WGRC + CFC

Prison Rape Elimination Act (PREA) Audit Report
Juvenile Facilities

☐ Interim ☒ Final

Date of Report September 25, 2018

Auditor Information

Name: Louis A. Goodman	**Email:** lgood321@icloud.com
Company Name: Goodman Consulting, LLC	
Mailing Address: P.O. Box 16047	**City, State, Zip:** Phoenix, AZ 85011
Telephone: 602-904-2851	**Date of Facility Visit:** February 5-7, 2018

Agency Information

Name of Agency Michigan Department of Health and Human Services		**Governing Authority or Parent Agency** *(If Applicable)* Click or tap here to enter text.	
Physical Address: 235 S. Grand Ave.		**City, State, Zip:** Lansing, MI 48909	
Mailing Address: 235 S. Grand Ave.		**City, State, Zip:** Lansing, MI 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: Click or tap here to enter text.

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, AA to Director GrijalvaN@michigan.gov	**Telephone:** Nancy Grijalva 517-241-1193

Agency-Wide PREA Coordinator

Name: Patrick Sussex	**Title:** PREA Juvenile Coordinator / Program Mgr.
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 Human Services, Clarence Fisher Center (CFC) and Wolverine Growth and Recovery Center (WGRC)			
Physical Address: **WGRC 1091 Commerce Dr., Vassar, MI 48768 / CFC 150 Enterprise Dr., Vassar, MI 48768** Click or tap here to enter text.			
Mailing Address (if different than above): Click or tap here to enter text.			
Telephone Number: WGRC 989-823-8394 CFC 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/who-we-are/regulatory-compliance/			
Is this facility accredited by any other organization? ☒ Yes ☐ No			

Facility Administrator/Superintendent

Name: WGRC Josh Kennard / CFC Kevin Voss	**Title:** Program Supervisors
Email: kennardj@wolverinehs.org / vossk@wolverinehs.org	**Telephone:** Kennard 989-823-3040 / Voss 989-823-3040

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 (RN)
Email: harrist@wolverinehs.org	**Telephone:** 989-823-3040

Facility Characteristics

Designated Facility Capacity: WGRC 63 / CFC 60	**Current Population of Facility:** WGRC 37 / CFC 48
Number of residents admitted to facility during the past 12 months	WGRC 57 CFC 102
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 10 days or more:	WGRC 57 / CFC 99
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 72 hours or more:	WGRC 57 / CFC 102
Number of residents on date of audit who were admitted to facility prior to August 20, 2012:	0
Age Range of Population:	12 - 17
Average length of stay or time under supervision:	7 months
Facility Security Level:	Non-secure
Resident Custody Levels:	Non-secure
Number of staff currently employed by the facility who may have contact with residents:	WGRC 64 / CFC 52
Number of staff hired by the facility during the past 12 months who may have contact with residents:	WGRC 102 / CFC 118
Number of contracts in the past 12 months for services with contractors who may have contact with residents:	13

Physical Plant

Number of Buildings: WGRC 6 CFC 1 (plus shared gym and medical buildings)	**Number of Single Cell Housing Units:** 0
Number of Multiple Occupancy Cell Housing Units:	0
Number of Open Bay/Dorm Housing Units:	WGRC 4 / CFC 4
Number of Segregation Cells (Administrative and Disciplinary:	0

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.):

none

Medical

Type of Medical Facility:	Minor medical on grounds by RN and visiting Nurse Practitioner, major medical off grounds
Forensic sexual assault medical exams are conducted at:	Saginaw Covenant Emergency Room

Other

Number of volunteers and individual contractors, who may have contact with residents, currently authorized to enter the facility:	13
Number of investigators the agency currently employs to investigate allegations of sexual abuse:	5

Audit Findings

Audit Narrative

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

Louis A. Goodman of Goodman Consulting, LLC performed an audit of two programs operated by Wolverine Human Services, Wolverine Growth and Recovery Center (WGRC) and Clarence Fisher Center (CFC), on its campus in Vassar, Michigan. Wolverine Human Services (WHS) operates the programs under its contract with the Michigan Department of Health and Human Services (MDHHS), which places juveniles found to be delinquent by the courts. The on-site portion of the audit was conducted February 5 - 7, 2018.

On November 28, 2017, the auditor provided the facility with an announcement of the audit for posting. The facility provided photographs of the posted announcement on December 19, 2017, and during the site visit, the auditor observed the notice posted throughout both WGRC and CFC, including in the living units.

On January 6, 2018, the facility mailed its Pre-audit Questionnaire to the auditor, who reviewed the information and documents that accompanied it prior to the site visit. Those documents included the WHS PREA policy, an organization chart for MDHHS, logs of unannounced rounds conducted by supervisors at the facility, a list of translators available to the facility, a WHS employment application, the WHS policy on recruitment, selection, and deployment, a memorandum of understanding between WHS and the Vassar Police Department, a memo from the director of a local sexual assault center, signature sheets from facility staff who completed PREA training, WHS' notice of PREA policy for contractors and interns, sample signature sheets from interns and contractors reflecting receipt and understanding of WHS' PREA policy, sample signature sheets reflecting residents' participation in PREA orientation, certificates of completion of a PREA investigating course conducted by the National Institute of Corrections, sample signature sheets for completion of specialized PREA training for medical and mental health staff, the facility's PREA Client Risk Assessment form, the WHS PREA Coordinated Response Plan, a juvenile justice facility statistical reporting form, 2016 and 2017 staffing plans for WGRC and CFC, the WHS PREA Training Instructor's Guide, and a WHS Staff PREA Orientation Packet.

The site visit commenced with a briefing attended by the MDHHS PREA Coordinator, the WHS PREA Compliance Manager, the WHS Director of Clinical and Quality Services, and the Program Supervisors of WGRC and CFC. Discussion included the plan and schedule for the site review, current population of the facility, and basic information of the programs at WGRC and CFC. The auditor was given current rosters of staff and residents, from which interviewees were randomly selected.

The auditor was given extensive tours of the WGRC and CFC facilities, including all living units, common areas, school facilities, and cafeterias/kitchens. Additionally, the tour included the campus' gymnasium and medical unit. During the tour the auditor was given access to all areas, and doors were unlocked at the auditor's request. Residents were observed in school, in the gym, and in one housing unit, and in all areas staffing requirements were met. Overall, the facility was clean and well-kept.

The remainder of the site visit was spent conducting interviews of staff and residents. Specialized staff were interviewed as required by audit guidelines. Those staff included the Program Supervisors of both WGRC and CFC, who fill the "superintendent" roles, the PREA Compliance Manager, supervisory staff, medical and mental health staff, administrative (human resources) staff, contractors who have contact with residents, investigative staff, staff who perform screening for risk of victimization and abusiveness, staff on the incident review ream, the designated staff member charged with monitoring retaliation, and intake staff. The facility does not have SAFE or SANE staff, it does not perform cross-gender strip or body cavity searches, and it does not use isolation, so there were no staff in those functions to interview. All staff at the facility are considered first responders. Twelve line-staff members were interviewed, having been randomly selected by the auditor from the rosters provided by the facility. They represented both WGRC and CFC and all three shifts. It should be noted that the auditor was unable to complete all of the staff interviews during the site visit, and therefore four of the randomly selected staff and one mental health staff member were interviewed by videoconference on February 9, 2018.

The auditor also conducted interviews of 16 residents during the site visit. Interviewees included two residents with educational disabilities, one LGBTI resident, and two residents who disclosed prior sexual victimization during risk screening. The remainder of the residents interviewed were selected at random from the rosters provided the auditor at the outset of the site visit. There were no residents at the facility who reported sexual abuse, no limited English proficient residents, and the facility does not use isolation, so there were no residents in isolation to be interviewed.

During the site visit, the auditor asked for and received additional documentation, including the WHS grievance policy, the WHS staffing plan, two incident review team reports and one investigative report. The auditor also reviewed six personnel files, which were randomly selected, for background check documentation and training records.

The site visit concluded with a debriefing attended by the same participants as the initial briefing. During the debriefing, the auditor shared preliminary observations. Subsequently, the auditor communicated questions and some preliminary findings to the facility's PREA Compliance Manager, who in turn provided additional information and clarification. Several additional documents were provided, including several WHS policies, a Client PREA Orientation document used by presenting staff, a sheet containing questions asked of applicants for staff positions, the PREA Incident Review Master Document, training modules from the specialized PREA-related training given medical and mental health providers, and excerpts from WHS' Human Resources Policy Manual. Also provided was a draft copy of the main WHS PREA policy, which contained several proposed amendments addressing issues noted by the auditor. This revised policy remained a draft at the time the Interim Report was due, and thus its changes could not be considered when making compliance determinations in the Interim Report.

The Interim Report for this audit, issued on March 24, 2018, contained 33 "standards met" findings and 10 "standards not met" findings. During the corrective action period, the facility submitted evidence of its corrective actions to the auditor. Documents provided include an amended version of the WHS PREA policy, WHS Procedure CR4, Rights of Persons with Developmental Disabilities, a revised version of the facility's PREA Coordinated Response Plan (WHS Policy RTX JJR), WHS HR forms for performance evaluation and promotion review, the PREA Questionnaire for Residential Personnel, a memo to the auditor from the facility PREA Compliance Manager dated September 14, 2018 regarding the provision of services to residents who are deaf or hearing impaired, and a letter from the WHS PREA Compliance Manager to the Vassar Chief of Police dated September 17, 2018.

Facility Characteristics

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

Wolverine Human Services operates a large campus in Vassar, Michigan that houses four programs, including Wolverine Growth and Recovery Center (WGRC) and Clarence Fisher Center (CFC), the subjects of this audit. The non-secure campus houses multiple buildings in a pleasant setting with open green spaces and wooded areas. A security gate at the entrance to the campus is staffed.

Wolverine Growth and Recovery Center (WGRC) houses a mixed population of male residents from the child welfare system and the juvenile justice system. Residents are housed according to their programs. The juvenile justice population is separated into a unit for sexual offenders, a substance abuse treatment unit, and a "military-based" unit that is reportedly being phased out. There are also units for foster care intensive assessment and shelter care for residents from the child welfare system.

The designated capacity of WGRC is 63 beds, and the population was 37 at the outset of the on-site audit. There are six housing units ("cabins") at WGRC, of which three house juvenile justice residents. Physically, WGRC consists of a multi-use building ("the Lodge"), which houses a cafeteria and administrative offices, a school building containing offices and six classrooms, and four buildings where residents are housed. One of the residential buildings contains three housing units, and the others contain one each. Each housing unit consists of a large dormitory that holds eight to twelve beds, an office, and a day room.

The dormitories are large rectangular rooms with no blind spots. There are no dividers separating the beds. Each housing unit has a large restroom that contains three shower stalls, as well as stalls containing toilets. The shower stalls have opaque curtains that hang nearly to the floor. The toilet stalls have dividers but do not have doors or individual curtains. However, there is a shower-type curtain that blocks any view into the area of the restroom where the toilets are located. The doorways to the restrooms are open.

Programming at WGRC varies, depending on the type of population in the housing unit, but includes cognitive behavioral therapy, individual counseling, restorative justice programming, psychiatric and psychological services, life skills training, and trauma informed services.

School at both WGRC and CFC is provided by Vassar Public School District and Tuscola Intermediate School District. Students earn high school credits and can earn diplomas. Students can also participate in GED preparation classes and, where appropriate, can take college classes.

The WHS Vassar campus has a gymnasium, which residents from WGRC and CFC use for recreation. The campus also has a stand-alone medical building that consists of a waiting area, a nurses' station, and examination rooms for medical services and dentistry.

Clarence Fisher Center (CFC) is an intensive substance abuse treatment program that houses both male and female residents. The program has a design capacity of 60 and housed 48 residents on the first day of the on-site audit. CFC is contained in a single building, with the exception of the shared gymnasium and

medical services unit discussed above. The CFC building holds a cafeteria and kitchen, three housing units for boys and one housing unit for girls, and a school wing with four classrooms, offices and a testing room.

Each housing unit consists of a large rectangular open dormitory with eight to twelve beds, staff offices, and a large group room. Similar to the housing units at WGRC, each CFC unit has a large restroom with an open doorway off the main dormitory. Each restroom has three shower stalls, each of which has an opaque shower curtain that hangs nearly to the floor. The restrooms also have two stalls containing toilets, which have similar shower curtains. There is a urinal in each of the male units.

Programming at CFC focuses on substance abuse treatment and consists of similar elements to the WGRC program: cognitive behavioral therapy, group and individual therapy, restorative justice programming, psychiatric and psychological services, life skills training, and trauma informed services.

Summary of Audit Findings

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

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

Number of Standards Exceeded: 0

Click or tap here to enter text.

Number of Standards Met: 43

115.311, 115.312, 115.313, 115.315, 115.316, 115.317, 115.318, 115.321, 115.322, 115.331, 115.332, 115.333. 115.334, 115.335, 115.341, 115.342, 115.351, 115.352, 115.353, 115.354, 115.361, 115.362, 115.363, 115.364, 115.365, 115.366, 115.367, 115.368, 115.371, 115.372, 115.373, 115.376, 115.377, 115.378, 115.381, 115.382, 115.383, 115.386, 115.387, 115.388, 115.389, 115.401, 115.403

Number of Standards Not Met: 0

Summary of Corrective Action (if any)

115.316

1. Make provisions to ensure that residents who are deaf or hard of hearing have an equal opportunity to participate in or benefit from all aspects of the facility's efforts to prevent, detect, and respond to sexual abuse and sexual harassment.

During the corrective action period, the facility implemented Procedure CR 4. The procedure states that facility will work with the county Intermediate School District to ensure appropriate services are provided to clients with disabilities, including by using assistive technology. The procedure also requires that individual needs of students will be addressed with appropriate materials or necessary tools to understand client orientation, including PREA, grievance processes, and residents' rights and responsibilities. The facility also produced evidence that it has two staff members proficient in American Sign Language.

115.317

1. In the employee promotion process, ask all promotional applicants who may have contact with residents directly about the misconduct described in subparagraph (a) of this standard: whether the employee has (1) engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution; (2) 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 (3) has been civilly or administratively adjudicated to have engaged in the activity described in (2).
2. Make the three inquiries described above in any interviews or written self-evaluations conducted as part of reviews of current employees.
3. Amend policy to imposed upon employees a continuing affirmative duty to disclose any misconduct described in the three criteria listed in no. 1 above.

During the corrective action period, the facility altered its promotion and employee evaluation processes to include specifically asking employees the questions set out in Standard 115.317(f) and in Corrective Action Item 1, above. The changes in these processes were evidenced by the Wolverine Human Services Performance Evaluation form and the Wolverine Human Services Human Resources Department Promotion Review form, to each of which has been added an employee questionnaire consisting of the three required questions. WHS also amended its PREA policy to impose upon employees a continuing affirmative duty to disclose any misconduct described Corrective Action item 1 for this standard.

115.321

1. WHS should utilize a uniform evidence protocol in its administrative investigations. The protocol must be developmentally appropriate for youth and, as appropriate, be adapted from or otherwise based on the most recent edition of the U.S. Department of Justice's Office on Violence Against Women publication, "A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents," or similarly comprehensive and authoritative protocols developed after 2011.
2. The facility must demonstrate that it has requested that the Vassar Police Department, when investigating an allegation of sexual abuse at the facility, follow the requirements of subsections (a) through (e) of this standard.

During the corrective action period, the auditor engaged in discussion with the MDHHS PREA Coordinator and the WHS PREA Compliance Manager on the issue of a uniform evidence protocol. Facility administrative investigations are carried out by investigators trained by the National Institute of Corrections (NIC) to conduct investigations of sexual abuse and sexual harassment in a confinement facility housing adolescents. The investigators follow the protocol taught in the NIC training. As a practical matter, once there is an allegation of sexual assault, the criminal investigation is conducted by the Vassar Police Department commences, and the administrative investigation stops. The facility relies upon the criminal investigation as to whether the sexual abuse occurred, and any further administrative investigation would focus on whether staff members' actions or failure to act contributed to the incident. Additionally, forensic examinations are conducted by certified Sexual Assault Nurse Examiners (SANEs), who are trained in and follow a uniform evidence protocol.

The facility has a memorandum of agreement with the Vassar Police Department for the criminal investigation of allegations of sexual assault, as noted above. During the corrective action period, the facility requested in a letter dated September 17, 2018, that, in conducting those investigations, the police department comply with subsections (a) through (e) of this standard.

115.333

1. Make provisions to provide all educational information, including information communicated orally to residents, in formats accessible to residents who are deaf or hard of hearing.

During the corrective action period, the facility provided newly enacted procedure CR 4, effective May 14, 2018. The procedure describes an agreement with Vassar Public Schools and Tuscola Intermediate School District under which the school districts will provide for the individual needs of students not only in school, but in the presentation of resident orientation, including discussion of PREA, grievances, and residents' rights and responsibilities. The school systems will employ assistive technology as part of its response to the needs of deaf students. In addition, the facility advised that two of its staff members are proficient in American Sign Language and would provide those services if necessary. Memo of September 14, 2018 from PREA Compliance Manager to the auditor.

115.352

1. Amend the facility policy to provide that a grievance alleging sexual assault or sexual harassment not be referred to a staff member who is the subject of the complaint.
2. Amend the facility policy regarding grievances alleging sexual abuse or sexual harassment to state that the facility's failure to file a timely response to a such a grievance shall be considered a denial.
3. Amend the facility policy to more fully describe the process and requirements regarding an emergency grievance alleging substantial risk of imminent sexual abuse. Included should be provisions that the grievance be immediately forwarded to a level of review at which corrective action may be taken; that an initial response shall be provided within 48 hours; that a final decision shall be issued within five days; and that the initial response and final decision shall document the facility's determination whether the resident is in substantial risk of imminent sexual abuse and the action taken in response to the emergency grievance.

During the corrective action period after submission of the Interim Report, the facility amended section E(5) of the WHS PREA policy to make the corrections required.

115.361

1. Amend the facility policy to require that, in the event of an allegation of sexual abuse of a resident over whom the juvenile court retains jurisdiction, the facility head or designee shall notify the victim's attorney or other legal representative of record within 14 days of receiving the allegation.

During the corrective action period, the facility amended paragraph F(8) to mandate notification of a resident's attorney within 14 days.

115.364

1. Amend the PREA policy to also state that the alleged victim of sexual abuse shall be requested not to eat, drink, urinate, or defecate and that the alleged perpetrator shall not be permitted to engage in those same activities.

During the corrective action period, the required amendment to WHS PREA policy, section H(1)(f) was made.

115.367

1. Amend the PREA policy to provide that protection from retaliation is required to be afforded residents and staff members who make allegations of sexual harassment.

During the corrective action period, the facility amended its PREA policy, Section F(11) to provide that protection from retaliation is provided in instances of allegations of sexual harassment made by residents or staff members.

115.376

1. Amend WHS policy to require that terminations for violations of sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and to any relevant licensing bodies.

During the corrective action period, the required corrective action was taken. The reporting requirement was added at section H(2)(e) of the WHS PREA policy.

115.382

1. Amend facility policy to require explicitly that if no qualified medical or mental health practitioners are on duty at the time a report of recent sexual abuse is made, staff first responders shall immediately notify the appropriate medical and mental health providers.

During the corrective action period, the required amendment to the WHS PREA policy was made at section F(2).

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.

WHS Policy PREA RTX JJR ("PREA policy") clearly state's its zero tolerance policy towards all forms of sexual abuse and sexual harassment. The 14-page policy goes on to lay out WHS' approach to preventing, detecting and responding to sexual abuse and sexual harassment.

MDHHS employs a PREA Coordinator whose position is in the upper-level of the agency hierarchy. In response to interview questions, the PREA Coordinator reports that he has sufficient time and authority to develop, implement, and oversee efforts to comply with PREA's requirements within his agency and its contract providers. WHS has appointed a PREA Compliance Manager for the Vassar facility. In interview she stated that she has sufficient time and authority to coordinate the facility's efforts to achieve and maintain compliance with PREA requirements.

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.

MDHHS contracts with private agencies for the confinement of juveniles committed to it. It provided a sample of the contract language it uses with each of the private entities, according to the PREA Coordinator. The language contains a requirement that the contracted entity comply with PREA standards, and it provides for contract monitoring by MDHHS to ensure such compliance.

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.

WHS developed a staffing plan for the Vassar campus, dated June 2, 2015, which the auditor reviewed. The plan requires line-of-sight supervision of youth at all times except during sleeping hours, in order to prevent sexual abuse and sexual harassment. The necessity of line-of-sight supervision at all times is well established in the facility's culture. During the interviews of randomly selected staff, almost all of them discussed the concept without being asked or prompted. The staffing plan also establishes staffing ratios that vary according to the program and the makeup of its population. For WGRC, the plan calls for ratios ranging from 1:8 to 1:6 during waking hours and from 1:16 to 1:12 during sleeping hours. For CFC, the plan calls for ratios of 1:6 during waking hours and 1:12 during sleeping hours. There is no video monitoring equipment in either program. The staffing plan takes into consideration the 11 factors listed above.

The 2017 annual staffing plan assessments for WGRC and CFC, each dated December 28, 2017, slightly modify the required ratios. In WGRC, waking hour ratios range from 1:7.5 to 1:4, depending on the population. CFC's amended plan calls for waking hour ratios of 1:7 and 1:6. The 1:6 ratio applies to units housing juvenile justice youth, according to the interview of CFC's Program Supervisor. Thus, both WGRC and CFC exceed the staffing ratios imposed by this standard: 1:8 during waking hours and 1:16 during sleeping hours.

The PREA Compliance Manager and both the WGRC and CFC Program Managers stated in interviews that there are no deviations from the facility's required staffing ratios. When staff call off sick, other staff are called in, or if necessary staff are held over from previous shifts or supervisors fill in the line-staff roles.

As noted above, the facility assessed the WGRC and CFC staffing plans within the last 12 months and in fact made adjustments to the staffing ratios it requires. The assessments reflect consideration of the factors required by this standard.

It should also be noted that, although the requirement of unannounced supervisory rounds in inapplicable to non-secure facilities, this facility nonetheless conducts them. Interviews of supervisors and logs reviewed by the auditor reflect that unannounced rounds are conducted regularly on all three shifts.

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

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This non-secure facility does not conduct strip searches or body cavity searches, according to the PREA Compliance Manager, who is also the facility's Client Rights Advocate. Pat down searches are conducted only when a resident returns from an off-site visit. The WHS PREA policy states at paragraph C(4) that cross-gender pat down searches are prohibited, except in exigent circumstances, and that any such searches must be documented along with the justification for them. In practice, cross-gender pat down searches have not occurred, as verified by all of the interviews of randomly selected staff and residents, as well as the Program Supervisors.

The WHS PREA policy states that non-medical staff of the opposite gender may not observe youth changing clothing, showering, or performing bodily functions. [Paragraph D(4)] All of the residents who were interviewed stated that they are not aware of cross-gender viewing ever having occurred, and staff were able to discuss measures taken to avoid such viewing. Since both WGRC and CFC residents live in open dormitory units, they are required to change clothes in the shower stalls, which have full length shower curtains. Views into the toilet stalls are also obscured by shower-type curtains. To further protect residents, only one resident is permitted into the restroom at a time, and when that

occurs, one staff member assumes a position at the doorway to the restroom, allowing line-of-sight observation of the dormitory to be maintained, while ensuring that no additional residents enter the restroom. Because the doorways to the restroom are open, same gender staff typically are designated to stand at the doorways. In any event, as noted above, the full-length, opaque shower curtains prevent any viewing of the resident who is changing, showering, or using the toilet.

Paragraph D(5) of the WHS PREA policy requires staff of the opposite gender to announce their presence when entering a resident housing unit. All of the residents and all of the line-staff who were interviewed confirmed that the announcements are consistently made. While touring the facility at the site visit, the auditor observed this requirement to be met by the administrators who led the tour.

Paragraph B(8) of the WHS PREA policy prohibits staff from searching or physically examining a transgender or intersex resident for the sole purpose of determining genital status. It also states that if a youth's genital status is unknown, it is to be determined during conversation with the youth, by reviewing medical records, or, if necessary, as part of a broader medical examination. As a practical matter, all residents who arrive at the facility have been involved with the juvenile justice system, and thus it is unlikely that genital status would be unknown. Facility administrators reported no such circumstance having arisen.

The facility trains staff as to how to conduct pat down searches of opposite gender residents in a respectful and professional manner, in the event exigent circumstances require them. When interviewed, staff discussed having received such training and were able to describe the process. The WHS PREA policy states at paragraph C(5) that searches of transgender and intersex residents must be conducted professionally, respectfully, and in the least obtrusive manner possible. Staff who conduct such searches are required to be trained to do so. Staff stated in interviews that transgender residents were to be allowed to select the gender of the staff member who conducted any pat down search.

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.

Residents at the facility are provided information related to sexual abuse and sexual assault first at intake and again when they are assigned a housing unit. The information at intake is provided both orally and in writing by a consistent staff member, who is experienced at communicating with the full range of residents assigned to the facility. Therapists provide more extensive information within 72 hours of a resident's arrival. The therapists are trained and accustomed to working with residents with varying intellectual and reading abilities and with a range of emotional disabilities. The intake worker and therapists are able to provide information in a manner that youth with intellectual or educational disabilities are able to understand. Oral information can be provided residents who are blind or have low vision.

At the time of the Interim Report, the facility had not provided any policy or information specific to deaf or hard of hearing residents. This standard requires that provision be made for the communication of information related to preventing, detecting, and responding to incidents of sexual abuse and sexual harassment. During the corrective action period, the facility informed the auditor that it has two staff members proficient in American Sign Language. Memorandum of September 14, 2018 to the auditor. The facility also produced evidence of agreements with Vassar Public Schools and Tuscola Intermediate School District, which provide educational services, whereby the school districts provide assistive technology to support students with disabilities and enable access to a full educational experience. Additionally, new Procedure CR 4 states that the "individual needs of the students will be provided with appropriate materials or necessary tools to understand client orientation, forms, and documents, including . . . PREA, Client Grievances, and Client Rights and Responsibilities."

WHS Policy CR PREA covers the provision of services to residents with limited English proficiency (LEP). It calls for the use of a qualified interpreter who is familiar with any specialized terms or

concepts peculiar to the resident's program. The policy includes both an attached copy and an internet link to the State of Michigan's listing of qualified interpreters. The list is comprehensive and includes interpreters available for numerous languages. The policy states that under no circumstances may another resident be used as an interpreter.

Corrective Action Required

1. Make provisions to ensure that residents who are deaf or hard of hearing have an equal opportunity to participate in or benefit from all aspects of the facility's efforts to prevent, detect, and respond to sexual abuse and sexual harassment.

During the corrective action period, the facility implemented Procedure CR 4, as noted above. The procedure states that facility will work with the county Intermediate School District to ensure appropriate services are provided to clients with disabilities, including by using assistive technology. The procedure also requires that individual needs of students will be addressed with appropriate materials or necessary tools to understand client orientation, including PREA, grievance processes, and residents' rights and responsibilities. The facility also produced evidence that it has two staff members proficient in American Sign Language.

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

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WHS policy does not explicitly prohibit the hiring and promotion of anyone who may have contact with residents or enlisting a contractor who may have contact with residents who (a) has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility or other institution; (b) has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or (c) has been civilly or administratively adjudicated to have engaged in the conduct described in (b). However, this standard does not explicitly require a policy. When interviewed, the human resources administrator assured that a such a person would neither be hired nor promoted. The assurance was supported by the facility's use of a pre-hiring questionnaire that explicitly asks an applicant whether he or she meets any of these disqualifying criteria. The human resources

administrator also stated that the agency would consider any incidents of sexual harassment in determining whether to hire or promote anyone, or enlist the services of any contractor, who may have contact with residents.

WHS Policy HR 3 sets out the requirements for hiring new employees. Before hiring a new employee, the facility performs a criminal background check and consults the Michigan Child abuse registry, as required by this standard. In addition, the facility consults both Michigan and national sex offender registries. The same checks are made for contractors who may have contact with residents. The facility repeats these checks annually for each employee, which is far more often than the five-year checks required by this standard. During the site visit, the auditor reviewed six randomly selected personnel files and found all of the required checks, both initial and annual, to have been performed. According to the HR administrator interviewed, the facility, when considering a person for hire, contacts all known former institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse.

Subsection (f) of this standard requires that the facility ask employees whether they have engaged in the misconduct described in subsection (a) of this standard when considering them for promotion and in any interviews or written self-evaluations conducted as part of reviews of current employees. Subsection (a) lists engagement in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution; and conviction or civil or administrative adjudication of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, of if the victim did not consent or was unable to consent. At the time of the Interim Report, the facility was not making those inquiries of promotional candidates or in performance reviews, as this standard requires. Subsection (f) also requires that the facility impose a continuing affirmative duty to disclose any such misconduct. It did not do so at the time of the Interim Report.

Based upon the interview of the Human Resources administrator, material omissions regarding such misconduct, or the provision of materially false information, are grounds for termination, and the facility provides information on substantiated allegations of sexual abuse or sexual harassment involving a former employee upon receiving a request for an institutional employer for whom such employee has applied to work.

Corrective Action Required

1. In the employee promotion process, ask all promotional applicants who may have contact with residents directly about the misconduct described in subparagraph (a) of this standard: whether the employee has (1) engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution; (2) 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 (3) has been civilly or administratively adjudicated to have engaged in the activity described in (2).
2. Make the three inquiries described above in any interviews or written self-evaluations conducted as part of reviews of current employees.
3. Amend policy to imposed upon employees a continuing affirmative duty to disclose any misconduct described in the three criteria listed in no. 1 above.

During the corrective action period, the facility altered its promotion and employee evaluation processes to include specifically asking employees the questions set out in Standard 115.317(f) and in Corrective Action Item 1, above. The changes in these processes were evidenced by the Wolverine Human Services Performance Evaluation form and the Wolverine Human Services Human Resources

Department Promotion Review form, to each of which has been added an employee questionnaire consisting of the three required questions. WHS also amended its PREA policy to impose upon employees a continuing affirmative duty to disclose any misconduct described Corrective Action item 1 for this standard.

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*)

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

The facility has not designed or acquired any new facility, nor has it planned any substantial expansion or modification of existing facilities since its last PREA audit. Neither has it installed a video monitoring system or other monitoring technology.

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*)

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

Instructions for Overall Compliance Determination Narrative

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The facility does not conduct criminal investigations of sexual abuse, but it does conduct administrative investigations. Therefore, it is required to use a uniform evidence protocol that is 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. At the time of the Interim Report, the facility had not provided evidence of compliance. Rather, in response to this requirement, it submitted only its agency coordinated response plan and the review form used by its incident response committee. These documents do not constitute the uniform evidence protocol required by this standard.

In the event of sexual abuse at the facility, WHS would transport the alleged victim to an outside facility, a Saginaw Covenant Hospital, where a Sexual Assault Nurse Examiner (SANE) would conduct an examination, at no cost to the victim. The MDHHS PREA Coordinator has verified the availability of SANEs at the hospital.

WHS unsuccessfully attempted to establish an agreement with a local sexual assault advocacy organization, The Sexual Assault Center, Saginaw, for the provision of a victim advocate in the event of sexual abuse in the facility. The auditor reviewed email communications in which the Sexual Assault Center declined to make that service available, citing restrictions imposed by its funding source. As a result, the facility would provide a qualified staff member to serve as a victim advocate, should the victim request one. The staff who would be provided is qualified mental health staff and has completed the training for medical and mental health staff developed by the National Commission on Correctional Health Care and offered by the National PREA Resource Center. The auditor reviewed modules one through four from that training, which were submitted by the facility.

WHS has entered into a memorandum of agreement with the Vassar Police Department (VPD), dated September 14, 2015. The VPD agreed to investigate allegations of sexual abuse at the facility, using investigators who have received special training in sexual abuse investigations involving juvenile victims whenever possible and following VPD investigatory protocols for the investigation of sexual abuse investigations involving juveniles. The nature and content of those protocols are not specified. Subsection (f) of this standard requires that an agency that does not conduct its own investigations request that the agency responsible for investigating allegations of sexual abuse follow the requirements of subsections (a) through (e) of this standard. It is not clear on the face of the memorandum of agreement whether WHS has made that request of the VPD. Specifically, it is

unknown whether the VPD uses a uniform evidence protocol, such as described above and in subsection (b) of this standard, nor whether WHS has requested that the VPD do so. Neither is it clear whether the VPD would make victim advocate available upon request, using either an outside agency or a specially trained staff member from the facility.

Corrective Action Required:

1. WHS should utilize a uniform evidence protocol in its administrative investigations. The protocol must be developmentally appropriate for youth and, as appropriate, be adapted from or otherwise based on the most recent edition of the U.S. Department of Justice's Office on Violence Against Women publication, "A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents," or similarly comprehensive and authoritative protocols developed after 2011.
2. The facility must demonstrate that it has requested that the Vassar Police Department, when investigating an allegation of sexual abuse at the facility, follow the requirements of subsections (a) through (e) of this standard.

During the corrective action period, the auditor engaged in discussion with the MDHHS PREA Coordinator and the WHS PREA Compliance Manager on the issue of a uniform evidence protocol. Facility administrative investigations are carried out by investigators trained by the National Institute of Corrections (NIC) to conduct investigations of sexual abuse and sexual harassment in a confinement facility housing adolescents. The investigators follow the protocol taught in the NIC training. As a practical matter, once there is an allegation of sexual assault, the criminal investigation conducted by the Vassar Police Department commences, and the administrative investigation stops. The facility relies upon the criminal investigation as to whether the sexual abuse occurred, and any further administrative investigation would focus on whether staff members' actions or failure to act contributed to the incident. Additionally, forensic examinations are conducted by certified Sexual Assault Nurse Examiners (SANEs), who are trained in and follow a uniform evidence protocol.

The facility has a memorandum of agreement with the Vassar Police Department for the criminal investigation of allegations of sexual assault, as noted above. During the corrective action period, the facility requested in a letter dated September 17, 2018, that, in conducting those investigations, the police department comply with subsections (a) through (e) of this standard.

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

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WHS PREA policy, subparagraph H, requires that each incident of alleged or reported sexual abuse be investigated to the fullest extent possible. Subparagraph H(3)(c) requires that the facility director or designee contact the police department with all allegations of sexual abuse or harassment unless they do not involve potentially criminal behavior. The policy is posted on the WHS website and differentiates between the investigative responsibilities of the facility and outside law enforcement. All referrals for investigation are documented by the facility.

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

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All facility staff receive training on sexual abuse and sexual assault related issues during their pre-service orientation. In addition, staff receive refresher training annually, which exceeds this standard's requirement of training every two years. Review of the training curriculum used at the facility to conduct the pre-service training reflects its coverage of all 11 elements required by section a of this standard and set forth above. In addition, the randomly selected staff who were interviewed confirmed that those required topics were addressed.

The training curriculum also demonstrates that the training is tailored to the unique needs of residents of juvenile facilities. Both male and female residents are housed on the WHS Vassar campus. Staff training therefore covers the needs of both populations. All staff who are new to the facility receive the orientation training, so any who might come from a single gender facility are trained regarding both male and female residents.

Because the training is part of pre-service orientation, all current staff have received the required training. Each of the randomly selected staff members who were interviewed reported having been trained in orientation. The auditor also reviewed six randomly chosen personnel files and found training records documenting both the pre-service training and the annual refreshers. At the conclusion of the training, each employee signs a verification of having received and understood its contents. The auditor found those signature sheets in the randomly chosen personnel files and reviewed additional samples of them provided by the facility.

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*)

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Paragraph C(1) of the WHS PREA policy requires that all contractors and interns who have contact with residents must complete training for sexual assault prevention, response, and reporting. The policy also requires that contractors and interns complete annual refresher training. The auditor reviewed the curriculum for the training, as well as sample signature sheets reflecting completion on the training by contractors. On the signature sheets, the signers acknowledged that they understood the material presented. Additionally, contractors who were interviewed stated that they had participated in the training. The facility also provided, and the auditor reviewed sample signature sheets on which contractors acknowledge receipt of the zero-tolerance policy on sexual abuse and sexual harassment and a PREA orientation packet for interns and contractors. Those signature sheets also include certification that the signatories understand their responsibilities under the WHS PREA policy and the rules and expectations for interns and contractors.

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*)

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Paragraph A(1) of the WHS PREA policy sets out the requirements for providing information and training to residents related to sexual assault and sexual abuse. It requires that a resident receive PREA orientation within 72 hours of arrival at the facility. That provision is inconsistent with subsection (a) of this standard, which requires that residents be made aware at intake of the zero-tolerance policy for sexual abuse and sexual harassment and of the methods by which they may report any incidents. While the policy should therefore be amended to include the intake requirement, the auditor found that, in practice, the agency is compliant with it. The agency reported that all residents receive the specified information at intake and provided sample resident signature sheets for review. This was confirmed in interviews of 16 residents, each of whom reported having been given the information upon arrival at the facility. It was corroborated in the interview of a staff member who conducts the intakes.

Additional information is provided residents by their case managers within 10 days of intake, as required by this standard. This actually occurs the same day as intake, the next day, or in the event of Friday afternoon intake, on the following Monday. The "PREA orientation" includes their right to be free from sexual abuse and sexual harassment, their right to be free from retaliation for reporting sexual abuse or sexual harassment, and agency policies and procedures for responding to such incidents. The information is provided in a written PREA Orientation packet, and the intake staff goes over the packet with the residents. Residents are also shown a video on their rights. The residents who were interviewed confirmed that they received the information, although one of them did not recall being shown a video. A description of the education process was provided by the intake staff who was interviewed.

The facility reports not having received a resident who was not proficient in English. In the event of a future limited English proficient resident, the facility provided an extensive Michigan state government list of interpreters it could use. However, at the time of the Interim Report, the facility had not demonstrated the availability of sign language interpreters or other accommodations for deaf or hearing-impaired residents. For residents who have intellectual disabilities or limited reading skills, the intake staff and case managers who provide the information are able to present it in an appropriate manner that enables the residents to understand it. All of the residents who were interviewed, including two with learning disabilities, stated that the information was understandable as presented.

The facility maintains records of the education sessions for residents in the form of signature sheets signed by residents. The auditor reviewed sample signature sheets provided by the facility.

Residents have continuing access to the information given them related to sexual abuse and sexual harassment in the form of the PREA Orientation Packets they receive when they arrive at the facility. There is also information available on posters that were observed throughout the facility.

Corrective Action Required:

1. Make provisions to provide all educational information, including information communicated orally to residents, in formats accessible to residents who are deaf or hard of hearing.

During the corrective action period, the facility provided newly enacted procedure CR 4, effective May 14, 2018. The procedure describes an agreement with Vassar Public Schools and Tuscola Intermediate School District under which the school districts will provide for the individual needs of students not only in school, but in the presentation of resident orientation, including discussion of PREA, grievances, and residents' rights and responsibilities. The school systems will employ assistive technology as part of its response to the needs of deaf students. In addition, the facility advised that two of its staff members are proficient in American Sign Language and would provide those services if necessary. Memo of September 14, 2018 from PREA Compliance Manager to the auditor.

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*)

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WHS PREA policy provides at paragraph C(7) that staff who conduct administrative investigations of sexual abuse allegations must receive specialized training to do so. The policy does not specify the content of the required training. The facility has five investigators who have received specialized training to conduct such administrative investigations. Each of them completed a course offered by the National Institute of Corrections entitled "PREA: Investigating Sexual Abuse in a Confinement Setting." The facility provided the certificates issued upon successful completion of that course. An interview of an investigator confirmed that the training addressed all of the specific topics required by this standard.

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*)

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

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WHS PREA policy, paragraph C(6), requires that all full and part time medical and mental health practitioners who regularly work with residents must receive specialized training in each of the four topics listed in subsection (a) of this standard. The facility provided, and the auditor reviewed the training modules used for medical and mental health staff. Medical staff employed by the facility do not conduct forensic examinations, and therefore no training on that subject is required.

The facility maintains records documenting that its medical and mental health care staff have completed the training required by this standard. It provided signature sheets to the auditor for review. Medical and mental health staff are also required to complete the general training mandated for all staff by Standard 115.331. Like all other staff, they complete the PREA orientation as part of their pre-service training. Completion of the training was confirmed in interviews of medical and mental health care staff. Similarly, interviews of contract providers reflected that they are given the training for contractors and interns.

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*)

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WHS PREA policy addresses assessment of residents to determine risk of sexual vulnerability or risk to sexually victimize other youth at paragraphs B(1) and (2). It requires that the assessment be conducted within 72 hours of a resident's arrival. Paragraph B(7) requires reassessment at least twice each year. All of the residents who were interviewed confirmed that they were given the assessments at intake. Intake staff stated in interview that the assessments are generally performed the day a resident arrives and are always performed within 72 hours. Staff also stated that residents are reassessed every three - four months. The assessment instrument itself states that re-assessment is to occur quarterly or as needed. Some of the residents interviewed indicated that they had been re-asked the assessment questions while at the facility.

The facility uses an objective screening instrument, a copy of which was provided to the auditor for review. The three-page instrument covers each of the 11 elements required by subsection (c) of this standard. The assessment is completed through conversation with the resident, as well as a review of any records that accompany the resident to the facility, according to the intake staff who was interviewed.

Policy does not address the dissemination of the information obtained in the assessments, but intake staff stated in interview that it is not available to line-staff. That information may be viewed only by administrators and the treatment team.

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

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WHS PREA policy, paragraph B(3), states that the facility must use all information obtained in a resident's risk assessment conducted pursuant to Standard 115.341 "to make housing, bed, program, education, and work assignments with the goal of keeping residents safe and free from sexual abuse." The policy also requires documentation of how the assessment information was used to inform placement and assignments. Intake staff stated in interview that the assessment information is, in fact, used for those purposes. Housing and bed assignments are particularly considered because of the dormitory settings in which residents reside.

The facility does not use isolation, although the WHS PREA policy provides at paragraph B(5) that a youth may be isolated as a preventive and protective measure only as a last resort and when other less restrictive measures are inadequate, and then only until an alternate means of keeping all youth safe can be arranged. If isolation were used, the policy provision states that the isolated resident must be given access to daily large-muscle exercise and legally required educational or special educational programming. A resident in isolation must also receive daily visits from a medical or mental health practitioner and must have access to other programs to the extent possible. While the policy contains these provisions regarding isolation, neither the WGRC nor the CFC buildings have any place where a resident could be isolated from the general population. Because isolation is not used, there is no need to review protective isolation every 30 days.

The WHS PREA policy, paragraph B(4), prohibits housing lesbian, gay, bisexual, transgender, and intersex (LGBTI) residents solely on the basis of such identification or status. Paragraph B(4)(e) states that "youth must not be considered more likely to perpetrate sexual abuse solely because of LGBTI identity."

Paragraph B(4)(a) of the WHS PREA policy states that the decision whether to place a transgender or intersex resident in a unit for males or females is to be made on a case-by-case basis and to be based on whether the placement would ensure the resident's health and safety, and whether the placement would present management or security problems. The resident's own view of his or her gender identity is to be taken into consideration when determining placement. Paragraph B(4)(d). Placement and programming assignments must be reviewed at least twice each year to assess any threats to safety experienced by the resident. Paragraph B(4)(b). All residents at WGRC and CFC, including transgender and intersex residents, shower separately from other residents.

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

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WHS PREA policy, paragraph E(1), addresses youth reporting of sexual abuse and sexual harassment. Residents may report privately by filing a grievance, which could be unsigned, writing a note to a staff member, which could also be unsigned, or contacting the Department of Health and Human Services Protective Services hotline, the number for which is posted prominently throughout the facility. Residents can also use the grievance process or write a note to report retaliation by other residents or staff for reporting sexual abuse or sexual harassment and to report neglect of duty by staff that may have contributed to such incidents. Interviews of residents during the site visit reflected their awareness of the ability to report incidents privately.

Reports to the Protective Services hotline may be made anonymously, and that upon receipt of such reports, they are immediately forwarded to the facility. The facility does not detain residents solely for civil immigration purposes.

Staff members at the facility accept and promptly document reports of sexual abuse or sexual harassment, including reports made in writing, anonymously, or by third parties. All of the staff members interviewed expressed awareness of those requirements. Any such reports must be immediately reported to a supervisor, and the staff member receiving the report must document it in an incident report by the end of the shift. WHS PREA policy, paragraph F(1).

Both residents and staff reported in their interviews that residents have access to pencils, paper, and grievance forms at all times, so that a report of sexual abuse or sexual harassment can be made at any time.

Staff members, like residents, may use the Protective Services hotline to make private reports of sexual abuse or sexual harassment, and staff members demonstrated awareness of this possibility in their interviews.

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.

The grievance process is one of the ways which a resident at the facility can report sexual abuse or sexual harassment. Such grievances are governed by provisions of the WHS PREA policy at paragraphs E(5) and J. Therefore, the facility is not exempt from this standard.

WHS policy states that a grievance alleging sexual abuse can be filed at any time, regardless of when the incident allegedly occurred. It also states that there is no requirement that youth use an informal process for grievances alleging sexual abuse or sexual harassment. A grievance alleging sexual abuse or sexual harassment need not be submitted to the staff member who is the subject of the complaint. Paragraph E(5). However, there was no policy provision at the time of the Interim Report ensuring that such a grievance not be referred to the staff member who is subject to the complaint. During the corrective action period, the WHS PREA policy was amended at paragraph E(5) to contain that provision.

Paragraph J(1) of the WHS PREA policy requires a final decision on any grievance alleging sexual abuse or sexual harassment within 90 days of its filing. The facility may claim an extension of time of up to 70 days and when doing so must notify the resident and the resident's parent or guardian of the extension. Paragraph J(2). However, at the time of the Interim Report there was no provision in policy dictating that the facility's failure to file a timely response to a grievance shall be considered a denial, as required by subsection (c) of this standard. The required provision was added to the WHS PREA policy during the corrective action period.

Paragraph J(3) of the WHS PREA policy provides that third parties, including fellow residents, staff, family, attorneys, and outside advocates may assist a youth filing a grievance alleging sexual abuse or sexual harassment. It also allows for such third parties to file a grievance on a resident's behalf. The policy further states that, as a condition of processing such a third-party grievance, the alleged victim must agree to it, unless the third party is the alleged victim's parent or guardian. If the alleged victim declines to have the grievance processed, the facility must document the resident's decision.

At the time of the Interim Report, the WHS PREA policy implicitly provided for emergency grievances by stating in paragraph (E)5 that "Emergency grievances alleging sexual abuse and/or imminent threat of sexual abuse must be responded to immediately." However, the policy did not specify the process for the immediate resolution. Subsection (f) of this standard requires that, in the event of an emergency grievance, it immediately be forwarded to a level of review at which corrective action can be taken, that an initial response be provided within 48 hours, and that a final decision be issued within five calendar days. The initial response and the final decision must document the facility's determination whether the resident is in substantial risk of imminent sexual abuse and the action taken in response to the emergency grievance. The facility policy was amended during the corrective action period to require a process compliant with subsection (f) of this standard.

Residents of the facility are not disciplined for allegations of sexual abuse or sexual harassment that are investigated and determined not to have occurred, so long as the allegation was made in good faith. WHS PREA policy, paragraph A(1)(g).

Corrective Action Required

1. Amend the facility policy to provide that a grievance alleging sexual assault or sexual harassment not be referred to a staff member who is the subject of the complaint.
2. Amend the facility policy regarding grievances alleging sexual abuse or sexual harassment to state that the facility's failure to file a timely response to a such a grievance shall be considered a denial.
3. Amend the facility policy to more fully describe the process and requirements regarding an emergency grievance alleging substantial risk of imminent sexual abuse. Included should be provisions that the grievance be immediately forwarded to a level of review at which corrective action may be taken; that an initial response shall be provided within 48 hours; that a final decision shall be issued within five days; and that the initial response and final decision shall document the facility's determination whether the resident is in substantial risk of imminent sexual abuse and the action taken in response to the emergency grievance.

During the corrective action period after submission of the Interim Report, the facility amended section E(5) of the WHS PREA policy to make each of the corrections required.

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

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

115.353 (a)

- Does the facility provide residents with access to outside victim advocates for emotional support services related to sexual abuse by providing, posting, or otherwise making assessible mailing addresses and telephone numbers, including toll-free hotline numbers where available, of local, State, or national victim advocacy or rape crisis organizations? ☐ Yes ☒ No

- Does the facility provide persons detained solely for civil immigration purposes mailing addresses and telephone numbers, including toll-free hotline numbers where available of local, State, or national immigrant services agencies? ☐ 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.

The facility provided evidence that it attempted to enter into an agreement with a local agency, the Saginaw Sexual Assault Center, for the provision of emotional support services to residents of the facility who are victims of sexual abuse. Unfortunately, in an email from its executive director dated December 11, 2014, the Sexual Abuse Center declined to provide those services, citing restrictions imposed by its funding source. As a result, the facility states that it will use trained staff members to provide emotional support to residents who are victims of sexual abuse. In view of the facility's unsuccessful good faith efforts to establish an agreement whereby outside victim advocates would be provided victims for emotional support, the auditor concludes that the facility has satisfied this standard by making provision for specially trained staff members to do so.

The facility provides residents with reasonable and confidential access to their attorneys. Administrators and residents stated in their interviews that residents can speak telephonically with their

attorneys when necessary and that the phone calls are not monitored. There is also provision for attorneys to meet with residents privately at the facility.

The facility provides reasonable access to parents or legal guardians. Residents stated in interviews that they are given weekly phone calls with their parents, that parents may visit every second week, and that residents who are nearing release are given home passes. The facility provides transportation to parents and guardians for visitation once a month.

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*)

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The WHS website provides information on PREA and on reporting sexual abuse and sexual harassment on their website at http://www.wolverinehs.org/who-we-are/regulatory-compliance/ Although it could be more explicit in providing a method for third parties to report sexual abuse or sexual harassment to facility officials, the website nonetheless satisfies this standard by providing a copy of the WHS PREA policy. It also provides a telephone number to report any incident to the MDHHS Protective Services hotline, and any such report would be communicated to the facility.

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*)

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WHS PREA policy, paragraph F(1), mandates that staff who receive a report of sexual abuse or attempted sexual abuse, become aware of retaliation against residents or staff who reported such an incident, or become aware of any staff negligence or violation of responsibilities that may have contributed to an incident or retaliation must immediately report to the supervisor. It was evident in interviews of staff that they are aware of this responsibility. Paragraph F(2) requires that the staff member who receives an allegation of sexual abuse must immediately call MDHHS Child Protective Services and make a report.

Paragraph H(1)(i) of the WHS PREA policy prohibits staff members from discussing sexual abuse allegations or incidents beyond the extent needed to maintain safety and security at the facility, with persons other than Supervision/Management, investigators, and prosecuting officials.

Medical and mental health practitioners are subject to the same reporting requirements as all other staff. They are also required, at the initiation of services, to inform residents of their duty to report and the corresponding limits to confidentiality. The practitioners who were interviewed all expressed awareness of these responsibilities and that they comply with them.

Upon receiving an allegation of sexual abuse, it is the responsibility of the Program Manager to promptly report the allegation to his superiors and to the "proper authorities," including police, Child Protective Services, and the Division of Child Welfare Licensing. WHS PREA policy, paragraph F(1). It is also the responsibility of the Program Manager or his designee to report the allegation to the alleged victim's parents or legal guardian, unless the facility has official documentation that they should not be notified, and to the victim's caseworker. In the Michigan system, every youth placed in the facility has a caseworker, whether or not part of the child welfare system. However, although residents placed at the facility remain under the jurisdiction of the juvenile court, at the time of the Interim Report it was not the practice of the facility to notify the resident's attorney or other legal representative within 14 days of an allegation that the resident was the victim of sexual abuse. Subsection (e)(3) of this standard requires such notification. The amendments made to the WHS PREA policy during the corrective action period include the attorney notification requirement at paragraph F(8).

The facility reports all allegations of sexual abuse and sexual harassment, including third-party and anonymous reports, to the facility's designated investigators, according to the Program Managers who were interviewed.

Corrective Action Required

1. Amend the facility policy to require that, in the event of an allegation of sexual abuse of a resident over whom the juvenile court retains jurisdiction, the facility head or designee shall notify the victim's attorney or other legal representative of record within 14 days of receiving the allegation.

During the corrective action period, the facility amended paragraph F(8) to mandate notification of a resident's attorney within 14 days.

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

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Instructions for Overall Compliance Determination Narrative

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In the event a resident is believed to be subject to a substantial risk of imminent sexual abuse, staff take immediate steps to protect the resident. Paragraph G of the WHS PREA policy dictates the immediate separation of the resident at risk from any potential perpetrator by arranging for separate housing, dining, and other elements of the daily routine. Staff who were interviewed on this issue stressed not only the immediate separation of the residents from one another, but that they would maintain close watch on the potential victim to assure his or her safety.

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

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WHS PREA policy, paragraph F(10), directs that when a report of alleged sexual abuse at another facility is received, the Director must report it to the director of the other facility within 72 hours. The same paragraph requires that "all other applicable reporting requirements still apply." Thus, a report would be made to the appropriate investigating agencies, including Child Protective Services. The facility would document that it has provided such notification. In the event the facility receives a report of an allegation of sexual abuse from the director of another facility, such a report would be treated like any third-party report of sexual abuse and investigated in accordance with PREA standards, according to the interviews of the WGRC and CFC Program Managers.

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

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No staff at the facility are designated as "security staff." All staff are considered first responders and subject to the security staff duties spelled out in this standard. Paragraph H(1) of the WHS PREA policy states sets out the requirements for first responders in the event of an suspected or alleged sexual abuse. The alleged victim and alleged perpetrator are required to be separated and kept isolated from each other. The area where the abuse is alleged to have occurred is to be sealed off until qualified investigators can gather evidence. At the time of the Interim Report, the procedure stated that the alleged victim must be requested not to shower, brush teeth, or change clothing, and the alleged perpetrator must not be permitted to do so. The procedure was silent, however, as to preventing the alleged victim and alleged perpetrator from eating, drinking, urinating or defecating. Those actions are also potentially destructive of evidence and are listed in subsections (a)(3) and (4) of this standard. During the corrective action period, the procedure was amended at paragraph H(1)(f) to list all of the activities spelled out in this standard. Staff who were interviewed were well versed in their responsibilities as first responders to an alleged sexual abuse.

Corrective Action Required

1. Amend the PREA policy to also state that the alleged victim of sexual abuse shall be requested not to eat, drink, urinate, or defecate and that the alleged perpetrator shall not be permitted to engage in those same activities.

During the corrective action period, the required amendment to WHS PREA policy, section H(1)(f) was made.

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

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The facility produced, and the auditor reviewed the facility's Coordinated Response Plan. The plan appropriately sets out the actions to be taken by staff first responders, medical and mental health practitioners, investigators, and facility administrators.

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

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The facility does not enter into collective bargaining with its employees.

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

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WHS PREA policy, paragraph F(11), addresses protection from retaliation after a sexual abuse allegation is made. However, the provision was silent at the time of the Interim Report as to retaliation after an allegation of sexual harassment. This standard requires protection of residents and staff from retaliation after allegations of sexual harassment, as well. The facility has designated its PREA Compliance Manager, who is also its Client Rights Advocate, as the position responsible for monitoring for retaliation.

Based upon the interview of the PREA Compliance Manager during the site visit, the facility employs multiple protection measures, including housing changes for resident victims or abusers, removal of alleged staff or resident abusers from contact with victims, and emotional support for residents or staff who fear retaliation. The WHS PREA policy requires that monitoring for retaliation continue for a minimum of 90 days after an allegation is made.

The PREA Compliance Manager is to employ multiple methods in monitoring for retaliation, "including but not limited to observation, direct questioning, and review of logs and incident reports." WHS PREA policy, paragraph F(11). In her interview, the PREA Compliance Manager confirmed that other methods used include reviewing housing or program changes of residents and any negative performance reviews or reassignments of staff. As a part of the monitoring process, the PREA Compliance Manager checks in with the resident or staff member who made the allegation. Protection from retaliation would also extend to any individual who cooperates with an investigation and expresses a fear of retaliation.

Corrective Action Required

1. Amend the PREA policy to provide that protection from retaliation is required to be afforded residents and staff members who make allegations of sexual harassment.

During the corrective action period, the facility amended its PREA policy, Section F(11) to provide that protection from retaliation is provided in instances of allegations of sexual harassment made by residents or staff members.

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*)

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The facility does not use isolation or protective segregation. It is therefore in compliance with this standard.

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*)

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

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Facility investigators do not conduct criminal investigations into allegations of sexual abuse or sexual harassment, but they conduct administrative investigations. Investigators are trained to conduct investigations promptly, thoroughly, and objectively. Investigations are conducted regardless of the source of the allegation, including third-party and anonymous reports. There are five trained investigators at the WHS facility, each of whom has completed the National Institute of Corrections course on investigations of sexual abuse at a confinement facility. The auditor reviewed the certificates of completion for that course. The course included training in sexual abuse investigations involving juvenile victims, according to the investigator who was interviewed during the site visit.

In conducting administrative investigations, investigators gather and preserve direct and circumstantial evidence as appropriate to the investigation. They interview alleged victims, suspected perpetrators, and witnesses, and they review prior complaints and reports of sexual abuse involving the suspected perpetrator. When the quality of evidence appears to support criminal prosecution, the agency does not conduct compelled interviews without consulting with prosecutors as to whether compelled interviews may be an obstacle for criminal prosecution.

Paragraph H of the WHS PREA policy states that WHS will not terminate an investigation solely because the source of the allegation recants it, nor because the alleged victim or perpetrator leaves the facility.

Credibility of an alleged victim, alleged perpetrator, or witness is assessed on an individual basis and is not determined by the person's status as resident or staff, according to the investigator who was interviewed. The investigator also confirmed that the facility does not require a resident who alleges sexual abuse to submit to a polygraph examination.

The administrative investigations the agency conducts include an effort to determine whether staff actions or failures to act contributed to the abuse. The investigations are documented in reports that include a description of the physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings. Substantiated allegations of conduct that appears to be criminal are referred for prosecution.

WHS PREA policy, paragraph F(9), addresses retention of "records of allegations." Records would include written investigative reports. The policy requires that all such records be retained for as long as the abuser is incarcerated or employed by the agency, plus five years.

Outside agencies, including the Vassar Police Department, Child Protective Services, and the facility's licensing authority might investigate allegations of sexual abuse. In such cases, the facility cooperates with the outside agency and remains in contact with it to remain informed about the progress of the investigation.

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*)

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Paragraph H of the WHS PREA policy provides that an evidentiary standard of preponderance of the evidence is employed in determining whether allegations of sexual abuse or sexual harassment are substantiated.

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*)

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

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The WHS PREA policy provides at paragraphs E(3) and (4) that following an investigation into a resident's allegation of sexual abuse in the facility, the facility must inform the resident of the outcome of the investigation. If the agency does not conduct the investigation, it remains in communication with the investigative agency in order to be able to satisfy this provision.

Following an allegation that a resident has been sexually abused by a staff member, WHS PREA policy, paragraph E(3) requires that unless the allegation is determined to be unfounded, the resident is informed whenever the staff member is no longer posted within the resident's unit; the staff member is no longer employed at the facility; the staff member has been indicted on a charge related to sexual abuse within the facility; or the staff member has been convicted on a charge related to sexual abuse within the facility. Notifications are required by the policy to be documented.

Following an allegation that a resident has been sexually abused by another resident in the facility, WHS PREA policy, paragraph E(4) requires that the resident be informed whenever the alleged abuser has been indicted on a charge related to sexual abuse within the facility or the alleged abuser has been convicted on a charge related to sexual abuse within the facility. Notifications are required by the policy to be documented.

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*)

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

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Staff at the facility who violate its policies on sexual abuse or sexual harassment are subject to disciplinary sanctions up to and including dismissal. For staff who have engaged in sexual abuse, the presumptive disciplinary sanction is dismissal. WHS PREA policy, paragraph H(2)(d). Disciplinary

sanctions for violations of agency sexual abuse or sexual harassment policies, other than actually engaging in sexual abuse, are imposed in accordance with WHS' employee discipline policy. Sanctions are 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 members with similar histories.

At the time of the Interim Report, WHS policy was silent as to the requirement in subsection (d) of this standard that all terminations for violations of sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and to any relevant licensing bodies. During the corrective action period, the WHS PREA policy was amended to add this requirement at section H(2)(e).

Corrective Action Required

1. Amend WHS policy to require that terminations for violations of sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and to any relevant licensing bodies.

During the corrective action period, the required corrective action was taken. The reporting requirement was added at section H(2)(e) of the WHS PREA policy.

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

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In interviews during the site visit, facility administrators reported that any contractor or volunteer who engaged in sexual abuse would be prohibited from contact with residents and that in the case of any other violation of facility sexual abuse or sexual harassment policies, a contractor or volunteer would be subject to remedial measures, including possible prohibition of further contact with residents.

The auditor reviewed orientation materials provided to contractors, interns, and volunteers regarding WHS' policies and practices regarding sexual abuse and sexual harassment. The materials include a warning that in the event a contactor or volunteer engages is sexual abuse of a resident, the abuse will be reported to law enforcement agencies, unless the activity was clearly not criminal, and to any relevant licensing bodies.

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.

The facility reports in the Pre-audit Questionnaire that 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, a resident may be subject to disciplinary sanctions only pursuant to a formal disciplinary process. Paragraph A(1)(g) of the WHS PREA policy states that a resident may be subject to disciplinary sanctions only upon a "positive finding" that the resident engaged in youth-on-youth sexual abuse. However, the policy does not clarify the process by which the positive finding would be determined.

The facility does not use isolation. Other disciplinary sanctions imposed would be 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. According to WHS Policy PREA BSM, which pertains to discipline for PREA-related allegations, and the interviews of mental health providers and administrators, the disciplinary process would consider whether a resident's mental disabilities or mental illness contributed to his or her behavior when determining what type of sanction, if any, is imposed.

As a treatment facility with a program for sexual offenders, the facility would offer therapy, counseling, or other interventions to any resident who committed sexual abuse in the facility. Participation in such interventions would not be a condition to access general programming or education, according to the interviews of facility administrators.

Paragraph A(1)(g) of the WHS PREA policy ensures that residents may be subject to disciplinary sanctions for sexual contact with staff only upon findings that the staff member did not consent to such contact. It also provides that a resident will not be subject to disciplinary sanctions for making an allegation of sexual abuse or sexual harassment, even if the abuse or harassment is determined not to have occurred, so long as the allegation was based on a reasonable belief that the abuse or harassment occurred and was made in good faith.

Paragraph H(3)(e) of the WHS PREA policy prohibits all sexual activity between residents, but states that sexual activity "is NOT deemed sexual assault IF the activity was not coerced."

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

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WHS PREA policy, paragraph B(2)(d), provides that if the orientation 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. Mental health staff indicated when interviewed during the site visit that the facility complies with this provision.

Information related to sexual victimization or abusiveness that occurred in an institutional setting is confidential. It is 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.

All of the residents of the facility are under the age of 18. Therefore, there is no requirement that medical and mental health practitioners obtain informed consent before reporting sexual abuse that occurred outside an institutional setting. Rather, the medical and mental health practitioners are mandatory reporters.

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

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In the event of sexual abuse at the facility, the victim would 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. Paragraph F(4) of the WHS PREA policy states that a youth believed or determined to be the victim of a sexual assault must be examined by medical staff for possible injuries. Medical staff interviewed stated that, in performing their duties, they are able to determine the nature and scope of treatment according to their professional judgment.

At the time of the Interim Report, the WHS PREA policy contained no provisions addressing the timely provision of medical or mental health services in the event of a recent incident of sexual abuse when there are no medical or mental health providers on duty. It is clear from the interviews of staff who would be first responders that the victim would be protected by being separated from the alleged perpetrator(s). However, it was unclear if and when medical and mental health providers would be notified. The PREA policy was revised during the corrective action period to require first responding staff or a supervisor to make those notifications immediately. WHS PREA policy at section F(2).

Paragraph F(6) of the WHS PREA policy requires that resident victims of sexual abuse be offered timely information about timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate. The same paragraph states that all medical and counseling services will be provided at no charge to the victim.

Corrective Action Required

1. Amend facility policy to require explicitly that if no qualified medical or mental health practitioners are on duty at the time a report of recent sexual abuse is made, staff first responders shall immediately notify the appropriate medical and mental health providers.

During the corrective action period, the required amendment to the WHS PREA policy was made at section F(2).

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.

The facility offers ongoing medical and mental health evaluation and, as appropriate, treatment to all of its residents as part of the services it provides. This includes victims of sexual abuse, regardless of where the victimization occurred. Interviews of medical and mental health providers confirmed that evaluation and treatment of such victims would be provided and would include, as appropriate, follow-up services, treatment plans, and when necessary, referrals for continuing care following placement in other facilities or return to the community. The interviewed medical and mental health providers also stated that medical and mental health services provided victims would be consistent with the community level of care.

Paragraph F(6) of the WHS PREA policy states that female victims of sexually abusive vaginal penetration must be offered pregnancy tests and 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. The same paragraph provides for testing for sexually transmitted infections, as medically appropriate. All treatment services are offered without charge and are rights granted by facility policy without any conditions, such as requiring cooperation with any investigation arising out of the incident.

The facility would attempt to conduct a mental health evaluation of any known resident-on-resident abuser within 60 days of learning of such abuse history and would offer treatment as deemed appropriate by mental health practitioners. Mental health practitioners, in their interviews, stated that such evaluation and treatment would occur in the normal course of the treatment the facility provides.

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.

Paragraph H(4) of the WHS PREA policy requires that a sexual abuse incident review be conducted within 30 days of the conclusion of every sexual abuse investigation, unless the allegation has been determined to be unfounded. The policy requires to review team to include an upper level administrator and a supervisor.

The facility provided two completed incident review documents to the auditor. Although the incidents reviewed in fact involved allegations of sexual harassment rather than sexual abuse, reviews were nonetheless completed and allow for evaluation of the process. Both reviews occurred within 30 days of the conclusion of the investigation. The review team included upper level management, including a Program Manager and the PREA Compliance Manager, and input was obtained from supervisors, investigators, and mental health practitioners. The review teams considered whether there was a need for policy change to better prevent similar incidents. They also considered whether the incidents were motivated by race; ethnicity; gender identity; LGBTI identification, status, or perceived status; gang affiliation; or other group dynamics. The reviews included an examination of the area in the facility where the incidents allegedly occurred and an assessment of the adequacy of staffing levels in that area. They also included an assessment as to whether monitoring technology should be employed.

The incident review teams prepared reports of their findings, including determinations made on the factors discussed above and recommendations for improvements. The facility head and PREA Compliance Manager were part of the review teams and thus received copies of the reports. The

PREA Compliance Manager reported that the facility implemented the recommendations made by the incident review teams.

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

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The MDHHS Umbrella PREA policy requires the annual collection of accurate, uniform data for every allegation of sexual abuse, sufficient to answer all questions on the annual Survey of Sexual Violence administered by the Department of Justice. MDHHS uses a standardized instrument, which the auditor reviewed. The agency reports on the Pre-audit Questionnaire that it maintains, reviews, and collects data as needed from all available incident-based documents. The agency also reports that it obtains incident-based and aggregated data from every private facility with which it contracts for the confinement of its residents. The auditor reviewed the MDHHS' 2016 annual report on the agency website at http://www.michigan.gov/documents/mdhhs/PrisonRapeEliminationActAnnualReport2016_560062_7.pdf.

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

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MDHHS reports in the Pre-audit Questionnaire that it reviews data collected and aggregated pursuant to Standard 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training. It prepares an annual report of its findings, which the auditor reviewed on the MDHHS website and found to contain all of the required elements, including a detailed comparison of the 2016 data with the 2015 data and assessment of progress made in addressing sexual abuse. The agency reports that the annual report was approved by the agency head. There are no redactions in the annual report.

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

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MDHHS Umbrella Policy 560 states that data collected regarding sexual abuse and sexual harassment is posted and stored on secure state servers under control of the PREA Juvenile Coordinator/Juvenile Justice Programs. All aggregated sexual abuse data can be found on the MDHHS website at the address set out above in the analysis of Standard 115.187. The auditor reviewed the 2016 annual report and found no personal identifiers. The agency reports that it maintains sexual abuse data collected pursuant to Standard 115.387 for at least 10 years after the date of the initial collection.

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.

The 2016 Annual Report posted on the MDHHS website states that during the three-year period beginning August 20, 2013, audits were conducted on each of the facilities operated by MDHHS or by private entities on behalf of the agency. One third of the facilities were audited each year during the three-year audit cycle.

During this audit, the auditor was given access to and was able to observe every area of the facility. The auditor also requested documents from the facility, and all requested documents were provided. During the audit the auditor privately interviewed 16 residents of the facility. Six weeks prior to the site visit, the auditor provided a notice of the impending audit to the facility, including the auditor's mailing address. The notice was posted throughout the facility and was observed by the auditor during the site visit. No communication was received from any resident.

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*)

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

Instructions for Overall Compliance Determination Narrative

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The MDHHS website publishes the 2016 PREA audit reports for the two facilities it operates at http://www.michigan.gov/mdhhs/0,5885,7-339-73971_34044_39057---,00.html. Audit reports for the private organizations that house residents on behalf of MDHHS are posted on the respective organizations' websites. The WHS website publishes 2015 and 2016 audit reports for the facilities it operates at http://www.wolverinehs.org/who-we-are/regulatory-compliance/.

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.

Louis A. Goodman — September 25, 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.