

PREA AUDIT REPORT INTERIM FINAL
JUVENILE FACILITIES

Date of report: 11-23-2016

Auditor Information			
Auditor name: David "Will" Weir			
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Email: will@preaamerica.com			
Telephone number: 405-945-1951			
Date of facility visit: October 12 and 13, 2016			
Facility Information			
Facility name: Bay Pines Center			
Facility physical address: 2425 North 30th St., Escanaba, MI 49829			
Facility mailing address: <i>(if different from above)</i> Click here to enter text.			
Facility telephone number: 906-789-1232			
The facility is:	<input type="checkbox"/> Federal	<input checked="" type="checkbox"/> State	<input type="checkbox"/> County
	<input type="checkbox"/> Military	<input type="checkbox"/> Municipal	<input type="checkbox"/> Private for profit
	<input type="checkbox"/> Private not for profit		
Facility type:	<input type="checkbox"/> Correctional	<input type="checkbox"/> Detention	<input checked="" type="checkbox"/> Other
Name of facility's Chief Executive Officer: Natalie Patterson			
Number of staff assigned to the facility in the last 12 months: 33			
Designed facility capacity: 40			
Current population of facility: 38			
Facility security levels/inmate custody levels: secure			
Age range of the population: 11-20			
Name of PREA Compliance Manager: Gerald Weaver		Title: Supervisor	
Email address: weaverg3@michigan.gov		Telephone number: 906-789-1232	
Agency Information			
Name of agency: Michigan Department of Health and Human Services			
Governing authority or parent agency: <i>(if applicable)</i> Click here to enter text.			
Physical address: 235 S. Grand Ave., Lansing, MI 48909			
Mailing address: <i>(if different from above)</i> Click here to enter text.			
Telephone number: 517-335-3489			
Agency Chief Executive Officer			
Name: Nick Lyon		Title: MDHHS Director	
Email address: Nancy Grijalva, AA to Director GrijalvaN@michigan.gov		Telephone number: Nancy Grijalva (517) 241-1193	
Agency-Wide PREA Coordinator			
Name: Patrick Sussex		Title: PREA Juvenile Coordinator / Program Mgr.	
Email address: sussexp@michigan.gov		Telephone number: 517-648-6503	

AUDIT FINDINGS

NARRATIVE

PREAmerica LLC was retained in April 2016 to perform the Bay Pines Center PREA Audit. Michigan PREA Juvenile Coordinator and Program Manager Patrick Sussex facilitated the process. Notices of the on-site audit were posted by August 31st and the Pre-Audit Questionnaire was received 09-22-2016.

The on-site audit was conducted as planned on October 12th and 13th. PREAmerica Auditor Will Weir and Project Manager Tom Kovach met with Agency Juvenile PREA Coordinator Patrick Sussex, Director Natalie Patterson, Secretary Pam Mlostek, and Shift Supervisor/PREA Coordinator/PREA Investigator Jerry Weaver. A facility tour was conducted and the audit team was provided with rosters of residents and staff. Random interviews with residents and staff started right away, as did document reviews.

An exit conference was held at the conclusion of the on-site audit. The audit team interviewed a total of 11 administrators and staff, including specialized staff. All residents randomly selected were interviewed. A total of 10 residents were interviewed, including 5 boys and 5 girls randomly selected to include residents from each living area.

The auditor team was impressed by the professionalism of the staff, the organizational skills of the administration, and the positive morale of the residents. Residents interviewed who were listed as victims in PREA allegations were pleased with the way investigations were handled. Residents, in general, reported that the staff are fair and consistent, and they had especially good things to say about the supervisors. Staff report the facility has a good working environment and they have an open door policy to the director and supervisors. Residents say they feel safe at the facility and that they can usually trust staff. Staff help them understand what they need to understand and spend extra time with the residents when needed. Such as, when someone has a learning disability or is having a bad day. The facility seems to do a good job screening everyone for risk of abusiveness and victimization and goes ahead and reassesses all residents, even if they are not known to be high risk. Residents reported no issues with searches that were performed, and indicate the facility is very serious about following all aspects of PREA.

Partial list of documents reviewed: Mission Statement; building schematic; rosters of staff and residents; investigations and notifications; Email communications from PREA Coordinator, Compliance Manager, and Director; Random HR files; First Responder Duties; PREA Policies; Search Policies; Grievance Policies and forms; Screening, Hiring, and Employment Policies; Employment Application and Follow-Up Questions; Visitation Policy and Rules; DHHS Division of Child Welfare Licensing Reports; Coordinated Response; Random examples of PREA Intake [Risk] Assessment; MOU with Tri County Safe Harbor; MOU with Michigan State Police; PREA Pre-Audit Questionnaire; Youth Orientation Packet; audit postings; third party reporting postings; advocacy and PREA reporting postings and notices; Organizational Chart; Mission Statement; Staff Training Curriculum and documentation; Refresher Training and verification; Notice of Zero Tolerance Policy for Volunteers, Contractors, and Interns (along with training packet and signature page); Staffing Plan; Staffing Plan Review; Resident PREA Training; Unannounced Rounds Log; Interpreter/Translator Services in DHHS Administrative Policies for Facilities/Hospital; Letter from Joy E. Hopkins, RN, of St. Francis Hospital and Medical Group regarding SANE Exams; Labor Contract; and Facility and Agency Annual Reports.

DESCRIPTION OF FACILITY CHARACTERISTICS

The main Bay Pines facility is located in an icositetranic sided building. Its core is a rectangle which houses the Gym, men's and women's locker rooms, training room, gym storage and medical area which includes a pharmacy and dental rooms. There is also a computer room. This area is surrounded by a hallway.

There are three housing areas, with single cells with a restroom and shower in each area. The largest one has three living areas for pods A, B and C. A detention office is located to observe each area with pod C being in an adjacent wing. The last area is pod D also with its own office and living area.

Pod D is by the Intake area. Beyond the intake area is a series of staff offices including a server room and two isolation rooms. There is a glass walled office which is situated to monitor the lobby and visitor area which is down a short hall. Opposite the visitor's rooms are the restrooms and a corner office. A conference room is next to the office equipment area. The filing room is next to the administrative offices.

The far end includes a maintenance garage, boiler room loading bay and cook's office next to the kitchen and dining areas. A laundry room sits on the corner opposite the four classrooms and IEP room.

Bay Pines Center provides care for youth of any gender. They have a short term residential detention program where youth can await court decisions, but their core program is rehabilitative treatment that provides individual and group therapeutic sessions based on cognitive behavioral frameworks providing much opportunity for accountability, social skills building, and a variety of academic opportunities and other services to help the youth succeed.

SUMMARY OF AUDIT FINDINGS

On October 12th and 13th, 2016, PREAmerica, LLC, DOJ certified PREA auditor Will Weir conducted site visits and interviews at Bay Pines Center in Escanaba, Michigan, to determine the facility's compliance with the Standards of the Prison Rape Elimination Act. Bay Pines Center was found to be compliant with all the Standards.

Number of standards exceeded: 0

Number of standards met: 41

Number of standards not met: 0

Number of standards not applicable: 0

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

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

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

Bay Pines Center has a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment, outlining how it will implement the agency’s approach to preventing, detecting, and responding to sexual abuse and sexual harassment, including definitions of prohibited behaviors. The policy includes sanctions for those found to have participated in prohibited behaviors and includes a description of agency strategies and responses to reduce and prevent sexual abuse and sexual harassment of residents. The agency designates an upper-level, agency-wide PREA coordinator who has sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards in all of its facilities. Audit interviews with JJP PREA Coordinator Patrick Sussex indicates he has sufficient time and authority to do this work. Also, interviews with the facility PREA Compliance Manager Gerald Weaver indicates he has sufficient time and authority to coordinate efforts to comply with the PREA standards. No interviews provided information to contradict these assertions. DHHS JJP PREA Coordinator Patrick Sussex reports to Dr. Herman McCall who is the Director of Juvenile Justice Programs. The agency organizational chart was provided. Mr. Weaver answers directly to facility Director Natalie Patterson.

Standard 115.312 Contracting with other entities for the confinement of residents

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

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Bay Pines does not contract for the confinement of its juveniles, but the State of Michigan does. PREA Standards state that a public agency that contracts for the confinement of its residents with private agencies or other entities, including other government agencies, shall include in any new contract or contract renewal the entity’s obligation to adopt and comply with the PREA standards. This standard applies to Michigan DHHS, and the agency requires PREA compliance. Standard language for contracts is as follows:

“ The contractor shall comply with all provisions of the Prison Rape Elimination Act (PREA). Compliance with PREA will be monitored by [Michigan Department of Human Services Bureau of Children and Adult Licensing] BCAL. Actions should be taken and documented that:

- a. Ensure staff training on PREA compliance
- b. Ensure a readily available objective reporting and investigation procedure
- c. Ensure youth knowledge of PREA regulations
- d. Ensures all volunteers, employees, contractors and other regular facility visitors with resident contact have been screened in compliance with PREA standards.”

Standard 115.313 Supervision and monitoring

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

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Bay Pines Center develops, documents, and makes its best efforts to comply on a regular basis with a staffing plan that provides for adequate levels of staffing, and video monitoring, to protect residents against abuse. The average daily number of residents is 37. The number upon which the staffing plan was predicated is 40. Each time the staffing plan is not complied with, the facility documents and justifies all deviations from the staffing plan; however, there have been no deviations. At least once every year the agency reviews the staffing plan considering all relevant factors, to see whether adjustments are needed to the staffing plan: in prevailing staffing patterns; the deployment of monitoring technology; or the allocation of agency resources to commit to the staffing plan to ensure compliance with the staffing plan. The facility requires that intermediate-level or higher-level staff conduct and document unannounced rounds to identify and deter staff sexual abuse and sexual harassment. This was verified by review of the policy and logs, as well as through interviews conducted.

Standard 115.315 Limits to cross-gender viewing and searches

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

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

As verified by a review of policy and interviews with staff and residents, the Bay Pines Center does not conduct cross-gender searches of residents. If such a search was done, it would only be under exigent circumstances and would be justified and documented, but there have been no cross-gender searches to document in the past 12 months. Staff have been trained on searches, including how to conduct searches of transgender and innersex residents in a respectful manner consistent with security needs. The facility has implemented policies and procedures that enable residents to shower, perform bodily functions, and change clothing without non-medical 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 (this includes viewing via video camera). Policies and procedures require staff of the opposite gender to announce their presence when entering a resident housing unit or area where residents are likely to be showering, performing bodily functions, or changing clothing. The facility has a policy prohibiting staff from searching or physically examining a transgender or intersex resident for the sole purpose of determining the resident's genital status. None of these searches have occurred in the past 12 months, and it appears there are no known transgender or innersex residents at this time.

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

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

relevant review period)

- Does Not Meet Standard (requires corrective action)

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

Interviews indicate all current residents speak English, but residents and staff interviewed indicate no doubt the facility would appropriately assist any resident that had difficulty communicating. The agency has established procedures to provide residents with limited English proficiency, and disabled residents, 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. Agency policy prohibits use of 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. There have been no exceptions, but the agency would document the if the resident interpreters, readers or other types of resident assistants had been used. In addition, staff indicate, during interviews conducted by the auditor, an understanding of why they would not rely on residents to provide such assistance. These policies are found in the Bay Pines PREA Policy and in the Interpreter/Translator Services section in the DHHS Administrative Policies for Facilities/Hospital.

Standard 115.317 Hiring and promotion decisions

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

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

Bay Pines Center policy prohibits hiring or promoting anyone who may have contact with residents, and prohibits enlisting the 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; 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 has been civilly or administratively adjudicated to have engaged in the activity described above. Bay Pines Center and DHHS Agency policy requires the consideration of 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. Files reviewed by the auditor, and interviews with administrators, indicate the agency conducts criminal background record checks, consults any child abuse registry maintained by the State or locality in which the employee would work; and consistent with Federal, State, and local law, makes 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. According to random files pulled, it appears all employees, contractors and volunteers have had background checks done as required. Criminal background checks of employees and contractors are completed every five years. In addition, agency policy states that material omissions regarding such misconduct, or the provision of materially false information, shall be grounds for termination. These policies are found in the DHHS Administrative and Support Services Manual in the JR1 100 Section (Screening, Hiring, and Employment). Some of these policies can be additionally verified by reviewing the employment application and associated questions asked of applicants. It appears these policies and practices have been in place since at least 2011.

Standard 115.318 Upgrades to facilities and technologies

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

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

According to the Pre Audit Questionnaire, the facility has not acquired a new facility or made a substantial expansion or modification to existing facilities since August 20, 2012. According to interviews with the administrators, any upgrades, expansions, acquisitions, and new construction of facilities will consider PREA. Also, when installing or updating a video monitoring system, electronic surveillance system, or other monitoring technology, the agency shall consider how such technology may ensure the agency's ability to protect residents from sexual abuse.

Standard 115.321 Evidence protocol and forensic medical examinations

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

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

The agency/facility is responsible for conducting administrative sexual abuse investigations (including resident-on-resident sexual abuse or staff sexual misconduct). There is a MOU with the Michigan State Police documenting their agreement to conduct criminal investigations using trained investigators who will follow appropriate protocols. When conducting a sexual abuse investigation, the investigators follow a uniform evidence protocol that is developmentally appropriate for youth, adapted from the most recent edition of the DOJ's Office on Violence Against Women publication, A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents. The facility offers all residents who experience sexual abuse access to forensic medical examinations, without cost, as per the guidance of the police, DHHS, Tri-County Safe Harbor (as per MOU verified by auditor), and St. Francis Hospital. Where possible, examinations are conducted by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs). When SANEs or SAFEs are not available, a qualified medical practitioner performs forensic medical examinations. The facility documents efforts to provide SANEs or SAFEs. During the past 12 months there were no forensic medical exams conducted, and no criminal investigations. The facility attempts to make a victim advocate from a rape crisis center available to the victim, in person or by other means. These attempts are documented. If and when a rape crisis center is not available to provide victim advocate services, the facility provides a qualified staff member from a community-based organization or a qualified agency staff member. Compliance with this Standard was verified through interviews with investigators and administrators as well as a telephone interview with Advocate and Liaison Jesse Fuller of Tri-County Safe Harbor. In addition the auditor reviewed Bay Pines PREA Policy, the MOUs with the Michigan State Police, the MOU with Tri-County Safe Harbor, and a letter from St. Francis Hospital.

Standard 115.322 Policies to ensure referrals of allegations for investigations

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

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

The agency ensures that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment. According to information provided in the Pre-Audit Questionnaire, as well as during interviews with both staff and residents, it appears there have been 7 allegations of sexual abuse or sexual harassment received in the past year. All 7 of these have been investigated administratively and did not require criminal investigation or prosecution. Although some investigations indicated a violation of facility rules, 6 of these allegations were found to be unsubstantiated as to sexual abuse or harassment. One allegation of harassment was substantiated. An 8th allegation, a suspected licensing violation, was received and investigated by Child Welfare Licensing and no violation was found. Policy requires that allegations of sexual abuse or sexual harassment be referred for investigation to an agency with the legal authority to conduct criminal investigations, unless the allegation does not involve potentially criminal behavior. The policy regarding the referral of allegations of sexual abuse or sexual harassment for a criminal investigation is published on the agency website and is made publicly available by other means as well. The agency documents all referrals of allegations of sexual abuse or sexual harassment for criminal investigation. The Bay Pines Center Directors and PREA Manager verified their intention and commitment to follow these policies and procedures.

Standard 115.331 Employee training

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

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

According to policy, curriculum, and training logs reviewed by the auditor, the agency trains all employees who may have contact with residents on the following required matters: (1) Its zero-tolerance policy for sexual abuse and sexual harassment; (2) How to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures; (3) Residents' right to be free from sexual abuse and sexual harassment; (4) The right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment; (5) The dynamics of sexual abuse and sexual harassment in juvenile facilities; (6) The common reactions of juvenile victims of sexual abuse and sexual harassment; (7) 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; (8) How to avoid inappropriate relationships with residents; (9) How to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents; (10) How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities; and (11) Relevant laws regarding the applicable age of consent. Between trainings, the agency provides employees who may have contact with residents with refresher information about current policies regarding sexual abuse and sexual harassment at least annually. All staff who may have contact with residents have been trained and have signed that they understand the training. Interviews conducted by the audit team indicate the employees understand the training.

Standard 115.332 Volunteer and contractor training

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

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

All volunteers and contractors who have contact with residents have been trained on their responsibilities under the agency's policies and procedures regarding sexual abuse and sexual harassment prevention, detection, and response. These include a doctor, dentist, 3 alternating hygienists, 2 nurse practitioners, and 2 nurses. The facility director and PREA compliance manager state the level and type of training provided to volunteers and contractors is based on the services they provide and level of contact they have with residents, as directed in policy. All volunteers and contractors who have contact with residents have been notified of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents. The agency maintains documentation confirming that volunteers/contractors understand the training they have received and these were reviewed by the auditor.

Standard 115.333 Resident education

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

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

The residents receive information at time of intake about the zero-tolerance policy and how to report incidents or suspicions of sexual abuse or sexual harassment. All residents admitted during the past 12 months were given this information at intake, and comprehensive information within 10 days of intake. This information is provided in an age appropriate fashion. All transfers are treated as admissions, so these residents get the same PREA training. The agency maintains documentation of resident participation in PREA education sessions and the auditor reviewed a sample of this documentation, as well as the resident training curriculum and handouts. The agency ensures that key information about the agency's PREA policies is continuously and readily available or visible through posters, resident handbooks, or other written formats. The agency provides resident education in formats accessible to all residents, including those who are limited English proficient, deaf, visually impaired, or otherwise disabled, as well as to residents who have limited reading skills. Information received during the pre-audit process, as well as during the on-site audit, including interviews with staff and residents indicate the residents understand the zero tolerance policy and various ways to report.

Standard 115.334 Specialized training: Investigations

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

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

Agency policy requires that investigators are trained in conducting sexual abuse investigations in confinement settings. Bay Pines Center has James Sanville and Gerald Weaver as their trained investigators. Documentation of their training was provided to the auditor. The training included techniques for interviewing juvenile sexual abuse victims, proper use of Miranda and Garrity warnings, sexual abuse evidence collection in confinement settings, and the criteria and evidence required to substantiate a case for administrative action or prosecution referral (although the State Police do the criminal investigations for Bay Pines Center). A review of investigations indicate these are being done according to PREA Standards and industry practices.

Standard 115.335 Specialized training: Medical and mental health care

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

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

All medical and mental health care practitioners who work regularly at this facility have received PREA training, but they do not conduct forensic exams, but would assist law enforcement if requested. Their training taught them how to detect and assess signs of sexual abuse and sexual harassment; how to preserve physical evidence of sexual abuse; how to respond effectively and professionally to juvenile victims of sexual abuse and sexual harassment; and how and to whom to report allegations or suspicions of sexual abuse and sexual harassment. Documentation of this training was made available to the auditor.

Standard 115.341 Screening for risk of victimization and abusiveness

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

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

Bay Pines Center conducts screening upon admission for risk of sexual victimization or sexual abusiveness toward other residents. As policy requires, all residents who were admitted to Lincoln Center in the past 12 months were screened within 72 hours of their intake using an objective screening instrument. Policy also requires that a resident’s risk level be reassessed periodically throughout their confinement, and interviews indicate that this reassessment is completed on all Bay Pines Center residents. The screening information is gleaned through conversations with the resident and during medical and mental health screenings; during classification assessments; and by reviewing court records, case files, facility behavioral records, and other relevant documentation from the resident’s file. The screening and reassessment attempts to ascertain information about: (1) Prior sexual victimization or abusiveness; (2) Any gender nonconforming appearance or manner or identification as lesbian, gay, bisexual, transgender, or intersex, and whether the resident may therefore be vulnerable to sexual abuse; (3)

Current charges and offense history; (4) Age; (5) Level of emotional and cognitive development; (6) Physical size and stature; (7) Mental illness or mental disabilities; (8) Intellectual or developmental disabilities; (9) Physical disabilities; (10) The resident's own perception of vulnerability; and (11) Any other specific information about individual residents that may indicate heightened needs for supervision, additional safety precautions, or separation from certain other residents. Although the screening and reassessment process is done discretely, with controls on the dissemination of the information, most residents interviewed remember being asked the questions on the screening tool and indicate they feel it is a good idea for this information to be used to help protect residents who may be at risk.

Standard 115.342 Use of screening information

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

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Bay Pines Center uses information from the risk screening required by §115.341 to inform housing, bed, work, education, and program assignments and has a policy that residents at risk of sexual victimization may only be placed in isolation as a last resort if less restrictive measures are inadequate to keep them and other residents safe, and only until an alternative means of keeping all residents safe can be arranged. Policy requires that residents at risk of sexual victimization who are placed in isolation have access to legally required educational programming, special education services, and daily large-muscle exercise. In the past 12 months no residents at risk of sexual victimization were placed in isolation. Residents have single occupancy rooms so isolation is rarely an issue at Bay Pines. Isolation is only to be used as a last resort and only until an alternative means of keeping all the residents safe can be arranged, which is usually within a matter of hours. Policy prohibits placing lesbian, gay, bisexual, transgender, or intersex residents in particular housing, bed, or other assignments solely on the basis of such identification or status. The facility also prohibits considering lesbian, gay, bisexual, transgender, or intersex identification or status as an indicator of likelihood of being sexually abusive. The agency makes housing and program assignments for transgender or intersex residents in the facility on a case-by-case basis, and with regular reviews.

Standard 115.351 Resident reporting

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

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

Bay Pines Center PREA Policy Section E, #1, states, "Youths must be supported and encouraged to report sexual assault/rape, attempted sexual assault/rape, and/or sexual harassment and be protected from retaliation. A youth that believes that they were the victim of a sexual assault/rape, attempted sexual assault/rape or sexual harassment, or believes another youth was the victim or sexual assault/rape, attempted sexual assault/rape, or sexual harassment, may report this information to a staff member. Youths may also write down their report and turn it in to staff, or use the facility grievance process to report. An option must exist for youths to report sexual abuse to someone outside of the facility. The outside reporting option for Facility is to place a call to Children's Protected Services, 1-855-444-3911. . . ." Staff must facilitate the resident's reporting method of choice, whether by providing paper and pencil and assisting in that way, or by having a supervisor facilitate a private call where the resident is provided a way to visit with CPS without being overheard. BPC PREA Policy

Section F, #1, states, “Staff receiving a report of sexual assault/rape or attempted sexual assault/rape that occurred in a facility, whether or not it is part of the agency; staff that become aware of sexual activity between residents or between a resident and staff, contractor, visitor, or volunteer; become aware of retaliation against students or staff that reported such an incident; and/or, become aware of any staff negligence or violation of responsibilities that may have contributed to an incident or retaliation must immediately report this to the supervisor. If a supervisor is not on duty the staff must call an administrator. The administrator is responsible for notifying the proper authorities which include the police, CPS, and the Division of Child Welfare Licensing (DCWL, formerly BCAL).” #2 states, “The staff member receiving the report of actual or suspected sexual abuse or rape must immediately call Children’s Protective Services and report the incident and/or allegation. The staff member receiving the report of actual or suspected sexual abuse or rape must submit an Incident Report before the end of their work shift and must complete a DHS-3200, Report of Actual or Suspected Child Abuse or Neglect, within 72 hours of becoming aware of the incident.” Interviews with residents and staff verify they are encouraged to report.

The agency provides a method for staff to privately report sexual abuse and sexual harassment of residents. The PREA Mandated Reporter website link it:

http://www.michigan.gov/mdhhs/0,5885,7-339-73971_7119_50648_44443-157836--,00.html

Standard 115.352 Exhaustion of administrative remedies

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

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

Administrative procedures have been established for dealing with resident grievances regarding sexual abuse. This policy allows a resident to submit a grievance regarding an allegation of sexual abuse at any time regardless of when the incident allegedly occurred. This policy does not require a resident to use an informal grievance process, or otherwise to attempt to resolve with staff, an alleged incident of sexual abuse. The agency's policy and procedure allows a resident to submit a grievance alleging sexual abuse without submitting it to the staff member who is the subject of the complaint. The grievance alleging sexual abuse will not be referred to the staff member who is the subject of the complaint. The agency has policy that requires a decision on the merits of any grievance or portion of a grievance alleging sexual abuse be made within 90 days of the filing of the grievance. There have no grievances filed that alleged sexual abuse in the last 12 months. All allegations came in through the reporting processes rather than the grievance procedures. The agency notifies the resident in writing when the agency files for an extension, including notice of the date by which a decision will be made. Agency policy permits third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, to assist residents in filing requests for administrative remedies relating to allegations of sexual abuse, and to file such requests on behalf of residents. If the resident declines to have third-party assistance in filing a grievance alleging sexual abuse, the agency documents the resident's decision to decline. Agency policy allows parents or legal guardians of residents to file a grievance alleging sexual abuse, including appeals, on behalf of such resident. If an emergency grievance is filed alleging that a resident is subject to a substantial risk of imminent sexual abuse, the issue will be handled immediately as with any allegation of imminent abuse, and a final decision will be made within 3 days. The agency has a written policy that limits its ability to discipline a resident for filing a grievance alleging sexual abuse to occasions where the agency demonstrates that the resident filed the grievance in bad faith. Interviews with staff and residents indicate residents can and do file grievances which are taken seriously and processed according to policy. There are locked grievance boxes placed in locations around the facility to facilitate the integrity of this process which is explained when residents are admitted to the facility as well as in their handbook.

Standard 115.353 Resident access to outside confidential support services

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

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

The facility provides residents access to outside victim advocates for emotional support services related to sexual abuse through the Tri-County Safe Harbor and by providing, posting, and otherwise making accessible the mailing addresses and telephone numbers of local, State, or national victim advocacy or rape crisis organizations. Staff and administrators verify that the facility does inform residents, prior to giving them access to outside support services, the extent to which such communications will be monitored and of the mandatory reporting rules governing privacy, confidentiality, and/or privilege that apply to disclosures of sexual abuse made to outside victim advocates, including any limits to confidentiality under relevant Federal, State, or local law. The facility maintains a memoranda of understanding (MOU) with Tri-County Safe Harbor, which was verified by the auditor via phone interview with Tri-County Victim Advocate Jessie Fuller. The facility provides residents with reasonable and confidential access to their attorneys or other legal representation, as well as reasonable access to parents or legal guardians. Interviews with staff and residents confirm a belief that outside support is available. Residents interviewed state they feel safe at Bay Pines Center and are convinced they could report anything without retaliation, and could use outside services if needed, and that they can have private visits. This was echoed in interviews with the Director, PREA Manager, and specialized staff as well.

Standard 115.354 Third-party reporting

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

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

The agency provides a method to receive third-party reports of resident sexual abuse or sexual harassment. Policy clearly states any staff can take complaints and that complaints can be anonymous. Anyone can call the Michigan reporting line by calling 855-444-3911. In addition, the facility distributes information on how to report resident sexual abuse or sexual harassment on behalf of residents by posting notices and posters in public areas. Also, DHHS agency website explains ways to report: http://www.michigan.gov/mdhhs/0,5885,7-339-73971_7119_50648_44443-157836--,00.html

Standard 115.361 Staff and agency reporting duties

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

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

It is required that all staff report immediately and according to agency policy: any knowledge, suspicion, or information they receive

regarding an incident of sexual abuse or sexual harassment that occurred. Policy also requires the reporting of any retaliation against residents or staff who reported such an incident, as well as any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. The agency requires all staff to comply with all applicable mandatory child abuse reporting laws, as well as reports, as (and when) appropriate, to licensing agencies and Adult Protective Services. Apart from reporting to designated supervisors or officials and designated State or local service agencies, agency policy prohibits staff from revealing any information related to a sexual abuse report to anyone other than to the extent necessary to make treatment, investigation, and other security and management decisions. Medical and mental health practitioners are mandated reporters and are required to inform residents at the initiation of services of their duty to report and the limitations of confidentiality. Upon receiving any allegation of sexual abuse, the facility promptly reports the allegation to the appropriate agency office and 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. If the alleged victim is under the guardianship of the child welfare system, the report shall be made to the alleged victim's caseworker instead of the parents or legal guardians. If a juvenile court retains jurisdiction over the alleged victim, the facility head or designee shall also report the allegation to the juvenile's attorney or other legal representative of record within 14 days of receiving the allegation. Interviews, and a review of investigations conducted, indicate these policies are being followed.

Standard 115.362 Agency protection duties

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

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

When the agency or facility learns that a resident is subject to a substantial risk of imminent sexual abuse, it takes immediate action to protect the resident. According to interviews conducted and documentation reviewed by the audit team, there have been no instances in the past year when the facility determined that a resident was subject to substantial risk of imminent sexual abuse. It is worthy of note that since each youth is housed in a single occupancy cell, the residents and staff believe the risk of resident on resident abuse is decreased.

Standard 115.363 Reporting to other confinement facilities

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

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

Bay Pines Center has a policy, verified by the director, requiring that, upon receiving an allegation that a resident was sexually abused while confined at another facility, the Director, as soon as possible (but no later than 72 hours), must notify the head of the facility or appropriate office of the agency or facility where sexual abuse is alleged to have occurred. This has not happened in the past 12 months. The agency documents that it has provided such notification within 72 hours of receiving the allegation. The agency/facility policy requires that allegations received from other facilities/agencies are investigated in accordance with the PREA standards. In the past 12 months, there have been no allegations of sexual abuse the facility received from other facilities.

Standard 115.364 Staff first responder duties

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

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

Bay Pines Center has a first responder policy for allegations of sexual abuse. The agency policy requires that, upon learning of an allegation that a resident was sexually abused, the first security staff or youth worker to respond to the report shall be required to separate the alleged victim and abuser and preserve and protect any crime scene until appropriate steps can be taken to collect any evidence. All staff have been trained as first responders. If the abuse occurred within a time period that still allows for the collection of physical evidence, the first responder requests 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. The first responder should also assure that the alleged abuser not take any actions that could destroy evidence. If the assault occurred within the past 96 hours the victim must be transported to St. Francis Hospital for examination by qualified personnel. Also, the director, the police, and Tri-County Safe Harbor is notified, and other notifications are made as in B115.361 above. All youth workers, security, and administrators interviewed seem to know these first responder duties in a general way. In the past 12 months, there were no allegations that a resident was sexually abused in a way that would have left any forensic evidence; the allegations were mainly regarding harassment and did not trigger first responder protocols other than separating the residents.

Standard 115.365 Coordinated response

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

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

The facility has developed a written institutional plan to coordinate actions taken in response to an incident of sexual abuse among staff first responders, medical and mental health practitioners, investigators, and facility leadership. This plan was provided to the auditor, and discussed during interviews with the Facility Director, PREA Compliance Manager, and the Advocate from Tri-County Safe Harbor.

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

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

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

The agency, facility, or any other governmental entity responsible for collective bargaining on the agency's behalf has not entered into or renewed any collective bargaining agreement or other agreement that prohibits the facility from protecting residents from contact with abusers. The Labor Contract was available to the audit team at the facility.

Standard 115.367 Agency protection against retaliation

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

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

The facility has 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. The Facility Director and PREA Compliance Manager are tasked with monitoring for possible retaliation, although everyone plays a part. Interviews indicate that they take this seriously and that they will take appropriate measures to protect any individual who expresses a fear of retaliation. They monitor the conduct and treatment of residents and staff who reported sexual abuse and of residents who were reported to have suffered sexual abuse to see if there are any changes that may suggest possible retaliation by residents or staff. The agency monitors the conduct or treatment for at least 90 days and longer if needed and acts promptly to remedy any such retaliation. There have been no reports of retaliation which occurred in the past 12 months. Bay Pine's monitoring includes any resident disciplinary reports, housing, or program changes, or negative performance reviews or reassignments of staff. Documentation of monitoring was reviewed by the Audit Team.

Standard 115.368 Post-allegation protective custody

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

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

The facility has a policy that residents who allege to have suffered sexual abuse may only be placed in isolation as a last resort if less restrictive measures are inadequate to keep them and other residents safe, and only until an alternative means of keeping all residents safe can be arranged. Policy requires that residents who are placed in isolation because they allege to have suffered sexual abuse have access to legally required educational programming, special education services, and daily large-muscle exercise. In the past 12 months there have been no residents who alleged to have suffered sexual abuse who were placed in isolation. Interviews conducted during the onsite audit indicate that since residents have single occupancy rooms, and limited movement, this standard is almost not applicable to Bay Pines Center because of the ability to protect residents without using protective custody.

However, it is appropriately covered in policy. BPC PREA Policy Section B, #5, states, “A youth may be isolated from other youth as a preventive and protective measure, but only as a last resort when other less restrictive measures are inadequate to keep the youth safe from other youths, and then only until an alternate means of keeping all youths safe can be arranged. During any periods of protective isolation, facility staff may not deny a youth otherwise under control, access to daily large-muscle exercise and legally-required educational programming or special education services.”

Standard 115.371 Criminal and administrative agency investigations

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

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

Bay Pines Center has a policy related to criminal and administrative agency investigations. The Michigan State Police conducts criminal investigations and they agree to have trained investigators conduct the investigations who will gather evidence appropriately and preserve it. Bay Pines Center conducts its own administrative investigations into allegations of sexual abuse and sexual harassment, and does so promptly, thoroughly, and objectively for all allegations, including third-party and anonymous reports. These administrative investigations include an effort to determine whether staff actions or failures to act contributed to the abuse and are documented in written reports that include a description of the physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings. The facility does not terminate an investigation solely because the source of the allegation recants the allegation. Substantiated allegations of conduct that appear to be criminal are referred for prosecution. When the quality of evidence appears to support criminal prosecution, the facility conducts compelled interviews only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution. The credibility of an alleged victim, suspect, or witness is assessed on an individual basis and shall not be determined by the person’s status as resident or staff. The departure of the alleged abuser or victim from the employment or control of the facility or agency does not provide a basis for terminating an investigation. They do not require a resident who alleges sexual abuse to submit to a polygraph examination or other truth-telling device as a condition for proceeding with the investigation of such an allegation. The facility retains all written reports pertaining to the administrative or criminal investigation of alleged sexual abuse or sexual harassment for as long as the alleged abuser is incarcerated or employed by the agency, plus five years. When outside agencies investigate sexual abuse, the facility cooperates with outside investigators and endeavors to remain informed about the progress of the investigation. There were no criminal investigations for the auditor to review, but 7 administrative investigations were reviewed and contain documentation verifying the investigators are following PREA Standards for investigations.

Standard 115.372 Evidentiary standard for administrative investigations

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

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

As verified by interviews with administrators and a review of Bay Pines Center policy, the agency imposes a standard of a preponderance of the evidence, or a lower standard of proof, when determining whether allegations of sexual abuse or sexual harassment are substantiated.

Standard 115.373 Reporting to residents

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

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

The agency has a policy requiring that any resident who makes an allegation that he or she suffered sexual abuse in the facility is notified as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded following an investigation, and that the notification is documented. Auditor Weir examined all 7 investigations conducted during the previous 12 months and found that proper notifications seem to have been made. All these investigations were administrative investigations completed within the facility, but if a criminal investigation is conducted in the future, they will request the relevant information from any outside investigative entity in order to inform the resident as required, according to their policy and interviews conducted. Following a resident's allegation that a staff member has committed sexual abuse against the resident, the facility subsequently informs the resident (unless the agency/facility has determined that the allegation is unfounded) whenever the staff member is no longer posted within the resident's unit; the staff member is no longer employed at the facility; the agency learns that the staff member has been indicted on a charge related to sexual abuse within the facility; or the agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility. Following a resident's allegation that he has been sexually abused by another resident, they will inform the alleged victim when they learn that the alleged abuser has been indicted on a charge related to sexual abuse within the facility or if they learn that the alleged abuser has been convicted on a charge related to sexual abuse within the facility.

Standard 115.376 Disciplinary sanctions for staff

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

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

Staff at Bay Pines Center are subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies, and this is made clear in the application and interview process, as well as new employee training. Disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) 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 with similar histories. 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, are reported to law enforcement agencies, unless the activity was clearly not criminal, and to any relevant licensing bodies. Interviews conducted during the onsite visit with administration, as well as with staff at different levels, provided no reason for the auditor to doubt that these policies are strictly enforced.

Standard 115.377 Corrective action for contractors and volunteers

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

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

Bay Pines Center policy requires that any contractor or volunteer who engages in sexual abuse be reported to law enforcement agencies, unless the activity was clearly not criminal, and to relevant licensing bodies. Policy requires that any contractor or volunteer who engages in sexual abuse, or any other violation of agency sexual abuse or sexual harassment policies, be prohibited from contact with residents. In the past 12 months, there have been no known incidents of contractors or volunteers engaging in sexual abuse of residents.

Standard 115.378 Disciplinary sanctions for residents

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

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

Residents are subject to disciplinary sanctions only pursuant to a formal disciplinary process following an administrative finding, or criminal finding, that the resident engaged in resident-on-resident sexual abuse. In the past 12 months there have been no findings of substantiated resident-on-resident sexual abuse that have occurred at the facility. There was one finding of substantiated sexual harassment. In the event a disciplinary sanction for resident-on resident sexual abuse results in the isolation of a resident, the facility policy requires that residents in isolation have daily access to large muscle exercise, legally required educational programming, and special education services, and all other programming, and the resident also gets daily medical and mental health care. The facility offers therapy, counseling, or other interventions designed to address and correct the underlying reasons or motivations for abuse and considers whether to require the offending resident to participate in such interventions as a condition of access to any rewards-based behavior management system or other behavior based incentives. Yet, access to general programming or education is not conditional on participation in such interventions. The agency disciplines residents for sexual contact with staff only upon finding that the staff member did not consent to such contact. The agency prohibits disciplinary action for a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred, even if an investigation does not establish evidence sufficient to substantiate the allegation. The agency prohibits all sexual activity between residents, but deems such activity to constitute sexual abuse only if it determines that the activity is coerced.

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

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

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

All residents at this facility who have disclosed any prior sexual victimization during a screening pursuant to §115.341 are offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening. In the past 12 months all residents who disclosed prior victimization during screening were offered a follow up meeting with a medical or mental health practitioner. Medical and mental health staff maintain secondary materials documenting compliance with the above required services. All residents who have previously perpetrated sexual abuse, as indicated during the screening pursuant to § 115.341, are also offered a follow-up meeting with a mental health practitioner. Information related to sexual victimization or abusiveness that occurred in an institutional setting is strictly limited to medical and mental health practitioners and other staff strictly limited to informing security and management decisions, including treatment plans, housing, bed, work, education, and program assignments, or as otherwise required by federal, state, or local law.

Standard 115.382 Access to emergency medical and mental health services

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

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

According to agency policy and interviews conducted, resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services. The residents answered questions in such a way to show they believe they will be cared for should something happen to them. Also, facility policies spell this out. The nature and scope of such services are to be determined by medical and mental health practitioners according to their professional judgment. Medical and mental health staff document the timeliness of emergency medical treatment and crisis intervention services provided; the appropriate response by non-health staff in the event health staff are not present at the time the incident is reported; and the provision of appropriate and timely information and services concerning contraception and sexually transmitted infection prophylaxis. Resident victims of sexual abuse while incarcerated are offered timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate. Treatment services will be provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with the investigation.

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

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

- Does Not Meet Standard (requires corrective action)

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

BPC PREA Policy Section F, 5 and 6 states: “5. Victims and perpetrators of sexual assault must be encouraged to complete tests for sexually transmitted diseases, including an HIV test. In the case of a substantiated incident of sexual assault, the perpetrator must be requested to complete an HIV test. If the perpetrator will not voluntarily take an HIV test, the facility Director or designee may seek a court order compelling the test. 6. The victim of sexual assault or attempted sexual assault must be provided mental health assistance and counseling as determined necessary and appropriate. Resident victims of sexual abuse will be offered timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate. Female victims of sexually abusive vaginal penetration must be offered pregnancy tests. If pregnancy results from sexual abuse while incarcerated, victims will receive timely and comprehensive information about, and timely access to, all lawful pregnancy-related medical services. All medical and counseling services will be provided at no charge to the victim.” Interviews indicate residents, even resident on resident abusers, are offered evaluation and follow-up services, treatment plans, and, when necessary, referrals for continued care following transfer to other facilities or release from custody.

Standard 115.386 Sexual abuse incident reviews

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

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

BPC PREA Policy Section I, #4, states, “A sexual abuse incident review will be conducted at the conclusion of every sexual abuse investigation unless the allegation has been determined to be unfounded. The sexual abuse incident review team will include at a minimum an upper level Administrator, and a supervisor. The review will occur within 30 days of the conclusion of the investigation. The review team must review each incident of sexual abuse for cause, staffing, and physical barriers, and make recommendations for prevention. Recommendations must be implemented or the reason(s) if not implemented must be documented.” The auditor reviewed the investigations, and interviewed the investigator, and found that reviews have been held regarding the 3 investigations to which this Standard applies.

Standard 115.387 Data collection

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

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

Director Patterson verifies that the agency collects accurate, uniform data for every allegation of sexual abuse at Bay Pines Center using a standardized instrument and set of definitions and provides this to the State of Michigan. As the Agency PREA Coordinator, Patrick Sussex states that he facilitates the collection and analysis of the data. The agency maintains, reviews, and collects data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews. Bay Pines Center and the State of Michigan will provide the Department of Justice with data from the previous calendar year upon request, but has not yet been requested to do so.

Standard 115.388 Data review for corrective action

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

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

DHHS JJP PREA Coordinator Patrick Sussex states the Bay Pines Center provides ongoing and annual data to his office. He reviews 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, and training, including: identifying problem areas; taking corrective action on an ongoing basis; and preparing an annual report of its findings from its data review and any corrective actions for each facility, as well as the agency as a whole. The annual report includes a comparison of the current year's data and corrective actions with those from prior years and provides an assessment of the agency's progress in addressing sexual abuse. DHHS makes its annual report readily available to the public annually through its website, as approved by the agency head.

Standard 115.389 Data storage, publication, and destruction

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

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

Michigan Juvenile Justice Services ensures that incident-based and aggregate data are securely retained. Agency policy requires that aggregated sexual abuse data from facilities under its direct control and private facilities with which it contracts be made readily available to the public, at least annually, through its website. Before making aggregated sexual abuse data publicly available, the agency removes all personal identifiers. The agency maintains sexual abuse data collected pursuant to §115.387 for at least 10 years after the date of initial collection, unless Federal, State or local law requires otherwise.

Below is the link to the DHHS public website that contains aggregated data on sexual abuse allegations, data comparisons and annual report, how to report sexual abuse, and public facility final reports from PREA audits.

http://www.michigan.gov/dhs/0,4562,7-124-5453_34044_39057---,00.html

AUDITOR CERTIFICATION

I certify that:

- The contents of this report are accurate to the best of my knowledge.
- No conflict of interest exists with respect to my ability to conduct an audit of the agency under review, and
- I have not included in the final report any personally identifiable information (PII) about any inmate or staff member, except where the names of administrative personnel are specifically requested in the report template.

D. Will Weir

11-23-2016

Auditor Signature

Date