plans, and the utilization of off-site medical providers where necessary.

According to medical staff, resident victims of sexualy abusive vaginal penetration wold be offered pregnancy tests, and in the event of pregnancy, such victims would receive timely and comprehensive information about and timely access to all lawful prgnancy-related services. All victims of sexual abuse would be offered tests for sexually transmitted infections, as medically appropriate.

The facility would attempt to conduct a mental health evaluation of any known resident-on-resident abusers within 60 days of learning of such abuse history and would offer treatment deemed appropriate by mental health practitioners.

Standard 115.386 Sexual abuse incident reviews

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

WHS PREA policy mandates a sexual abuse incident review at the concludion of every sexual abuse investigation, and the resulting reviews of both sexual abuse investigations in the past year were provided. Although the first review did not occur within 30 days of the investigation, that deficiency was corrected on the second review. The review team, which included all of the participants required by this standard, addressed all of the elements listed in subparagraph (d) of this standard and produced a detailed written report of its findings. Recommendations for improvement identified in the review were implemented, as evidenced by training issues identified and staff training conducted. The facility provided training sign-in sheets for review.

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Standard 115.387 Data collection

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Both the MDHHS and WHS collect and aggregate data for allegations of sexual abuse annually, as required by this standard. MDHHS collects such data from the facilities it operates, as well as all of the facilities, including WHS, with which it contracts for the confinement of juveniles. WHS PREA policy requires this annual report.

Standard 115.388 Data review for corrective action

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Both the MDHHS and WHS review the data collected and aggregated annually pursuant to Standard 115.387 in order to assess and improve its PREA-related policies, practices, and training. Each entity produces an annual report that identifies problem areas and corrective actions taken. Those reports are approved by the head of the respective agency, and each is published on the agency's website.

Standard 115.389 Data storage, publication, and destruction

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The MDHHS retains data it collects pusuant to Standard 115.387 on a secure server. It makes all aggreaged sexual abuse data from both the facilities it operates and the ones with which it contracts available to the public on its website. Publicly published data contains no personal identifiers. By policy, MDHHS maintains sexual abuse data for at least 10 years after its publication.

AUDITOR CERTIFICATION

I certify that:

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

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

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

Auditor Signature

November 20, 2015

Date