Prison Rape Elimination Act (PREA) Audit Report
Juvenile Facilities

☐ Interim ☒ Final

Date of Report May 28, 2018

Auditor Information

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Company Name: Audit Associates	
Mailing Address: 13154 Mill Stone Drive	**City, State, Zip:** Austin, Texas 78729
Telephone: 512-431-4051	**Date of Facility Visit:** October 23-24, 2017

Agency Information

Name of Agency Wolverine Human Services		**Governing Authority or Parent Agency** **Michigan Department of Health and Human Services**	
Physical Address: 235 S. Grand Ave		**City, State, Zip:** Lansing, Michigan 48909	
Mailing Address: 333 S. Grand Ave; P.O. Box 30195		**City, State, Zip:** Lansing, Michigan 48909	
Telephone: 517-335-3489		**Is Agency accredited by any organization?** ☐Yes ☒ No	
The Agency Is:	☐ Military	☐ Private for Profit	☐ Private not for Profit
☐Municipal	☐ County	☒ State	☐ Federal

Agency mission: Improving the quality of life in Michigan by providing services to vulnerable children and adults that will strengthen the community and enable families and individuals to move toward

independence			
Agency Website with PREA Information: http://www.michigan.gov/dhs/0,4562,7-124-5453_34044_39057---,00.html			
Agency Chief Executive Officer			
Name: Nick Lyon		**Title:** MDHHS Director	
Email: Nancy Grijalva, Administrative Assistant to Director: GrijalvaN@michigan.gov		**Telephone:** Nancy Grijalva: (517) 241-1193	
Agency-Wide PREA Coordinator			
Name: Patrick Sussex		**Title:** PREA Juvenile Coordinator/Program Manager	
Email: sussexp@michigan.gov		**Telephone:** 517-648-6503	
PREA Coordinator Reports to: Dr. Herman McCall, Children's Services Administration Director		**Number of Compliance Managers who report to the PREA Coordinator** 0	
Facility Information			
Name of Facility: Wolverine Secure Treatment Center			
Physical Address: 2424 N. Outer Dr., Saginaw, Michigan 48601			
Mailing Address (if different than above):			
Telephone Number: 989-823-3040			
The Facility Is:	☐ Military	☐ Private for Profit	☒ Private not for Profit

☐Municipal	☐ County	☐ State	☐ Federal	
Facility Type:	☐ Detention	☒ Correction	☐ Intake	☐ Other
Facility Mission: Helping Children to be Victors				
Facility Website with PREA Information: http://www.wolverinehs.org				
Is this facility accredited by any other organization? ☒Yes ☐No				

Facility Administrator/Superintendent	
Name: Troy Mitchell	**Title:** Facility Director
Email: mitchellt@wolverinehs.org	**Telephone:** 989-776-0400

Facility PREA Compliance Manager	
Name: Kentera Patterson	**Title:** PREA Compliance Manager
Email: pattersonk@wolverinehs.org	**Telephone:** 989-823-3040

Facility Health Service Administrator	
Name: Teresa Harris	**Title:** Health Systems Manager
Email: harrist@wolverinehs.org	**Telephone:** 989-823-3040

Facility Characteristics	
Designated Facility Capacity: 100	**Current Population of Facility:** 100
Number of residents admitted to facility during the past 12 months	79

Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 10 days or more:	79
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 72 hours or more:	78
Number of residents on date of audit who were admitted to facility prior to August 20, 2012:	0

Age Range of Population:	12-21 years

Average length of stay or time under supervision:	12
Facility Security Level:	Secure
Resident Custody Levels:	Secure
Number of staff currently employed by the facility who may have contact with residents:	135
Number of staff hired by the facility during the past 12 months who may have contact with residents:	61
Number of contracts in the past 12 months for services with contractors who may have contact with residents:	13

Physical Plant

Number of Buildings: 1	**Number of Single Cell Housing Units:** 96
Number of Multiple Occupancy Cell Housing Units:	10
Number of Open Bay/Dorm Housing Units:	0
Number of Segregation Cells (Administrative and Disciplinary:	2

Description of any video or electronic monitoring technology (including any relevant information about where cameras are placed, where the control room is, retention of video, etc.):

A video monitoring system with cameras located throughout the interior and exterior of the building augments the facility's zero-tolerance efforts. Since the last PREA Audit, additional closed-circuit television cameras and related devices were installed in the therapists' offices and classrooms. The current staffing plan includes a section on video monitoring systems and states that the system is not actively monitored but is considered a deterrent to sexual acting out and other safety violations and is used in post-incident investigations. The plan also states that the system was designed to monitor youth activities and increase youth safety. During interviews, the Director of Clinical & Quality Services and Facility Director stated the cameras were added to address the previous inspection recommendations, cover blind spots, and enhance residents' safety including protection from sexual abuse. Current potential blind spots were discussed during the facility inspection on first day of the audit. In the control room, the auditors viewed live feed from seven cameras and noted coverage or lack of coverage. Video is retained for approximately two weeks.

Medical	
Type of Medical Facility:	Off grounds at Saginaw Covenant Hospital for other than routine services
Forensic sexual assault medical exams are conducted at:	Saginaw Covenant Hospital

Other	
Number of volunteers and individual contractors, who may have contact with residents, currently authorized to enter the facility:	2
Number of investigators the agency currently employs to investigate allegations of sexual abuse:	3 plus 1 backup from Vassar, MI

Audit Findings

Audit Narrative

Introduction

The Prison Rape Elimination Act (PREA) on-site audit of Wolverine Secure Treatment Center (WSTC) was conducted on October 23-24, 2017. WSTC is a secure residential treatment program located in Saginaw, Michigan and operated by the Wolverine Human Services (WHS). WHS is a private partner contracted by the Michigan Department of Health and Human Services (DHHS) to provide juvenile justice services. The previous audit occurred on January 26-27, 2015 at which time the facility had no corrective actions and became fully PREA compliant after implementing follow-up actions requested by the auditor. In the final report, the previous auditor noted:

> *After a discussion with PREA Coordinator, and providing a list of noted concerns, the PREA Coordinator advised the documents needed would be provided during the onsite visit. Specific corrective actions during the onsite visit taken to address some of the deficiencies are summarized in [the previous audit] report under the related standards*.

Nicole Prather and Debbie Unruh, U.S. Department of Justice Certified PREA auditors, conducted the audit. The State of Michigan DHHS sought the services of auditors through a Request for Proposal (RFP). Audit Associates, LLC, of which both auditors are members, responded to the RFP with a proposal. The Michigan DHHS accepted the proposal and a contract was executed that contained a summary of dates, work to be conducted, and payment terms including the payor, Michigan DHHS, and the payee, Audit Associates, LLC. The initial contract was effective on April 6, 2016 and expires on April 5, 2018. No third-party entity was involved in this process. Nicole Prather was the lead auditor, and Debbie Unruh was the secondary. Both auditors conducted interviews, reviewed documentation onsite, and collaborated during each phase of the audit. Nicole Prather was the point of contact throughout the audit and authored the Interim and Final Audit Reports. No barriers hindered the audit process, and the auditors were granted access to staff members, residents, all areas in the facility, and relevant documents. The audit process was discussed with the Compliance Coordinator and Compliance Manager through emails and phone calls. Both understood that the purpose of the audit was to determine compliance with each PREA Standard and that to make determinations the auditors would need access to supporting documentation, staff and youth, and all areas of the facility. The facility provided each of these, and the auditors determined corrective actions that would enhance current practices, policy and documentation, and staff and youth knowledge and understanding of the PREA Standards. The auditors discussed the corrective action and interim and final reports timelines with the Compliance Coordinator, Compliance Manager, and the Director of Clinical and Quality Services.

Pre-Onsite Audit

Pre-audit preparation included sending the PRC Process Map showing the audit process from pre- to post-audit, the PRC Audit Checklist listing the documentation per each Standard, and the PREA audit notification to the facility Compliance Manager and PREA Coordinator. The auditors verified the notices were posted at least six weeks prior to the audit and included necessary contact information as the Compliance Coordinator provided photographs of the notices throughout the facility. The date on the email with the attached photographs confirmed they were posted at least six weeks prior to the audit and contained the required information. The auditor contact information and the confidentiality statement on the notices provided staff and youth the opportunity to correspond with the auditors, but no correspondence was received.

The completed Pre-Audit Questionnaire (PAQ), facility policies, procedures, and documentation supporting compliance with each Standard were uploaded to a secure drive and mailed to the auditors. The auditors conducted a thorough reviewed of the PAQ, policies, and other documents including organizational charts, mission statement, protocols, reports, staffing plans, contract language, and training curricula specific to each Standard. Gaps were identified, and questions and requests for clarification and additional information were listed in the comments section by Standard in an Issue Log. The auditors sent the log via email to the facility Compliance Manager and Compliance Coordinator. Responses were typed within the document, returned, and reviewed by the auditors. Follow-up phone calls and emails were exchanged to gain further clarification and to continue discussions of the audit process. Included in the log were questions and additional information requested regarding the three PREA-related allegations reported on the PAQ as having occurred during the audit period. Two of these resulted in an administrative investigation, and none resulted in a criminal investigation. The one that was not investigated was unsubstantiated after an internal review, and was not investigated. The Compliance Manager stated the investigative files would be made available onsite. Details of the onsite review of these files are discussed in Standard 115.371.

Two forms were sent to the facility, completed by the facility, and sent back to the auditors. The first list contained staff members with specialized designations. The auditors randomly selected 17 staff members from the list provided by the Compliance Manager, highlighted the selected staff members, and sent the document via email back to the Manager two days prior to the audit. The selected staff members represented correctional, supervisory, and staff representing different levels of seniority and authority assigned to each shift. Additional interview details are discussed in the Onsite Audit section below.

The second list contained residents representing the targeted population designations including youth with a learning disability, and youth who reported sexual abuse, disclosed prior sexual victimization during intake, and identify as lesbian, gay, bisexual, transgender, and intersex (LGBTI). The form was returned to the auditors via email. The interview selection process is discussed in the Onsite Audit section.

An Internet search, review of the Facebook page, news articles, and images of the facility was conducted. No negative press, litigation, or DOJ involvement was noted. Additionally, the 2016-2017 annual strategic planning meeting agenda and minutes noted that a regulatory review was conducted and determined all licensing was in good standing and there were no repeat citations or gross misconduct violations. The Michigan DHHS and WHS websites were also reviewed. The DHHS website contains links to a juvenile justice section that includes a list and link to state-operated facilities, interstate compact for juveniles, detention support services, federal grant information, youth resources, and policy and compliance that includes juvenile justice policy manuals, facility PREA audit reports, annual PREA audit report, juvenile assessment system statistical report, guides and checklists, and training materials. The WHS website contains links to performance and quality improvement plan, PREA reports, PREA policy (outlined below), client and agency rights and responsibilities, grievance policy and procedures, and mandated reporters resource guide. The guide contains the Michigan Child Protection Law, list of mandated reporters, responsibility and role of reporters, types of reports that may be made, reporting process map, definitions, indicators of child abuse and neglect, outcomes of CPS investigations, hotline numbers, and the reporting form.

PREA Policy

WSTC adheres to *PREA Policy: WHS Prison Rape Elimination Act for Residential Services*. The policy is contained in one document, which is posted on the WHS website at www.wolverinehs.org and is organized as follows.

Purpose Statement
List of PREA-Related Definitions
Age of Consent
Standard Operating Procedure
- A. Providing Sexual assault Prevention Information to Youth
- B. Youth Assessment
- C. Staff Training on Offender Sexual Assault Prevention and Reporting
- D. Staff Supervision Relative to PREA Standards
- E. Youth Response to Sexual Assault
- F. Staff Response to Sexual Assault
- G. Alternate Housing Placement of Victims and Perpetrators
- H. Investigation Protocols
- I. Independent Audits and Facility Monitoring and Reporting
- J. Exhaustion of Administrative Remedies

Authority

Onsite Audit

On the afternoon of the first day, a brief entry meeting was conducted with the Director of Clinical & Quality Services, Facility Director, Compliance Coordinator, and Compliance Manager to discuss

the audit methodology including the facility inspection, additional documents and files to be reviewed onsite, and interview logistics. These staff members and additional supervisory staff accompanied the auditors in two groups during a facility inspection of all areas including the 10 dorms, offices, mechanical and storage closets, education areas attached to each living unit, medical area, laundry room, points store, the cafeteria and kitchen, theater, and the gym. One 62,000 square-foot building contains each of these areas. On the first day of the onsite audit, 97 residents were placed at the facility. Additional information regarding the facility layout is included in the Facility Characteristics section below.

The auditors informally interviewed youth and staff throughout the inspection and asked questions such as:

- Do you know how to report sexual abuse and harassment?
- Can you change clothes and use the bathroom without opposite-gender staff watching you?
- Do supervisors walk through this unit?
- Is the current number of staff present typical?

Doors into living units, control rooms, classrooms, and closets were checked, and all were secure. Telephones are not present in living units; however, they are available in therapists' offices. During formal and informal interviews, youth and staff members stated that youth may use the telephone to call the hotline and may do so privately as long as staff members maintain a line of sight through the therapist office window. The phone number posted in living units was called and answered, which confirmed access. Resident records are maintained in a locked room with limited staff member access. Following the inspection, the auditors viewed live feed from seven cameras and noted coverage or lack of coverage. Potential blind spots are discussed in in the Facility Characteristics section below. No intake, screening, or resident education session was conducted during the onsite audit, so these processes was not observed; however, questions regarding each of these were asked during youth and staff interviews and are discussed per Standard below.

During the second day of the audit, formal interviews with staff members and youth were conducted in private offices in the administration building and adjacent to the gymnasium. The Director of Clinical and Quality Services was interviewed as the Agency Head designee. The Facility Director has multiple responsibilities and was interviewed using three interview protocols: Superintendent, Investigative Staff, and Incident Review Team. No external investigator was interviewed; the Facility Director serves as the internal investigator, and the local police department conducts criminal investigations. The Compliance Manager was interviewed using the Compliance Manger and Incident Review Team interview protocols. A registered nurse was interviewed using the Medical and Mental Health Care Staff protocol. A therapist was interviewed using the Mental Health Care and Staff that Perform Screening for Risk of Victimization and Abusiveness. The intake assistant was interviewed using the Intake Staff and Random Staff protocols. A residential care coordinator was interviewed using the Intermediate- or Higher-Level and Random Staff protocol. Twelve additional Random Staff Interview protocols were used to

interview youth care workers, and of these, three were also interviewed as First Responders. The PREA Coordinator confirmed in writing that a SAFE/SANE nurse at a local hospital would provide these services if needed. One contractor was also interviewed by telephone to discuss the PREA training she received. The facility does not have a Memorandum of Understanding (MOU) with outside advocates/crisis services outside sexual assault advocacy agency, but residents and staff may make reports to the Michigan DHHS Protective Services and the National Sexual Assault Hotline, which is posted in each living unit. The hotline number was tested and confirmed to be available to take reports.

An up-to-date roster organized by living units and age was provided onsite on the second day of the audit. The residents to be interviewed were selected from the roster and targeted population form. The auditors selected at least one resident from each living unit including five females and six males. The auditors ensured an appropriate representation of age range, gender, and placement length. Eight residents were selected from the targeted population form including residents with a disability, and residents who identify as LGBTI, reported sexual abuse, and disclosed sexual victimization during the risk screening. The one resident who reported sexual abuse declined to speak with the auditors. A total of 15 youth interviews were conducted, as the one resident who reported sexual abuse declined to speak with the auditors.

WSTC staff members walked youth to and from the interviews, and the staff members were interviewed according to their shift and availability. The auditors completed interviews and onsite documentation review on the second day. Also on the second day, the Compliance Manager, Director of Clinical & Quality Services, and PREA Juvenile Coordinator/Program Manager of Michigan Department of Health and Human Services Juvenile Justice Programs (PREA Coordinator) provided additional documentation requested by the auditors during the pre-audit phase. A conference room was provided to the auditors for the duration of the audit.

During the inspection, consideration was given to camera placements and potential blind spots, the configuration of living units and restroom and shower areas, programming activities and educational programs, the level of youth supervision, indicators of any area lacking sufficient monitoring, PREA notifications, and hotline number postings. Blind spots were noted and discussed with facility supervisors during the walkthrough and described in the Facility Characteristics below. The configuration of living units allowed for sufficient line of sight, and two staff members were present in each dorm. Youth and staff stated the level of supervision and ratio was typical during day-to-day operations. The bathrooms contained separate toilet and shower stalls allowing for sufficient privacy and supervision when in use. Small signs containing the sexual assault hotline number were present in each dorm, and residents were aware of the sign and number. Staff members of the opposite gender were observed announcing their presence in dorms, and residents confirmed this expectation was practiced at all times.

The interviewers used the National PREA Resource Center's Interview Protocols for Juvenile Facilities for guidelines and interview questions. Responses to questions regarding staff members'

knowledge of PREA policies, reporting responsibilities, first responder and investigative duties, and training were compiled and integral to determining PREA compliance. Residents' responses to questions regarding their knowledge of PREA policies, the education and services they receive, and intake process was also essential in determining compliance.

In addition to completing interviews, the second day of the on-site portion involved reviewing additional documentation for each standard.-The auditors requested 12 resident and 12 personnel to be reviewed. Of these, seven youth master files corresponding to seven of those who were interviewed and six personnel files corresponding to six of those who were interviewed were reviewed onsite. The safe housing assessments and reassessments for two additional youth whose assessment data resulted in specific housing and bed assignments were also reviewed. The investigative reports for the two resident-on-resident sexual abuse allegations were also reviewed onsite and discussed below in the investigations section. The youth files were reviewed to determine compliance with intake procedures, safe housing determinations, PREA comprehensive education, and disclosures of prior victimization. The personnel files were reviewed to determine compliance with criminal background checks, disclosure of PREA standards violations, reference checks, Child Abuse Registry checks, and acknowledgment forms from PREA annual and refresher trainings.

On the afternoon of the second day, the auditors conducted a brief exit meeting to discuss overall PREA compliance, staff and resident knowledge of PREA, and actions to be taken following the on-site portion.

An Interim PREA Audit Report indicating the compliance determinations for each standard was sent to the facility on December 29, 2017.

Facility Characteristics

WSTC is a secure residential treatment program within the Wolverine Human Services (WHS), which is a private partner contracted by the Michigan Department of Health and Human Services (DHHS) to provide juvenile justice services. The facility was built in 1997, is located in Saginaw, Michigan, and serves adolescent males and females between the ages of 12 – 21. A secure gatehouse controls entry into and exit from the WSTC, and the perimeter is contained within a secure fence. The facility is comprised of one building, which includes clusters of housing units, cafeteria, infirmary, laundry room, points store, cafeteria and kitchen, theater, gym, offices, and an education area with classrooms, a combined administrative office area, and teacher break room. The 10 housing units include 96 single-occupancy cells and 10 (one for each unit) double-occupancy cells. Each unit contains a day area, storage closet, and bathrooms comprised of individual toilet and shower stalls. Connected to pairs of living units are pods that serve as workspace for supervisory staff members and central supervision of two pods at once. Also attached to each unit is a classroom, which limits movement to education. The living unit pairs, therapy offices, training room, and the two segregation cells surround and the doors open to the

central gymnasium. All areas provide adequate lines of sight, and the facility's 73 indoor and 16 outdoor cameras provides additional safety and monitoring capabilities.

During a youth's average length of stay of 12 months, he or she participates in assessments of medical, educational, safe housing, risk, and psychological strengths and needs, which drives treatment plans. Therapists provide treatment, which includes individual, group, and family counseling, Cognitive Behavioral Therapy, and specialized programming for substance abuse, sexual offending, and mental health.

Education is provided by Tuscola Independent School District who is responsible for hiring education staff members. The living unit pairs, therapy offices, training room, and the two segregation cells surround and open to the gymnasium, which is used for recreation. Residents also participate in outside recreation in a secure area, have access to an onsite theater, and may participate in yoga in a yoga room. Cafeteria staff members prepare meals in the facility kitchen, and residents walk from their unit to the cafeteria, move through the feeding line one unit at a time, and eat in the cafeteria. Two groups at a time are present, and each group sits on opposite sides of the cafeteria. The facility does not use isolation, and the Facility Director said isolation would only be used for aggressive youth and any segregation would likely not exceed 30 minutes; therefore, meals would not be served to youth in this area. Routine medical services are provided in the onsite infirmary, which includes a dental exam room and dental chair, additional exam rooms, and a medication room and cart, which is used to deliver medications to youth in their living units. For other than routine services, youth are transported to Saginaw Covenant Hospital.

The facility utilizes a central laundry area where staff members and youth participating in a work-study program. A point store contains items residents may "purchase" as incentives for positive behavior and progress. Also in this room is an area used for court proceedings via videoconferences. Each area was observed during the facility inspection, and potential blind spots were noted and discussed with supervisory staff who accompanied the auditors. These included an area in the principal's office/teacher break room, the secretary's office, storage closets in all housing units, each pod attached to pairs of living units, laundry room used by residents, and the dry storage, mop closet, and walk-ins in the kitchen.

The budgeted capacity is 100, and on the first day of the audit, 97 residents were assigned to the facility and placed by treatment need and age in one of the four female or six male living units. Although the facility's capacity is 100, 110 beds are available for use. The Compliance Manager and stated the facility has never been over the budgeted capacity. The average daily population during the audit period was 100 residents. Supervision is provided by youth care workers and mid-level supervisory staff members holding the titles of residential care coordinator, team manager, and safety and security team. The facility maintains a direct care staff-to-youth ratio of 1:5 during waking hours and 1:10 during sleeping hours when residents are in individual rooms. The ratio during waking hours exceeds the state requirement of 1:6 and the PREA standard of 1:8.

The ratio during sleeping hours meets the state requirement and exceeds the PREA standard of 1:16.

During the last 12 months, 79 youth were assigned to WSTC; 78 of these had stays longer than 72 hours and received comprehensive PREA education. During the audit period, WSTC employed 135 staff members including 61 who were hired during the past 12 months. All staff members are considered security staff. Also during the audit period, WSTC authorized two volunteers or contractors who may have contact with residents to enter the facility and executed 13 contracts for services with contractors who may have contact with residents. Medical services other than routine services are provided off site at a local hospital. Three WHS supervisory staff members who have received specialized investigator training conduct administrative investigations for WSTC, one of whom is housed at WSTC. Criminal investigations are conducted by Buena Vista Police Department. Residents and staff may make reports by calling the number posted in each living unit for the National Sexual Abuse Hotline.

Summary of Audit Findings – Interim Audit Report

The audit findings are based on evidence that is categorized into three groups: documentation, interviews, and observations. To determine compliance, the auditors analyzed evidence in each group, for each provision, for every Standard. The facility policy is assessed according to the PREA Standards and as outlined in the PREA Audit Tool. The auditors assessed supporting documentation, interview responses, and observations according to the Audit Tool, the Audit Checklist, and interview protocols. A summary including the assessment of each these three elements follows each Standard.

The Interim PREA Audit Report findings included 33 standards in compliance, 7 standards in noncompliance, and 1 standard exceeding compliance. Overall, WSTC's policies align with the PREA Standards regarding prevention planning, responsive planning, training and education, screening for risk, reporting, response to allegations, investigations, discipline, medical and mental health care, and data collection and review. Several policy revisions were included as corrective actions and are addressed by Standard and provision below.

The facility's prevention efforts include a zero-tolerance of sexual abuse and harassment evidenced by policy, documentation, and interviews; the education of youth regarding the policy; requirements of contracted entities to adhere to the same zero tolerance; staffing plans intended to protect youth against sexual abuse; and disallowing or limiting cross-gender viewing. WSTC supervisory staff members conduct unannounced rounds on all shifts. No trends were noted. A video monitoring system with cameras located throughout the interior and exterior of the building augments the zero-tolerance efforts. Interviews with staff and youth indicated they had received training and information regarding the right to be free from sexual abuse and harassment and all could articulate how to make reports. Staff members provided inconsistent responses regarding cross-gender pat down searches.

Evidence of responsive planning includes providing youth with SAFE/SANE services, policy and procedures regarding investigations, and the training of investigators to obtain usable physical evidence. No forensic medical examinations have been necessary, but facility protocol stipulates that youth requiring the examination would be transported to a local hospital. Two administrative investigations were conducted following residents' reports of sexual misconduct.

Training and education efforts include the development of PowerPoint presentations and utilizing the PRC and additional training curricula to provide information and education to staff members during annual and refresher staff trainings. Youth PREA education occurs during intake and again once youth are placed in housing units. Interviews with youth indicated PREA education is provided upon their arrival to the facility and continues once they are placed on a dorm. Interviews with staff members indicated they had received PREA training during new-hire and annual trainings. The contractor said she received sufficient training regarding PREA policies.

Screening for risk of sexual victimization and abusiveness efforts include the policy and practice that an intake staff member screens each youth for risk of sexual abuse victimization and abusiveness upon the youth's arrival to the facility. The objective screening instrument is used along with psychological assessments to determine housing and room assignments. Subsequent housing decisions are determined by additional periodic screenings and additional information such as incident reports, investigations, and therapists and/or direct-care staff members' recommendations or concerns.

Multiple reporting options are present at WSTC. The National Sexual Assault Hotline number is posted in living units, and the Michigan DHHS toll-free number and other PREA-related information is included in the Client Orientation Packet, which was noted to have a reading level of grade 14.6. Grievance procedures are in place, and youth are provided the tools necessary to complete and submit them. During interviews, staff members and youth could articulate multiple reporting options.

Official responses following a resident report of sexual abuse are governed by WHS policy and contained in a written institutional plan to coordinate responses to allegations of sexual abuse. The duties of specific staff members including medical and mental health practitioners, supervisors, and first responders are outlined in the plan. Staff members at all levels understood and could explain their duties.

WSTC conducts administrative investigations, and Buena Vista Police Department conducts criminal investigations of sexual abuse and harassment allegations. Two administrative investigations were conducted and reviewed. One investigator (the Facility Director) was interviewed and demonstrated compliance with each PREA Standard involving investigations, collection of evidence, notifications, referring for prosecution, and actions taken following an investigation. The investigative reports contained all required information except documentation

of youth notifications at the conclusion of the investigation. Additional details of the reports are discussed in the investigation section below.

Overall, WSTC's policies align with the PREA Standards regarding the reporting, responses, and immediate actions following a report of sexual abuse. WSTC has a written plan to coordinate responses to allegations of sexual abuse. The plan includes procedures for specific staff members and the actions each must take. Staff members demonstrated an overall knowledge of first responder duties during interviews.

Number of Standards Exceeded: 1

115.317: Hiring and Promotion Decisions

Number of Standards Met: 33

Number of Standards Not Met: 7

115.313: Supervision and Monitoring
115.315: Limits to cross-gender viewing and searches
115.316: Residents with disabilities and residents who are limited English proficient
115.333: Resident education
115.363: Reporting to other confinement facilities
115.373: Reporting to residents
115.378: Disciplinary sanctions for residents

Recommendations: 5

Compliance for these Standards was based on practice and interview information, but the auditors recommended implementing the changes to improve current practice and/or revising policy to improve alignment with PREA Standards; however, the implementation of these recommendations has no implication on compliance.

115.321: Evidence protocol and forensic medical examinations
115.331: Employee training
115.333: Resident education
115.353: Resident access to outside support services and legal representation.
115.367: Agency protection against retaliation

Summary of Corrective Action:

During the 180-day corrective action period, the facility addressed each Standard found to be in noncompliance. The PREA Compliance Manager provided additional documentation and revised policy, and the auditor conducted follow-up interviews by telephone. As a result of the corrective actions, the auditors determined the facility meets the requirments of 40 Standards and exceeds the requirements of one Standard, and thus, achieved full compliance with all Standards as of the

date of this report. Actions taken for the following Standards and determinations of compliance during the corrective action period are discussed below in the Corrective Action Taken section of the corresponding Standards.

115.313: Supervision and Monitoring
115.315: Limits to cross-gender viewing and searches
115.316: Residents with disabilities and residents who are limited English proficient
115.333: Resident education
115.363: Reporting to other confinement facilities
115.373: Reporting to residents
115.378: Disciplinary sanctions for residents

Summary of Audit Findings – Final Audit Report

Number of Standards Exceeded: 1

115.317: Hiring and Promotion Decisions

Number of Standards Met: 40

Number of Standards Not Met: 0

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.

Documentation and Policy Reviewed:

1. Completed PAQ
2. PREA Policy: WHS Prison Rape Elimination Act for residential programs
3. Organizational chart

Interviews:

1. Compliance Coordinator
2. Compliance Manager

Observations:

1. Compliance Coordinator and Compliance Manager performing PREA-related duties

(a): The WHS agency written policy requires that all residential juvenile staff members have zero tolerance for sexual abuse and harassment of residents. The policy includes definitions of types of

sexual abuse, indecent exposure, voyeurism, sexual misconduct and exploitation, age of legal consent, and first responder duties. The standard operating procedures include details regarding the processes for 1) providing sexual assault prevention information to youth, 2) youth assessment of sexual vulnerability and potential victimization and subsequent housing decisions, 3) staff training on sexual assault prevention and reporting, who must be trained, training topics, and specialized training, 4) staff supervision relative to PREA Standards, ratio requirements, awareness of behaviors, and opposite announcing requirements, 5) responses to sexual assault, notification and documentation requirements, client's rights, reporting options, monitoring for retaliation, 6) alternate housing placement of victims and perpetrators, 7) investigation protocols, actions to be taken for suspected or alleged resident-on-resident or staff-on-resident sexual activity, 8)independent audits and facility monitoring and reporting, distribution of reporting options, and data collection, and 8) administrative remedies.

(b): The state of Michigan has a designated state PREA Juvenile Coordinator as well as facility-level PREA Compliance Managers. The Coordinator is listed on an organizational chart for the facility where the Coordinator's official workstation is located. He stated he did not supervise facility-level Compliance Mangers as they are under the supervision of the Directors at their individual facilities. The Coordinator said he provided technical assistance to them and assisted them in achieving PREA compliance but did not have supervisory authority over them as most facilities are privately operated.

(c): The WHS organizational chart includes the PREA Director's position within the agency, and the WSTC chart includes the Compliance Manager who reports to the Director of Clinical & Quality Services who reports to the Senior Vice President of Residential Services. The facility Manager said she had sufficient time and authority to perform her duties. She said she ensures the intake process is followed, receives weekly information from each of her facilities, receives any PREA-related information, is aware of all investigations, makes sure facilities take appropriate actions following investigations, and conducts reviews of the investigation and follow-up actions taken by the facility.

Summary of Findings:

The auditors reviewed WSTC's PREA Policy and evaluated the document against the requirements of this Standard and the PREA Audit Tool, which stipulate: the policy must a) be written, b) mandate zero tolerance, and c) mandate the designation of agency-wide Compliance Coordinator and facility-level Compliance Managers. The facility's written PREA Policy contains each of these three requirements, which supported compliance with provision (a). The organizational chart includes the Compliance Manager and Compliance Coordinator positions as required by the facility policy and provisions (b) and (c), which supported compliance with these provisions. During interviews, the staff members in these positions stated they have sufficient time and authority to be effective in their respective roles as provisions (b) and (c) require. Both staff members stated they have dedicated offices at other facilities, and throughout the audit, they were

observed interacting with facility employees and performing duties related to the audit, which further supported the auditors' determination of compliance with provisions (b) and (c). Based on the documents reviewed, interview responses, and observations, the auditors determined the facility satisfied each element in the Audit Tool, demonstrated compliance with all provisions, and thus met the requirements of this Standard.

Corrective Action: None

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 OR the response to 115.312(a)-1 is "NO".) ☒Yes ☐No ☐ NA

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations

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

Documentation and Policy Reviewed:

1. Completed PAQ
2. Michigan DHHS Contract Language (page 26, section 23)
3. PREA Facility Compliance Assessment form

Interviews:

1. Compliance Coordinator

Observations:

1. WSTC, the facility operated by contractor WHS, implementation of the PREA Standards

(a): Michigan DHHS holds the contract for WSTC, and WHS is the contractor. Contract language for all contracted juvenile justice residential providers requires that each contractor shall comply with all provisions of the PREA and that compliance will be monitored by DCWL (Department of Child Welfare Licensing). The policy also requires that actions should be taken and documented that ensures 1) staff are trained on PREA compliance, 2) objective reporting and investigation procedures, 3) youth understand PREA regulations, and 4) volunteers, employees, contractors, and other regular facility visitors have been screened according to PREA standards.

(b): The DHHS requires all of the contracted facilities to comply with the PREA. The Compliance Coordinator provided documentation that evidences periodic PREA compliance assessments for WSTC and other WHS facilities were conducted and recommendations made. The PREA Facility Compliance Assessment form includes notes, questions, and elements to consider per each PREA standard during facility assessments. The Compliance Coordinator said the Director of Clinical & Quality Services accompanies him during assessments, takes notes, and implements any suggestions for improvement.

Summary of Findings:

The auditors reviewed the Michigan DHHS contract language and evaluated the language against the requirements of this Standard and the PREA Audit Tool, which stipulate: a) the contract must require compliance with the PREA Standards and b) the contract must provide for monitoring of the contractor. The contract language includes each of these elements, which supports compliance with provisions (a) and (b). The PREA Facility Compliance Assessment form used during monitoring visits and an email thread discussing needed improvements provided evidence that monitoring occurred between audits, which supported compliance with provision (b). During interviews, the Compliance Coordinator described the monitoring visit procedures, which also supports compliance with provision (b). Additional evidence of compliance was present throughout the audit, as the auditors observed WSTC's implementation of the PREA Standards as

required by contract language. Based on the documents reviewed, interview responses, and observations, the auditors determined the facility satisfies each element in the Audit Tool, demonstrates compliance with both provisions, and thus, meets the requirements of this Standard.

Corrective Action: None

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

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

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

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: The prevalence of substantiated and unsubstantiated incidents of sexual abuse? ☒Yes ☐No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Generally accepted juvenile detention and correctional/secure residential practices? ☒Yes ☐No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any judicial findings of inadequacy? ☒Yes ☐No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any findings of inadequacy from Federal investigative agencies? ☒Yes ☐No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any findings of inadequacy from internal or external oversight bodies? ☒Yes ☐No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: All components of the facility's physical plant (including "blind-spots" or areas where staff or residents may be isolated)? ☒Yes ☐No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: The composition of the resident population? ☒Yes ☐No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: The number and placement of supervisory staff? ☒Yes ☐No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Institution programs occurring on a particular shift? ☒Yes ☐No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any applicable State or local laws, regulations, or standards? ☒Yes ☐No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: 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 only until October 1, 2017.) ☒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 only until October 1, 2017.) ☒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 only until October 1, 2017.) ☒Yes ☐No ☐NA

- Does the facility ensure only security staff are included when calculating these ratios? (N/A only until October 1, 2017.) ☒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.

Documentation and Policy Reviewed:

1. Completed PAQ
2. PREA Policy: WHS Prison Rape Elimination Act for residential programs, Section I
3. Current staffing plan
4. Signed Staff Plan Review illustrating annual reviews and development process
5. Supervisory Unannounced Rounds forms

Interviews:

1. Facility Director
2. Compliance Manager
3. Compliance Coordinator
4. Staff responsible for conducting unannounced rounds

Observations:

1. Camera placement
2. Video surveillance system
3. Staffing levels during facility inspection

(a): WHS policy requires that the facility must develop, document, and implement a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring to protect residents from sexual abuse. The staffing plan, annual strategic planning meeting agenda, and dated and signed staffing plan review confirms the facility has approved and conducted an annual and periodic review of the plans. Items determined to meet or exceed compliance include staff-to-youth ratios, staff supervision of youth, and on-duty supervisory personnel. One action taken per the staffing plan review was upgrading the video monitoring system. Confirmation that this action was taken was determined through interviews, observation of camera placement during the

facility inspection, and observation of live feed from seven cameras following the inspection. The Director of Clinical & Quality Services and Facility Director stated the cameras were added to address the previous inspection recommendations, cover blind spots, and enhance residents' safety including protection from sexual abuse. The Compliance Manger stated that the Compliance Coordinator, Director of Clinical & Quality Services, Program Managers, Senior VP of Programs, and other supervisory staff members also consider PREA-related items such as staffing ratios, occupancy, and overall referrals and discharges in the weekly administrative meetings. During the facility inspection and informal interviews, residents and youth care workers stated supervisory staff members are visible and make frequent visits to their units during each shift.

(b): Interviews with the Director and the PAQ responses indicate the facility did not deviate from the staffing plan in the past 12 months. The staffing plan document includes a review of staff-to-youth ratios, the availability of supervisory staff, and findings of inadequacy. The document indicates that each of these was found compliant or found to exceed compliance; thus, no documentation of deviations from the staffing plan was included or required.

(c): The staffing plan requires and the Director reported that the facility maintains a direct care staff-to-youth ratio of 1:5 during waking hours and 1:10 during sleeping hours when residents are in individual rooms. The ratio during waking hours exceeds the state requirement of 1:6 and the PREA standard of 1:8. The ratio during sleeping hours meets the state requirement and exceeds the PREA standard of 1:16. Only staff members who provide direct supervision and were trained in crisis intervention, first aid, and PREA, and are included in the ratio. During the facility inspection, these ratios were met or exceeded in all areas. During informal interviews, residents and youth care workers stated the level of supervision present on the day of the audit was typical in day-to-day operations. The unannounced rounds sheets indicate "staff monitoring clients" occurred during each round, and references no instance of the staff-to-youth ratio not being met.

(d): WHS policy requires that the staffing plan be reviewed at least once per year. The facility Director and the facility Compliance Manager stated that during the annual review, consideration is given to the 11 elements of this provision. The 11 elements and additional considerations including a review of staff-to-youth ratios, the availability of supervisory staff, findings of inadequacy, and camera coverage are included in the current and previous annual review documents. The documents indicate that each item was found compliant or found to exceed compliance. The annual strategic planning meeting minutes noted that staffing numbers over the past year have increased as the census has grown and includes the number of staff and intern new hires and staff terminations. One action taken as a result of the review is discussed in provision (a) above. The staffing plan, annual strategic planning meeting agenda, and dated and signed staffing plan review confirms the facility has approved and conducted an annual and periodic review of the plan. The review documentation from the previous year includes reviews of census and occupancy trends, staff ratios, licensing and audit information, and revisions such as the addition of positions. The review includes a signature page indicating attendance of administrative team members. Although the titles of the team members are not included in the signature area, the

auditors confirmed through interviews and introductions during the onsite portion that the Compliance Manager, Director of Clinical & Quality Services, Facility Director, and Residential Care Coordinator were in attendance. The Compliance Coordinator stated he is responsible for providing technical assistance to facilities as requested and/or required relative to development and review of staffing plans. The Compliance Manger confirmed this is the practice and stated that the Compliance Coordinator, Director of Clinical & Quality Services, Program Managers, Senior VP of Programs, and other supervisory staff members also consider PREA-related items such as staffing ratios, occupancy, and overall referrals and discharges in the weekly administrative meetings.

(e): The requirements for unannounced rounds are not included in WHS policy. However, unannounced rounds sheets were provided and include the date, time, unit visited, remarks of staff and group activity, staff member's name and title, and initials managerial staff members. Interviews with supervisory staff members confirm that unannounced rounds are conducted and documented each day. The Supervisory Unannounced Rounds forms include the date, time, unit visited, staff remarks regarding observations, and name and title of the staff member. All shifts and days of the week were covered, and no trends were noted.

Summary of Findings:

The auditors reviewed WHS PREA Policy, staffing plans and reviews, and unannounced rounds forms. These documents were assessed against the requirements of this Standard and the PREA Audit Tool, which require: a) the development and implementation of a staffing plan that provides adequate staffing levels and the determination of the need for video monitoring; b) compliance with the plan and documentation of deviations; c) maintaining PREA-required staffing ratios; d) at least annual assessments of the staffing plan, staffing patterns, video monitoring systems, and available resources; and e) conducting and documenting unannounced rounds. The facility staffing plan and development process include all elements of provision (a). The facility's review includes staff members' signatures confirming their presence and documented safety measures taken as a result of the review, thus supporting compliance with provisions (a) and (d). Evidence supporting compliance with provisions (a) and (b) was demonstrated during interviews, as the Facility Director and Compliance Manager described the staffing plan review process, communicated knowledge of the items in provision (a), and reported the facility had not deviated from the plan. Evidence of compliance with provisions (a), (b), and (c) was demonstrated through observations of camera placement, live video in the control room, staffing levels in living units and other areas where residents and staff were present, and formal and informal interviews during which staff and residents stated that the staffing levels observed during the inspection were typical during day-to-day operations. The completed unannounced rounds documentation forms demonstrate partial compliance with provision (e), as the practice of conducting these rounds is in place. Based on the documents reviewed, interview responses, and observations, the auditors determined the facility satisfies all but one element in the Audit Tool and demonstrates compliance with all but one provision. Since the facility policy does not include details regarding unannounced rounds as required by provision (e), the auditors determined the facility does not meet the requirements of this Standard, and a corrective action was initiated.

Corrective Action:

1. Revise policy to include the requirements for conducting unannounced rounds.

Corrective Action Taken:

1. The facility provided the revised WHS PREA Policy, which includes the requirements for conducting unannounced rounds per provision (e). The policy states that supervisors will conduct unannounced rounds to ensure and verify compliance with PREA standards and protocols, and to support safety and reporting. Additionally, the policy states that unannounced rounds will occur across all shifts and staff is prohibited from warning other staff when unannounced supervisory rounds are occurring. Based on the revised policy, the auditors determined the facility demonstrates compliance with all provisions, and thus, meets the requirements of this Standard.

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 implement policies and 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.

Documentation and Policy Reviewed:

1. Completed PAQ
2. WHS PREA Policy Sections B, C, and D
3. Shift and search logs
4. Training curricula
5. Staff training logs

Interviews:

1. Compliance Manager
2. Facility Director
3. Youth Care Workers
4. Random youth

Observations:

1. Individual rooms
2. Showers and bathrooms in all living units

(a): The WHS training curricula include a PowerPoint outlining policies regarding searches. Slide number 10 states that WHS prohibits body cavity and strip searches by staff members. The PAQ indicated that the facility does not conduct these types of searches, and none were conducted during the last 12 months. No logs documenting these searches were reviewed, as none were conducted during the audit period. During interviews, non-medical staff members stated that these searches are prohibited and would not be conducted at the facility absent an exigent circumstance. The medical staff member, a registered nurse, reported that cavity searches would not occur in the facility and would be conducted at the local hospital. The training they received regarding searches is described in provision (b).

(b): WHS policy prohibits cross-gender pat searches except in exigent circumstances, and in that event, the circumstances must be documented with the justifications that lead to the search. During interviews, all youth, including two who identify as LGBTI, reported being pat searched by a same-gender or preferred-gender staff member, and none reported being searched by a cross-gender staff member. Non-medical staff members' responses were inconsistent regarding cross-gender pat searches and exigent circumstances. Of the 12 youth care workers interviewed, one stated she had received training on how to conduct cross-gender pat searches, one stated she was trained on how to conduct a cross-gender air search, and one stated she would conduct this type of search if the circumstance was life threatening but had not received training. All other youth care workers said they would never conduct a cross-gender search and would wait for a same

gender staff member, as one is always available. The majority could not articulate examples of exigent circumstances that would allow a cross-gender pat search.

(c): WHS policy requires that cross-gender pat searches and body cavity and strip searches are prohibited except in exigent circumstances, and in that event, the circumstances must be documented with the justifications that lead to the search. The PAQ indicated that the facility does not conduct these types of searches, and none were conducted during the last 12 months.. The Compliance Manager stated that if these searches were to occur, they would be documented on a staff statement form and shift log to explain the details of the search.

(d): WHS policy prohibits cross-gender non-medical staff members from observing youth changing clothing, showering, or performing other bodily functions where buttocks or genitalia of youth are exposed except in exigent circumstances or when such viewing is incidental to routine checks.

Policy requires that staff members of the opposite gender are required to announce their presence when entering youth sleeping and bathroom areas, and when a staff of the opposite gender is assigned to work with the group, staff must announce their presence when entering a resident housing unit. During the facility inspection, staff members were observed announcing their presence in living units, and during informal and formal interviews, staff members and youth reported the practice of announcing opposite-gender staff members is consistently followed.

(e): WHS policy prohibits searching or examining a transgender or intersex youth for the sole purpose of determining the youth's genital status. Policy states that if a youth's genital status is unknown, it may be determined during conversations with the youth, 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. Staff members communicated an understanding of the policy during interviews.

(f): WHS policy prohibits cross-gender pat searches except in exigent circumstances and stipulates that all direct-care staff members must be trained in conducting these searches. Policy also states searches of transgender and intersex residents must be conducted in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs. Staff who search transgender and intersex youth must be trained in how to conduct such searches. However, policy does not include the procedures specific to conducting cross-gender pat searches and searches of transgender and intersex youth. Staff responded inconsistently when asked about policy regarding cross-gender pat searches, whether they received training related to these searches, whether WSTC allows such searches in exigent circumstances, and what constitutes an exigent circumstance.

Training curricula provided include a PowerPoint outlining WSTC policies regarding pat searches, the PREA Training Course Instructor's Outline which mentions searches, and a link to the National PREA Resource Center's training for orientation on cross-gender and transgender pat searches.

Summary of Findings:

The auditors reviewed policy and training curricula regarding strip, body cavity, and gross-gender searches and compared these documents against the details of this Standard and the PREA Audit Tool, which: a) prohibit cross-gender strip and body cavity searches; b) prohibit cross-gender pat searches except during an exigent circumstance; c) require documentation and justification of cross-gender visual body cavity searches and cross-gender pat searches; d) require policy and procedures that ensure residents' privacy while showering, changing clothes, and performing other bodily functions; requires staff members of the opposite gender to announce their presence; e) prohibit examining a transgender or intersex youth to determine genital status; and f) require training regarding searches. Evidence of compliance includes facility policy and practice and training materials that align with provisions (a) – (f). Additional evidence of compliance includes search logs showing only allowable searches were performed and interview responses corroborating that searches are consistently conducted per facility policy and this Standard. The auditors determined compliance with provision (d) because: 1) the auditors observed opposite-gender staff members following WHS and PREA policy by announcing their presence when entering living units, 2) staff and residents reported this was the expected practice, and 3) bathrooms, showers, and rooms were observed to provide privacy to residents when changing clothes, showering, and performing bodily functions. The auditors determined the facility meets the requirements of provisions (a), (c), and (e) after reviewing policy, making observations, and interviewing staff members and residents. The auditors determined the facility does not meet the requirements of provisions (b) and (f), as staff members responded inconsistently when asked about cross-gender pat searches and exigent circumstances. A corrective action was initiated for these two provisions.

Corrective Action:

1. Provide additional/refresher training to address staff members' inconsistent responses regarding cross-gender pat searches and the exigent circumstances that would allow such searches. Provide documentation such as training sign-in sheets demonstrating that staff members received and understood the training.

Corrective Action Taken:

1. The PREA Compliance Manager provided training attendance sheets for a training conducted during the corrective action period. The training addressed PREA pat down searches, and the attendance sheets included signatures, assigned shift, the training location, and the date, which indicated that staff members attended and received the training. The auditor conducted follow-up interviews with staff members from the day and evening shifts and representing a variety of positions. Each could articulate the training he or she received regarding cross-gender pat searches including how the pat search would be conducted, exigent circumstances that would warrant the search, notifications to

supervisory staff members, and the documentation process. None said they were aware of any such searches having been conducted. Based on the training sheets provided, staff members' responses, and current policy regarding cross-gender pat searches, the auditors determined the facility satisfies the requirements of this provision, and thus, meets the requirements of this Standard.

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.

Documentation and Policy Reviewed:

1. Completed PAQ
2. WHS PREA Policy Section A
3. Translator Resource List
4. Client Orientation Packet
5. Training curricula

Interviews:

1. Youth with intellectual disability
2. Staff member who provides initial PREA training to youth
3. Director of Clinical & Quality Services

Observations:

1. Interactions between staff members and residents

(a): WHS policy requires that PREA-related information be provided verbally and in written form and in a language and format that the youth can understand. Policy states that accommodations must be provided so that limited English proficient, deaf, blind, or otherwise disabled residents have full access to this information. Policy prohibits using resident readers or interpreters to provide this information except when to do so would cause an unnecessary delay that could compromise the youth's safety. Policy states that video presentations may be used to supplement the content of the presentation but direct verbal and written information must be included.

For limited English proficient youth, WSTC utilizes translator services on the Michigan Department of State Translators Resource List, which includes the agency, telephone number, location, and language. No translators on the list included services for youth who are deaf, hard of hearing, or visually impaired.

All staff members, including intake staff members who provide residents PREA-related information, are required to view the PREA Resource Center's webinar titled *Making PREA and Victim Services Accessible to Incarcerated People with Disabilities: An Implementation Guide for Practitioners October 29, 2015* twice per year and during initial training. In the training, strategies for increasing access include a maximum reading level of 5th grade, sans serif font, increased font,

ample contrast, limited amount of text, text aligned on the left margin, appropriate hierarchy of information, and upper and lower-case letters.

During interviews, the Director of Clinical & Quality Services stated residents are provided a PREA Orientation Packet and client's rights checklist that are reviewed with the youth by an intake staff member. She stated residents also watch the PREA Resource Center video, acknowledge their understanding, and meet with a therapist who reviews the information. A resident with a disability/low reading skills said he received PREA information in a "pamphlet" and was told that if he had questions, to ask a staff member. He said a therapist provided this information.

According to Word's built-in text leveling tool, the WHS Preventing Sexual Assault Client Orientation Packet has a Flesch-Kincaid reading grade level of 14.6 meaning youth with college level reading skills would be able to read and/or understand the document. The PREA Training video link provided for Standard 115.333 is viewed by all residents upon intake and is designed specifically for juveniles. Additionally, for Standard 115.333, Client Signature Sheets for PREA Orientation were provided and indicate residents sign the sheets to acknowledge their receipt and understanding of the orientation. Additional signature sheets in youths' files were reviewed on site.

(b): WSTC has taken steps to ensure youth who are limited English proficient have equal opportunity to participate and benefit from efforts to prevent, detect, and respond to sexual abuse. Translator services are provided by agencies included on the Michigan Department of State Translators Resource List. The auditors contacted three of the agencies on the list to confirm these services would be offered to youth at WSTC.

(c): WHS policy prohibits using resident readers or interpreters to provide this information except when to do so would cause an unnecessary delay that could compromise the youth's safety. WSTC reports no occurrences of the use of youth interpreters in the last 12 months. Staff members stated they would not use youth interpreters except in exigent circumstances. No limited-English proficient residents were placed at the facility during the onsite audit. Residents with a disability/low reading skills did not report the use of resident readers and said they received PREA information in a "pamphlet,' which a therapist explained.

Summary of Findings:

The auditors assessed WHS policy and training curricula addressing equal access to PREA-related information and education against the elements of this Standard and the PREA Audit Tool, which require: a) youth with disabilities have equal opportunity to participate or benefit from the facility's efforts to prevent, detect, and respond to sexual abuse and harassment; b) youth who are limited English proficient have meaningful access to these efforts; and c) resident interpreters will not be used except in limited circumstances. The auditors determined WHS policy addresses each of these requirements, which support compliance with provisions (a) and (c). Evidence supporting compliance with provisions (a) and (b) include a list of translator services that provide language

assistance to limited English proficient residents; however, no translators provided assistance to residents who are deaf, hard of hearing, or visually impaired. A corrective action was initiated for this provision. Interviews with staff members provided evidence and justification of compliance with provisions (a) and (c), as they described the processes for providing PREA-related information to residents and reported that resident interpreters would not be used to assist residents in making a report of sexual abuse or harassment. Residents' responses during interviews supported compliance with provisions (a) – (c), as they stated they understood the PREA-related information provided to them, and reported residents readers were not used to relay this information. Resident signatures acknowledging their receipt of the Client Orientation Packet containing details about PREA provided additional evidence of compliance with provision (a). When considering whether staff members effectively communicated with residents, the auditors observed staff members interacting with residents and determined that general communication with residents was age and level appropriate. In making a final determination of compliance with provision (a), the auditors used Word's built-in text leveling tool, which leveled the WHS Preventing Sexual Assault Client Orientation Packet at a reading grade level of 14.6 meaning youth with college level reading skills would be able to read the material. Based on the advanced reading level, the auditors concluded the facility does not meet the requirements of provision (a), and thus a second corrective action was initiated.

Corrective Action:

1. Provide agreement with or procedures for translator services for youth who are deaf, hard of hearing, or visually impaired.

2. The National PREA Resource Center checklist includes documents to review during the on-site portion of the audit. One item was not present for review for this standard:
    a. "Written materials used for effective communication about PREA with residents with disabilities or limited reading skills."

       The Client Orientation Packet was reviewed and leveled using Word's built-in text leveling tool. The WHS Preventing Sexual Assault Client Orientation Packet has a Flesch-Kincaid reading grade level of 14.6 and is not level appropriate for youth. Provide evidence of alternative reading materials and evidence they are being utilized.

Corrective Action Taken:

1. The PREA Compliance Manager stated that a table outlining sexual abuse truths and untruths would now be included as reading material for residents with disabilities and/or low reading skills. The auditors confirmed that the reading level was reduced to grade 4.9 and determined that the facility demonstrates compliance with this provision.

2. The PREA Compliance Manager provided new WHS policy and procedure titled "Helping clients access assistive technology; Class: Rights of Persons with Developmental

Disabilities." The document outlines the relationship between the facility and the school district that provides education to the facility clients. The educational program identifies individual needs of students "suspected of communication, intellectual, verbal, visual, hearing, and/or physical disabilities and thus will establish eligibility for programs and services." Additionally, "the individual needs of students will be provided with appropriate materials or necessary tools to understand client orientation, forms and documents; including but not limited to PREA, Client Grievances and Client Rights & Responsibilities." Based on the new policy, the auditors determined the facility satisfies the requirements of this provision, and thus, meets the requirements of this Standard.

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, or 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)

- Unless prohibited by law, 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.

Documentation and Policy Reviewed:

1. Completed PAQ
2. WHS Human Services Employment Application
3. WHS Recruitment and Selection Policy and Procedures
4. Staff manual

5. Personnel files

Interviews:

1. Human Resources staff

Observations: No observations relative to this Standard were required.

(a): WHS policy requires that WHS ensures employees/volunteers/contractors and interns or prospective employees/volunteers/contractors and interns will not be hired and/or continue employment if they are listed on the public sex offender registries. Policy also states that employment requirements include a TB test, driver's license clearance, references, criminal background checks, and sex offender registry checks (State of Michigan and Dru Sjodin National Sex Offender Registry, central registry clearance, etc.). The Human Resources Department also verifies applicants' work history and educational background.

Six personnel files reviewed on site included proper background checks, references, certificates, degrees, licenses, performance evaluations, PREA training documentation, and specialized trainings.

(b): WHS policy does not explicitly state that the agency consider any incidents of sexual harassment in determining whether to hire or promote staff or enlist the services of contractors who may have contact with youth. However, the WHS Human Services Employment Application requires that employees disclose such information. Interviews with Human Resources staff demonstrated compliance with this practice. The staff member said the questions regarding prior incidents of sexual harassment are asked on the application, and the Michigan Internet Criminal History Access Tool and national sex offender registries are consulted annually for each employee, intern, volunteer, and contractor.

(c): WHS policy requirements regarding background and reference checks and specific forms placed in each personnel file are discussed in provision (a). The facility reported that in the past 12 months, criminal background checks were conducted for 135 persons hired who may have contact with youth. Interviews with Human Resources administrative staff verified the practice of conducting such checks for all employees.

(d): WHS policy requires that before enlisting the services of a contractor who may have contact with youth, WHS performs criminal background checks. The facility reported that in the past 12 months, criminal background checks were conducted for 13 contracts for services for all staff covered in the contract who may have contact with youth.

(e): WSTC exceeds this standard as the agency conducts annual criminal background checks rather than every five years. The Human Resources staff member stated annual checks are

conducted for staff, volunteers, and contractors. The initial and annual criminal background check histories of WHS staff members' personnel file review also support compliance with this standard.

(f): Policy does not explicitly state that the agency considers any incidents of sexual harassment in determining whether to hire or promote staff or enlist the services of contractors who may have contact with youth. However, compliance with this provision is demonstrated through the use of the WHS Human Services Employment Application, which requires that employees disclose such information. The Human Resources staff member confirmed that staff members must disclose this information and are terminated if they fail to do so. Additional evidence of compliance includes signature pages included in personnel files confirming staff read and understood each section of the staff manual. One section describes the staff member's continuing affirmative duty to report changes in driving or criminal records.

(g): The WHS Human Services Employment Application states that if the information provided by the applicant is found to be not completely accurate, the applicant may be immediately discharged for that reason alone. The Human Resources staff member confirmed that staff members must disclose information regarding sexual misconduct and/or harassment, and if they fail to do so, they are terminated.

(h): The staff manual includes a section pursuant to this provision. Interviews with Human Resources staff member stated this information would be disclosed to another institution to which a former employee applies.

Summary of Findings:

The auditors assessed WHS policy and the employment application against the elements of this Standard and the PREA Audit Tool, which require: a) the agency shall not hire or promote anyone who has engaged, been convicted of, or has been adjudicated to have engaged in sexual misconduct; and b) the agency consider incidents of sexual harassment when hiring or promoting employees or contracting services. Based on the comparison, the auditors determined that WHS policy aligns with the requirements of provisions (a) – (f). Although policy does not explicitly address provisions (b) and (f), sufficient evidence supporting compliance with these provisions is present in the employment application. The auditors reviewed personnel files and determined necessary background and criminal history checks were conducted more frequently than provision (e) requires. Additional evidence relied upon for provision (f) include the staff manual, which states the agency would provide information on substantiated allegations of sexual harassment of a former employee if requested by an institution to which the former employee applies to work. During interviews, the human resources staff member articulated the facility's hiring and promotion processes as described in policy and this Standard. The auditors determined WSTC exceeds the requirements of this Standard based on the interview responses, documentation review, and evidence of annual background checks.

Corrective Action: None

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.

Documentation and Policy Reviewed:

1. Completed PAQ
2. Staffing plan
3. Invoice from the Michigan company that installed additional security equipment

Interviews:

1. Facility Director
2. Director of Clinical & Quality Services

Observations:

1. Camera placement

(a): This provision is not applicable, as the facility has not made substantial expansions or modifications.

(b): Since the last PREA Audit, additional closed-circuit television cameras and related devices were installed in the therapists' offices and classrooms. The current staffing plan includes a section on video monitoring systems and states that the system is not actively monitored but is considered a deterrent to sexual acting out and other safety violations and is used in post-incident investigations. The plan also states that the system was designed to monitor youth activities and increase youth safety. Compliance was also supported during interviews, as the Director of Clinical & Quality Services and Facility Director stated the cameras were added to address the previous inspection recommendations, cover blind spots, and enhance residents' safety including protection from sexual abuse.

Summary of Findings:

Because the facility did not acquire a new facility and had not made substantial expansions or modifications of the existing facility, the auditors determined compliance with provision (a). When considering compliance with provision (b), the auditors: 1) reviewed the facility staffing plan and the invoice from the company that installed additional cameras at the facility, 2) noted camera placement during the facility inspection, and 3) reviewed the responses of the Facility Director and Director of Clinical & Quality Services provided during interviews. The staffing plan references the video monitoring system confirming this topic was discussed; the invoice confirms additional cameras were installed at the facility; the interview responses confirmed the cameras were added to provide additional safety; and the additional cameras and live feed observed during the onsite audit confirmed the camera placement provided additional coverage. For these reasons, the auditors determined compliance with provision (b), and thus the facility meets the requirements of this Standard.

Corrective Action: None

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? ☒Yes ☐No

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

115.321 (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? (Check N/A if agency attempts to make a victim advocate from a rape crisis center available to victims per 115.321(d) above.) ☒Yes ☐No ☐NA

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

Documentation and Policy Reviewed:

1. Completed PAQ
2. Uniform evidence protocol
3. WHS PREA Policy Section F, and G
4. WHS Critical Incident Response and Reporting – Residential Programs Policy
5. Written confirmation from the PREA Compliance Coordinator confirming SAFE/SANE services
6. Mental health care training documentation
7. MOU between WHS and the Buena Vista Township Police Department
8. Documentation of attempts to enter into MOU with outside advocates

Interviews:

1. Staff members
2. Compliance Manager
3. Youth

Observations: No observations relative to this Standard were required.

(a): The PAQ indicated WSTC is responsible for conducting administrative investigations, and the Buena Vista Township Police Department is responsible for criminal investigations. The investigators follow a uniform investigation protocol from the National Institute of Corrections for obtaining usable physical evidence. During interviews, all but two staff members said they did not understand the agency's protocol for obtaining usable physical evidence if a resident alleges sexual abuse. All understood and could describe their responsibility should they be the first person to be alerted that a resident has allegedly been the victim of sexual abuse. Actions they said would be taken included notifying supervisors, separating the alleged perpetrator and victim, securing the scene, and not allowing residents to change clothes, shower, or brush their teeth.

Additionally, the WHS Critical Incident Response and Reporting – Residential Programs policy lists incidents deemed critical, procedures and actions to be taken, and documentation and reporting responsibilities.

(b): The investigators follow a uniform evidence protocol as outlined in the National Institute of Corrections *PREA: Investigating Sexual Abuse in a Confinement Setting* training. Certifications of completion were included for Standard 115.334.

(c): WHS policy requires that the victim of sexual assault or attempted sexual assault must be provided mental health assistance and counseling as determined necessary and appropriate. Resident victims of sexual abuse must be offered timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate. Female victims of sexually abusive vaginal penetration must be offered pregnancy tests. If pregnancy results from sexual abuse while incarcerated, victims will receive timely and comprehensive information about, and timely access to, all lawful pregnancy-related medical services. All medical and counseling services will be provided at no charge to the victim.

The PAQ indicated there have been two medical forensic exams conducted by SAFEs/SANEs in the past 12 months. WHS policy states and the Compliance Coordinator confirmed that forensic exams are conducted at Saginaw Covenant Hospital.

(d): Efforts to enter into an MOU with outside advocates/crisis services were documented in correspondence with two agencies; however, an MOU was not achieved. During the facility inspection, the number for the National Sexual Assault Hotline was posted on small signs in each living unit. WSTC provides victim advocacy services from a qualified staff member/therapist. One resident was present at the facility who reported sexual abuse but declined speaking with the auditors. The Compliance Manager stated that all staff members receive quarterly mental health training titled *Mental Health First Aid USA* from the National Council for Behavioral Health. Staff members' signature sheets indicating they received the specialized training for mental health professionals were reviewed and confirmed the training was understood and received.

(e): WHS policy requires that the victim of sexual assault or attempted sexual assault must be provided mental health assistance and counseling as determined necessary and appropriate. The Compliance Manger stated that if forensic exam is required, a transporter and Youth Care Worker accompany the youth during the process. These staff members receive mental health training, which was confirmed onsite.

(f): WSTC is responsible for conducting administrative investigations. Three investigators and one backup investigator in Vassar, Michigan conduct these investigations and follow a uniform protocol from the National Institute of Corrections. The Buena Vista Township Police Department is responsible for criminal investigations. The MOU states that the agreement between the parties is for services related to the implementation of the PREA, specifically those standards that address

investigations of youth allegations sexual abuse, investigatory protocols, allegations for investigation, and specialized training in investigations. WSTC agreed to cooperate with the police investigation, continue the investigation if the source of the allegation recants, protect evidence and incident scenes, and monitor the sexual abuse victim for at least 90 days. The police department agreed to investigate thoroughly, utilize investigators who have received specialized training involving juveniles, follow the police department protocols, and make an effort to share information about the progress of the investigation within the State of Michigan laws. During interviews, the Facility Director stated that allegations of sexual abuse are referred to the police department as well as the state police.

(g): This provision is not applicable as the agency is responsible for conducting administrative investigations, and the Buena Vista Township Police Department is responsible for criminal investigations.

(h): The Facility Director who serves as an investigative staff member stated he received the National Institute of Corrections training through a webinar and video. He reported the training included interviewing techniques, evidence collection, criteria and evidence required to substantiate a case for administrative prosecution and understood agency policy and practices regarding forensic examinations. Additionally, staff members who would accompany residents to forensic examinations receive education titled *Mental Health First Aid USA* from the National Council for Behavioral Health.

Summary of Findings:

The auditors assessed WHS policy against the elements of this Standard and the PREA Audit Tool, which require: a) following a uniform evidence protocol for obtaining usable physical evidence; b) using a developmentally appropriate protocol based on *A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents*; c) offering forensic medical examinations at no cost to the resident; d) attempting to make outside victim services available; e) providing a qualified victim advocate to accompany residents through the examination process; f) requesting the investigating agency follow the requirements of this Standard; and g) ensuring the staff member who serves in this role is screened and receives education regarding sexual assault and forensic examinations. The auditors determined WHS policy contains the requirements of all provisions of this Standard. Staff members' overall knowledge regarding the collection of evidence and actions to be taken following an allegation of sexual abuse supported compliance for provisions (a) and (b). Additional evidence supporting compliance with these provisions include the facility's use of the National Institute of Corrections: *A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents* for investigator training and certificates of completion of this training.

Although a SAFE/SANE was not interviewed, the auditors determined compliance with provision (c) after reviewing documentation and policy that forensic examinations are conducted at the

local hospital. The facility attempted to enter into an MOU with outside victim advocates and crisis services, but an MOU was not attained. However, the auditors determined compliance with provision (d) because the Compliance Manager stated and signature sheets confirm that WHS provides applicable training to facility staff members who provide these services when needed. The Compliance Manager's knowledge of this process and the procedures for transporting residents to the examination as prescribed in WHS policy supported compliance with provision (e). To strengthen compliance with provision (e), the auditors recommended designating specific staff members to provide these services and expanding policy to include additional details specific to these procedures. The auditors determined compliance with provision (f) after reviewing the MOU with the local police department, which describes the responsibilities of the facility and the department. Based on training records and staff members' responses during interviews, the auditors concluded that staff who would accompany youth to forensic examinations and staff who conduct investigations demonstrated sufficient knowledge and received relevant and appropriate training, thus supporting compliance with provision (h). Since the facility demonstrated compliance with each provision, the auditors determined WSTC meets the requirements of this Standard.

Corrective Action: None

Recommendations:

1. Designate specific staff member(s) responsible for accompanying and supporting the victim through the forensic medical examination process and investigatory interviews, and providing emotional support, crisis intervention, information, and referrals.

2. Although policy requires that the victim of sexual assault or attempted sexual assault must be provided mental health assistance and counseling as determined necessary and appropriate, the auditors recommend including in policy the specific details regarding the process pursuant to provision (e).

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 such publication describe the responsibilities of both the agency and the investigating entity? [N/A if the agency/facility is responsible for criminal investigations. See 115.321(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.

Documentation and Policy Reviewed:

1. Completed PAQ
2. WHS PREA Policy Section H
3. Investigative reports
4. WHS website: wolverinehs.org

Interviews:

1. Facility Director
2. Investigative staff member (Facility Director)

Observations: No observations relative to this Standard were required.

(a): WSTC is responsible for conducting administrative investigations, and local police department conducts criminal investigations. Policy requires that each incident of alleged or reported sexual abuse must be investigated to the fullest extent possible, and states that evidence collected must be maintained under strict control. The Director of Clinical & Quality Services stated that administrative and criminal investigations are completed for all allegations of sexual abuse or harassment. She said a brief internal investigation is conducted for each allegation, and if a determination is made that the allegation is potentially criminal, the police department and DHHS are notified. She stated that investigations include separating the alleged perpetrator and victim, removing staff members pending the outcome of the investigation, obtain statements, review cameras, and follow protocols outlined in policy.

The PAQ indicated there were three allegations of sexual abuse, two of which resulted in an administrative investigation, and none of which resulted in a criminal investigation in the past 12 months. Both allegations involved resident-on-resident sexually abusive contact. The one allegation that was not investigated was unsubstantiated following an internal review, and the investigator determined an investigation was not warranted. The auditors reviewed the two allegations resulting in investigative reports. Details of the review are included in Standard 115.371.

(b): WHS policy requires that all allegations of sexual abuse or harassment are reported to the proper authorities which may include the police, Child Protective Services (CPS), and the Division of Child Welfare Licensing (DCWL). The staff member receiving the allegation of sexual abuse must immediately call CPS and report the incident and/or allegation. The staff member receiving the report of actual or suspected sexual abuse or rape must submit an Incident Report before the end of their work shift and must complete a DHHS-3200, Report of Actual or Suspected Child Abuse or Neglect, within 72 hours of becoming aware of the incident.

Policy governs both administrative and criminal investigations and is posted on the WHS website. During interviews, investigative staff supported compliant investigative practices.

(c): The responsibilities of each entity is included in policy and posted on the WHS website. The MOU with the police department outlines their responsibilities for conducting criminal investigations.

(d): This provision does not apply as a state entity is not responsible for conducting administrative or criminal investigations of sexual abuse or harassment.

(e): This provision does not apply as a Department of Justice component is not responsible for conducting administrative or criminal investigations of sexual abuse or harassment.

Summary of Findings:

The auditors assessed WHS policy against the elements of this Standard and the PREA Audit Tool, which require that: a) the agency ensures that an investigation is completed for all allegations, b) the agency ensures allegations are appropriately referred for investigation and this information is public, and c) if a separate entity conducts criminal investigations, the publication describes those responsibilities. The auditors determined the WHS policy includes each element, which supports compliance with provisions (a) – (c). The auditors reviewed two thorough investigative reports, which provided additional evidence of compliance with provision (a). The Director of Clinical & Quality Services and investigative staff member demonstrated their knowledge of investigation procedures during interviews, which supported compliance with provisions (a) and (b). A determination of compliance with provision (b) was made following the auditors' review of WHS policy to confirm investigative responsibilities were described and by visiting the WHS website to confirm the agency publishes the policy. Evidence of compliance with provision (c) was demonstrated through an MOU, which describes the investigative responsibilities of WSTC and the local police department. The facility demonstrated compliance with all provisions, and thus meets the requirements of this Standard.

Corrective Action: None

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.

Documentation and Policy Reviewed:

1. Completed PAQ
2. WHS PREA Policy Section C
3. PREA Training signature and acknowledge sheets
4. PRC Webinar *Understanding the Importance of Implementing and Effective System Response for LGBTI Youth in Custody* summary
5. Staff Orientation Packet

Interviews:

1. Medical and Mental Health Care staff members
2. Random staff members

Observations:

1. Interactions between staff members and residents

(a): WHS policy requires all staff members who may have contact with youth attend training that addresses sexual assault prevention, incident response, and reporting. During interviews, medical and mental health care staff and random staff members reported they had been trained on each element during orientation and refresher trainings, which consisted of video, handouts, documents, and question and answer sessions in the facility's training room. The training curricula provided, staff signature sheets, and policy do not include all 11 items in the provision; however, staff members reported receiving training and demonstrated knowledge of each of the 11 items. Additionally, the Compliance Manager stated the facility utilizes the PRC training *Responding to Sexual Abuse of Youth in Custody: Addressing the Needs of Boys, Girls, and Gender Nonconforming Youth* to address communication specific to gender.

(b): The training materials are tailored to the unique needs of juveniles. The PRC training *Responding to Sexual Abuse of Youth in Custody: Addressing the Needs of Boys, Girls, and Gender Nonconforming Youth* addresses gender-specific communication. Signature sheets reviewed prior to the audit confirmed staff members received PREA-related training. Additional signature sheets and training records were reviewed in six personnel files during the audit. Details of the files are discussed in 115.117.

(c): The facility reported the following.

- 138 staff members are currently employed by the facility who may have contact with youth.
- All staff members were trained or retrained on the PREA requirements outlined in provision (a).
- The facility provides staff members refresher trainings twice annually.

Training records review is discussed above.

(d): Five signature sheets reviewed prior to the audit and six signature sheets and additional training records reviewed in personnel files on site support compliance with this provision, which requires the facility to document such training.

Summary of Findings:

The auditors assessed WHS policy against the elements of this Standard and the PREA Audit Tool, which require that: a) employees receive training on 11 specific topics; b) the training is unique to

the characteristics of the facility and additional training is provided when a staff member transfers from a male to female living unit, or vice versa; c) training remains current and refresher training occurs every two years; and d) training is documented. The auditors determined WHS policy contains each of these elements except item numbers 8 and 9 in provision (a), which support compliance with provisions (a) – (c). The auditors determined compliance with items 8 and 9 during interviews when staff members confirmed familiarity with each of the 11 items. The auditors interviewed random and medical and mental health care staff and concluded they received, understood, and communicated sufficient knowledge about the 11 items pursuant to provision (a) during annual and refresher training. The auditors observed staff members following PREA guidelines when entering living units, as they announced their presence when entering opposite-gender living units. The auditors also observed staff members communicating professionally with all residents including one transgender resident, which strengthened the determination of compliance with provision (a). The auditors reviewed the training curricula and determined the topics are specific to the characteristics of WSTC in that the training was designed for those providing care to male and female juveniles as well as gender-nonconforming juveniles, which support compliance with provision (b). The auditors reviewed training records and signature sheets to confirm all employees received and acknowledged they understood the initial and twice per year training, which exceeds the requirement of provision (c). Since the facility demonstrated compliance with each provision, the auditors determined the facility meets the requirements of this Standard.

Corrective Action: None

Recommendation:

1. Include in policy and revise the employee training signature sheets to include each of the 11 items pursuant to this standard.

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.

Documentation and Policy Reviewed:

1. Completed PAQ
2. WHS PREA Policy
3. Training records

Interviews:

1. Contractor who has contact with youth

Observations: No observations relative to this Standard were required.

(a): WHS policy requires that all volunteers and contractors must complete the same training as employees for sexual assault prevention, incident response, and reporting including annual and twice annual refresher training. At the conclusion of each training session, contractors and volunteers must sign that they attended and understood the training. During interviews, a contractor reported receiving PREA-related training on her responsibilities regarding sexual abuse prevention, detection, and response. She said she was trained on how to make a report,

what should be reported, and how to identify the signs of abuse. The training curricula are discussed in Standard 115.331.

(b): The facility reports that the level and type of training the volunteers and contractors receive is based on the services they provide and level of contact with youth. Volunteer interview details are included above in provision (a).

(c): A sample of signature sheets includes documentation of receipt and acknowledgment of understanding the training. Personnel files confirm that this documentation is maintained, and policy requires the signature sheets are kept for seven years per the Record Retention Schedule.

Summary of Findings:

The auditors assessed WHS policy against the elements of this Standard and the PREA Audit Tool, which require that: a) volunteers and contractors who have contact with residents receive training, b) the level of training is based on the service provided and level of contact, and c) the training is documented. The auditors determined that WHS policy addresses all of the required elements, which support compliance with provisions (a) – (c). The auditors interviewed a contractor to confirm she received and understood PREA-related training, which supported compliance with provision (b). The auditors reviewed personnel files and training signature sheets to confirm training was documented and maintained, which supports compliance with provision (c). Based on the interview responses and documentation review, the auditors determined sufficient evidence was present for each provision, and thus the facility meets the requirements of this Standard.

Corrective Action: None

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 such education? ☒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.

Documentation and Policy Reviewed:

1. Completed PAQ
2. WHS Policy Section A
3. Intake records including resident education
4. Client Orientation Packet
5. Hotline posters in living units

Interviews:

1. Intake staff
2. Random youth

Observations:

1. Posters containing PREA-related information

(a): WHS policy requires that youth receive PREA-related training within the first 72 hours of youth intake. The training residents receive during this time frame is the comprehensive education contained in the Client Orientation Packet. This exceeds the requirement of this provision to provide the education within 10 days. Policy states that the information provided includes but is not limited to:

1. Zero-tolerance policy

2. Self-protection including avoiding risk situations related to sexual assault prevention/intervention
3. Reporting procedures
4. Treatment and counseling
5. Protection against retaliation
6. Risks and potential consequences for engaging any type of sexual activity while at the facility
7. Disciplinary action(s) for making false allegations

The facility reports that in the previous 12 months, 78 out of the 79 youth who were admitted to WTSC received PREA education. The one youth who did not receive the education was not at the facility long enough to receive it. The auditors reviewed seven intake records selected on site. Each file included the PREA Client Risk Assessment and signature sheets signed by staff members and the resident confirming receipt of PREA education. The Preventing Sexual Assault Client Orientation Packet includes types and definitions of sexual abuse/harassment, the zero tolerance policy, the Department of Human Services Protective Services toll-free number, how to report, counseling services offered, and safety measures youth can take during their stay. During interviews, the Compliance Manager stated that upon intake youth watch the PREA video and receive comprehensive PREA education and receive PREA information in group once per month. She said youth are screened for risk the following day. The intake staff member said that youth view a video and receive written material. She stated that comprehension is checked when youth are asked to explain what they learned. All youth interviewed stated they watched the PREA video and received written materials/manual on the first day they arrived to the facility. The disabled youth stated he received a "pamphlet" that was "handed to" him and instructed him "to ask questions" if he did not understand. He said his therapist would help him if he needed more information or clarification regarding PREA.

(b): WHS policy exceeds the requirement of this provision (10 days) and requires that youth receive PREA-related training within the first 72 hours of youth intake. The training includes the comprehensive education that is contained in the Client Orientation Packet.
During interviews, the Compliance Manager stated that upon intake youth watch the PREA video and receive comprehensive PREA education and receive PREA information in group once per month. She said youth are screened for risk the following day. The intake staff member said that youth view a video and receive written materials. She stated that comprehension is checked when youth are asked to explain what they learned. Youth corroborated this practice during interviews and said they received the education and watched the PREA video during intake, once placed on a dorm, and multiple times on the dorm thereafter. Youth files included signature sheets acknowledging receipt of the education, and all were dated the same of following day of placement at the facility.

(c): WHS policy states that all youth receive PREA education upon intake regardless if the youth was transferred from another facility. Staff members and youth interviews supported compliance with this practice. The intake records included in residents' files supported compliance with this provision.

(d): WHS policy requires that the agency provide PREA information in formats accessible to all youth including those who are limited English proficient, deaf, visually impaired, otherwise disabled, or have limited reading skills. The PREA materials provided to youth and the procedures for translator services for youth who are deaf, hard of hearing, visually impaired, have limited reading skills, or who are otherwise disabled are discussed in Standard 115.316.

(e): WSTC documents youth participation in PREA education by requiring youth to acknowledge their understanding by signing and dating the Client Signature Sheet for PREA Orientation. The auditors reviewed seven intake records on site. Each file included the PREA Client Risk Assessment and signature sheets signed by staff members and the resident confirming receipt of PREA education. The Preventing Sexual Assault Client Orientation Packet includes types and definitions of sexual abuse/harassment, the zero tolerance policy, instructions and the Department of Human Services Protective Services toll-free number, how to report, counseling services offered, and safety measures. During interviews, staff and youth said they periodically participate in PREA-related training and groups on their dorms.

(f): PREA information is available and visible to youth through small signs posted on the dorms and in the client packet. The auditors noted the signs were visible in living units and common areas during the facility inspection, but they were small and poorly lit. During interviews, youth said they receive PREA-related information during intake and again once they are assigned to a dorm.

Summary of Findings:

The auditors assessed WHS policy against the elements of this Standard and the PREA Audit Tool, which require that: a) during intake, residents receive PREA-related information in an age-appropriate manner; b) within 10 days, residents receive comprehensive age-appropriate PREA education; c) current residents who have not received PREA-education, shall be educated within one year; d) education is provided in accessible formats; e) resident education is documented; and f) key information is available and visible. The auditors reviewed intake records, resident signature sheets, and the resident orientation packet and determined the facility is compliant with provision (a) in that the information is comprehensive. The auditors used the leveling tool described in Standard 115.316 to measure the age-appropriateness and readability of the written material contained in the orientation packet and determined the material to be written at a college level. A corrective action requesting a revision of the client orientation packet was initiated for Standard 115.316 and this Standard as well. During interviews, residents, including those with a disability, reported receiving the PREA education during intake and again during groups in their

living units, which provided the auditors with additional evidence of compliance with provision (a). The auditors determined compliance with provision (b) based on the facility's practice of exceeding the requirement to provide comprehensive education within 10 days of intake. The auditors verified this practice by asking questions during resident and the intake staff member interviews and by checking the date of intake against the date of the residents' signatures acknowledging the education was provided. The auditors determined compliance with provision (c), as the facility reported there were no current residents who had not received the education. Additionally, all residents interviewed reported receiving the education, and all files reviewed contained documentation of the education. The same method for Standard 115.316 and provision (a) of this Standard was used to determine compliance with provision (d); the auditors concluded corrective action was needed in order to provide written PREA information in a format that is accessible to residents with disabilities and/or low reading skills. The resident signature sheets contained in resident files provided sufficient evidence for the auditors to determine compliance with provision (e). During the facility inspection, the auditors noted the placement of posters containing PREA-related information that were visible in living units and other common areas. Although the auditors determined the postings were sufficient to determine compliance, a recommendation was made to increase the size and visibility of the posters. Based on the corrective action regarding the reading level of the client packet, the auditors determined the facility does not meet the requirements of this Standard.

Corrective Action:

1. For standard 115.316, the auditors requested alternative reading materials and the procedures or translator services for youth who are deaf, hard of hearing, or visually impaired, as well as for youth with reading skills or otherwise disabled. The corrective actions for Standard 115.316 will also satisfy the requirements for Standard 115.333.

Recommendation:

1. The PREA-related information posted on the dorms included letter-size sheets of paper posted behind a metal grate. The toll-free number was small and difficult to read. The auditors recommend enlarging the information and/or provide the information in juvenile-friendly formats.

Corrective Action Taken:

1. The PREA Compliance Manager stated that a table outlining sexual abuse truths and untruths would now be included as reading material for residents with disabilities and/or low reading skills. The auditors confirmed that the reading level was reduced to grade 4.9 and determined that the facility demonstrates compliance with this provision.

2. The PREA Compliance Manager provided new WHS policy and procedure titled "Helping clients access assistive technology; Class: Rights of Persons with Developmental

Disabilities." The document outlines the relationship between the facility and the school district that provides education to the facility clients. The educational program identifies individual needs of students "suspected of communication, intellectual, verbal, visual, hearing, and/or physical disabilities and thus will establish eligibility for programs and services." Additionally, "the individual needs of students will be provided with appropriate materials or necessary tools to understand client orientation, forms and documents; including but not limited to PREA, Client Grievances and Client Rights & Responsibilities." Based on the new policy, the auditors determined the facility satisfies the requirements of this provision, and thus, meets the requirements of this Standard.

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.

Documentation and Policy Reviewed:

1. Completed PAQ
2. WHS Policy Section C
3. Certificates of Completion of National Institute of Corrections Training
4. Training curriculum

Interviews:

1. Investigative staff

Observations: No observations relative to this Standard were required.

(a): In addition to the general PREA training, WHS policy requires that staff members who investigate allegations of sexual abuse receive specialized training that includes interviewing juvenile sexual abuse victims. The auditors verified the investigators' certificates of completion of *PREA: Investigating Sexual Abuse in a Confinement Setting* by the National Institute of Corrections

(NIC). The investigator stated he received this training, which included interviewing techniques and evidence collection.

(b): WHS policy requires investigator training that addresses the elements of this standard. The NIC training that investigators receive includes each element. The investigator interviewed communicated knowledge of the training, which includes interviewing juvenile sexual abuse victims, use of Miranda and Garrity warnings, evidence collection, and the criteria to substantiate a case for administrative action or prosecution referral.

(C): The auditors verified certificates of completion of the required training for the facility investigators.

(d): The auditor is not required to audit this provision.

Summary of Findings:

The auditors assessed WHS policy against the elements of this Standard and the PREA Audit Tool, which require that: a) facility investigators receive additional training in conducting investigations, b) the training contains specific elements, and c) the completion of the training is documented. The auditors reviewed WHS policy and concluded each element of this Standard is sufficiently referenced. This supports compliance with provisions (a) – (c). The auditors reviewed certificates of completion of the investigation training, which provide additional evidence of compliance with provisions (a) and (c). The auditors visited the NIC website and read the overview of the training, which states that the training includes each of the required elements of provision (b). This training is also available on the PRC website. The auditors previewed the nine modules and verified the training includes details for each required element in provision (b). Further compliance with this provision was demonstrated during an interview of an investigative staff member, during which he provided details about and communicated understanding of the training he received. Compliance with provision (c) was determined based on the certificates of completion provided to the auditors. Since the facility demonstrated compliance with all provisions, the auditors concluded the facility meets the requirements of the Standard.

Corrective Action: None

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? ☒Yes ☐No

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

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

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

115.335 (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.) ☒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? ☒Yes ☐No

115.335 (d)

- Do medical and mental health care practitioners employed by the agency also receive training mandated for employees by §115.331? ☒Yes ☐No

- Do medical and mental health care practitioners contracted by and volunteering for the agency also receive training mandated for contractors and volunteers by §115.332? ☒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.

Documentation and Policy Reviewed:

1. Completed PAQ
2. WHS PREA Policy Section C
3. Certificates of Completion of PREA Training
4. Training records in personnel files

Interviews:

1. Medical and mental health care staff

Observations: No observations relative to this Standard were required.

(a): WHS policy requires that in addition to the PREA training all employees receive, full- and part-time medical and mental health staff are trained in how to detect and assess signs of sexual abuse, preserve physical evidence, respond to victims of sexual abuse, and reporting. Individual signature sheets included mental and medical health care staff members' signatures indicating each of four PRC modules were completed. The module titles are Detecting and Assessing Signs, Reporting and PREA Standards, Effective and Professional Responses, and Medical/Forensic Exam and Evidence. Medical and mental healthcare staff members said they received this training as well as new hire and periodic PREA-related training.

(b): This provision is not applicable; WHS policy requires that an off-site Sexual Assault Nurse Examiner or Sexual Assault Forensic Examiner conduct forensic medical exams.

(c): The auditors reviewed documentation to verify that medical and mental health care staff received appropriate PREA training. In addition to the online training, all staff members attend annual training, which includes PREA-specific topics.

(d): WHS policy requires that full- and part-time medical and mental health staff are trained in each of the 11 required elements outlined in 115.331 (a). Individual signature sheets included mental and medical health care staff members' signatures indicating each of four PRC modules were completed. The module titles are Detecting and Assessing Signs, Reporting and PREA Standards, Effective and Professional Responses, and Medical/Forensic Exam and Evidence. Medical and mental healthcare staff members said they received this training as well as new hire and periodic PREA-related training.

Summary of Findings:

The auditors assessed WHS policy against the elements of this Standard and the PREA Audit Tool, which require that: a) medical and mental health care staff members receive PREA-related training, b) medical staff who conduct forensic examinations receive PREA-related training, c) the training is documented, d) medical and mental health care staff members receive training pursuant to Standard 115.331 and/or 115.332. The auditors reviewed WHS policy and determined each element of this Standard is addressed, which supports compliance with provisions (a) – (d). The signature sheets acknowledging the receipt and understanding of the training received by medical and mental health care staff members as well as the responses given during interviews led the auditors to a determination of compliance with provision (a). Provision (b) was not applicable, as forensic examinations were confirmed to be conducted off site. The auditors determined compliance with provision (c) because the signature sheets provided prior to the onsite audit and those observed in personnel files confirmed medical and mental health care staff received and understood the training. Additional signature sheets confirmed that all staff members, including medical and mental health care staff received training pursuant to Standards 115.331 and 115.332. Since the auditors concluded the facility is compliant with each provision, WTCS meets the requirements of this Standard.

Corrective Action: None

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: Prior sexual victimization or abusiveness? ☒Yes ☐No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: 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: Current charges and offense history? ☒Yes ☐No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Age? ☒Yes ☐No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Level of emotional and cognitive development? ☒Yes ☐No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Physical size and stature? ☒Yes ☐No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Mental illness or mental disabilities? ☒Yes ☐No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Intellectual or developmental disabilities? ☒Yes ☐No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Physical disabilities? ☒Yes ☐No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: The resident's own perception of vulnerability? ☒Yes ☐No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: 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.

Documentation and Policy Reviewed:

2. Completed PAQ
3. WHS PREA Policy Section B
4. PREA Client Risk Assessments/Reassessments

Interviews:

1. Random youth
2. Staff responsible for risk screening (therapists)
3. Compliance Manager
4. Compliance Coordinator

Interviews:

1. Area in which resident files are stored

(a): WHS policy requires that within 72 hours of arrival at the facility, an objective assessment is used to obtain information about each youth's history and behavior to determine the resident's potential risk of sexual vulnerability and victimization potential. The risk assessment document requires that all clients be reassessed at least quarterly and as needed. Information obtained in this assessment is be used to inform housing, bed, program, seating, education, and work assignments for clients with the goal of keeping all clients safe and free from sexual abuse. The Treatment Team (or other as applicable) must review the completed assessment, in addition to available medical and mental health screenings, classification assessments, the case file, and other relevant records, and make and/or add to any recommendations for group, room, seating, or other assignments.

The auditors reviewed the risk assessment in each youth file and two additional assessments for which the intake staff member made a determination that the youth was at greater risk of being victimized or victimizing others. Each of these contained notes regarding specific room/dorm assignments, precautions, and additional supervision requirements.

The reassessments are conducted using the initial assessment document, which contains the 11 items per provision (c).

During interviews a therapist (staff member responsible for screening for risk) said that although policy required the screening be conducted within 72 hours after the youth's arrival, the practice is to screen on the first day and no later than 24 hours after arrival. She said the information is ascertained through a records review and when talking with the youth during the intake process. She reported that every 90 days, all youth are reassessed using the same instrument as the one used during intake. The dates on the initial and subsequent risk screenings supported this practice. The majority of youth said they were asked the questions outlined in provision (c) during admission and again throughout their confinement.

(b): The auditors reviewed the assessment and determined the assessment is an objective screening instrument. The intake assessments reviewed appeared to have been conducted in a consistent manner and contained similar but distinct notes regarding the therapists' observations and conclusions.

(c): The PREA Client Risk Assessment form is used to obtain the 11 items per this standard. All completed risk assessments included responses for each of the 11 items confirming that they are consistently addressed.

(d): The intake staff member said he reviews the youth's file, court records, history, prior commitment types, prior abuse or victimization, mental health screenings, and any other documentation included in the youth's file before interviewing the youth during intake process. She described the screening and said it contained questions regarding information such as age and grade level, previous charges, history of abuse, size, vulnerability, gender nonconforming behavior, and gender identity.

(e): WHS practice establishes appropriate controls to prevent sensitive information obtained from these screenings from being exploited to the youth's detriment by staff or other youth. During interviews, facility staff members stated the information from the screenings is limited to specific staff members including clinicians, medical staff, and administrators.

Summary of Findings:

The auditors assessed WHS policy against the elements of this Standard and the PREA Audit Tool, which require that: a) the resident's history is reviewed within 72 hours and periodically, b) the assessment is objective, c) the agency ascertains information about each of the items per this provision, d) the information is ascertained through conversation and records review, and e) the dissemination of information is controlled. The auditors reviewed WHS policy and determined each element of this Standard is addressed, which supports compliance with provisions (a) – (e). The auditors reviewed eight risk assessments and concluded the assessment was conducted during intake and throughout the resident's confinement, which supports compliance with provision (a). The assessment procedures appear to be conducted in a similar manner for each youth, which supports compliance with provision (b). The auditors compared the assessment to the items in provision (c) and determined that each item is addressed, which supports compliance with this provision. During interviews, the intake staff member and residents reported that the intake process includes gleaning information through conversation. The intake staff member reported that all information in the resident's file is reviewed, which supports compliance with provision (d). Compliance with provision (e) was determined based on the locked area with limited access in which resident files are stored. Since the facility demonstrated compliance with all provisions, the auditors determined the facility meets the requirements of this Standard.

Corrective Action: None

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? ☒Yes ☐No

- During any period of isolation, does the agency always refrain from denying residents daily large-muscle exercise? ☒Yes ☐No

- During any period of isolation, does the agency always refrain from denying residents any legally required educational programming or special education services? ☒Yes ☐No

- Do residents in isolation receive daily visits from a medical or mental health care clinician? ☒Yes ☐No

- Do residents also have access to other programs and work opportunities to the extent possible? ☒Yes ☐No

115.342 (c)

- Does the agency always refrain from placing: Lesbian, gay, and bisexual 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 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 paragraph (b) of this section, does the facility clearly document: The basis for the facility's concern for the resident's safety? (N/A for h and i if facility doesn't use isolation?) ☒Yes ☐No ☐NA

- If a resident is isolated pursuant to paragraph (b) of this section, does the facility clearly document: The reason why no alternative means of separation can be arranged? (N/A for h and i if facility doesn't use isolation?) ☒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? ☒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.

Documentation and Policy Reviewed:

1. WHS PREA Policy Section B
2. PREA Client Risk Assessments/Reassessments

Interviews:

1. Compliance Manager
2. Staff responsible for risk screening
3. Facility Director
4. Medical staff member

Observations:

1. Living units of LGBTI and transgender residents

(a): WHS policy requires that information obtained using the screening instrument is used to make housing, bed, program, education, and work assignments for residents with the goal of keeping residents safe and free from sexual abuse. The facility must document how the assessment information was used to inform placement and assignments. The auditors reviewed two additional assessments that resulted in a determination that the youth was at greater risk of being victimized or victimizing others. The assessments contained notes regarding specific room/dorm assignments, precautions, and additional supervision requirements. Interviews with staff verified this is this practice. The facility's action to make specific housing and bed assignment decisions for two youth who were determined to be at greater risk confirms compliance with this Standard.

(b): WHS policy requires that a youth may only be isolated from other youth as a preventive and protective measure, but only as a last resort when other less restrictive measures are inadequate to keep the youth safe from other youths, and then only until an alternate means of keeping all youths safe can be arranged. During any periods of protective isolation, facility staff may not deny a youth otherwise under control, access to daily large-muscle exercise and legally-required educational programming or special education services. Any youth in isolation must receive daily visits from a medical or mental health care clinician and must have access to other programs to the extent possible. Assessment activities must be documented. The facility reports no instances of youth at risk of sexual victimization were held in isolation in the past 12 months; therefore, no isolation documentation was available for review. Interviews with staff confirm that isolation is rarely used. Several staff members reported that it had not been used since they began working at the facility several years ago. The Facility Director said isolation would only be used for aggressive youth and any isolation would likely not exceed 30 minutes. No residents reported being placed in isolation.

(c): WHS policy requires that LGBTI youth are not placed in particular housing, beds, or other assignments on the basis of such identification. During interviews, two youth who identify as LGBTI reported not being placed in a dorm based on this status. Interviews with staff also verified compliance with this practice as they stated LGBTI youth are not placed in particular housing, beds, or other assignments.

(d): WHS policy requires decisions to be made on a case-by-case basis whether to place a transgender or intersex youth in a facility for male or female residents. Placement decisions are

based on whether the placement would ensure the resident's health and safety, and whether the placement would present management or security problems. The facility must also review placement and programming assignments at least twice each year, allow transgender and intersex youths the opportunity to shower separately from other residents, consider the youth's own view of his/her gender identity, and a youth must not be considered more likely to perpetrate sexual abuse solely because of LGTBI identity. One youth who identified as transgender female was being housed with females, which was according to her preference. The Compliance Manager said all decisions are made on a case-by-case basis and that WSTC did not have special housing units for LGBTI residents.

(e): WHS policy requires that placement and programming assignments be assessed at least twice per year. Interviews with staff verified compliance with this practice. The Compliance Manager and intake staff member said that placement decisions are designed to keep all youth safe.

(f): WHS policy requires WSTC to consider the youth's own views concerning his or her own safety when making placement and programming assignments. The Facility Director, Compliance Coordinator, and Compliance Manager corroborated this practice during interviews. Documentation of housing placement decisions and special considerations reviewed on site support compliance with this provision.

(g): WHS policy requires that transgender or intersex youth be provided the opportunity to shower separately from other youth. Interviews with staff verified compliance with this practice, and the two youth who identified as LGBTI said they showered separately.

(h): The facility reports that no residents at risk of sexual victimization were held in isolation in the past 12 months. Interviews with staff verified compliance with this practice.

(i): WHS policy exceeds the 30-day review requirement and requires daily visits from a mental health professional to any youth in protective custody. No staff members had provided this service as no youth had been held in protective custody.

Summary of Findings:

The auditors assessed WHS policy against the elements of this Standard and the PREA Audit Tool, which require that: a) the agency uses information gained pursuant to Standard 115.341 to make placement decisions designed to keep all residents safe; b) residents are isolated as a last resort and if they are isolated, resident receive access to exercise and education; c) LGBTI residents are not placed in specific housing based on this status; d) placement decisions are made on a case-by-case basis; e) placement decisions for transgender and intersex youth are reassessed twice per year; f) the views of transgender and intersex residents are given serious consideration; g) transgender and intersex are given the opportunity to shower separately; h) isolation of residents is documented; and i) residents held in isolation receive a review every 30 days. The auditors

reviewed WHS policy and determined that all provisions are sufficiently addressed, which supports compliance with provisions (a) – (i). The auditors reviewed two assessments that resulted in specific housing and bed assignments, which evidenced the implementation of provision (a). Staff members' and residents' responses during interviews confirmed that isolation is rarely used and had not been used during the audit period, thus supporting compliance with provisions (b), (h), and (i). Resident responses during interviews and verification of the housing assignments of LGBTI youth confirmed compliance with provision (c). During the interview with the transgender female, she reported and her reassessment documentation confirmed that she is housed according to her preference, showers separately, and is reassessed twice per year as are all residents, which support compliance with provisions (c) – (g). Since sufficient evidence was present to determine compliance with all provisions, the auditors determined the facility meets the requirements of this Standard.

Corrective Action: None

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? ☒Yes ☐No

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.

Documentation and Policy Reviewed:

1. Completed PAQ
2. WHS PREA Policy Sections E and F
3. Michigan DHHS mandatory reporting webpage

4. Client Orientation Packet
5. Investigative report containing evidence that verbal reports are documented and reported

Interviews:

1. Random staff members
2. Youth
3. Compliance Manager

Observations:

1. Posted hotline numbers in living units

(a): WHS policy requires that staff and youth are supported and encouraged to report sexual assault, attempted or threatened sexual assault, and/or sexual harassment and be protected from retaliation. A youth who believes that he or she is the victim of a sexual assault, attempted sexual assault, or sexual harassment, or believes another youth was the victim of sexual assault or attempted sexual assault must report this information. Internal reports can be made to staff or by submitting written allegations or grievances. These procedures are described in the client packet. During interviews, staff and youth described each of these options for internal reporting.

(b): WHS policy requires that an option exists for youths to report sexual abuse to someone outside of the facility. The outside reporting option for WHS/WSTC is the Michigan DHHS. This toll-free number is posted on the dorms and included in the client packet. The National Sexual Assault Hotline is also posted. During interviews, youth were able to articulate the various ways to make a report including telling a trusted staff member, reporting to a family member, and writing a grievance, which they said could be turned in privately and/or anonymously. Several said they could call the number posted on the dorms, and during the facility inspection, youth were aware of the sign that contained the number. The PAQ indicated the facility does not detain residents solely for civil immigration.

(c): WHS policy requires that reports made verbally, in writing, anonymously, and from third parties are accepted and are be reported. According to the PAQ, the two PREA-related reports were made verbally. The reports were included in incident reports, which were included in the investigative reports and provided to the auditors. Staff members could articulate their reporting duties, which included writing the incident report and notifying supervisors and DHHS/CPS. Youth articulated understanding of the various reporting options, but several said they were not sure if they could report anonymously or privately.

(d): The facility provides youth access to the tools necessary to make a written report. Grievance forms are available on the dorms, and youth may drop the completed grievance into a locked box. The youth who reported a sexual abuse declined to speak with the auditors, but others confirmed that they have access and the tools needed to make a written report.

(e): WHS provides staff members the same reporting options as youth. All staff said they could make anonymous reports to DHHS.

Summary of Findings:

The auditors assessed WHS policy against the elements of this Standard and the PREA Audit Tool, which require that: a) the agency provides multiple ways to privately report sexual abuse or harassment; b) residents are provided an anonymous reporting option to an outside entity, and residents detained for civil immigration shall be provided information on how to contact consular officials; c) staff shall accept verbal, written, anonymous, and third party reports and must document verbal reports; d) residents have the tools needed to make written reports; and e) staff have a method to privately report sexual abuse or harassment of residents. The auditors reviewed WHS policy and determined that each element of this Standard is included, which supports compliance with provisions (a) – (e). To support compliance with provisions (a) and (b), the auditors noted the hotline numbers posted in each living unit, conducted informal interviews with residents and staff and asked them to point out the posted numbers and to explain reporting options, and called the posted number to confirm reports are accepted. A determination of compliance with provisions (c), (d), and (e) was based on interview responses which included explanations of a variety of reporting options and the procedures for making reports. Additional evidence for provision (c) was contained in the investigative reports. Each of these includes the documentation of two verbal reports made by residents and subsequent investigations. Since the facility demonstrated compliance with each provision, the auditors determined WSTC meets the requirements of this Standard.

Corrective Action: None

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 ☐NA

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.

Documentation and Policy Reviewed:

1. Completed PAQ
2. WHS PREA Policy A, E, G, and J
3. Client Orientation Packet

Interviews:

1. Compliance Manager
2. Facility Director

Observations: No observations relative to this Standard were required.

(a): WSTC's administrative procedures for addressing resident reports regarding sexual abuse is through the grievance system. Policy requires that personnel who have received specialized training in conducting administrative investigations of sexual abuse and sexual harassment allegations internally investigate alleged or suspected incidents of youth-on-youth sexually

abusive contact. The supervisor or administrator must notify the trained investigator to schedule an internal investigation. The facility Director or designee determines if police will be contacted for further investigation, based on the results of the internal investigation. The Compliance Manager and Facility Director supported compliance with policy and said that a brief internal review of all sexual abuse allegations occurs for all reports. If the review determines the incident is criminal in nature, the Buena Vista Police Department is notified and conducts the investigation.

(b): WHS policy requires that WSTC investigate all allegations of sexual abuse regardless of how much time has passed since the alleged incident. The policy also states that youth are not required to use an informal process for resolving grievances alleging sexual abuse or sexual harassment. The client packet includes the types and definitions of sexual abuse/harassment, the zero tolerance policy, instructions for reporting, the Department of Human Services Protective Services toll-free number, counseling services offered, and safety measures youth can take during their stay.

(c): WHS policy requires that a grievance alleging sexual abuse or sexual harassment does not have to be submitted to the person that is the subject of the allegation. The client packet includes details about the grievance process and includes information regarding the youth's right to submit a grievance.

(d): WHS Policy requires that WSTC:

1. Must issue a final decision (initial decision and appeal decision if appealed) on the merits of a grievance alleging sexual abuse or harassment within 90 calendar days of the initial filing of the grievance
2. May claim an extension of time to respond of up to 70 calendar days if the normal time period for a response is insufficient to make a decision
3. Must notify the youth and the youth's parent/guardian in writing of any such extension

No grievances were submitting alleging sexual abuse or harassment. The two reports received during the audit period were reported verbally. The youth who reported a sexual abuse declined to speak with the auditors.

(e): WHS policy requires that third parties, including fellow youths, staff, family, attorneys, and outside advocates may assist a youth filing grievances relating to allegations of sexual abuse and harassment. If a third party, other than the parent or guardian, files a grievance on the youth's behalf, the facility must request as a condition of processing that the alleged victim agree to the grievance filed on his behalf and may also require that the alleged victim pursue any subsequent steps in the remedy process. If the alleged victim declines to have the grievance processed on his behalf, the facility must document the youth's decision.

WHS publicly distributes information on how to report alleged abuse or sexual harassment on behalf of a youth by posting this information on the agency's website. The auditor reviewed the agency website to confirm the information was available. The facility reported that no third party reports were received in the previous 12 months.

(f): WHS policy requires that emergency grievances alleging sexual abuse and/or the imminent threat of sexual abuse is responded to immediately. The facility reported that there have been no emergency grievances alleging risk of imminent sexual abuse in the last 12 months.

(g): WHS policy requires that clients may not be disciplined for making an allegation of sexual abuse or sexual harassment if the investigation determines that the abuse did not occur, so long as the allegation was based upon a reasonable belief that the abuse occurred and the allegation was made in good faith. The client packet explains that clients are encouraged to report even suspected violations but cautions clients that making false allegations is a violation of facility rules and the law. The packet states that clients who intentionally lie when accusing someone of sexual assault and/or related sexually inappropriate behavior will receive consequences that could include criminal charges. The facility reported there have been no youth grievances alleging sexual abuse that resulted in disciplinary action by the agency against the youth for having filed a grievance.

Summary of Findings:

The auditors assessed WHS policy against the elements of this Standard and the PREA Audit Tool, which require that: b) the agency does not impose a time limit to submit a grievance regarding sexual abuse, may apply time limits on a portion of the grievance that does not allege sexual abuse, shall not require the use of an informal grievance process, the agency's ability to defend against a lawsuit based on the statute of limitations; c) residents may submit a grievance without submitting it to eh staff member who is the subject of the complaint; d) the agency shall issue decisions about a allegations of sexual abuse within 90 days; a 70-day extension may be issued; if the resident does not receive a decision within the administrative process time limit, the resident may consider the absence of a response to be a denial at that level; e) third parties may assist residents in filing administrative remedies relating to sexual abuse; if third parties other than parents of guardians files such a request, the facility may require the alleged victim to agree to have the request filed on his/her behalf; if the resident does not agree, the facility must document the resident's decision; a parent may submit this request without the youth's agreeing to have the request filed on his/her behalf; f) the agency shall establish procedures for the filing of emergency grievances of imminent sexual abuse and immediate action must be taken to protect the resident; and (g) residents may be disciplined for alleging sexual abuse in bad faith. The agency is not exempt from provision (a), as the facility has administrative procedures to address resident grievances regarding sexual abuse. The auditors reviewed WHS policy, determined that each element is addressed, and thus evidences compliance with provisions (a) – (g). Compliance with provision (b) and (c) was based on the auditors' review of the Client Orientation Packet, which contains information pursuant to these provisions. No grievances alleging sexual abuse were submitted during the audit period; however, the auditors reviewed the investigative reports that followed two verbal reports alleging sexual abuse, both of which were completed within 90 days, and determined compliance with provision (d). No third party or emergency reports were received during the audit period, so the auditors relied upon agency policy and interview

responses, both of which indicated third party reports would be accepted, to determine compliance with provisions (e) and (f). The auditors determined compliance with provision (g) based on WHS policy and the Client Orientation Packet, which include information regarding these types of grievances. Since the facility demonstrated compliance with each provision, the auditors determined WSTC meets the requirements of this Standard.

Corrective Action: None

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 assessable mailing addresses and telephone numbers, including toll-free hotline numbers where available, of local, State, or national victim advocacy or rape crisis organizations? ☒Yes ☐No

- Does the facility provide persons detained solely for civil immigration purposes mailing addresses and telephone numbers, including toll-free hotline numbers where available of local, State, or national immigrant services agencies? ☒Yes ☐No

- Does the facility enable reasonable communication between 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.

Documentation and Policy Reviewed:

1. WHS PREA Policy Section E
2. Documentation of attempts to enter into MOU
3. Client Orientation Packet

Interviews:

1. Random youth
2. Facility Director
3. Compliance Manager

Observations:

1. Posted hotline numbers in living units

(a): WSTC provides access to outside victim advocates for emotional support services related to sexual abuse. During the facility inspection, the number for the National Sexual Assault Hotline was posted on small signs in each living unit. WSTC provides victim advocacy services from a qualified staff member/therapist. One resident was present at the facility who reported sexual abuse but declined speaking with the auditors. Several residents said outside services were available through the hotline posted in their living units, and several said that their counselors

would provide support services. The Compliance Manager stated that all staff members receive quarterly mental health training titled *Mental Health First Aid USA* from the National Council for Behavioral Health. A sample record was provided that evidenced completion of this training. Staff members' signature sheets showing they received additional specialized training for mental health professionals were reviewed and confirmed the training was understood and received.

(b): WHS policy requires that clients are informed, prior to giving them access to outside victim advocates for emotional support services related to sexual abuse, 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. During interviews, staff members communicated understanding of mandatory reporting laws. Youth stated the communications with the "hotline" would be private and also understood the limits of confidentiality.

(c): Efforts to enter into an MOU with community providers that provide emotional support services were documented in correspondence with two agencies; however, an MOU was not achieved. WSTC provides victim advocacy services from a qualified staff member/therapist.

(d): WHS policy does not stipulate that youth are provided reasonable and confidential access to their attorneys and parents or legal guardians. However, interviews indicated this is the practice as all youth said they receive this access. The Facility Director and Compliance Manager stated that youth may not be denied this access and are provided multiple opportunities to contact attorneys and parents or guardians by phone, mail, visitation, and home passes. These staff members and residents also said youth may talk privately inside a therapist's office while a staff member maintains line of sight outside the office.

Summary of Findings:

The auditors assessed WHS policy against the elements of this Standard and the PREA Audit Tool, which require that: a) the facility shall provide residents access to outside victim advocates related to sexual abuse, b) the facility informs residents of the extent to which communications are monitored and of mandatory reporting, c) the facility shall attempt to enter into an MOU with community service providers that provide residents with emotional support services, and d) the facility shall provide confidential access to legal representation. The auditors reviewed WHS policy and determined that all provisions except (d) are addressed. During the facility inspection, the auditors observed the hotline numbers posted in each living unit, which supports compliance with provision (a). Additional evidence of compliance with this provision was noted during informal and formal interviews when residents articulated how to make calls to the hotline. Compliance with provision (c) was determined during interviews when residents communicated their understanding of privacy and confidentiality limitations. To determine compliance with provision (d), which is not explicitly described in policy, the auditors relied upon interviews with staff members and residents who explained that residents are consistently provided access to their attorneys and legal representation and may speak to them privately. Since the facility

demonstrated compliance with each provision, the auditors determined the facility meets the requirements of this Standard.

Corrective Action: None

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.

Documentation and Policy Reviewed:

1. Completed PAQ
2. WHS PREA Policy Section A
3. Michigan DHHS and WHS websites
4. Client Orientation Packet

Observations: No observations relative to this Standard were required.

(a): The PAQ indicated that third-party reports may be received through the grievance system or CPS. The Michigan DHHS and WHS websites inform readers about and includes links and phone

numbers to make reports of sexual abuse or harassment on behalf of a youth. The options include the Michigan DHHS and the National Sexual Assault Hotline.

Summary of Findings:

The auditors assessed WHS policy against the elements of this Standard and the PREA Audit Tool, which require that: a) the agency shall have a method to receive third-party reports. Since WHS policy contains this information, compliance with this provision is supported. For additional evidence, the auditors visited the state and agency websites, which inform the public about and contains links to third-party reporting options. The auditors determined the facility meets the requirements of provision (a), and thus this Standard.

Corrective Action: None

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 the 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? (N/A if the alleged victim is not under the guardianship of the child welfare system.) ☒Yes ☐No ☐NA

- 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.

Documentation and Policy Reviewed:

1. Completed PAQ
2. WHS PREA Policy Sections F and H
3. Training PowerPoint
4. Investigative reports

Interviews:

1. Facility Director
2. Compliance Manager
3. Compliance Coordinator
4. Medical staff
5. Random staff

Observations: No observations relative to this Standard were required.

(a): WHS policy requires that the supervisor is immediately notified when: Staff receive a report of sexual assault or attempted sexual assault that occurred in a facility, whether or not it is part of the facility

- Staff become aware of sexual activity between residents or between a resident and staff, contractor, visitor, or volunteer
- Staff become aware of retaliation against students or staff that reported such an incident
- Staff become aware of any staff negligence or violation of responsibilities that may have contributed to an incident or retaliation

If a supervisor is not on duty the staff must contact an administrator. The administrator is responsible for notifying the proper authorities, which may include police, CPS, and the Division of Child Welfare Licensing. Interviews with staff demonstrate their knowledge of their reporting responsibilities, which include reporting to their supervisor and CPS and documenting the report.

(b): WHS policy requires and staff training curricula informs staff members that all employees comply with mandated reporting laws. The training states that staff must report violations or

suspected violations to the Facility Director, Program Manager, or designee. Training also requires staff members receiving the report of actual or suspected sexual abuse to complete a DHHS incident report before their end of their work shift and immediately call DHHS/CPS. Policy states that incident reports must contain all facts as known, including the victim's statement of allegation in the victim's own words and must not express the writer's opinion.

The mandatory reporting laws are also included on the agency's website in the *Mandated Reporters' Resource Guide.* Interviews with staff indicated they received training and understand the mandatory reporting requirements.

(c): WHS policy prohibits staff members from discussing the details of sexual abuse allegations or incidents beyond the extent needed to maintain safety and security at the facility. Staff members may only discuss the details with supervisors, managers, investigators, and prosecuting officials. Interviews with staff demonstrate they understand the requirements of protecting sensitive youth information.

(d): WHS policy requires all staff including medical, mental health staff, clergy, and attorneys whose communications may otherwise be privileged to report abuse as required by law and to inform youth of the limitations of confidentiality. During interviews, the medical staff member confirmed compliance with this standard. She stated that she had not received and was unaware of medical and mental care staff receiving a report of sexual abuse, but if she received such a report, she would report to her supervisor and CPS. She said intake staff members explain the limitations of confidentiality to residents.

(e): WHS policy requires that the facility administrator is responsible for notifying the proper authorities, which may include police, CPS, and the Division of Child Welfare Licensing. Policy requires that the Facility Director ensures that incidents of sexual abuse, findings from investigations, and other pertinent information is reported to the youth's court of jurisdiction, the youth's worker, and to the youth's parent or legal guardian. Case manager notes in one investigative report includes documentation that the youth's CPS worker and police were informed of the youth's allegation, resulting investigation, and actions taken by the facility. The Compliance Manager and Facility Director stated that case managers notify parents, guardians, or CPS workers immediately and no later than 24 hours after the notification of the allegation.

(f): WHS policy requires that all staff members immediately report all allegations of sexual abuse and sexual harassment to their supervisor. WHS training curricula require staff members' compliance with mandated reporting laws. The training also states that staff report violations or suspected violations to the Facility Director, Program Manager, or designee. The Facility Director is one of the designated facility investigators and stated that he is notified of all allegations involving sexual abuse.

Summary of Findings:

The auditors assessed WHS policy against the elements of this Standard and the PREA Audit Tool, which require that: a) the agency shall require staff to report any knowledge, suspicion, or information regarding sexual abuse, retaliation, and neglect; b) the agency shall require staff to comply with mandatory reporting laws; c) staff shall not reveal information regarding sexual abuse incidents other than to the extent necessary; d) medical and mental health staff must report sexual abuse to supervisors, state and local agencies where required by mandatory reporting laws and inform residents of the limitations of confidentiality; e) upon receiving a sexual abuse allegation, the facility head or designee must report to appropriate agencies, and the resident's parents, caseworker, legal guardian, or legal representative; and f) the facility shall report sexual abuse allegations to investigators. The auditors reviewed WHS policy and concluded that each element is addressed, which supports compliance with provisions (a) – (f). Evidence relied upon to determine compliance with provisions (a) and (b) was based upon interviews with staff members who communicated an understanding of their reporting duties. Evidence for provisions (b) and (d) included a slide in training curricula that details reporting requirements and the Michigan DHHS and WHS website, which include a link to the Mandatory Reporting Guide. Compliance with provision (c) was determined through interviews, during which staff members communicated their understanding of protecting information related to sexual abuse reports. Compliance with provisions (d) and (e) was also based on interviews, during which staff members articulated knowledge of their reporting duties and understood to whom they would report any information regarding sexual abuse. The auditors reviewed two investigative reports and concluded that since the two verbal allegations of sexual abuse were reported to designated investigators and subsequently investigated, compliance with provision (f) was evident. Since WSTC demonstrated compliance with each provision, the auditors determined the facility meets the requirements of this Standard.

Corrective Action: None

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.

Documents and Policy Reviewed:

1. Completed PAQ
2. WHS PREA Policy Section G
3. Investigative reports

Interviews:

1. Facility Director
2. Director of Clinical & Quality Services
3. Compliance Coordinator
4. Random staff

Observations: No observations relative to this Standard were required.

(a): WHS policy requires that the Facility Director or designee take immediate steps to protect sexual abuse victims from further victimization (if still at the facility) 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. These same protections must be provided to any youth believed to be in imminent danger of being sexually abused. The Facility Director said the resident would immediately be removed and placed in a different group or dorm if any risk of harm were present. The Director of Clinical & Quality Services stated that immediate action is taken to protect residents who are at risk of imminent abuse and include dorm and bed assignments. Staff members said they would protect and separate youth who are at risk of abuse or harm, notify a supervisor, and make recommendations for a different dorm assignment. The PAQ indicates there have been no instances of this in the past 12 months.

Summary of Findings:

The auditors assessed WHS policy against the elements of this Standard and the PREA Audit Tool, which require that: a) when an agency learns a resident is at risk of imminent sexual abuse, immediate action to protect the resident must be taken. The auditors reviewed policy and determined this provision is addressed. Since an incident of this type did not occur during the audit period, the auditors relied on staff members' responses during interviews and assessed their knowledge regarding the actions that would be taken if this should occur. The auditors noted that staff members communicated an understanding of these actions and were able to articulate specific and immediate actions per WHS policy. The actions described in the investigative reports, which included changes in bed and housing assignments and maintaining proximity to the alleged victim provided additional evidence of compliance with provision (a). The auditors determined the facility meets the requirements of provision (a), and thus this Standard.

Corrective Action: None

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.

Documents and Policy Reviewed:

1. Completed PAQ
2. WHS PREA Policy Section F

Interviews:

1. Facility Director
2. Director of Clinical & Quality Services

(a): WHS policy requires that if a report is received of alleged sexual abuse from another facility, the Director must report Director-to-Director to the other facility within 72 hours. All other applicable reporting requirements still apply. The facility reports there have been no allegations of this type received in the past 12 months, and no notifications from other facilities in the past 12 months were received. The Facility Director confirmed knowledge of this requirement and said he would report the allegation to the Facility Director of the other facility.

(b): WHS policy requires that the notification will be provided as soon as possible, but no later than 72 hours after receiving the allegation.

(c): No allegations were received in the previous 12 months; therefore, no notifications were made.

(d): WHS policy does not contain the agency's guidelines requiring that allegations received from other facilities/agencies are investigated in accordance with the PREA standards and are the responsibility of the facility where the alleged abuse occurred. The Facility Director stated that in the past, an allegation of this type was received and investigated according to this provision. The procedures included completing a state of Michigan incident report, submitting it to CPS,

conducting an investigation, and notifying licensing and the other facility's administrator. The Director of Clinical & Quality Services confirmed these procedures.

Summary of Findings:

The auditors assessed WHS policy against the elements of this Standard and the PREA Audit Tool, which require that: a) upon receiving an allegation of sexual abuse that occurred at another facility, the facility head notifies the facility head or appropriate office where the alleged abuse occurred; b) the notification shall be provided immediately but no later than 72 hours after receiving the allegation; c) the notification shall be documented; and d) the facility head or agency office shall ensure the allegation is investigated. Since no allegations of this type were reported during the audit period, the auditors relied upon policy and interview responses for all provisions. The auditors determined that each provision except (d) is addressed in policy. The interview responses of the Director of Clinical & Quality Services and Facility Director confirmed their knowledge of documentation and reporting responsibilities when a sexual abuse allegation is received from another facility. The facility demonstrated compliance with provisions (a) – (c), but policy did not contain the elements of provision (d). The auditors determined the facility did not meet the requirements of this Standard and a corrective action was initiated.

Corrective Action:

1. Revise policy or provide evidence that contains the requirement that allegations received from other facilities/agencies are investigated in accordance with the PREA standards and are the responsibility of the facility where the alleged abuse occurred.

Corrective Action Taken:

1. WHS PREA Policy was revised to include:

   > If a report is received of alleged sexual abuse from another facility, the Director must report Director-to-Director to the other facility within 72 hours. The allegation shall be investigated in accordance with the PREA standards and are the responsibility of the facility where the alleged abuse occurred. (All other applicable reporting requirements still apply.)

   Based on the revised policy, the auditors determined the facility meets the requirements of this Standard.

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.

Documents and Policy Reviewed:

1. Completed PAQ
2. WHS PREA Policy Section F; H, #1
3. WHS PREA Policy Definitions Section
4. PREA Incident Allegation Response Checklist For WHS Managers form

Interviews:

1. Security staff and non-security staff first responders
2. Random staff

Observations: No observations relative to this Standard were required.

(a): WHS defines a first responder as any/all facility personnel to whom an incident or report of alleged sexual abuse, or any other form of abuse/neglect of youth is reported. Policy contains all of the required elements of the first responder duties outlined in this standard. Additionally, the allegation response form lists detailed immediate and follow-up actions first responders and supervisors are required to take as well as documentation and reporting responsibilities.

Three staff members were interviewed using the first responder interview protocol. Each communicated an understanding of his/her first responder duties, and each was able to describe the procedures that would be followed to protect the youth and the crime scene. The two investigative files confirm first responder actions were taken and include separating the alleged victim and perpetrator, maintaining proximity, reporting, and collecting statements. Additional details regarding the investigations are provided in Standard 115.371. The one youth who reported a sexual abuse declined to speak with the auditors.

(b): WHS policy defines and the PAQ indicated that all staff members are considered to be security staff members and that the two reports were made verbally. The investigative reports indicate the verbal reports were appropriately documented and steps pursuant to policy and this provision were taken following the residents' allegations.

Summary of Findings:

The auditors assessed WHS policy against the elements of this Standard and the PREA Audit Tool, which require that: a) upon learning that a resident was sexually abused, the first responder must

separate the alleged victim and abuser, preserve the scene and collect evidence, collect physical evidence if the abuse occurred within a time period that this evidence may be collected, and ensure physical evidence is protected; and b) if the first responder is not a security staff, the responder shall request that the alleged victim not take any actions that could destroy physical evidence and then notify security staff. The auditors determined that WHS policy contains each of these elements, which supports compliance with provisions (a) and (b). Additional evidence of compliance with both provisions includes the investigative reports that contain details of actions taken following the two verbal reports. Compliance with provisions (a) and (b) was determined through interviews, during which staff members communicated an understanding of the actions they would take following an allegation of sexual abuse. Since the facility demonstrated compliance with both provisions, the auditors determined WSTC meets the requirements of this Standard.

Corrective Action: None

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.

Documents and Policy Reviewed:

1. Completed PAQ
2. WHS PREA Coordinated Response Plan
3. WHS PREA Policy Definitions Section
4. PREA Incident Allegation Response Checklist For WHS Managers form

Interviews:

1. Facility Director

Observations: No observations relative to this Standard were required.

(a): WSTC maintains a written institutional plan to coordinate responses to allegations of sexual abuse. The plan includes procedures for first responders, supervisors, the Facility Director or Program Manager, medical and mental health providers, and investigators. Actions include contacting supervisors; separating the victim and alleged perpetrator; protecting the incident scene; reporting to CPS; not allowing the victim to wash, change clothes, etc.; and documenting all information on an incident report; and cooperating with investigators, prosecutors, and facility administration. Supervisors must respond to assist the first responder, contact the Facility Director and Program Manager, facilitate transportation for a forensic exam if needed, protect evidence, and implement special instructions from the Facility Director. The Facility Director or Program Manager must assume overall responsibility and ensure that first responder activities have occurred, an investigation referral is made, all reporting is conducted, alternate housing and accommodations are made for the victim, the victim receives follow-up medical and mental health services, an investigation is conducted, retaliation monitoring occurs for at least 90 days, and a post-indecent review is conducted and documented. Medical and mental health staff must provide services under the oversight of the Facility Director or Chief Health Services Coordinator. Investigators must complete an investigation and report findings to facility leadership. The Facility Director summarized the coordinated response plan and actions to be taken by all staff members as described above.

Summary of Findings:

The auditors assessed WHS policy against the elements of this Standard and the PREA Audit Tool, which require that: a) the facility shall develop a written institutional plan to coordinate actions in response to an incident of sexual abuse. The auditors determined the facility policy contains sufficient details regarding this provision. Additional support of compliance was determined following a review of the WSTC's institutional plan, which includes actions to be taken by various staff members and the Facility Director's interview during which he demonstrated comprehension of the written plan. The auditors concluded that the facility meets the requirements of provision (a), and thus meets the requirements of this Standard.

Corrective Action: None

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.

Documents and Policy Reviewed:

1. Completed PAQ

Interviews:

1. Director of Clinical & Quality Services

Observations: No observations relative to this Standard were required.

(a): WHS meets the requirements of this provision as WHS does not enter into collective bargaining agreements that would limit the ability to remove alleged staff sexual abusers from contact with any youth pending an investigation determination. The Director of Clinical & Quality Services confirmed that the agency does not enter into collective bargaining agreements.

(b): The auditors are not required to audit this provision.

Summary of Findings:

The auditors assessed WHS policy against the elements of this Standard and the PREA Audit Tool, which require that: a) the agency shall not enter into a collective bargaining agreement that limits the agency's ability to remove alleged abusers from contact with residents pending the outcome of investigation or disciplinary actions. Provision (b) is not required to be audited. Since WSTC policy contains language pursuant to provision (a), and provision (b) is not required to be audited, the auditors determined the facility meets the requirements of this Standard.

Corrective Action: None

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 for residents or staff who fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations, 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? ☒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.

Documents and Policy Reviewed:

1. Completed PAQ
2. WHS PREA Policy Section F, #10
3. WHS PREA Coordinated Response Plan
4. Documentation of monitoring for retaliation

Interviews:

1. Director of Clinical & Quality Services
2. Facility Director
3. PREA Compliance Coordinator
4. Staff who monitor for retaliation (Compliance Manager)

Observations: No observations relative to this Standard were required, as no resident was being monitored for retaliation during the onsite audit.

(a): WHS policy requires that a designated facility employee monitor staff and youth to prevent retaliation for a minimum of 90 days after a sexual abuse allegation is made. Monitoring should include multiple methods, including but not limited to observation, direct questioning, and review of logs and incident reports. The Compliance Manager is the designated monitor for WSTC. The facility reported that there have been no incidents of retaliation that have occurred in the past 12 months.

(b): WSTC uses multiple protection measures to protect youth and staff from retaliation, such as housing transfers, transfers of youth, removal of alleged abuser from contact with the alleged abuser, and emotional support services. Protection and monitoring efforts were documented in the investigative reports and include evidence of housing transfers, notification to pertinent staff members and authorities, case notes from therapists and case managers, mental health services, and weekly monitoring observation and meeting notes. One report includes a recommendation for monitoring for retaliation for two weeks. The other report indicates monitoring efforts were in place for six weeks. The Director of Clinical & Quality Services said the Compliance Manager conducted monitoring visits and informed supervisory staff members of any concerns. The Facility Director described multiple measures that could be taken to protect residents such as follow-up meetings with the resident, housing transfers, and checking logs for potential retaliation. The staff member charged with monitoring for retaliation (Compliance Manager) described similar actions that could be taken to protect residents. She reported that in the past, monitoring efforts continued for two to three weeks, but after a review of policy understood the efforts should continue for a minimum of 90 days. No residents were being held in isolation for protection measures or otherwise. The one resident who reported sexual abuse declined to speak with the auditors.

(c): WHS policy requires monitoring for retaliation for at least 90 days following a report, except when the allegation is determined to be unfounded. Administrators and the staff member responsible for monitoring were knowledgeable about the duty to monitor for retaliation for at least 90 days. They said the time would be extended if needed, as there is no maximum time for monitoring efforts. While interviews supported compliance with this provision, the completed monitoring forms indicated the monitoring was conducted from two to six weeks.

(d): WHS policy requires that staff members conduct periodic status checks of the alleged victim. The staff member responsible for monitoring for retaliation stated there is no maximum length of time a youth would be monitored, and status checks could include watching for bruises, nonverbal cues, and behavioral changes. The investigative reports include case notes from therapists and case managers, which supports compliance with this provision.

(e): WHS policy does not explicitly require that staff take appropriate measures to protect any other individual who cooperates with the investigation who may be at risk of retaliation or who expresses a fear of retaliation. However, during interviews, staff members described multiple measures that could be taken to protect residents.

(f): The auditors are not required to monitor this provision.

Summary of Findings:

The auditors assessed WHS policy against the elements of this Standard and the PREA Audit Tool, which require that: a) the agency establishes policy to protect residents and staff from retaliation, b) the agency shall use multiple protection measures, c) the agency shall monitor for retaliation for at least 90 days, d) monitoring shall include periodic status checks, and e) if any individual expresses fear of retaliation, the agency takes steps to protect the individual. Provision (f) is not required to be audited. The auditors determined that WSTC policy contains each provision element except provision (e), and a corrective action was initiated. Evidence of compliance with provision (a) includes the facility's designation of a staff member who is responsible for retaliation monitoring. During staff member's interview, she communicated an understanding of her monitoring duties. Interview responses of additional staff members support compliance with provisions (b) – (e), as they were able to articulate various measures that were taken following the two verbal reports alleging sexual abuse and the resulting investigations. Compliance with these provisions was further demonstrated during a review of the documented efforts to monitor for retaliation that were included in the investigative reports. Since policy did not contain the elements of provision (e), the auditors determined the facility does not meet the requirements of this Standard.

Recommendation:

1. Revise policy to include the requirements in provision (e).

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.

Documentation and Policy Reviewed:

1. Completed PAQ
2. WHS PREA Policy Section B

Interviews:

1. Facility Director
2. Staff who supervise youth in isolation
3. Medical and mental health care staff

Observations: Rooms used for isolation

(a): WHS policy stipulates that a youth may be isolated from other youth as preventive and protective measures, but only as a last resort when other less restrictive measures are inadequate to keep the youth safe from other youths, and then only until an alternate means of keeping all youths safe can be arranged. During any periods of protective isolation, facility staff may not deny a youth otherwise under control, access to daily large-muscle exercise and legally required educational programming or special education services. Any youth in isolation must receive daily visits from a medical or mental health care clinician and must have access to other programs to the extent possible. The facility reported no instances of residents who alleged to have suffered sexual abuse being placed in isolation. The Facility Director said isolation would only be used for aggressive youth and any isolation would likely not exceed 30 minutes. The staff member designated to monitor youth in isolation said the isolation room is rarely used and when it is, youth remain in the room for a few minutes for a "cooling off" period. The medical staff member stated isolation is not used unless a youth needs to be isolated in the infirmary for medical reasons.

Summary of Findings:

The auditors assessed WHS policy against the elements of this Standard and the PREA Audit Tool, which require that: a) any segregated housing used to protect a resident alleged to have suffered sexual abuse shall be subject to the requirements in Standard 115.342. The auditors' determination of compliance with this provision was based on policy review, interview responses, and observation of the isolation rooms. The policy contains details regarding provision (a), and staff members reported that this type of segregation is not used. No residents were placed in isolation during the facility inspection, and no indication that these rooms were utilized with frequency was noted. Additional support of compliance was based on residents' responses, which confirmed that this or any type of isolation is not used. Since WSTC is compliant with provision (a), the auditors determined the facility meets the requirements of this Standard.

Corrective Action: None

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 entity investigates sexual abuse, does the facility cooperate with outside investigators and endeavor to remain informed about the progress of the investigation? (N/A if an outside agency does not conduct administrative or criminal sexual abuse investigations. See 115.321(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.

Documentation and Policy Reviewed:

1. Completed PAQ
2. WHS PREA Policy Section A, #1, c; H
3. Investigative reports
4. Investigative staff training certifications

Interviews:

1. Facility Director
2. Random staff
3. Investigator (Facility Director)
4. Compliance Manager
5. Compliance Coordinator

Observations: No observations relative to this Standard were required.

(a): WHS Policy requires that each incident of alleged or reported sexual abuse be investigated to the fullest extent possible including allegations from third-party and anonymous reports. The two investigative reports appear thorough and include the following.

1. PREA Committee attendance sign-in sheets
2. Written and transcribed statements from Therapists, the Compliance Manager, Youth Care Workers, and residents
3. Incident reports
4. Initial actions taken regarding staff, residents, environment, and any injuries, illness, or property damage
5. Investigation conclusion
6. Notifications including the Facility Director, and Vice President of Residential Programs
7. Incident Review Team activities such as reviewing incident reports, evidence, staffing, and youth schedules, and the assessment of each element pursuant to provision 115.386 (d)
8. Review team recommendations

The interview with investigator also demonstrated understanding of the initiation of an investigation and the investigation process.

(b): WHS policy requires that qualified investigators take victim statements, open an investigation, and if applicable collect physical evidence. WSTC uses investigators who have received specialized training in sexual abuse investigations involving juvenile victims per Standard 115.334. The investigators follow a uniform evidence protocol as outlined in the National Institute of Corrections *PREA: Investigating Sexual Abuse in a Confinement Setting* training. Certifications of completion were included for Standard 115.334. The investigator confirmed his understanding of interviewing youth, evidence collection in confinement settings, and criteria needed to substantiate a case.

(c): The investigative staff member demonstrated knowledge regarding evidence collection and stated that he would report the incident to the police department and state police if evidence needed to be collected. WHS Policy Investigation Protocols regarding evidence include the following.

- All full and part time medical and mental health care practitioners who work regularly with residents must receive specialized training on preserving physical evidence.
- If sexual abuse occurred within 96 hours, the area where the incident occurred must be secured for evidence collection.
- Evidence collected must be maintained under strict control.
- Qualified investigators must take victim statements, open an investigation, and if applicable collect physical evidence.
- The area where the suspected assault took place is sealed off until qualified investigators can gather evidence.
- Any clothing or articles belonging to the victim are left in place and not handled or disturbed until investigators have gathered evidence.
- The victim must be requested not to shower, brush teeth, or change clothing before being transported to the hospital. The alleged perpetrator must not be allowed to change clothing, wash, or brush teeth.

Two investigative reports alleging sexual abuse were reviewed and are described in provision (a) above. WHS policy requires that records of allegations be kept for as long as an employee is employed at the facility or the youth is in residence at the facility, plus five years.

(d): WHS policy requires that an investigation will not be terminated because the source of the allegation recants the allegation. The investigator supported compliance with this standard stating that an investigation would not end due to an allegation being recanted.

(e): During the investigative staff member interview, he said that his responsibility regarding this type of evidence is to report all information gathered to the police and if this type of interview is required, the police would conduct it. The two investigative reports documented evidence collection including statements, incident reports, and video review.

(f): WHS policy prohibits making a determination based on the credibility of the alleged victim. The investigator reported this and stated that all allegations of sexual abuse are considered the truth until investigated. He reported that WSTC does not use polygraph tests or any other truth-telling devices. The one resident present at the facility who reported sexual abuse declined to be interviewed.

(g): WHS policy requires that the sexual abuse review team consider whether staffing contributed to the abuse. The incident review within in the investigative reports includes notes regarding the consideration of staff actions and staffing in general. The investigator stated that all investigative facts and findings must be documented. The investigative reports also demonstrate that findings are documented as each includes this determination.

(h): WSTC does not conduct criminal investigations. The police department conducts and documents these types of investigations.

(i): WHS policy states and the investigator corroborated that based on the results of the investigation, facility personnel and prosecuting authorities meet to determine if prosecution is appropriate. The facility reported there have been no substantiated allegations of conduct that appear to be criminal that were referred for prosecution sine the last PREA audit.

(j): WHS policy requires that Records of allegations are kept for as long as an employee is employed at the facility or the youth is in residence at the facility, plus five years.

(k): WHS does not terminate investigations solely on the basis that the alleged abuser or victim is no longer with the agency. The investigative staff said the investigation would continue regardless if the alleged abuser or victim is no longer employed or placed at WSTC.

(l): The auditors are not required to audit this provision.

(m): During interviews, the investigator (Facility Director) stated that the WSTC conducts and documents the investigation and provides all information to the police department; the prosecutor makes the final determination. The Compliance Manager stated that the MOU with the police requires that the police update the facility on investigation progress and follow a national standard for sexual abuse investigation protocols. The MOU indicates the police department agrees to investigate thoroughly, utilize investigators who have received specialized training involving juveniles, follow the police department protocols, and make an effort to share information about the progress of the investigation within the State of Michigan laws.

Summary of Findings:

The auditors assessed WHS policy against the elements of this Standard and the PREA Audit Tool, which require that: a) the agency conducts thorough and prompt investigations; b) investigators must have specialized training; c) investigators shall gather evidence and shall review prior complaints involving the suspected perpetrator; d) the investigation continues if the complainant recants the allegation; e) the agency conducts compelled interviews only after consulting with prosecutors; f) the credibility of the alleged victim shall be assessed on a case-by-case basis, and no polygraphs or truth-telling devices are used as a condition of continuing the investigation; g) administrative investigations shall include the consideration of staff actions and shall be documented in written reports; h) criminal investigations shall be documented in written reports; i) substantiated allegations that appear criminal shall be referred for prosecution; j) the agency maintains all written reports 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; k) the departure of the alleged abuser or victim from the facility or from employment shall not provide a basis for terminating an investigation; and m) the facility cooperates with outside investigators. Provision (l) is not required to be audited. The auditors determined that the facility policy addresses each of these provisions, which supports compliance with provisions (a) – (m).

The auditors determined compliance with provision (a) after reviewing the two investigations following allegations of resident-on-resident sexual abuse. Both were determined to have been conducted promptly, thoroughly, and objectively based on 1) the dates of the initiation and conclusion of the investigation, 2) the comprehensive notes, evidence collected, actions taken, and recommendations contained in the report, and 3) the consistency of the investigation process in the two reports. Compliance with provision (b) was based on documented evidence of the specialized training the investigators received. The investigative reports include details about the evidence reviewed including resident and staff statements and video footage, which supports compliance with provision (c). Compliance with provision (d) was determined, as neither resident recanted his or her allegation, and neither investigation resulted in a referral for prosecution. Compliance with provision (f) was based on details in the report indicating each resident's statement was considered credible. The reports contain details regarding the consideration of staff actions as contributing factors, which supports compliance with provision (g). Compliance with provisions (a) – (m) was based on interview responses, which revealed an understanding of the requirements of each provision. Since policy, interview responses, and investigative reports demonstrated compliance with each provision, the auditors determined WSTC meets the requirements of this Standard.

Corrective Action: None

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.

Documentation and Policy Reviewed:

1. Completed PAQ
2. WHS PREA Policy Section H
3. Investigative reports

Interviews:

1. Administrative Investigator (Facility Director)

Observations: No observations relative to this Standard were required.

(a): WHS policy requires that substantiation of an allegation will be based on an evidentiary standard no higher than a preponderance of the evidence. Both investigations involving allegations of sexual abuse were unsubstantiated based on evidence including staff and youth statements, incident reports, and camera review. The investigative staff member stated he understood the standard to substantiate an allegation.

Summary of Findings:

The auditors assessed WHS policy against the elements of this Standard and the PREA Audit Tool, which require that: a) the agency standard to substantiate a case is a preponderance of the evidence. Since policy addresses and the investigator communicated an understanding of this provision, the auditors determined the facility meets the requirements of this Standard.

Corrective Action: None

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 an agency 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.

Documentation and Policy Reviewed:

1. Completed PAQ
2. WHS PREA Policy
3. Investigative reports

Interviews:

1. Facility Director
2. Investigative staff

Observations: No observations relative to this Standard were required.

(a): WHS policy requires that following a youth's allegation that he or she has suffered abuse, WHS informs and documents informing the youth of the outcome of the investigation. WHS must also inform the youth (unless the facility has determined that the allegation is unfounded) whenever:

- The staff member is no longer posted within the resident's unit;
- The staff member is no longer employed at the facility;
- WHS learns that the staff member has been indicted on a charge related to sexual abuse within the facility; or
- WHS learns that the staff member has been convicted on a charge related to sexual abuse within the facility.

Although the investigative reports contain notes stating the resident should be notified of the outcome of the investigation, whether the notification was made was not documented. The Facility Director stated that per policy, youth are notified whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded following each investigation.

(b): This provision does not apply; the agency/facility is responsible for conducting administrative investigations.

(c): WHS policy requires that youth are notified when 1) the staff member is no longer posted within the youth's unit; 2) the staff member is no longer employed at the facility; 3) when the staff member has been indicted; or 4) when the staff member has been convicted on a charge related to sexual abuse within the facility. The facility reported that there have been no substantiated or unsubstantiated complaints of sexual abuse committed by a staff member against a resident in the past 12 months.

(d): WHS policy requires that following a youth's allegation that he or she was sexually abused by another youth, the facility informs the youth when 1) the abuser has been indicted, or 2) the abuser has been convicted on a charge related to sexual abuse. The PAQ indicates two

notifications were made; however, the notifications were not documented within the investigative reports. The Director of Clinical & Quality Services stated the youth notifications were verbal.

(e): WHS policy requires documentation on all such notifications or attempted notifications under this standard. Documentation of these notifications was not available for review.

Summary of Findings:

The auditors assessed WHS policy against the elements of this Standard and the PREA Audit Tool, which require that: a) following an investigation, the agency shall inform the resident of the outcome; c) the agency informs the resident when the staff member is no longer posted in the resident's unit, the staff member is no longer employed at the facility, the agency learns that the staff member has been indicted on a charge related to sexual abuse within the facility, or the agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility; d) following a resident's allegation that he or she has been sexually abused by another resident, the agency informs the alleged victim whenever the alleged abuser has been indicted or convicted on a charge related to sexual abuse within the facility; and e) notifications are documented. Provision (b) does not apply, as the agency conducts administrative investigations, and (f) is not required to be audited. The auditors determined the facility policy addresses each of these provisions, which supports compliance with each applicable provision. Although staff members communicated an understanding of the resident notification requirements, the notifications were not documented in the investigative reports; thus the auditors determined the facility does not meet the requirements of this Standard, and a corrective action was initiated to demonstrate compliance with provisions (a), (d), and (e).

Corrective Action:

1. Provide evidence that notifications pursuant to this Standard are made and documented.

Corrective Action Taken:

1. During the audit, the PAQ indicated two notifications were made; however, the notifications were not documented within the investigative reports as required by provision (d). The PREA Compliance Manager provided a Case Note from a retaliation-monitoring meeting with a resident regarding a subsequent investigation notification. The note contained documentation that the resident was informed of the findings of the allegation. Based on the documented notification, the auditors determined the facility meets the requirements of this Standard.

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.

Documentation and Policy Reviewed:

1. Completed PAQ
2. WHS PREA Policy Section H

Interviews: No interviews protocols are directly related to this Standard.

Observations: No observations relative to this Standard were required.

(a): WHS policy requires that if it is found/proven that an employee participated in behaviors prohibited by the PREA Policy, it could be cause for immediate termination from employment with the facility. Dismissal is the presumptive discipline for staff upon a finding that they engaged in sexual abuse of a youth. In the past 12 months, the agency reported that no staff member has violated the WHS policy regarding sexual abuse or sexual harassment.

(b): WHS policy requires that termination of employment is the presumptive disciplinary sanction for staff members who have engaged in sexual abuse. In the past 12 months, the agency reported that no staff member has violated the WHS policy regarding sexual abuse or sexual harassment.

(c): WHS policy stipulates that termination of employment is the presumptive disciplinary sanction for staff members who have engaged in sexual abuse. The Compliance Manager said termination is the sanction for a staff member who has engaged in any type of sexual abuse. The facility reported zero instances of staff members being reported to law enforcement or licensing bodies following a termination or resignation prior to termination.

(d): WHS policy requires that suspected or alleged staff-on-youth sexual activity of any type is immediately reported to the Facility Director who will make all required notifications, including notification to the police to open an investigation and notification to the suspected employee restricting work activities. No staff members have been terminated for PREA-related conduct.

Summary of Findings:

The auditors assessed WHS policy against the elements of this Standard and the PREA Audit Tool, which require that: a) staff shall be subject to disciplinary sanctions up to and including termination for violations of PREA policy, b) termination is the presumptive sanction for sexual abuse, c) sanctions are commensurate with the nature of the violation, and d) terminations for

PREA violations shall be reported to law enforcement agencies. The facility reported that no staff members have been terminated pursuant to this Standard, so the auditors determined compliance based on policy review. Since policy addresses each provision, the auditors concluded the facility meets the requirements of this Standard.

Corrective Action: None

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.

Documentation and Policy Reviewed:

1. Completed PAQ
2. WHS PREA Policy Section H and Definitions Section
3. Training curriculum

Interviews:

1. Facility Director

Observations: No observations relative to this Standard were required.

(a): WHS policy does not explicitly require that if a contractor or volunteer engages in sexual abuse, he or she shall be prohibited from having contact with youth and shall be reported to law enforcement agencies and relevant licensing bodies. However, in the WHS policy definitions section, staff sexual misconduct includes misconduct by volunteers and contractors. In the training curriculum, slides 3 and 4 mandate that volunteers and contractors must abide by the same laws and are held accountable to the same standards as staff. The Facility Director and Compliance Manager confirmed that volunteer and contractor infractions are treated the same as any facility staff member and would be removed from having contact with youth just as staff members would. In the past 12 months, the facility reports that no contractors or volunteers have been reported for engaging in sexual abuse of youth.

(b): WHS policy does not detail remedial measures taken in the case of contractors and volunteers; however, policy requires that if any staff member, which includes volunteers or contractors per the definitions section, who are suspected or alleged to have engaged in staff-on-youth sexual activity of any type must not, pending notification from the Director or designee, be in direct contact with facility residents. The Facility Director stated that a volunteer or contractor who engaged in sexual misconduct with youth would be reported to licensing, CPS, the police, and the agency that enlisted his or her services, and all contact with youth would be suspended. The facility reported no cases of a volunteer or contractor who was disciplined for policy violation.

Summary of Findings:

The auditors assessed WHS policy against the elements of this Standard and the PREA Audit Tool, which require that: a) contractors or volunteers who violate PREA policy shall be prohibited from contact with residents and reported to law enforcement agencies if the activity was criminal and b) the facility shall take appropriate remedial measures in the case of any other violation of agency sexual abuse or harassment policies by a contractor or volunteer. Since the facility reported no instances of volunteer or contractor PREA violations, the auditors determined compliance based on policy review and interview responses. WHS policy addresses both provisions. The Facility

Director's responses provided additional evidence of compliance, as he communicated knowledge of actions that would be taken following a PREA violation by a contractor or volunteer. Since compliance was demonstrated with both provisions, the auditors determined the facility meets the requirements of this Standard.

Corrective Action: None

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)

- 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.

Documentation and Policy Reviewed:

1. Completed PAQ
2. WHS PREA Policy Sections A and H
3. Client Orientation Packet

Interviews:

1. Facility Director
2. Medical and mental health care staff

Observations: No observations relative to this Standard were required.

(a): WHS policy requires that residents may be subject to disciplinary sanctions only pursuant to positive findings that the youth engaged in youth-on-youth sexual abuse. The client packet explains that clients are encouraged to report even suspected violations but cautions clients that making false allegations is a violation of facility rules and the law. The packet states that clients who intentionally lie when accusing someone of sexual assault and/or related sexually inappropriate behavior will receive consequences that could include criminal charges. The facility reports there has been one administrative finding regarding youth-on-youth sexual abuse occurring in the facility in the past 12 months.

(b): WHS policy regarding resident sanctions are described in provision (a) above. The Facility Director said sanctions could include a variety of consequences including a "level drop." The facility reported that in the past 12 months there have been no youth placed in isolation as a disciplinary sanction for youth-on-youth sexual abuse. The Facility Director said isolation is not used as a sanction and only used for a cooling off space for aggressive youth.

(c): WHS policy does not require that the disciplinary process consider whether a youth's mental disability or mental illness contributed to his or her behavior. However, the Facility Director said these factors are considered when determining sanctions.

(d): The PAQ indicated WSTC offers therapy, counseling, or interventions designed to address and correct the underlying reasons or motivations for abuse. The PAQ also indicated the facility may require participation in these interventions as a condition of access to behavior-based incentives,

but not as a condition to access general programming. Medical and mental health care staff members said counseling and therapy is offered to all youth placed at the facility.

(f): WHS policy requires that a youth may be disciplined for sexual contact with staff only upon a finding that the staff did not consent to such contact.

(g): WHS policy prohibits all sexual activity between residents. Sexual activity is not deemed sexual assault if the activity was not coerced.

Summary of Findings:

The auditors assessed WHS policy against the elements of this Standard and the PREA Audit Tool, which require that: a) residents may be subject to sanction only pursuant to a formal disciplinary process; b) sanctions shall be commensurate with the circumstances of the abuse committed, and the facility must provide specific services to residents who receive sanctions resulting in isolation; c) the disciplinary process shall consider a resident's mental disability when determining sanctions; d) if the facility offers therapy, counseling, and other interventions, the facility shall consider whether to offer the services to the offender, and the agency may require participation in such interventions as a conditions of access to rewards-based incentives but not as a condition to access to general programming; e) the agency may discipline a resident for sexual contact with staff only upon a finding that the staff member did no consent; f) reports made in good faith shall not constitute false reporting; and g) the agency may prohibit all sexual activity between residents, may discipline resident s for such activity, and may not deem the activity sexual abuse if it determines that the activity is not coerced. The auditors determined that WHS policy addresses each provision except provision (c), and a corrective was initiated. Staff members' interview responses confirmed their knowledge of sanctions including isolation, mental health care services, and the consideration of a resident's mental illness when determining sanctions. Since the facility did not demonstrate compliance with all provisions, the auditors determined WSTC does not meet the requirements of this Standard.

Corrective Action:

1. Revise policy to require that the disciplinary process consider whether a youth's mental disability or mental illness contributed to his or her behavior.

Corrective Action Taken:

1. The Client Discipline Policy for PREA-Related Allegations Section (a) was revised to include: "Consideration of whether the client's mental disabilities or illnesses contributed to the behavior…" as an additional guideline to be used when determining the type of disciplinary sanction following a resident's false allegation or report. Based on the revised policy, the auditors determined the facility meets the requirements of this Standard.

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.

Documentation and Policy Reviewed:

1. Completed PAQ
2. WHS PREA Policy Sections B and E
3. Intake screenings

Interviews:

1. Medical and mental health care staff

Observations:

1. Area where resident files are stored

(a): WHS policy requires that if the risk screening indicates that the resident has been a victim of sexual abuse or has committed sexual abuse, the resident will be examined by a medical or mental health provider within 14 days of the completed assessment. During interviews, the staff member who conducts the screening stated that trauma counseling is provided to all youth regardless of the results of the screening and that these sessions occur within 24 hours or as soon as possible. Youth interviews indicated follow-up medical and mental health care is offered on the first day and regularly thereafter. Residents reported meeting with their therapist weekly and being able to request additional sessions if they wish. The auditors reviewed the risk assessment in each youth file and two additional assessments that resulted in a determination that the youth was at greater risk of being victimized or victimizing others. Each of these contained notes regarding specific room/dorm assignments, precautions, and additional supervision requirements. Intake assessments pursuant to Standard 115.341 and case notes from therapists also demonstrate compliance with this provision.

(b): The screening is used and compliance was determined in the same manner as described in provision (a) for youth who have perpetrated sexual abuse.

(c): WHS policy limits the staff members who have access to information pursuant to this standard and states that the Treatment Team (or other as applicable) must review the completed assessment, in addition to available medical and mental health screenings, classification assessments, the case file, and other relevant records, and make and/or add to any recommendations for group, room, seating, or other assignments. Youth files are stored in a

secure location, which was observed during the walk through. Limited staff members have access to these files.

(d): WHS policy requires that residents age 18 and older must give written informed consent before medical/mental health personnel engage in reporting regarding victimization occurring outside of a facility or institutional setting. The medical staff member said that informed consent is obtained for youth age 18 and older.

Summary of Findings:

The auditors assessed WHS policy against the elements of this Standard and the PREA Audit Tool, which require that: a) if the intake screening indicates the resident has experienced prior sexual victimization, the resident is offered a follow-up meeting with a medical or mental health care practitioner within 14 days of intake; b) if the screening indicates the resident has previously perpetrated sexual abuse, the resident is offered a follow-up meeting with a medical or mental health care practitioner within 14 days of intake; c) any information related to sexual abuse or victimization shall be strictly controlled; and d) medical and mental health practitioners shall obtain informed consent before reporting information about prior victimization that did not occur in an institution, unless the resident is under the age of 18. WHS policy addresses each provision, which supports compliance with provisions (a) – (d). Compliance with provisions (a) and (b) was demonstrated during a review of intake assessments and subsequent individualized actions taken based on the screening information. Compliance with provision (c) was demonstrated during interviews, during which staff members explained the limited access to resident files containing sensitive information. Additional compliance was evidenced during the facility inspection when the auditors noted the locked area in which the files are stored. The auditors determined additional compliance with provision (d) during an interview with a medical practitioner who communicated an understanding of informed consent. Since the facility demonstrated compliance with all provisions, the auditors determined that WSTC meets the requirements of this Standard.

Corrective Action: None

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.

Documentation and Policy Reviewed:

1. Completed PAQ
2. WHS PREA Policy Section F
3. Medical/Mental Health Records
4. Client Orientation Packet
5. WHS Residential Programs PREA Coordinated Response Plan

Interviews:

1. Medical and mental health care staff
2. Staff who conducts risk assessments

Observations:

1. Medical and mental health care service areas

(a): WHS policy requires that if it is believed or determined that a sexual assault occurred and that the alleged sexual assault occurred within the last 96 hours, the facility director or designee must make immediate arrangements to transport the youth to Saginaw Covenant Hospital for a forensic examination, and the area where the incident occurred must be secured for evidence collection. If it is believed or determined that a sexual assault occurred more than 96 hours previous, the emergency room will be contacted for further instructions. Following emergency response and completion of the rape kit (if applicable) a youth believed or determined to have been the victim of a sexual assault must also be examined by medical staff for possible injuries, regardless of when the alleged sexual assault occurred.

Medical and mental health care staff said all youth received these services and when emergency medical treatment is required, youth are transported to the community hospital. The one resident who reported sexual abuse declined to be interviewed.

(b): WHS policy requires that staff first responders take preliminary steps to protect the victim pursuant to Standard 115.362. According to the coordinated response plan, the Facility Director or Program Manager ensures that the victim receives follow-up medical examinations regardless of when the incident occurred of if a forensic examination occurred and that the victim receives psychological and counseling services. Interviews with staff demonstrate their knowledge of first responder protocols and procedures for acute cases of sexual abuse. Although the two cases of alleged sexual misconduct were not emergency incidents, mental health care case notes indicate these staff members were notified, and subsequent services were provided.

(c): WHS policy requires that resident victims of sexual abuse are 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. Female victims of sexually abusive vaginal penetration must be offered pregnancy tests. If pregnancy results from sexual abuse while incarcerated, victims will receive timely and comprehensive information about, and timely access to, all lawful pregnancy-related medical services. All medical and counseling services will be provided at no charge to the victim.

The Compliance Coordinator and facility staff members confirmed medical services would occur at the local hospital where the youth would be transported for the exam and follow-up services provided at the facility.

(d): WHS policy requires and the client orientation packet explains that all medical and counseling services will be provided at no charge to the victim. Interviews corroborate that victims are not charged for these treatment services.

Summary of Findings:

The auditors assessed WHS policy against the elements of this Standard and the PREA Audit Tool, which require that: a) resident victims of sexual abuse shall receive access to emergency medical treatment and crisis interventions as determined by medical and mental health practitioners; b) if no qualified staff members are on duty at the time of report of recent abuse, the first responder shall take steps pursuant to Standard 115.362 to protect the resident; c) resident victims of sexual abuse while incarcerated shall be offered information and access to emergency contraception and sexually transmitted infection prophylaxis in accordance with professionally accepted standards of care; and d) treatment shall be provided at no cost to the resident. The auditors determined that WHS policy addresses each provision. The services described in this Standard were not necessary to provide during the audit period; however, resident files, the client packet, and the investigative reports provide sufficient evidence that medical and mental health care services are provided to all youth at no charge. The dedicated medical area and therapists' offices observed during the facility inspection indicate these areas are used to provide medical and mental health care services, which supports compliance with provision (c). Additional evidence supporting compliance with all provisions was based on interview responses. Staff members articulated their knowledge of the general medical and mental health care services all residents receive and emergency services that would be provided if needed. Residents also confirmed that they receive these services at no cost. Evidence supporting compliance with provision (d) is included in the investigative reports, which indicate appropriate actions were taken to protect residents following verbal reports of sexual abuse. Since the facility demonstrated compliance with all provisions, the auditors determined WSTC meets the requirements of this Standard.

Corrective Action: None

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.) ☒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.) ☒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.

Documentation and Policy Reviewed:

1. Completed PAQ
2. WHS PREA Policy Section F
3. Investigative reports
4. Resident files

Interviews:

1. Medical and mental health care staff
2. Staff member who conducts risk assessments
3. Random youth

Observations:

1. Medical and mental health care service areas

(a): WHS policy requires that the victim of sexual assault or attempted sexual assault are provided mental health assistance and counseling as determined necessary and appropriate. Interviews with medical and mental health staff indicated all youth undergo a screening during intake and periodically throughout their stay and receive follow-up services as needed. The auditors reviewed youth files, all of which included therapy progress notes, treatment plans, and initial and subsequent risk assessments. The auditors noted the dedicated medical and mental health care spaces during the facility inspection.

(b): WHS policy does not outline the evaluation and treatment of victims and does not include details regarding follow-up services, treatment plans, and referrals for continued care following a youth's transfer to other facilities or release from custody. However, the investigative reports

include follow-up action plans and case management notes from therapists, which indicate services were offered to the alleged victims and perpetrators involved in each case. The medical and mental health care staff members said counseling and therapy is offered to all youth including those who are offenders and victims. The auditors reviewed youth files, all of which included therapy progress notes, treatment plans, and initial and subsequent risk assessments. The youth who reported sexual abuse declined to speak with the auditors.

(c): During interviews, medical and mental health care staff reported the level of care received at WSTC is consistent with the community level of care.

(d): WHS policy requires and the medical staff member stated that pregnancy tests are offered to female victims of sexually abusive vaginal penetration.

(e): WHS policy requires and the medical staff member stated that if pregnancy results from sexual abuse while incarcerated, victims will receive timely and comprehensive information about, and timely access to, all lawful pregnancy-related medical services. All medical and counseling services must be provided at no charge to the victim.

(f): WHS policy requires resident victims of sexual abuse are offered timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate. The resident who reported sexual abuse declined to speak with the auditors. No medical records were reviewed that contained documentation that these tests were required.

(g): WHS policy requires and the client packet explains that all treatment services are provided to the victim without financial cost.

(h): WHS policy requires that if the risk screening indicates that the resident has been a victim of sexual abuse or has committed sexual abuse, the resident will be examined by a medical or mental health provider within 14 days of the completed assessment. Medical and mental health care staff members reported that all youth receive a mental health evaluation during intake, the day after intake, and periodically throughout their stay. Youth also reported having access to these services.

Summary of Findings:

The auditors assessed WHS policy against the elements of this Standard and the PREA Audit Tool, which require that: a) the facility shall offer medical and mental health evaluations to all residents who have been victimized in a juvenile facility; b) the evaluation and treatment shall include follow-up services, treatment plans, and referrals for continued care if necessary; c) the facility shall provide services consistent with the community level of care; d) resident victims of vaginal penetration shall be offered pregnancy tests; e) if pregnancy results, the victim shall receive access to lawful pregnancy-related medical services; f) resident victims while incarcerated shall be offered tests for sexually transmitted infections; g) treatment shall be provided at no cost to the resident; and h) the facility shall attempt to evaluate all known resident-on-resident abusers

within 60 days of learning of such history and offer treatment when deemed appropriate by mental health care staff. The auditors determined that WHS policy addresses all elements, which supports compliance with provisions (a) – (h). During the facility inspection, the auditors conducted a walkthrough of the medical area and therapists' offices. One resident was observed receiving individual therapy in one of the offices, and the medical area appeared to be utilized by the facility, thus supporting compliance with provision (a). Although the resident who reported a sexual abuse was not interviewed, the auditors determined compliance with provisions (b) and (c) following a review of resident files, which contained therapy notes, treatment plans, and initial and subsequent risk assessments, and thus indicated all residents receive ongoing mental health care. During interviews, residents confirmed they receive these services, which provided additional support of compliance with these provisions. No residents were victims of vaginal penetration; therefore, no residents received the services pursuant to provisions (e) and (f). The auditors determined compliance with these provisions based on policy review and interview responses, which indicated knowledge that these services would be provided if needed. Compliance with provision (g) was also based on interviews, during which staff and residents confirmed medical and mental health care services are provided at no cost to the resident. Resident assessments that indicate he or she was the victim of sexual abuse or has committed sexual abuse resulted in a mental health evaluation within 14 days of the assessment. Since the facility exceeds the 60-day requirement of providing additional services, and all residents receive ongoing treatment, the auditors determined compliance with provision (h). Since the facility demonstrated compliance with all provisions, the auditors determined WSTC meets the requirements of this Standard.

Corrective Action: None

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.

Documentation and Policy Reviewed:

1. Completed PAQ
2. WHS Policy Section H
3. WHS Sexual Abuse Allegation/Incident Review forms

Interviews:

1. Facility Director
2. Compliance Coordinator
3. Incident review team member (Compliance Manger)

Observations: No observations relative to this Standard were required.

(a): WHS policy requires that a sexual abuse incident review be conducted at the conclusion of every sexual abuse investigation unless the allegation has been determined to be unfounded. The sexual abuse incident review team must include at a minimum an upper level administrator and a supervisor. The facility reported that in the past 12 months, there have been two administrative investigations resulting in incident reviews. The auditors reviewed both investigative reports.

The incident review forms included:

- WHS policy governing the reviews
- Dates of the allegation and review; review team members, which included the Facility Director, Compliance Managers, Therapist, Case Manager, and Team Manager
- Review activities specific to the incident including evidence review
- Items assessed and corresponding conclusions regarding policy changes, potential motivations of the incident, staffing levels, and potential barriers
- Team recommendations

(b): WHS policy requires the review to occur within 30 days of the conclusion of the investigation. The two incident reviews and corresponding investigations supported compliance with this standard as the reviews occurred within 30 days of the closure of the investigation.

(c): WHS policy requires that the sexual abuse incident review team includes at a minimum an upper level administrator and a supervisor, and facility form requires input from investigators, supervisors, and medical and mental health practitioners. The signature pages and members

present section on the review form confirmed that staff members pursuant to this provision were present for the review. During interviews, the Facility Director reported that these and additional staff members who were involved in the incident participated in all reviews. The review form included notes documenting the items assessed and corresponding conclusions regarding policy changes, potential motivations of the incident, staffing levels, potential barriers, and recommendations.

(d): The review forms included notes that address each of the elements for this provision and corresponding conclusions. During interviews, the Facility Director and Compliance Manager said that each item is considered during the review and that the information and recommendations often result in additional staff training. The Compliance Manager said she authored the reports and submitted them to the appropriate staff members.

(e): WHS policy requires that the recommendations are implemented and if not implemented, the reason(s) must be documented. Recommendations noted on the review reports included additional staff training on maintaining line of sight, statement collection procedures, retaliation monitoring, and improved incident report writing. Interviews with the Compliance Manager and Facility Director corroborated the practice of implementing the action plans following each review.

Summary of Findings:

The auditors assessed WHS policy against the elements of this Standard and the PREA Audit Tool, which require that: a) the facility shall conduct an incident review at the conclusion of every sexual abuse investigation; b) the review shall be conducted within 30 days of the conclusion; c) the review team shall include upper-level management and input from line supervisors, investigators, and medical and mental health care staff; d) the review team shall consider policy or practice change, potential motivations of the incident, the area where the incidence allegedly occurred, and monitoring technology, and prepare a report of findings; and e) the facility shall implement recommendations for improvement or document the reasons for not doing so. The auditors determined WHS policy addresses each element, which supports compliance for all provisions. To determine compliance with provisions (a)-(e), the auditors reviewed the incident review documentation. The completed administrative investigation contains a review that includes each element in provision (a), and thus demonstrated compliance with this provision. The dates the reviews occurred support compliance with provision (b). The signatures of staff members involved in the review demonstrate compliance with provision (c), as all required staff members were present. The items pursuant to provision (d) are included in the review and notes addressing the items support compliance with this provision. Since the team's recommendations involved improved processes for subsequent investigations, and no subsequent investigations had been conducted, the auditors confirmed compliance with provision (e) during interviews with staff members who confirmed the practice of implementing the action plans following each

review. Since compliance was demonstrated for each provision, the auditors determined the facility meets the requirements of this Standard.

Corrective Action: None

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.

Documentation and Policy Reviewed:

1. Completed PAQ
2. Michigan DHHS PREA Policy
3. Data collection instrument
4. Annual PREA Compliance Reports
5. WHS website

Interviews:

1. Compliance Coordinator

Observations: No observations relative to this Standard were required.

(a): Michigan DHHS PREA policy requires that each facility collect accurate, uniform data for every allegation of sexual abuse. At a minimum, the data must be sufficient to answer all questions on the annually required Survey of Sexual Violence. Aggregated data must be reviewed in order to assess and improve sexual abuse prevention, detection, and response practices, and must be made available to the public (with personal identifiers removed) at least annually. The agency's 2015 and 2016 PREA Compliance Reports are posted on the WHS website. The reports include aggregated resident and incident data for each WHS facility, PREA definitions, and corrective actions taken by each facility. The data collection instrument is utilized by all state facilities by Michigan DHHS and includes the data necessary to answer all questions from the Survey of Sexual Violence conducted by the U.S. Department of Justice.

(b): WHS policy requires that the agency aggregate the data at least once each year. The auditors reviewed two annual reports that included aggregated resident and incident data for each WHS

facility. The interview with the Compliance Coordinator corroborated that the data is collected once per year. He described his responsibilities as facilitating data from all public and contracted juvenile justice residential facilities in Michigan, analyzing the data, and taking or directing appropriate actions for PREA compliance.

(d): Michigan PREA policy requires that each facility collect accurate, uniform data for every allegation of sexual abuse. The facility reported the agency maintains, reviews, and collects data from multiple sources. The interview with the Compliance Coordinator confirmed the data is retained securely on state servers.

(e): Michigan PREA policy requires that each facility collect accurate, uniform data for every allegation of sexual abuse. The Compliance Coordinator stated that data is collected from all public and contracted juvenile facilities. The auditors reviewed the agency website to ensure the data is aggregated by each facility.

(f): WHS policy does not require the agency to provide all such data from the previous calendar year to the DOJ no later than June 30, and the PAQ indicates DOJ has not requested agency data.

Summary of Findings:

The auditors assessed WHS policy against the elements of this Standard and the PREA Audit Tool, which require that: a) the agency shall collect data for every allegation of sexual abuse; b) the agency shall aggregate the data at least annually; d) the agency shall maintain, review, and collect the data from incident documents, reports, investigative files, and sexual abuse incident reviews; e) the agency shall obtain this data from every contracted facility; and f) upon request, the agency shall provide the data from the previous calendar year to the DOJ no later than June 30. The auditors determined that WHS policy addresses each of these elements, which supports compliance with each provision. Compliance with provision (a) was demonstrated following the auditors' review of the aggregated data for each WHS facility posted on the agency website and confirmation that the data collected answered all questions from the Survey of Sexual Violence conducted by the DOJ. To confirm the data is aggregated at least annually, the auditors reviewed two annual reports, which support compliance with provision (b). The auditors based compliance with provision (d) on the state PREA Coordinator's interview responses, which included confirmation that the data is retained on state servers. The auditors reviewed the reports posted on the agency website and noted the data is aggregated by facility, which supports compliance with provision (e). Provision (f) is not applicable, as the DOJ has not requested the agency data. Since compliance was demonstrated for each provision, the auditors determined the facility meets the requirements of the Standard.

Corrective Action: None

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.

Documentation and Policy Reviewed:

1. Completed PAQ
2. Michigan DHHS PREA Policy
3. Data collection instrument
4. Annual PREA Compliance Reports
5. WHS website

Interviews:

1. Director of Clinical & Quality Services
2. Compliance Coordinator
3. Compliance Manager

Observations: No observations relative to this Standard were required.

(a): Michigan PREA policy requires that each facility collect accurate, uniform data for every allegation of sexual abuse. At a minimum, the data must be sufficient to answer all questions on the annually required Survey of Sexual Violence. Aggregated data must be reviewed in order to assess and improve sexual abuse prevention, detection, and response practices. Documentation of corrective action plans based on PREA-related incidents is included in the annual reports. Actions specific to WSTC included a new protocol for housing and bed assignments, a new protocol for the frequency of room checks in double-occupancy rooms, and the addition of surveillance cameras. Agency corrective actions included revised protocols and additional staff training. The Director of Clinical & Quality Services reported that incident-based sexual abuse data is reviewed during monthly Performance and Quality Improvement meetings and that all allegations, investigations, and findings were reviewed. The Compliance Manager stated that agencies prepare annual reports

of findings and take corrective actions based on the collected data pursuant to Standard 115.387. The Compliance Manager said she authored the reports and submitted them to the appropriate staff members.

(b): The Michigan Department of Health and Human Services - Juvenile Justice Programs Prison Rape Elimination Act 2016 Annual Data and Annual Report contains a comparison and data analysis of the current year's agency data and corrective actions with those from prior years. The analysis addresses incident, population, and allegations trends; overall PREA compliance, and investigative findings.

(c): Michigan DHHS PREA policy requires that each facility collect accurate, uniform data for every allegation of sexual abuse and make this information available to the public through a public website. Although policy does not require the agency head to approve the report, the Compliance Coordinator and Director of Clinical & Quality Services confirmed that the Michigan Director approves the report before it is posted on the website.

(d): A review of the posted data indicates WHS takes appropriate measures to redact specific material from the reports when publication would present a clear and specific threat to the safety and security of the facility. The Compliance Coordinator reported that all personal information is removed prior to submission of the report. The auditors reviewed two annual reports to ensure no personal identifiers were present.

Summary of Findings:

The auditors assessed WHS policy against the elements of this Standard and the PREA Audit Tool, which require that: a) the agency shall review and assess the data collected pursuant to Standard 115.387 and prepare a report of findings; b) the report shall include a comparison of the current year's data and corrective actions to prior years and provide the agency's progress in addressing sexual abuse; c) the report shall be approved by the agency head and be made available to the public; and d) the agency may redact material if it presents a clear and specific threat to the safety and security of the facility. The auditors determined WHS policy addresses provisions (a), (b), and (d). Additional compliance with provision (a) was based on a review of the corrective actions detailed in the report and interview responses confirming the actions were taken. The auditors reviewed two annual reports and determined the current year's agency data and corrective actions with those from prior years were completed as required by provision (b). The auditors based compliance with provision (c) on interviews, during which the Compliance Coordinator and Director of Clinical & Quality Services confirmed that the Michigan Director approves the report before it is posted on the website. During interviews, the Compliance Coordinator stated that all personal information is redacted from the report prior to its publication. The auditors' review of the reports confirmed that no personal identifiers were included, which supports compliance with provision (d). Since the facility demonstrated compliance with each provision, the auditors determined that WHS meets the requirements of this Standard.

Corrective Action: None

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.

Documentation and Policy Reviewed:

1. Completed PAQ
2. Michigan DHHS PREA Policy
3. WHS website

Interviews:

1. Facility Director
2. Compliance Coordinator

Observations: No observations relative to this Standard were required.

(a): WHS policy does not require that all sexual abuse data be securely retained. However, the PREA Compliance Coordinator confirmed compliance and stated the data is retained on secure state servers.

(b): WHS policy requires that WHS posts on its website all aggregated sexual abuse data. The auditors confirmed the data is included on the WHS website.

(c): The auditors reviewed the published data to ensure WHS removes all personal identifiers prior to making aggregated sexual abuse data publicly available.

(d): The PAQ indicated the agency is required to maintain sexual abuse data collected pursuant to Standard 115.387 for at least 10 years after the date of initial collection; however, this requirement is not included in policy. Previous audit reports from 2015 and 2016 are available on the WHS website.

Summary of Findings:

The auditors assessed WHS policy against the elements of this Standard and the PREA Audit Tool, which require that: a) the agency shall ensure the data collected pursuant to Standard 115.387 are securely retained; b) the agency shall makes the data available to the public; c) the agency removes personal identifiers from the public data; and d) the agency maintains the data for 10 years. The auditors determined WHS policy addresses provisions (b) and (c). The auditors visited the agency website to confirm the aggregated data with personal identifiers removed is readily available to the public. Compliance with provision (a) was based on the interview with the Compliance Coordinator who confirmed the data is securely stored on state servers. The agency is required to maintain sexual abuse data for at least 10 years, which demonstrates compliance with provision (d). Since the facility demonstrated compliance with all provisions, the auditors determined the facility meets the requirements of this Standard.

Corrective Action: None

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 three-year period starting on August 20, 2013, and during each three-year period thereafter, 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? (N/A before August 20, 2016.) ☒Yes ☐No ☐NA

115.401 (b)

- During each one-year period starting on August 20, 2013, 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? ☒Yes ☐No

115.401 (h)

- Did the auditor have access to, and the ability to observe, all areas of the audited facility? ☒Yes ☐No

115.401 (i)

- Was the auditor permitted to request and receive copies of any relevant documents (including electronically stored information)? ☒Yes ☐No

115.401 (m)

- Was the auditor permitted to conduct private interviews with inmates, residents, and detainees? ☒Yes ☐No

115.401 (n)

- Were 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.

Documentation and Policy Reviewed:

1. Completed PAQ
2. WHS PREA Policy Section I
3. Michigan DHHS Juvenile Justice Programs PREA 2016 Annual Data and Annual Report
4. Photographs of audit notice posting
5. Overall documentation sent on a password-protected drive

Interviews: No interviews specific to this Standard were conducted.

Observations:

1. All areas within the facility

(a): WHS policy requires that in addition to internal administrative review and analysis, and DCWL monitoring, an independent and qualified auditor audits the facility at least every three years. The Michigan DHHS website contains facility PREA audit reports that were conducted in 2015 and 2016, and the WHS website contains PREA audit reports for each audited facility.

(b): The Michigan DHHS Juvenile Justice Programs PREA 2016 Annual Data and Annual Report contains information regarding PREA Compliance Activities conducted beginning in 2012. The report includes a requirement that one-third of all public facilities and private facilities that contract with the state to provide juvenile justice services to MDHHS youth must be audited during each audit year.

(h): During the on site portion of the audit, the auditors conducted a facility inspection and observed all areas within the facility.

(i): The auditors received documentation relevant to each PREA Standard prior to the on site audit. Additional documents were requested and sent via email. During the on site portion, personnel and youth files were reviewed, and additional electronic documents were reviewed with the Compliance Manager.

(m): During the facility inspection, the auditors informally interviewed youth and staff in each area. Following the inspection and during the second day of the audit, formal interviews with staff members and youth were conducted in private offices in the administration building.

(n): Prior to the on site audit, notices were posted that included necessary contact information, thus enabling residents to send confidential information or correspondence to the auditors.

Summary of Findings:

The auditors assessed WHS policy and practice against the elements of this Standard, which require that: a) during the three-year period starting on August 21, 2013, and each three-year period thereafter, the agency shall ensure each facility is audited at least once; b) during each one-year period, the agency shall ensure that each facility type is audited; h) the auditor shall have access to and observe all areas of the facility; i) the auditor shall be permitted to request and receive relevant documents; m) the auditor shall be permitted to conduct private interviews with residents; and n) residents shall be permitted to send confidential correspondence to the auditor in the same manner as if they were communicating with legal counsel. Compliance with provision (a) was based on the auditors' review of the Michigan DHHS website, which contains facility PREA audit reports that were conducted in 2015 and 2016, and the WHS website, which contains PREA audit reports for each audited facility. This review evidenced that each facility was audited at least once during the three-year cycle. The auditors relied upon policy and the PREA-related activities included in the state's annual report to determine compliance with provision (b). Since the auditors were provided access to all areas within the facility during the facility inspection, compliance with provision (h) was demonstrated. Since the auditors were permitted to request and received relevant documents prior to, during, and after the onsite audit portions, compliance with provision (i) was demonstrated. The auditors were provided private offices in which to conduct interviews with residents, and thus determined the facility demonstrated compliance with provision (m). The audit notices that were posted throughout the facility prior to the onsite audit enabled residents to correspond with the auditors by including the auditors' contact information; thus compliance with provision (n) was demonstrated. Since the facility complied with each provision, the auditors determined WSTC meets the requirements of this Standard.

Corrective Action: None

Standard 115.403: Audit contents and findings

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

115.403 (f)

- The agency has published on its agency website, if it has one, or has otherwise made publicly available, all Final Audit Reports within 90 days of issuance by auditor. The review period is for prior audits completed during the past three years PRECEDING THIS AGENCY AUDIT. In the case of single facility agencies, the auditor shall ensure that the facility's last audit report was published. The pendency of any agency appeal pursuant to 28 C.F.R. § 115.405 does not excuse noncompliance with this provision. (N/A if there have been no Final Audit Reports issued in the past three years, or in the case of single facility agencies that there has never been a Final Audit Report issued.) ☒Yes ☐No ☐NA

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Documentation and Policy Reviewed:

1. WHS website
2. Final audit reports of WHS facilities

Interviews:

1. Compliance Coordinator

(f): The WHS website contains prior final audit reports that were posted within 90 days of issuance by the auditor. The Compliance Coordinator monitors these postings and confirmed they were posted within 90 days.

Summary of Findings:

The auditors assessed WHS practice against the elements of this Standard, which require that: f) the agency shall ensure that the auditor's report is published on the agency website or otherwise made readily available to the public. The auditors determined compliance with this provision by visiting the agency website and confirming previous audit reports are posted; thus the facility meets the requirements of this Standard.

Corrective Action: None

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.

Nicole Prather May 28, 2018

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.