PREA AUDIT REPORT ☐ INTERIM ☒ FINAL
JUVENILE FACILITIES

Date of report: February 1, 2016

Auditor Information			
Auditor name:	Ray Reno		
Address:	P.O. Box 372, Larned, Ks. 67550		
Email:	rayreno1@gmail.com		
Telephone number:	620-285-1405		
Date of facility visit:	June 11-12, 2015		
Facility Information			
Facility name:	Teaching Family Homes		
Facility physical address:	7820 State Highway 123, Newberry, MI 49868		
Facility mailing address: *(if different from above)* Click here to enter text.			
Facility telephone number:	906-293-5670		
The facility is:	☐ Federal	☐ State	☐ County
	☐ Military	☐ Municipal	☒ Private for profit
	☐ Private not for profit		
Facility type:	☒ Correctional	☐ Detention	☐ Other
Name of facility's Chief Executive Officer: David Edie			
Number of staff assigned to the facility in the last 12 months: 12			
Designed facility capacity: 8			
Current population of facility: 8			
Facility security levels/inmate custody levels: Non-Secure			
Age range of the population: 11-18			
Name of PREA Compliance Manager: David Edie		**Title:** Facility Director	
Email address: dedie@tfhomes.org		**Telephone number:** 906-293-5670	
Agency Information			
Name of agency: Teaching Family Homes of Upper Michigan (TF Homes)			
Governing authority or parent agency: *(if applicable)* Click here to enter text.			
Physical address: 1000 Silver Creek Rd. Marquette, MI 49855			
Mailing address: *(if different from above)* Click here to enter text.			
Telephone number: 906-249-5437			
Agency Chief Executive Officer			
Name: Cathy Enright		**Title:** Director	
Email address: Click here to enter text.		**Telephone number:** 906-249-5437	
Agency-Wide PREA Coordinator			
Name: Patrick Sussex		**Title:** Juvenile PREA Coordinator	
Email address: sussexp@michigan.gov		**Telephone number:** 517-648-6503	

AUDIT FINDINGS

NARRATIVE

The PREA audit of Teaching Family Homes (TF Homes) facility was conducted on June 11 and 12, 2015, by certified PREA auditor, Ray Reno.

Prior to the onsite portion of the audit, the auditor provided the facility with the Auditor Notice which was posted April 30, 2015, six weeks prior to the onsite audit. The Pre-Audit Questionnaire, along with other supporting documentation, was provided to the auditor for review, via flash drive, in advance of the onsite portion of the audit. Correspondence between the auditor, the PREA Coordinator, and the PREA Compliance Manager occurred throughout the pre-audit phase.

The auditor reported to TF Homes on June 11, 2015, to initiate the onsite portion of the audit. A brief opening meeting was conducted to introduce the auditor to the TF Homes administration. The tour of the facility then followed.

Interviews began immediately after the tour and included specialized and random staff, as well as random and targeted youth. A total of 10 specialized staff interviews were conducted, which included administrative and agency staff. Because the facility is very small, some staff filled more than one role and received more than one specialized interview. A total of five random staff and six random youth interviews were conducted; one youth refused, and one failed to appear for interview. There were no youth in isolation and therefore, no staff that supervise youth in isolation to interview.

TF Homes does not have an isolation unit. All but one of the rooms at TF Homes are single-occupancy; there is one double-occupancy that had only one youth assigned to it. There were no disabled or limited-English-proficient youth reported or observed by the auditor.

There were zero incidents of sexual abuse/sexual harassment reported during the 12 month review period. Human Resources is located in the Marquette office, and the auditor conducted a phone interview with HR staff. Training records were available and reviewed by the auditor while onsite. Other additional documentation was provided upon auditor request throughout the onsite portion of the audit.

Many of the documents requested by the Pre-Audit Questionnaire were not included in the information provided pre-audit. Some additional documentation was provided upon auditor request prior to arrival, though it was still incomplete and proved difficult to conduct a thorough pre-audit review. PREA compliance efforts began at TF Homes a short time before the audit. While policy has been created, practice is not yet congruent with policy, and adequate awareness of PREA throughout the facility will require significantly more time and effort. That said, TF Homes is committed to and invested in doing so. It was obvious to the auditor from interviews with staff and residents that sexual safety is important, and that they are putting forth effort to create a reporting environment.

Upon the completion of the onsite audit, on June 12, 2015, the auditor spoke with the PREA Coordinator to discuss preliminary audit findings.

DESCRIPTION OF FACILITY CHARACTERISTICS

Teaching Family Homes is a secure male residential treatment facility situated in the Lakes Area of Michigan's Upper Peninsula, in the town of Newberry. Fully licensed by and contracted with the State of Michigan, TF Homes provides intensive, specialized residential group home serving boys, ages 10-17, with delinquency issues including aggression, sexual conduct, and substance abuse. This program provides mental health and behavioral stabilization in a staff secure environment, with a good staff-to-child ratio; the facility has a current capacity for eight residents. On-site schooling, as well as individual and group therapy is provided. Teaching Family Homes has a comprehensive website at www.teachingfamilyhomes.org.

During the facility tour, the auditor noted there were no surveillance cameras inside or outside of the facility, nor any means to record or review activity. There are a number of blind spots and other areas out-of-view for staff where it would be prudent to deploy mirrors, cameras, and a DVR system. As it currently is, multiple areas pose potential risk. Bathroom doors had no locks, which is also a risk.

During the walk-through, the auditor observed a definite lack of PREA signage. The only postings noted were the toll-free numbers for reporting. It is recommended that PREA signage be posted prominently throughout the facility.

SUMMARY OF AUDIT FINDINGS

At the time of the interim report, 23 standards were met, 14 standards were not met, 4 were not applicable, and 0 were exceeded.

As of February 14, 2016, T. F. Homes is fully compliant will all applicable audit standards.

Teaching Family Homes provides a valuable service for at-risk youth. While the facility has only been working toward full compliance for a short time, it is evident from the amount of work completed during the corrective action phase of the audit that the sexual safety of the youth is of the utmost importance. The facility leadership made clear, that compliance with the PREA standards was a top priority. The saturation of the PREA standards into daily operations, from the top all the way down, has made the facility a safer place, both for the resident offenders and the staff who care for them.

Number of standards exceeded: 0

Number of standards met: 37

Number of standards not met: 0

Number of standards not applicable: 4

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy Review:
The facility has a very good, comprehensive, PREA policy. Policy number 14M titled PREA Standards and Policy, fully outlines the facilities zero tolerance policy toward sexual abuse and sexual harassment. It should be noted that the policy that was provided was not signed or dated, and the effective date was blank.

Interviews, Document Review, and Site Tour:
The facility has designated the Director, David Edie as the PREA Compliance Manager. Although there are five facilities associated with TF Homes, only one is required to be compliant with PREA regulations, due to housing residents who are part of the Michigan correctional system.

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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This standard is N/A

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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Policy Review:
The facility has a written staffing plan that meets the staffing ratios required.

Interviews, Document Review, and Site Tour
Although the facility has a written staffing plan that meets the staffing ratios required, there was no documentation provided or discovered to indicate that the eleven (11) criteria outlined in 115.113a 1-11, were taken into consideration to calculate adequate staffing levels. A form was provided that addressed many of the items listed above under the heading "Plan Review," but it was not signed or dated. There was no evidence provided to document that the plan had been reviewed in the past 12 months with the PREA Coordinator to consider the elements of 115.113d 1-4. Supervisory staff said they have not deviated from the minimum staffing number during the past year, and typically, they are staffed above the minimum level. It was noted during the facility tour, that there were no surveillance cameras inside the facility or on the grounds. An interview was conducted with one of the overnight staff who reported that administrative staff made regular rounds on that shift and supporting documentation was provided. Staff report that they operate with a 1:4 ratio during the day, and a 1:8 ratio at night.

Corrective Action:
It is evident by the fact that a staffing plan review form exists, that the facility is making an effort to be compliant with this standard. A comprehensive review of the staffing plan needs to be completed that takes into account all of the criteria listed in the standard, and provide documentation to show it was completed, along with their findings.

Completed:
A comprehensive review of the TF Homes staffing plan has been completed. The review was completed using the criteria from the standards and included the 11 criteria mentioned above. This standard has now been met.

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)

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Policy Review:
The facility PREA policy, 14M, prohibits cross gender searches, and searches to determine sexual status. The same policy prohibits female staff from entering areas where the youth are likely to be in a state of undress, showering, or using the toilet.

Interviews, Document Review, and Site Tour:
It was reported that no cross gender pat searches or strip searches were conducted during this review period. Female staff interviewed reported that they normally do not enter an area where the youth would be in a state of undress, showering, or using the toilet, but if they were to, they would announce their presence prior to entry. Youth reported that they were never searched by female staff and they females had not come into the area when they in a state of undress, showering, or using the toilet. The facility reported that there had been no transgender or intersex residents placed there within this review period.

Recommendation:
The placement of video surveillance cameras and DRV's would enhance security and also provide an area where, should exigent circumstances exist, cross gender pat searches could be completed and documented.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

Policy Review:
The facility is not able to accept residents who are blind or non-verbal. Language translation services are available, if needed, from the Northern Michigan University. Policy 14M prohibits the use of youth resident translators, except in an emergency.

Interviews, Document Review, Site Tour:
There were no non English speaking residents placed in the facility during this review period.

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.

Policy Review:
Potential employees are interviewed by facility staff, but the final hiring decisions are made by HR staff in the Marquette office. No HR policy was provided, but a blank application was made available.

Interviews, Document Review, Site Tour:
The application has a "yes" or "no" box to answer two questions related to the applicant's sexual history. Question 1) "Have you 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)?" And Question 2) "Have you been convicted, or civilly or administratively adjudicated, 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?" A phone interview was conducted with HR staff in the Marquette office about the hiring process. HR staff complete a background check and consult the state child abuse registry prior to hire. They also report that background checks are completed on all staff annually. It has not been the practice to check with previous institutional employers prior to hire. During this review period, there were only two staff hired at the Newberry facility, and neither of them had previously been employed by an institutional employer. It also has not been the practice to ask staff directly about sexual misconduct prior to promotion.

Corrective Action:
Staff must develop a policy and practice to contact prior institutional employers about candidate's sexual misconduct, to ask staff directly about sexual misconduct prior to promotion, and to impose upon employees a continuing affirmative duty to disclose any such misconduct. Facility staff will need to maintain documentation to meet the standard. The auditor provided a sample letter and documentation log.

Completed:
Documentation has been received to show that policy and practice now include contacting prior institutional employers to seek information about previous sexual misconduct. Policy has been updated to include the provision that staff are required to report misconduct. Also, policy and practice now requires criminal history checks and a review of the employee's supervisor file whenever the employee goes up for a promotion. There has only been one promotional opportunity since the completion of the interim report, and the new process was not fully implemented at the time, but it is now. This standard has been satisfied.

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)

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N/A. No upgrades were completed during this period of review.

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)

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Policy Review:
The PREA policy, 14M, outlines clearly the steps to be taken should there ever be a report of sexual abuse or sexual harassment. The facility has staff who are trained and capable of conducting administrative investigations, and the policy is clear that any criminal investigation will be referred to the Luce County Sheriff's office for investigation.

Interviews, Document Review, Site Tour:
The facility has done a great job of creating MOU's with the Luce County Sheriff, who have signed the document and agreed to conduct criminal investigations using investigators who have received special training in child sexual abuse, and with the Harbor House community crisis center, who have signed their document agreeing to provide emotional support related to sexual abuse. Additionally, the facility provided documentation stating that the Helen Newberry Joy Hospital will have a trained SANE nurse available, if needed. Although there were no sexual abuse or sexual harassment cases reported during this review period, the facility appears to stand ready, should such an event occur. The auditor attempted to contact the investigator from the Luce County Sheriff's office for interview, but was unsuccessful.

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.

Policy Review:
The facility PREA policy 14M outlines clearly the steps to be taken should an allegation of sexual abuse occur. The policy directs that all allegations of sexual abuse or sexual harassment are referred immediately for investigation.
Interviews, Document Review, Site Tour:
During interviews with staff, all knew to immediately separate victim from abuser, to protect the scene and guard evidence, and to immediately report the incident to a supervisor, the child abuse hotline, and the sheriff's office investigator. All staff interviewed reported

they had been trained on PREA, and documentation was included for several random staff. There were no reports of sexual abuse or sexual harassment during this review period.

Corrective Action:
The agency is required to publish their policy on its website, or make the policy available to the public through other means.

Completed:
The PREA policy is now posted on TF Homes website. This standard is satisfied.

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.

Policy Review:
PREA policy 14M, section C. directs that all facility staff, contractors, and volunteers who have contact with youths must complete initial and annual training for sexual assault, rape prevention, incident response, and reporting. Additionally, the policy requires that all trainees sign an attendance sheet documenting that they attended and understood the training.

Interviews, Document Review, Site Tour:
Interviews with staff indicated that they had been trained and all could adequately explain the zero-tolerance policy for sexual abuse and sexual harassment. Most understood their responsibility in the prevention, detection, reporting, and response to a sexual abuse or sexual harassment incident. Staff were aware of the relevant laws relating to mandatory reporting of sexual abuse. Documentation was provided for random staff indicating they had received and understood PREA training.

Recommendation:
The auditor requests a copy of the PREA training lesson plan for documentation.

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.

Policy Review:
PREA policy 14M, section C. directs that all contractors and volunteers who have regular contact with youth must complete initial and annual training for sexual assault, rape prevention, incident response, and reporting. Additionally, policy requires that all trainees sign an attendance sheet documenting that they attended and understood the training.

Interviews, Document Review, Site Tour:
Facility administration reported that there has only been one volunteer during this review period. Staff reported the volunteer had attended

training; however, documentation of the training was not provided or discovered. Additionally, the volunteer was not available for interview.

Corrective Action:
Provide documentation indicating the volunteer has received the appropriate training. Also, the auditor requests a copy of the PREA training lesson plan for documentation.

Completed:
This documentation has been received. This standard is satisfied.

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.

Policy Review:
PREA policy 14M, section A. directs that at the time of intake, youth orientation process will occur; this will include review of policy and procedures related to PREA. The policy states that this orientation must occur within the first day of youth's admission, and that an annual refresher orientation on PREA will be provided. The facility issues an excellent Youth Safety Guide; the guide clearly outlines that TFH has a zero-tolerance for sexual abuse and sexual harassment. Also included is information on how to report abuse, including phone numbers.

Interviews, Document Review, Site Tour:
Documentation in the form of sign-off sheets were provided to the auditor, indicating that the youth resident received PREA orientation information. However, the documentation was insufficient, due to not being able to determine that the information was provided within 10 days of the resident's arrival at the facility. The PREA standards require that the resident receives this information within 10 days, and PREA policy 14M states the information will be given on the first day. Without having the date of admission on the acknowledge form, the documentation does not prove that the standard has been met.

Corrective Action:
Documentation needs to be provided to show that the residents were given the PREA information within 10 days of their arrival to the facility.

Recommendation:
It is recommended that the date of admission be added to the signature page of the Youth Safety Guide. It was noted during the site tour that there was no PREA signage visible, other than the hotline numbers; auditor recommends that PREA signage be posted in all areas where youth residents have authorized access.

Completed:
The intake policy and practice has been updated to require new arrivals are given PREA education within 10 days. Documentation was provided to show that this is happening. Also, the Youth Safety Guide now has a signature page with a date. Additional PREA signage has been posted throughout the facility in all areas. This standard is satisfied.

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.

Policy Review:
PREA policy 14M, section H. directs that each incident of alleged or reported sexual abuse/sexual assault must be investigated to the fullest extent possible. Section H.1.d. requires that qualified investigators conduct the investigation and collect physical evidence.

Interviews, Document Review, Site Tour:
The facility has assigned one staff as a PREA investigator, and he has provided documentation to show he completed the online training provided through NIC titled, "PREA: Investigating Sexual Abuse in a Confinement Setting." All cases of sexual abuse will be referred to the Luce County Sheriff's Office for investigation. However, the facility investigator has the training to complete administrative investigations that are non-criminal. The Luce County Sheriff's Office does have an investigator who has been specially trained to conduct youth sex abuse investigations. The auditor attempted to contact the investigator, but he was unavailable. The auditor left his name and phone number and asked that he be called to conduct a phone interview, but there has been no response to date.

Comments:
The auditor left several messages with the Luce County Sheriff's Office investigator asking to have a phone interview, however, the calls were not returned.

Standard 115.335 Specialized training: Medical and mental health care

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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Policy Review:
PREA policy 14M, section C.5. requires that all full- and part-time medical and mental health staff receive specialized training on detecting signs of sexual abuse, preserving physical evidence, effective response, and reporting.

Interviews, Document Review, Site Tour:
Staff reported receiving training on PREA recently. However, no documentation was provided to verify this training.

Corrective Action:
Provide documentation to verify that all medical and mental health staff have completed the required specialized training.

Completed:
Documentation has been provided to show that the staff in question has completed a training class through NIC titled "Behavioral Health Care for Sexual Assault Victims in a Correctional Setting". This standard is satisfied.

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.

Policy Review:
PREA 14M, section B.1. directs that the youth residents' behavior history be reviewed during initial screening and intake within 72 hours of arrival at the facility. The youth is to be reassessed periodically throughout his stay. Also provided was a PREA Intake Screening Form, which contains all of the information required to meet this standard.

Interviews, Document Review, Site Tour:
Although the PREA policy includes instructions for documenting how this standard will be met, and a well-designed separate PREA screening form exists, which contains the essential requirements of the standard, the auditor was not provided documentation to show that the form has been in use during this review period. Staff interviewed were aware of how to detect signs of sexual abuse and how to preserve evidence. Staff were able to articulate what information was confidential.

Corrective Action:
Provide PREA Intake Screening Forms completed during this review period.

Completed:
Documentation was provided to show that the forms are being completed within 72 hours of arrival to the facility. The form allows the interviewer to obtain all of the required information. The mental health staff who administer this form have received all of the training required by the standard. This standard has been satisfied.

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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Policy Review:
PREA policy 14M clearly states how screening information will be used. Also included in the policy is information on placement on LGBTI residents. Policy adequately describes procedures to be followed should a youth resident need to be isolated as a preventive or protective measure.

Interviews, Document Review, Site Tour:
Youth residents at this facility are not assigned to work and jobs off-site. Each of the rooms are single-occupant, except for one, which was unoccupied during the auditor's visit. During this review period, no LGBTI residents were placed at the facility, and no residents were placed in isolation. Interviews with staff indicated an understanding of using isolation only as last resort, and only when less-restrictive measures were inadequate to keep a resident safe. Staff reported that youth were under direct supervision most of the time. Staff seemed unsure and somewhat apprehensive about how the facility would handle a LGBTI resident.

Recommendation:
Provide additional training to better educate staff on LGBTI youth.

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)

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Policy Review:
PREA policy 14M clearly outlines that there are multiple ways for residents to report sexual abuse or sexual harassment, or staff neglect. Residents are offered more than one way to report to a public or private entity.

Interviews, Document Review, Site Tour:
Youth residents were knowledgeable about PREA and how to report sexual abuse and sexual harassment. Most of the residents said that they had recently received information concerning PREA, and all said that they felt safe at the facility. Staff were aware that if a resident were to report sexual abuse or sexual harassment, it was their duty to immediately notify a supervisor. There have been no cases of sexual abuse or sexual harassment reported during this review period. Residents reported that sexual safety was not an issue at this facility.

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.

Policy Review:
TF Homes' unnumbered grievance policy outlines the procedures for a resident to file a grievance, as well as the procedures and timeframes for staff to acknowledge the grievance. Grievances involving sexual abuse or sexual harassment will immediately be reported to the chief executive officer. The grievance policy states that a grievance concerning sexual abuse or harassment may be filed at any time, regardless of when the abuse is alleged to have occurred. Residents are not required to attempt an informal resolution on any grievance that alleges sexual abuse or sexual harassment. The policy requires that the grievance not be referred to a staff member who is the subject of the complaint. Final agency decisions will be completed and returned to the resident within 90 days of filing the grievance. The facility may claim an extension of the time to respond, for up to 70 days, if justified. Third parties including fellow residents, staff members, family members, attorneys, and outside advocates are permitted to assist the resident in filing a grievance that alleges sexual abuse, and are also permitted to file requests on behalf of residents. The policy states that if a third party, other than a parent or guardian, files a grievance on the youth's behalf, the facility must request, as a condition of processing, that the alleged victim agrees with the grievance. If the victim declines to have the grievance processed on his behalf, the facility is required to document the youth's decision. Per the grievance policy, all grievances alleging that a resident is subject to a substantial risk of imminent sexual abuse, will be handled as an emergency grievance, and be forwarded to the chief executive officer immediately.

Interviews, Document Review, Site Tour:
The emergency grievance policy does not include the provision under 115.352(f)(2), which requires that immediate corrective action be taken and shall provide an initial response within 48 hours, and final agency decision within five calendar days. The initial response and final agency decision shall document the agency's determination, whether the resident is in substantial risk of imminent sexual abuse, and the action taken in response. Staff were aware of their responsibilities when a resident submitted a grievance concerning sexual abuse or sexual harassment, but also reported that no grievances had been filed during this review period. Youth residents were aware that there is a grievance procedure, but were unaware there were special rules for filing alleging sexual abuse or sexual harassment. Most said that sexual

abuse/harassment situations are not an issue at the facility.

Corrective Action:
Add the language from 115.352(f)(2) to the grievance procedure, educate staff and youth on the procedure, and document such education.

Completed:
Documentation has been provided to show that the grievance procedure has been modified to include the missing information. The information has been provided to both staff and residents. There were no grievances submitted during this review period. This standard is satisfied.

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.

Policy Review:
PREA policy 14M, section E. outlines how a youth who believes he was the victim of a sexual assault, or a potential sexual assault, or he believes another youth was the victim of a sexual assault, may choose to report the incident to someone outside of the facility. Youth are authorized to call Children's Protected Services or the Marquette Women's Center Sexual Assault Crisis Line. The policy outlines the rules for confidentiality if at any time a youth discloses information about sexual abuse. The facility has provisions to provide residents with reasonable and confidential access to their attorney, parents, and guardians.

Interviews, Document Review, Site Tour:
The facility successfully entered into an MOU with the Harbor House crisis center, which provides that residents who were the victims of sexual violence would have access to emotional support via telephone conversations with a counselor or advocate free of charge. During site tour, the auditor observed several posters with toll-free numbers to outside resources. Additionally, when residents arrive to the facility, they are given a copy of the Youth Safety Guide, which contains toll-free numbers for other outside resources. Youth residents were aware of the toll-free numbers and their right to report sex abuse if needed. The auditor dialed the number listed on the toll-free hotline, and got a recording asking to leave a message, which was done. The call was returned a short time later.

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.

Policy Review:
PREA policy 14M outlines that residents are allowed to report sexual abuse of another resident. Also, PREA policy says that residents will receive a copy of the PREA orientation handbook and the Youth Safety Guide. There are instructions in the guide on how to report sexual abuse and sexual assault.

Interviews, Document Review, Site Tour:

The Youth Safety Guide outlines that residents can submit a grievance about sexual abuse on behalf of another resident into the grievance box. The resident can also report sexual abuse on behalf of another resident by submitting a letter or note in the facility mail, or giving the letter/note directly to any staff.

Recommendation:
The auditor suggests increasing the distribution and more prominently display information on third-reports of sexual abuse or sexual harassment. Include information in the literature to parents/guardians, post on bulletin boards in visiting rooms, education areas, on the facility website, etc.

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.

Policy Review:
PREA policy 14M requires all staff to immediately report to the facility director any knowledge, suspicion, or information they receive regarding sexual abuse or sexual harassment, and/or retaliation against residents or staff who report such an incident. The policy also requires the facility to comply with the mandatory child protection law, as outlined in policy 2B. PREA policy also prohibits staff from discussing the details of allegations or incidents beyond the extent needed to maintain safety and security. The policy directs medical and mental health staff to report sexual abuse to supervisors, and to the Department of Human Services. PREA policy provides that the director or designee report the allegation to the victim's parents or guardian.

Interviews, Document Review, Site Tour:
Staff appeared to have a good understanding of their responsibility to report immediately if they had any knowledge, suspicion, or information about an allegation of sexual abuse or sexual harassment. Staff were aware of the prohibition against talking with others without the need to know about any sexual abuse or sexual harassment reports. Staff understood the responsibility to protect reporters and not allow any form of retaliation by youth or staff. Facility staff stated there were no allegations or reports of sexual abuse or sexual harassment during the current review period.

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.

Policy Review:
PREA policy 14M outlines the actions necessary to protect any resident who is subject to substantial risk of imminent sexual abuse.
Interviews, Document Review, Site Tour:
Staff interviewed reported they knew the steps that could be taken if they became aware of a resident in imminent danger of sexual abuse, such as separating the victim from the perpetrator, or placement at another youth home. No resident reported being in imminent danger during this review period.

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.

Policy Review:
PREA policy 14M, section F.10. states that if a report of sexual abuse is received, the facility director must to report to the other facility's director within 72 hours.

Interviews, Document Review, Site Tour:
Facility director reported that no youth had made an allegation of being sexually-abused at another facility during this past review period.

Recommendation:
The auditor recommends that staff review the language in PREA policy 14M, section F.10. and compare it to the language in 115.363. What currently is written is somewhat confusing and could be worded to make it more compatible with the standard, to include a requirement to document that notification was provided.

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.

Policy Review:
PREA policy 14M, section H. outlines that when a report of sexual abuse is received, the first responder is to separate the victim and alleged perpetrator and prevent them from communicating with each other. Responders are required to seal off and protect the area where the assault occurred in order to protect potential evidence. The policy directs that if the assault is alleged to have occurred within the past 96 hours, the victim is to be transported to the hospital for examination. The PREA Coordinated Response Plan directs the first responder to not allow the victim to wash, change clothes, etc. 115.364(a)(4) requires that if the abuse occurred within a time period that would still allow for the collection of physical evidence, staff should ensure the abuser does not take any actions that could destroy physical evidence, such as washing, brushing teeth, changing clothes, defecating, smoking, drinking, or eating. This information is not present in either the PREA policy or the Coordinated Response Plan.

Interviews, Document Review, Site Tour:
Staff were aware of the first responder obligation to separate and keep safe, to protect a potential crime scene, to notify the supervisor, and to report to child protective services. However, though staff were aware of the need to keep the victim from activities which might destroy physical evidence, no mention was made of the need to prevent the perpetrator from doing so.

Corrective Action:
Need to add language to the PREA policy and the first responder's actions listed in the PREA Coordinated Response Plan regarding

protecting and collecting potential evidence from the alleged abuser. Additional training will need to be provided to all staff, and documented.

Completed:
The PREA policy has been updated ad now includes the language that was previously missing. Staff have been given training on the new information. This standard is satisfied.

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.

Policy Review:
PREA policy 14M and attachment 6, PREA Coordinated Response Plan, includes the actions to be taken for first responders, supervisors, administration, the facility director, medical and mental health providers, and investigators. The same information that was missing as noted in 115.364 needs to be added to 115.365 also.

Interviews, Document Review, Site Tour:
Staff were aware of the first responder obligation to separate and keep safe, to protect a potential crime scene, to notify the supervisor, and to report to child protective services. However, though staff were aware of the need to keep the victim from activities which might destroy physical evidence, no mention was made of the need to prevent the perpetrator from doing so.

Recommendation:
The facility does have a written institutional coordinated response plan, but it is incomplete until information noted above is added to the plan. Additional training will need to be provided to all staff, and documented.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Not Applicable

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.

Policy Review:
PREA policy 14M outlines the actions required to protect residents and staff who report sexual abuse, or cooperate with investigations, from retaliation. Policy designates the Program Consultant as the staff member who will monitor the conduct and treatment of residents or staff who report abuse, and residents who were reported to have suffered abuse, for a minimum of 90 days to see if there are any changes that may suggest retaliation.

Interviews, Document Review, Site Tour:
Interview with the Program Consultant indicated that he was aware of his responsibilities to monitor both staff and resident victims for a minimum of 90 days. He also reported that there were no reported incidents to monitor during the current review period. The auditor did provide sample monitoring forms for their use.

Standard 115.368 Post-allegation protective custody

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Not Applicable

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.

Policy Review:
The PREA policy, 14M, outlines clearly the steps to be taken should there ever be a report of sexual abuse or sexual harassment. The facility has staff who are trained and capable of conducting administrative investigations, and the policy is clear that any criminal investigation will be referred to the Luce County Sheriff's office for investigation.

Interviews, Document Review, Site Tour:
The facility has done a great job of creating MOU's with the Luce County Sheriff, who have signed the document and agreed to conduct criminal investigations using investigators who have received special training in child sexual abuse. Although there were no sexual abuse or sexual harassment cases reported during this review period, the facility appears to stand ready, should such an event occur. The auditor attempted to contact the investigator from the Luce County Sheriff's office for interview, but was unsuccessful. In the MOU, TF Homes agrees to: cooperate fully with policy investigators; not terminate an investigation solely because the source of the allegation recants the allegation; make every effort to protect evidence and incident scenes; and gather and preserve direct and circumstantial evidence. The Luce County Sheriff's Office agrees to: promptly, thoroughly, and objectively investigate allegations of sexual abuse at TF Homes as requested; utilize investigators who have received special training in sexual abuse investigations involving juvenile victims; follow Luce County Sheriff Department investigatory protocols during the investigation; and make effort to share information about the progress of any investigation with TF Homes, with a report that includes a description of the evidence and the investigative facts and findings.

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.

Policy Review:
PREA policy 14M, section J.1.c. outlines that the agency imposes a standard of a preponderance of the evidence or lower as the standard of proof for determining whether allegations of sexual abuse or sexual harassment are substantiated.

Interviews, Document Review, Site Tour:
There were no reports of sexual abuse or sexual harassment to substantiate during the review period.

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.

Policy Review:
PREA policy 14M, section J.2.b. The policy meets all the criteria listed in the PREA standard.

Interviews, Document Review, Site Tour:
The Program Consultant indicated that the steps are in place, but there were no reports of sexual abuse or sexual harassment in the past review period.

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.

Policy Review:
PREA policy 14M, section J.1.a. outlines that staff are subject to disciplinary sanctions, up to and including termination for violating sexual abuse or sexual harassment policies. However, the policy does not state that termination shall be the presumptive disciplinary sanction for staff who have engaged in sexual abuse, as required by 115.376(b); nor does the policy direct that staff who were terminated for violations of the agency's sexual abuse or sexual harassment policies, or staff who resigned in lieu of termination, shall be reported to law enforcement agencies (unless the activity was clearly not criminal), as stated in 115.376(d).

Interviews, Document Review, Site Tour:
The Program Consultant indicated that the steps are in place, but there were no reports of sexual abuse or sexual harassment in the past review period.

Corrective Action:
Need to add language to the PREA policy regarding termination being the presumptive disciplinary sanction for staff's violations of sexual abuse policies, as well as the requirement to report staff sexual abuse to law enforcement. Additional training will need to be provided to all staff, and documented.

Completed:
Documentation has been provided to show that the missing information has been added to policy. Staff have been made aware of the changes through staff training, through meetings, and through correspondence. This standard has been satisfied.

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.

Policy Review:
PREA policy 14M, section J.1.b. outlines that contractors or volunteers are prohibited from contact with residents. However, the policy does not state that the facility is required to report sexual abuse to law enforcement agencies (unless the activity was clearly not criminal), as stated in 115.377(a).

Interviews, Document Review, Site Tour:
The Program Consultant indicated that the steps are in place, but there were no reports of sexual abuse by contractors or volunteers in the past review period.

Corrective Action:
Need to add language to the PREA policy regarding the requirement to contractor or volunteer sexual abuse to law enforcement. Additional training will need to be provided to all staff, and documented.

Completed:
Documentation was provided to show that the missing information has been added to the policy. There is a very small number of contractors/volunteers who have contact with the residents and they have been provided the information. Future contractor/volunteers who may have contact with receive the information prior to having contact. This standard has been satisfied.

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.

Policy Review:
PREA policy 14M, section J.2.a. reads that "Residents are subject to disciplinary sanctions only pursuant to a formal disciplinary process following an administrative finding that the resident engaged in resident-on-resident sexual abuse."

Interviews, Document Review, Site Tour:
Through interviews, there were no disciplinary sanctions issued, because there were allegations or substantiated cases of resident-on-resident sexual abuse.

Recommendation:
The policy needs to be reviewed and have language added from 115.378(b), (c), (d), (e,), (f) and (g). A formal disciplinary process should be developed and implemented, should the need arise in the future.

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.

Policy Review:
PREA policy 14M, section B.6. requires that residents who disclose any prior victimization during a screening must be offered a follow-up meeting with a medical or mental health practitioner within 14 days. All residents who disclose during screening that they previously perpetrated sexual abuse are offered a follow-up meeting with a mental health practitioner. Referrals must be documented. However, additional information from standard 115.381(c) and (d) needs to be included in the PREA policy.

Interviews, Document Review, Site Tour:
During resident interviews, one resident reported telling staff during the sexual victimization screening, that he had been sexually abused years ago while in the community. The staff member who performs the sexual victimization screening was interviewed and was able to provide documentation where she had held a follow-up meeting with that resident within 14 days.

Corrective Action:
Add language from 115.381(c) and (d) needs in the PREA policy.

Completed:
Documentation has been received to show that the missing information has been added to policy. This standard has been satisfied.

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.

Policy Review:
PREA policy 14M, section F. outlines that if it is believed or determined that a sexual assault occurred, the Program Consultant or supervisor must make immediate arrangements for transport to a facility-designated emergency room for treatment. The victim will be provided mental health assistance and counseling as determined necessary. Treatment is provided without financial cost to the resident.

Interviews, Document Review, Site Tour:
There were no reports of sexual abuse during the review period.

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.

Policy Review:
While some of the provisions of this standard can be found in the PREA policy, others are missing and need to be incorporated, including 115.383(b), (c), (g), and (h).
Interviews, Document Review, Site Tour:
The mental health staff who were interviewed were fairly knowledgeable about the majority of this standard, although there were no reports of sexual abuse during the review period.

Corrective Action:
Add language from 115.383(b), (c), (g), and (h) into PREA policy.

Completed:
Documentation was provided to show that the missing information was added to the facility policy. Staff have been provided training on the required follow up procedures for both victims and perpetrators of sex abuse. This standard is satisfied.

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.

Policy Review:
The facility provided a Sex Abuse Incident Review Form that is to be used at the conclusion of every sexual abuse investigation, except those determined to be unfounded. The form takes into account all of the elements of the standard.

Interviews, Document Review, Site Tour:
An interview with a member of the Incident Review Team revealed that if there were to be an incident needing to be reviewed, the team would meet, go over the facts, and complete the forms, and implement any recommendations from the team. There were no incident review forms provided because there were no reports of sex abuse reported by the residents during the review period.

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.

Policy Review:
The facility did collect uniform data for the survey of sexual violence. The information was provided to the Michigan Department of Human Services and posted on the Michigan.gov website.

Interviews, Document Review, Site Tour:
The auditor was provided with data collected and posted on the State of Michigan DHS website. Pre-audit documentation assigned DHS as the agency. The auditor noted that DHS does comply with this standard, although they cannot be considered the agency considering the nature of the contractual relationship between TF Homes and DHS (see FAQ page on the PRC website under Contracts). TF Homes has no PREA data or information on their website.

Completed:
TF Homes now collects the needed data independent from Michigan DHS and has the information posted on their public website. This standard is satisfied.

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.

Policy Review:
The agency did collect and aggregate the data, and prepared an annual report of its findings. The report did include a comparison from previous years. The agency's report was approved by the agency head and made available on the Department of Human Services website.

Interviews, Document Review, Site Tour:
Interview with the Program Consultant revealed that they had no information to review, since they had no reports of sexual abuse or sexual harassment; thus, no corrective action was needed.

Completed:
TF Homes now collects the needed data independent from Michigan DHS and has the information posted on their public website. This standard is satisfied.

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.

Policy Review:
The agency will ensure that data is collected and securely retained. The data will be aggregated each year and made available to the public. The agency shall maintain sexual abuse data for at least ten years.

Interviews, Document Review, Site Tour:
There has been no data to aggregate, as there have been no occurrences of sexual abuse or sexual harassment during the review period. But the Program Consultant and facility director have assured that if there is data to collect, it will be posted on the DHS website and retained for ten years.

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.

Ray Reno, Auditor — February 14, 2016

Auditor Signature — Date