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| **Prison Rape Elimination Act (PREA) Audit Report**  **Community Confinement Facilities**  **☐ Interim ☒ Final**  **Date of Interim Audit Report:** 6/24/21 **☐ N/A**  *If no Interim Audit Report, select N/A*  **Date of Final Audit Report:** 9/14/21 | | | | | | | | | | |
| **Auditor Information** | | | | | | | | | | |
| **Name:** Todd W. Butler | | | | | | **Email:** Butlerstonehouseauditing@gmail.com | | | | |
| **Company Name:** BSH Auditing | | | | | | | | | | |
| **Mailing Address:** 9099 Lakeside Dr | | | | | | **City, State, Zip:** Perrinton, MI 48871 | | | | |
| **Telephone:** 906-287-0320 | | | | | | **Date of Facility Visit:** May 15-19, 2021 | | | | |
| **Agency Information** | | | | | | | | | | |
| **Name of Agency:** Twin County Community Probation Center, Inc. | | | | | | | | | | |
| **Governing Authority or Parent Agency** *(If Applicable)***:** Click or tap here to enter text. | | | | | | | | | | |
| **Physical Address:** 520 South Main ST. | | | | | | **City, State, Zip:** Three Rivers, MI 49093 | | | | |
| **Mailing Address:** Same | | | | | | **City, State, Zip:** Same | | | | |
| **The Agency Is:** | ☐ Military | | | | | ☐ Private for Profit | | | ☒ Private not for Profit | |
| ☐ Municipal | ☐ County | | | | | ☐ State | | | ☐ Federal | |
| **Agency Website with PREA Information:** TCCPC.net | | | | | | | | | | |
| **Agency Chief Executive Officer** | | | | | | | | | | |
| **Name:** Tom Miles | | | | | | | | | | |
| **Email:** tmiles@tccpc.comcastbiz.net | | | | | | **Telephone:** 269-278-1375 | | | | |
| **Agency-Wide PREA Coordinator** | | | | | | | | | | |
| **Name:** Sean Schmitt | | | | | | | | | | |
| **Email:** sschmitt@tccpc.comcastbiz.net | | | | | | **Telephone:** 269-278-1375 | | | | |
| **PREA Coordinator Reports to:**  Agency Director – Tom Miles | | | | | | **Number of Compliance Managers who report to the PREA Coordinator:**  0 | | | | |
| **Facility Information** | | | | | | | | | | |
| **Name of Facility:** Twin County Community Probation Center, Inc. | | | | | | | | | | |
| **Physical Address:** 520 South Main St | | | | **City, State, Zip:** Three Rivers, MI 49093 | | | | | | |
| **Mailing Address (if different from above):**  Same | | | | **City, State, Zip:** Same | | | | | | |
| **The Facility Is:** | | ☐ Military | | | | | ☐ Private for Profit | | | ☒ Private not for Profit |
| ☐ Municipal | | ☐ County | | | | | ☐ State | | | ☐ Federal |
| **Facility Website with PREA Information:** TCCPC.net | | | | | | | | | | |
| **Has the facility been accredited within the past 3 years?** ☐ Yes ☒ No | | | | | | | | | | |
| **If the facility has been accredited within the past 3 years, select the accrediting organization(s) – select all that apply (N/A if the facility has not been accredited within the past 3 years):**  ☐ ACA  ☐ NCCHC  ☐ CALEA  ☐ Other (please name or describe: Click or tap here to enter text.  ☒ N/A | | | | | | | | | | |
| **If the facility has completed any internal or external audits other than those that resulted in accreditation, please describe:**  Click or tap here to enter text. | | | | | | | | | | |
| **Facility Director** | | | | | | | | | | |
| **Name:** Tom Miles | | | | | | | | | | |
| **Email:** tmiles@tccpc.comcastbiz.net | | | | | **Telephone:** 269-278-1375 | | | | | |
| **Facility PREA Compliance Manager** | | | | | | | | | | |
| **Name:** Sean Schmitt | | | | | | | | | | |
| **Email:** sschmitt@tccpc.comcastbiz.net | | | | | **Telephone:** 269-278-1375 | | | | | |
| **Facility Health Service Administrator** ☒ N/A | | | | | | | | | | |
| **Name:** Click or tap here to enter text. | | | | | | | | | | |
| **Email:** Click or tap here to enter text. | | | | | **Telephone:** Click or tap here to enter text. | | | | | |
| **Facility Characteristics** | | | | | | | | | | |
| **Designated Facility Capacity:** | | | | 102 | | | | | | |
| **Current Population of Facility:** | | | | 59 | | | | | | |
| **Average daily population for the past 12 months:** | | | | 60 | | | | | | |
| **Has the facility been over capacity at any point in the past 12 months?** | | | | ☐ Yes ☒ No | | | | | | |
| **Which population(s) does the facility hold?** | | | | ☐ Females ☐ Males ☒ Both Females and Males | | | | | | |
| **Age range of population:** | | | | 18-80 | | | | | | |
| **Average length of stay or time under supervision** | | | | 120-150 | | | | | | |
| **Facility security levels/resident custody levels** | | | | All one level, minimum security | | | | | | |
| **Number of residents admitted to facility during the past 12 months** | | | | | | | | 196 | | |
| **Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for *72 hours or more*:** | | | | | | | | 150 | | |
| **Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for *30 days or more:*** | | | | | | | | 115 | | |
| **Does the audited facility hold residents for one or more other agencies (e.g. a State correctional agency, U.S. Marshals Service, Bureau of Prisons, U.S. Immigration and Customs Enforcement)?** | | | | | | | | ☐ Yes ☒ No | | |
| **Select all other agencies for which the audited facility holds residents: Select all that apply (N/A if the audited facility does not hold residents for any other agency or agencies):** | | | ☐ Federal Bureau of Prisons  ☐ U.S. Marshals Service  ☐ U.S. Immigration and Customs Enforcement  ☐ Bureau of Indian Affairs  ☐ U.S. Military branch  ☐ State or Territorial correctional agency  ☐ County correctional or detention agency  ☐ Judicial district correctional or detention facility  ☐ City or municipal correctional or detention facility (e.g. police lockup or city jail)  ☐ Private corrections or detention provider  ☐ Other - please name or describe: Click or tap here to enter text.  ☒ N/A | | | | | | | |
| **Number of staff currently employed by the facility who may have contact with residents:** | | | | | | | | 25 | | |
| **Number of staff hired by the facility during the past 12 months who may have contact with residents:** | | | | | | | | 0 | | |
| **Number of contracts in the past 12 months for services with contractors who may have contact with residents:** | | | | | | | | 0 | | |
| **Number of individual contractors who have contact with residents, currently authorized to enter the facility:** | | | | | | | | 0 | | |
| **Number of volunteers who have contact with residents, currently authorized to enter the facility:** | | | | | | | | 0 | | |

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| --- | --- | --- | --- |
| **Physical Plant** | | | |
| **Number of buildings:**  **Auditors should count all buildings that are part of the facility, whether residents are formally allowed to enter them or not. In situations where temporary structures have been erected (e.g., tents) the auditor should use their discretion to determine whether to include the structure in the overall count of buildings. As a general rule, if a temporary structure is regularly or routinely used to hold or house residents, or if the temporary structure is used to house or support operational functions for more than a short period of time (e.g., an emergency situation), it should be included in the overall count of buildings.** | | | 1 |
| **Number of resident housing units:**  **Enter 0 if the facility does not have discrete housing units. DOJ PREA Working Group FAQ on the definition of a housing unit: How is a "housing unit" defined for the purposes of the PREA Standards? The question has been raised in particular as it relates to facilities that have adjacent or interconnected units. The most common concept of a housing unit is architectural. The generally agreed-upon definition is a space that is enclosed by physical barriers accessed through one or more doors of various types, including commercial-grade swing doors, steel sliding doors, interlocking sally port doors, etc. In addition to the primary entrance and exit, additional doors are often included to meet life safety codes. The unit contains sleeping space, sanitary facilities (including toilets, lavatories, and showers), and a dayroom or leisure space in differing configurations. Many facilities are designed with modules or pods clustered around a control room. This multiple-pod design provides the facility with certain staff efficiencies and economies of scale. At the same time, the design affords the flexibility to separately house residents of differing security levels, or who are grouped by some other operational or service scheme. Generally, the control room is enclosed by security glass, and in some cases, this allows residents to see into neighboring pods. However, observation from one unit to another is usually limited by angled site lines. In some cases, the facility has prevented this entirely by installing one-way glass. Both the architectural design and functional use of these multiple pods indicate that they are managed as distinct housing units.** | | | 2 |
| **Number of single resident cells, rooms, or other enclosures:** | | | 0 |
| **Number of multiple occupancy cells, rooms, or other enclosures:** | | | 0 |
| **Number of open bay/dorm housing units:** | | | 8 |
| **Does the facility have a video monitoring system, electronic surveillance system, or other monitoring technology (e.g. cameras, etc.)?** | | | ☒ Yes ☐ No |
| **Has the facility installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology in the past 12 months?** | | | ☐ Yes ☒ No |
| **Medical and Mental Health Services and Forensic Medical Exams** | | | |
| **Are medical services provided on-site?** | | ☐ Yes ☒ No | |
| **Are mental health services provided on-site?** | | ☐ Yes ☒ No | |
| **Where are sexual assault forensic medical exams provided? Select all that apply.** | | ☐ On-site  ☒ Local hospital/clinic  ☒ Rape Crisis Center  ☒ Other (please name or describe: YWCA of Kalamazoo) | |
| **Investigations** | | | |
| **Criminal Investigations** | | | |
| **Number of investigators employed by the agency and/or facility who are responsible for conducting CRIMINAL investigations into allegations of sexual abuse or sexual harassment:** | | | 0 |
| **When the facility received allegations of sexual abuse or sexual harassment (whether staff-on-resident or resident-on-resident), CRIMINAL INVESTIGATIONS are conducted by: Select all that apply.** | | | ☐ Facility investigators  ☐ Agency investigators  ☒ An external investigative entity |
| **Select all external entities responsible for CRIMINAL INVESTIGATIONS: Select all that apply (N/A if no external entities are responsible for criminal investigations)** | ☒ Local police department  ☒ Local sheriff’s department  ☒ State police  ☐ A U.S. Department of Justice component  ☐ Other (please name or describe: Click or tap here to enter text.)  ☐ N/A | | |
| **Administrative Investigations** | | | |
| **Number of investigators employed by the agency and/or facility who are responsible for conducting ADMINISTRATIVE investigations into allegations of sexual abuse or sexual harassment?** | | | 0 |
| **When the facility receives allegations of sexual abuse or sexual harassment (whether staff-on-resident or resident-on-resident), ADMINISTRATIVE INVESTIGATIONS are conducted by: Select all that apply** | | | ☐ Facility investigators  ☐ Agency investigators  ☒ An external investigative entity |
| **Select all external entities responsible for ADMINISTRATIVE INVESTIGATIONS: Select all that apply (N/A if no external entities are responsible for administrative investigations)** | ☒ Local police department  ☒ Local sheriff’s department  ☒ State police  ☐ A U.S. Department of Justice component  ☐ Other (please name or describe: Click or tap here to enter text.)  ☐ N/A | | |

**Audit Findings**

**Audit Narrative (including Audit Methodology)**

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

The certified PREA audit of the Twin County Community Probation Center, Inc. (TCCPC) began in March 2021 with the on-site review concluding 19 May 2021. The purpose of the audit was to determine the agency’s compliance with of the Prison Rape Elimination Act (PREA) as well as compliance with the agency’s agreement to comply with PREA as a condition of their contract to house residents on behalf of the Michigan Department of Corrections.

The lead auditor for this audit was Todd Butler who was assisted by his business partner Janice Butler. Todd received his Department of Justice PREA Auditor Certification in May of 2014. He was recertified in June of 2020. Todd is a 15-year veteran with the Department of Corrections, four-year veteran of workforce development, and 16-year military veteran. Janice is a one-year Corrections veteran and has been assisting on PREA Audits for three years. No additional assistance was provided during this audit.

Audit timeline and contract negations between TCCPC and the audit team began in March of 2020 when TCCPC Executive Director, Tom Miles reached out inquiring about the availability of an audit. After several discussions with the agency, the Audit team concluded they were 6-12 months away from being ready for an audit depending on how quickly they implemented their new PREA compliant policies and practices. A tentative date for the onsite visit was set for early 2021.

A contract was entered into between TCCPC and the audit team on March 9, 2021 with the on-site visit scheduled for May 15-19, 2021. The parties agreed to utilize a digital audit format within the Online Audit System (OAS). The agency began uploading documentation into the OAS in April 2021. The On-Site visit was conducted May 15, 17-19 2021. The Interim Audit Report was provided to the agency on June 24, 2021.

The audit team conducted the initial walk through of the facility on a Saturday in order to keep program disruptions to a minimum and give the audit team an opportunity to see the facility with the maximum number of residents present. This proved to be an excellent method as the team was able to spend an entire day walking through the facility, engaging with residents, and met staff who only worked weekends. The atmosphere was relaxed and staff were welcoming of the audit team’s presence and input.

The facility tour consisted of walkthroughs of the entire facility and facility grounds. The agency operates a single facility, consisting of one building with male residents on one side and female residents on the other separated by an operations center. The administrative section of the building appears to be the newest addition and consists of staff offices, human resources, staff bathrooms, and the facilities IT center. The facility was clean, modern and easy to maneuver through. At first glance, the audit team recognized the physical layout was designed with safety and security in mind. There were limited blind spots, the resident rooms were open and bright, and there appeared to be cameras covering every square inch of the facility.

The tour began with the audit team arriving approximately 35 minutes ahead of schedule. The audit team parked in the visitor’s lot and remained in their car observing the exterior and surroundings of the facility. Within a couple minutes, a staff member approached inquiring why we were there. He stated staff had been watching us on camera since we pulled in. It gave the audit team an immediate sense that the facility was on the ball in regard to security. The audit team was welcomed into the facility and greeted by the agency’s PREA Coordinator. After a few minutes of pleasantries and introductions, the tour of the facility began.

We started the tour in the operations center where the audit team was able to review the capabilities of the facility’s technology. All camera angels were reviewed. No cameras had the ability to see into the restroom or shower areas ensuring the privacy of residents while changing their clothing, bathing, and performing bodily functions. Although the cameras could not record or show video from within the restrooms or shower areas, audio recording was available allowing staff to be alerted if there was a disturbance occurring in an area with no camera footage.

The tour continued throughout the facility and consisted of review the intake area, drug testing restrooms, resident rooms, resident restroom and shower areas, class rooms, visiting areas, dining facility and kitchen, utility closets, mechanical rooms, loading dock, court yards, and concluded with a walkthrough the administrative wing. The modernness of the facility is impressive for a community confinement facility, the nicest facility seen by this audit team yet.

While conducting the tour, the audit team was able to conduct informal interviews with residents and staff in order to get a general feel for the culture of the facility. A couple staff interviewed only worked for the agency on the weekends. Touring the facility on a Saturday afforded the audit team an opportunity to engage staff that would otherwise not have been available. Overall, the staff and residents alike were comfortable and had a willingness to engage with the audit team. All staff interviewed during the tour indicated they worked there because they believe in what the agency is doing regarding services provided to residents and the attitude of rehabilitation that is obviously imbedded within the agency’s overall culture. Residents echoed this sentiment stating this was the best facility they ever been to, for those who have experienced other community confinement settings, or jail.

The tour concluded after approximately five hours. The audit team thanked staff for their time. The agency’s PREA Coordinator confirmed the timeline for the following week.

The following Monday, the audit team arrived at the facility at 0900. Once again, the team was greeted by the agency’s PREA Coordinator. The team was briefly introduced to administrative staff, including the Agency Director, Human Resource Director, Security Director, various security staff, counselors and secretaries. The audit team laid out the agenda for the coming days and requested a list of all staff and residents currently at the facility. The PREA Coordinator provided an alpha roster of all residents currently within the program at TCCPC and the HR Director provided a list of all staff on both day and night shift. The audit team highlighted names at random for targeted interviews.

For resident interviews, the audit team selected 10 random and eight targeted. The targeted were chosen based off information provided to the audit team regarding the demographics of the resident population. Specifically, the facility had only one resident with a physical disability, one who was blind (although only in one eye), and one who identified as gay. These met the minimum requirements for targeted interviews of a facility this size. There were no youthful residents, limited English proficient residents, or transgender/intersex residents present to be interviewed. Therefore, the audit team opted for additional targeted interviews of residents who had reported previous sexual abuse and those with a known cognitive disability, as well as increased the number of random interviews to conduct. Overall, the audit team conducted 18 interviews, two more than required for a facility this size.

The same methodology was used to determine staff interviews. The audit team randomly selected 16 staff to interview, including staff on the night shift. In addition to the random staff interviews, the agency conducted interviews of the Agency Director, the PREA Coordinator, intake staff, first responder staff, staff responsible for retaliation monitoring, sexual abuse incident review panel staff, staff responsible for performing risk screening, and administrative staff.

In addition to residents and staff, the audit team conducted in-person interviews with every volunteer present during the on-site tour. This included medical and mental health volunteers and volunteers responsible for sexual abuse support. Additionally, the audit team spoke with the local rape crises center, local law enforcement, and the local interpretive services center and conducted interviews over the phone. In all, the audit team spent more than 20 hours conducting interviews of staff, residents, and volunteers before, during and after the on-site visit.

The final day of the on-site visit consisted of reviewing and collecting documentation from resident and staff files. This included collecting a complete resident roster and staff roster. Due to the size of the facility, the audit team was able to briefly review the files of every staff and resident. The audit team randomly selected files to have copied in their entirety to review at a later date. Overall, files were detailed, complete, and contained the documentation one would expect of a facility achieving PREA compliance.

The on-site tour concluded with a brief exit interview with the Agency Director and PREA Coordinator. The audit team covered general areas in need of improvement, laid out the timeline for the remainder of the audit process, and thanked everyone for their time, efforts, and willingness to implement PREA in order to ensure the continued safety of the residents placed in their care.

The interim audit report was completed on June 23, 2021. After a thorough review of the report by the audit team, it was provided to the agency on June 25, 2021 with findings of **six** (6) exceeding the standard, **five** (5) not meeting the standard, and the remainder meeting the standard. The audit team discussed the standards not met with the agency, outlined a pathway to compliance and set a deadline to meet those requirements of Tuesday, December 21, 2021.

**Facility Characteristics**

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

Established in 1979 the Twin County Community Probation Center (TCCPC) is a private, nonprofit corporation which contracts with the Michigan Department of Corrections and its affiliates to provide community-based probation residential and housing services. The purpose of TCCPC is to provide residents with a secure and safe environment. One that promotes accountability, instills responsibility, and affords the opportunity to gain access to the services needed to assist them in addressing deficit behaviors, thereby developing the skills necessary in getting their lives back on track, become a contributing member of their community and get back to their families where they belong.

The agency’s target population is non-violent offenders who, without program intervention, would spend their sentences in prison or jail. The goal is to work with residents to establish individual plans addressing deficit behaviors, coupled with helping the resident establish future goals and plans of action.

The agency operates a single facility located at 520 S. Main St, Three Rivers, Michigan. The agency came into existence renting space from a local Catholic Church, later purchased their own building which has since become unusable, and currently resides in a newly renovated space they purchased in 2016. The new facility is modern and loaded with technological support to aid in resident safety and success. The facility is capable of housing more than 100 residents, but due to COVID limitations, is operating at less than half their capacity. The facility consists of 8 rooms each consisting of 6-15 beds per room. The population of the facility consists of both male and female residents ranging in age from 18-80. The average length of stay for a resident is approximately 120-150 days. Over the past year, the agency has accepted 115 residents with an average daily population of 60.

The facility is operated by its 25 full-time staff, and several part-time staff. The agency does not employ medical or mental health staff, educators, or investigatory staff. Instead, the agency depends on volunteers and local law enforcement from the community to fulfill resident needs in these areas.

Regarding PREA compliance, the facility is specifically designed, in regard to its physical construction, with security in mind. The flow of the building allows easy access for staff to physically and visually inspect the entire facility, either in person or via the vast camera system. The atmosphere within the facility is specifically designed with rehabilitation in mind, from the color choices on the walls to the open format allowing limited opportunity for misconduct. This all ensures the sexual safety of the residents while residing with TCCPC.

The small size of the facility allows the agency to operate with a small staff. This awards the agency to virtue of being picky with the staff they hire ensuring they get the highest-level professionals who want to work in this field. After spending just a few days at the facility engaging with residents and staff, it is apparent to the audit team that the agency is successful in its mission and goals.

**Summary of Audit Findings**

*The summary should include the number and list of standards exceeded, number of standards met, and number and list of standards not met.*

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

**Standards Exceeded**

**Number of Standards Exceeded:** 5

**List of Standards Exceeded:** 115.211, 115.217, 115.218, 115.241, 115.253

**Standards Met**

**Number of Standards Met:** 37

**Standards Not Met**

**Number of Standards Not Met:** Click or tap here to enter text.

**List of Standards Not Met:** Click or tap here to enter text.

**PREVENTION PLANNING**

**Standard 115.211: Zero tolerance of sexual abuse and sexual harassment; PREA coordinator**

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

**115.211 (a)**

* Does the agency have a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment? ☒ Yes ☐ No
* Does the written policy outline the agency’s approach to preventing, detecting, and responding to sexual abuse and sexual harassment? ☒ Yes ☐ No

**115.211 (b)**

* Has the agency employed or designated an agency-wide PREA Coordinator? ☒ Yes ☐ No
* Is the PREA Coordinator position in the upper-level of the agency hierarchy? ☒ Yes ☐ No
* Does the PREA Coordinator have sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards in all of its facilities? ☒ Yes ☐ No

**Auditor Overall Compliance Determination**

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

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

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

**Instructions for Overall Compliance Determination Narrative**

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

.211(a) Agency policy, titled “Employee Policy and Procedure Manual-PREA Policy and Procedures” clearly and plainly states “TCCPC is committed to zero (0) tolerance for sexual misconduct between staff, volunteers, contractors, visitors, or residents whether committed by staff, volunteers, contractors, visitors, or other residents.” It further states that any sexual misconduct whether consensual or not is strictly prohibited and disciplinary and/or criminal charges may occur if at the appearance of any sexual contact has been made.

The PREA Policy outlines any case with the appearance of sexual contact prompts intervention including investigations resulting in disciplinary actions including the criminal prosecution when and where appropriate.

The policy requires staff to follow the agency’s PREA Policy, required training on sexual abuse and harassment prevention and detection as well as responsibilities in the detection, prevention, response, and reporting of alleged sexual abuse and sexual harassment.

.211(b) Agency policy requires the employment of a full-time staff member, designated by the Executive Director, as the PREA Coordinator/PREA Manager who reports directly to the Program Director. The Program Director is the number 2 person in the overall chain-of-command within the organization. Seeing as the PREA Coordinator/PREA Manager is only one-step removed from the agency’s top personnel (Executive Director), the auditor is assured the PREA Coordinator/PREA Manager is clearly an upper-level employee with agency wide oversight. Furthermore, he has a direct hand in the development and implementation of the agency’s PREA prevention efforts, including policy and training development, demonstrating he has sufficient time and authority to perform his duties as the PREA Coordinator/PREA Manager appropriately.

Based upon the detailed policy and subsequent procedure, along with a thorough review of staff and resident files, coupled with thorough discussions with staff, residents, and volunteers, it is clear to the audit team that TCCPC has not only mandated through policy and rule, but established a culture of zero tolerance for sexual misconduct within its facility and throughout its agency. Furthermore, the agency strictly prohibits any form of sexual contact, consensual or otherwise, further contributing to its ability to detect and respond to sexual abuse should it occur.

Based off the details outlined above, the auditor believes the agency has successfully developed a culture of protection for its residents in all aspects of resident safety, including sexual safety, and has gone beyond the minimum requirements to be found compliant with this standard. Therefore, the audit team has determined the agency has exceeded the standard.

**Standard 115.212: Contracting with other entities for the confinement of residents**

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

**115.212 (a)**

* If this agency is public and it contracts for the confinement of its residents with private agencies or other entities including other government agencies, has the agency included the entity’s obligation to comply with the PREA standards in any new contract or contract renewal signed on or after August 20, 2012? (N/A if the agency does not contract with private agencies or other entities for the confinement of residents.) ☐ Yes ☐ No ☒ NA

**115.212 (b)**

* Does any new contract or contract renewal signed on or after August 20, 2012 provide for agency contract monitoring to ensure that the contractor is complying with the PREA standards? (N/A if the agency does not contract with private agencies or other entities for the confinement of residents.) ☐ Yes ☐ No ☒ NA

**115.212 (c)**

* If the agency has entered into a contract with an entity that fails to comply with the PREA standards, did the agency do so only in emergency circumstances after making all reasonable attempts to find a PREA compliant private agency or other entity to confine residents? (N/A if the agency has not entered into a contract with an entity that fails to comply with the PREA standards.) ☐ Yes ☐ No ☒ NA
* In such a case, does the agency document its unsuccessful attempts to find an entity in compliance with the standards? (N/A if the agency has not entered into a contract with an entity that fails to comply with the PREA standards.) ☐ Yes ☐ No ☒ NA

**Auditor Overall Compliance Determination**

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

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

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

**Instructions for Overall Compliance Determination Narrative**

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

The agency currently does not contract with any other entity for the confinement of its residents.  Therefore, functionally speaking, this standard does not apply to the audit.  However, the agency has put into place a requirement for any contracted entity, should one ever occur, any contract shall include the provisions of this standard.  Due to the fact the agency has demonstrated its ability to plan ahead and actively implement policy language and requirements to adhere to this stand if/when the time comes that they need to enter into such contracts, the auditor is sufficiently convinced the agency would be in full compliance with this standard. Because “does not apply” is not an option and the audit team believes the agency would be fully compliant if they had such contracts, the audit team finds the facility meets the standard.

**Standard 115.213: Supervision and monitoring**

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

**115.213 (a)**

* Does the facility have a documented staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse?
* ☒ Yes ☐ No In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: The physical layout of each facility? ☒ Yes ☐ No
* In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: The composition of the resident population? ☒ Yes ☐ No
* In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: The prevalence of substantiated and unsubstantiated incidents of sexual abuse? ☒ Yes ☐ No
* In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Any other relevant factors? ☒ Yes ☐ No

**115.213 (b)**

* In circumstances where the staffing plan is not complied with, does the facility document and justify all deviations from the plan? (N/A if no deviations from staffing plan.) ☐ Yes ☐ No ☒ NA

**115.213 (c)**

* In the past 12 months, has the facility assessed, determined, and documented whether adjustments are needed to the staffing plan established pursuant to paragraph (a) of this section? ☒ Yes ☐ No
* In the past 12 months, has the facility assessed, determined, and documented whether adjustments are needed to prevailing staffing patterns? ☒ Yes ☐ No
* In the past 12 months, has the facility assessed, determined, and documented whether adjustments are needed to the facility’s deployment of video monitoring systems and other monitoring technologies? ☒ Yes ☐ No
* In the past 12 months, has the facility assessed, determined, and documented whether adjustments are needed to the resources the facility has available to commit to ensure adequate staffing levels? ☒ Yes ☐ No

**Auditor Overall Compliance Determination**

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

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

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

**Instructions for Overall Compliance Determination Narrative**

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

.213(a) Agency policy, titled “Employee Policy and Procedure Manual-Prevention Planning” requires the TCCPC PREA Coordinator assist the facility with the development and documentation of its staffing plan. The policy requires the insurance that levels of supervision are adequate enough to ensure residents are safe from sexual abuse. Determinations of adequate staffing, per the policy, are based upon the physical layout of the facility, composition of the residents currently housed at the facility, the prevalence of substantiated and unsubstantiated incidents of abuse, and other salient issues. Furthermore, the policy outlines the staffing plan will address the agency’s development of video monitoring systems and other monitoring technologies.

During the onsite visit, the audit team inquired of several residents whether they believed the staffing levels were adequate to ensure their safety. All residents indicated they see staff constantly throughout the facility and the video/audio technology available allows for constant monitoring and/or listening of every inch of the facility. The physical layout of the facility was designed in a way residents could not hide in blind spots are be otherwise obscured from staff view in all areas except the bath/shower rooms.

.213(b) The agency has indicated that the staffing plan is never deviated from. The agency requires all staff to remain on assignment until properly relieved and has implemented a pager duty program establishing on-call staff who cover for instances of call-ins or no-shows. The process guarantees the staffing plan is fully complied with each and every shift. While conducting staff interviews, the audit team was assured the facility is fully staffed on each and every shift. All staff were aware of the call-in procedure and the pager duty process. It was determined that supervisory staff were the one’s assigned the page duty on a rotational basis and every supervisor interviewed indicated they were willing and able to cover shifts for “line staff” when necessary.

It was apparent from talking with staff throughout the facility visit that everyone working for TCCPC was there because they wanted to be there and call-ins were not an issue. A review of the facility’s staffing reports indicated there were no deviations from their staffing plan. Furthermore, the facility routinely has more staff on than what is required their contract with the Michigan Department of Corrections.

.213(c) Agency policy requires the agency’s staffing plan undergo a review by the TCCPC PREA Coordinator at least annually to ensure staffing patterns are adequate, if other technologies are needed or necessary, and the estimated cost of adding staff or technology to the facility.

The agency has completed their annual staffing plan for calendar year 2021. Considering this is the first year the facility is working toward full compliance toward PREA and this is their first PREA audit, this is the first time the agency has documented such a review.

Considering the detailed requirement to review their plan outlined in policy and a specific checklist to document such reviews has been implemented, the audit team if fully confident the agency will continue to review and document their staffing plan in accordance with this standard. Therefore, the audit team finds the agency has met this standard.

**Standard 115.215: Limits to cross-gender viewing and searches**

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

**115.215 (a)**

* Does the facility always refrain from conducting any cross-gender strip or cross-gender visual body cavity searches, except in exigent circumstances or by medical practitioners? ☒ Yes ☐ No

**115.215 (b)**

* Does the facility always refrain from conducting cross-gender pat-down searches of female residents, except in exigent circumstances? (N/A if the facility does not have female residents.)

☒ Yes ☐ No ☐ NA

* Does the facility always refrain from restricting female residents’ access to regularly available programming or other outside opportunities in order to comply with this provision? (N/A if the facility does not have female residents.) ☒ Yes ☐ No ☐ NA

**115.215 (c)**

* Does the facility document all cross-gender strip searches and cross-gender visual body cavity searches? ☒ Yes ☐ No
* Does the facility document all cross-gender pat-down searches of female residents? (N/A if the facility does not have female residents). ☒ Yes ☐ No ☐ NA

**115.215 (d)**

* Does the facility have policies that enable residents to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks? ☒ Yes ☐ No
* Does the facility have procedures that enables residents to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks? ☒ Yes ☐ No
* Does the facility require staff of the opposite gender to announce their presence when entering an area where residents are likely to be showering, performing bodily functions, or changing clothing? ☒ Yes ☐ No

**115.215 (e)**

* Does the facility always refrain from searching or physically examining transgender or intersex residents for the sole purpose of determining the resident’s genital status? ☒ Yes ☐ No
* If a resident’s genital status is unknown, does the facility determine genital status during conversations with the resident, by reviewing medical records, or, if necessary, by learning that information as part of a broader medical examination conducted in private by a medical practitioner? ☒ Yes ☐ No

**115.215 (f)**

* Does the facility/agency train security staff in how to conduct cross-gender pat down searches in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs? ☒ Yes ☐ No
* Does the facility/agency train security staff in how to conduct searches of transgender and intersex residents in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs? ☒ Yes ☐ No

**Auditor Overall Compliance Determination**

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

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

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

**Instructions for Overall Compliance Determination Narrative**

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

.215(a) Agency policy, titled “Employee Policy and Procedure Manual-Limits to Cross Gender Viewing and Searches” states the agency prohibits cross-gender pat-downs, strip searches or cross-gender visual body cavity searches. The policy further states “at no time” will a male staff member touch a female resident for any reason outside exigent circumstances and, should such a circumstance occur, it shall be documented. The policy further provides methods of action for the absence of female staff, should this situation occur, that provides a means for ‘searching’ female residents in order to maintain the safety and security of the facility, its residents, and its staff. The policy outlines the following:

1. The female resident will empty their pockets, purse, jacket, etc.
2. The female resident will then clear a metal detector devise to ensure no contraband is present.

Every resident and staff interview confirmed the facility does not allow any type of cross gender searches and no pat searches of female residents by male staff for any reason. If there is ever a reason for male staff to search and female resident it is done so by requiring the resident to empty her pockets, purse, etc. and performing a metal detection scan with a hand held “wand” device. This is a hard and fast rule at the facility that is not deviated from for any reason.

.215(b) As stated above for section (a) of this standard, the agency’s policy strictly prohibits male staff from touching female residents for any reason, absent exigent circumstances, and should such a circumstance present itself, the incident is thoroughly logged. Furthermore, the agency has developed a method to prevent the introduction of contraband into the facility by a female resident, absent a physical search by a female staff member. This process allows a means to ensure every female resident is awarded the opportunity to participate in regularly available programming and other outside opportunities without limitation due to cross-gender searches.

.215(c) Agency policy strictly prohibits conducting cross-gender pat-downs, strip searches, or cross-gender visual body cavity searches. Therefore, considering these incidents are strictly prohibited, it stands to reason there is no need for a policy requiring the logging of such incidents if they should occur. However, the agency has addressed in their policy the need to thoroughly document any incident of a male staff member touching a female resident for any reason. Interviews with staff verified this requirement is common knowledge assuring the audit team incidents would be logged if they ever occurred.

.215(d) The agency’s physical plant and technology are developed in a manner that allows for staff and/or video surveillance of residents at all times and in all locations throughout the facility except in the restroom/shower areas. In order to ensure residents are not in view of opposite gender staff in any state of undress, agency rules require residents to remain clothed at all times and to only shower, perform bodily functions, and change clothing while in the bathroom or shower areas. This prohibits any possibility of non-medical staff from viewing residents in a state of undress.

The same policy also requires staff of the opposite gender to announce their presence when entering a resident bedroom or bathroom. It was clear from the facility visit, and staff and resident interviews, that male staff announce their presence every time they enter the female side of the facility. However, observations made during the visit and information gathered during staff and resident interviews, it was discovered the agency does not enforce the requirement for female staff to announce their presence before entering the living area (room) of male residents. The rationale provided was the agency prohibits female staff from entering the restroom/shower area and therefore should never see a resident in a state of undress. However, it was apparent during resident interviews that many of the male residents routinely changed their cloths in their rooms rather than going to the bathroom/shower area to do so. This is a violation of agency rules, however there appear to be no repercussions for residents do so rendering the rule ineffective.

While conducting interviews with residents, 100% of them indicated they have never been in the presence of opposite gender staff while in a state of undress. However, in order to fully comply with this standard, the agency must enforce its rule to require opposite gender staff to announce their presence for both male and female staff. The audit team addressed this issue with the agency’s Program Director who assured the audit team this practice will be immediately implemented.

In order to come into compliance with this standard the agency needs to demonstrate the requirement of opposite gender staff announcing their presence has been sufficiently communicated to all staff. This can be accomplished by conducting staff training or a documented distribution of the rule provided to 100% of the staff with a signature verifying staff have read and are aware of the requirement to announce their presence before entering the living area (rooms) of opposite gender residents.

.215(e) Agency policy strictly prohibits staff from searching or physically examining a suspected transgender or intersex resident for the sole purpose of determining the resident’s genital status. If the resident’s genital status is unknown, it may be determined through conversations with the resident.

The agency has indicated they do not have the resources readily available to meet the needs of this population therefore does not accept transgender or intersex residents in the program.

.215 (f) The agency does not allow male staff to perform any sort of searches of female residents. They have a detailed process in place for staff to perform searches of females, when necessary, in order to prevent restricting female residents from participating in any activities should a female staff member not be readily available. This process has been detailed in the auditor’s response to subsection (a) above.

However, the agency has not implemented a cross-gender training policy to cover those emergent incidents that may arise. Furthermore, by the use of the term “The agency shall train…,” this portion of the standard requires the agency to sufficiently train, at a minimum, security staff in this practice of appropriately conducting cross-gender searches. In order to come into full compliance with this portion of the standard, the agency must provide sufficient training to security staff and provide the audit team with the training material and signed documentation that all security staff have completed the training. The audit team has provided a link (below) that the agency could use to meet this standard.

<https://www.bing.com/videos/search?q=cross+gender+pat+down+search+training+video&docid=607994153166911582&mid=91BB80191F59B056BB1091BB80191F59B056BB10&view=detail&FORM=VIRE>

For these reasons mentioned above in sub-sections (d) and (f), the audit team has found the agency does not meet the standard.

Post Interim Report Update:

During the corrective action period the agency successfully compiled and completed the necessary training to achieve fully compliance with this standard. Specifically, the agency added language to their policy (PREA Standard), section 4 “Limits to cross-gender viewing and searches” that requires all staff to announce their presence before entering resident bedrooms and bathrooms of the opposite gender. Furthermore, they provided training on this topic with all staff and required they sign acknowledgement of the requirement. The agency provided the audit team with a completed signature sheet of every staff member signing acknowledgment of the requirement.

The agency also utilized the training video provide by the audit team as a tool to address the proper method of conducting cross-gender searches. Although the agency continues to prohibit cross-gender searches of any kind, this training provides staff with sufficient understanding of how to conduct such searches if required to do so in an emergent circumstance. Again, the agency required staff to sign acknowledgement of receipt of and understanding of the training and provided that documentation to the audit team.

Due to the efforts of the agency and the above referenced documentation provided to the audit team, the agency now meets this standard.

**Standard 115.216: Residents with disabilities and residents who are limited English proficient**

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

**115.216 (a)**

* Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency’s efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who are deaf or hard of hearing? ☒ Yes ☐ No
* Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency’s efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who are blind or have low vision? ☒ Yes ☐ No
* Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency’s efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have intellectual disabilities? ☒ Yes ☐ No
* Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency’s efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have psychiatric disabilities? ☒ Yes ☐ No
* Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency’s efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have speech disabilities? ☒ Yes ☐ No
* Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency’s efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Other? (if "other," please explain in overall determination notes.) ☒ Yes ☐ No
* Do such steps include, when necessary, ensuring effective communication with residents who are deaf or hard of hearing? ☒ Yes ☐ No
* Do such steps include, when necessary, providing access to interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary? ☒ Yes ☐ No
* Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Have intellectual disabilities? ☒ Yes ☐ No
* Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Have limited reading skills? ☒ Yes ☐ No
* Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Are blind or have low vision? ☒ Yes ☐ No

**115.216 (b)**

* Does the agency take reasonable steps to ensure meaningful access to all aspects of the agency’s efforts to prevent, detect, and respond to sexual abuse and sexual harassment to residents who are limited English proficient? ☒ Yes ☐ No
* Do these steps include providing interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary? ☒ Yes ☐ No

**115.216 (c)**

* Does the agency always refrain from relying on resident interpreters, resident readers, or other types of resident assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the resident’s safety, the performance of first-response duties under §115.264, or the investigation of the resident’s allegations? ☒ Yes ☐ No

**Auditor Overall Compliance Determination**

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

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

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

**Instructions for Overall Compliance Determination Narrative**

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

.216(a) Agency policy, titled “Employee Policy and Procedure Manual-Residents with Disabilities and who are Limited English Proficient” clearly states TCCPC shall take any and all necessary steps to ensure those who poses disabilities or are limited English proficient have sufficient 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. The policy goes on to list efforts the agency is committed to, including making available appropriate and effective interpreter and/or translator services and requiring staff to read aloud written documentation for those who need it.

The agency has provided a statement in Spanish, the most likely non-English language to present itself among its residents, on all PREA related posters, flyers, and the TCCPC Offender PREA Acknowledgement form stating TCCPC will provide a translator or interpreter if needed.

The agency requires all staff to undergo training titled “Deaf and Hard of Hearing” as well as “Disability Awareness for Offenders (ADA).” These training modules, collectively, sufficiently address the requirements of this standard.

While conducting the facility tour, the audit team noticed sufficient signage throughout the facility that detailed the agency’s efforts to ensure the sexual protection of its residents along with details on how to ask for assistance if needed in order to take advantage of the facility’s efforts. Furthermore, during intake, staff read aloud the agency’s efforts to keep them safe ensuring everyone entering the facility is aware of the resources available to them.

Interviews with staff and residents demonstrated that 100% had a least minimal knowledge of who when to report sexual abuse and/or harassment, the resources available and how to access them, and that any sexual conduct, consensual or otherwise, was strictly forbidden.

.216(b) As articulated in the auditor’s response to section (a) above, the agency has sufficiently addressed this requirement within its policy. Upon conducting detailed interviews with the PREA Coordinator and other upper-level management staff, all are aware of the requirement to provide interpreter services when necessary. The interpreter services the agency utilizes are the same services the local courthouse uses for hearings conducted in languages other than spoken English. Those services are provided by Enlaces Language Solutions, LLC. The audit team reached out to Enlaces and verified they are available and willing to provide services when necessary. The agency is committed to procuring these services whenever necessary to address the needs of non- or limited-English speaking/comprehending residents. However, as of this audit, the agency has not needed to procure interpreter services for any reason.

.216(c) Agency policy, titled “Employee Policy and Procedure Manual” strictly prohibits the use of resident interpreters, resident readers, or other types of resident assistance except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the resident’s safety, the performance of first-responders, or investigative duties.

Upon conducting staff interviews, it was determined that the facility would rely on other residents to act as interpreters in limited circumstances and only if necessary to address emergent situations or where delay in procuring services may cause harm to a resident. The facility utilizes a “see and say” type of card titled “Language Identification Flashcard” provided on the Census Bureau website that has simple phrases printed on a large laminated sheet in 38 different languages. The intent of this tool is to show it to someone who is non-English speaking and they can point to the phrase they understand in order for the agency to determine the language they need to have interpreted. Although this is not required by the standards in any way, it was another example of how the facility goes above and beyond to meet the needs of their residents.

Reviewing policy, interviewing staff, and making contact with the interpreter services program provided by the agency, the audit team is fully confident of the agency’s ability and willingness to provide these services whenever necessary. Although the need has yet to arise requiring the agency to provide documentation to demonstrate compliance, they have taken steps above and beyond what is required. Therefore, the audit team finds the agency meets this standard.

**Standard 115.217: Hiring and promotion decisions**

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

**115.217 (a)**

* Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997)? ☒ Yes ☐ No
* Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse? ☒ Yes ☐ No
* Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has been civilly or administratively adjudicated to have engaged in the activity described in the question immediately above? ☒ Yes ☐ No
* Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997)? ☒ Yes ☐ No
* Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse? ☒ Yes ☐ No
* Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has been civilly or administratively adjudicated to have engaged in the activity described in the question immediately above? ☒ Yes ☐ No

**115.217 (b)**

* Does the agency consider any incidents of sexual harassment in determining whether to hire or promote anyone who may have contact with residents? ☒ Yes ☐ No
* Does the agency consider any incidents of sexual harassment in determining whether to enlist the services of any contractor, who may have contact with residents? ☒ Yes ☐ No

**115.217 (c)**

* Before hiring new employees who may have contact with residents, does the agency: Perform a criminal background records check? ☒ Yes ☐ No
* Before hiring new employees who may have contact with residents, does the agency, consistent with Federal State, and local law: Make its best efforts to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse? ☒ Yes ☐ No

**115.217 (d)**

* Does the agency perform a criminal background records check before enlisting the services of any contractor who may have contact with residents? ☒ Yes ☐ No

**115.217 (e)**

* Does the agency either conduct criminal background records checks at least every five years of current employees and contractors who may have contact with residents or have in place a system for otherwise capturing such information for current employees? ☒ Yes ☐ No

**115.217 (f)**

* Does the agency ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in written applications or interviews for hiring or promotions? ☒ Yes ☐ No
* Does the agency ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in any interviews or written self-evaluations conducted as part of reviews of current employees? ☒ Yes ☐ No
* Does the agency impose upon employees a continuing affirmative duty to disclose any such misconduct? ☒ Yes ☐ No

**115.217 (g)**

* Does the agency consider material omissions regarding such misconduct, or the provision of materially false information, grounds for termination? ☒ Yes ☐ No

**115.217 (h)**

* Does the agency provide information on substantiated allegations of sexual abuse or sexual harassment involving a former employee upon receiving a request from an institutional employer for whom such employee has applied to work? (N/A if providing information on substantiated allegations of sexual abuse or sexual harassment involving a former employee is prohibited by law.) ☒ Yes ☐ No ☐ NA

**Auditor Overall Compliance Determination**

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

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

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

**Instructions for Overall Compliance Determination Narrative**

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

.217(a)(b) Agency policy, titled “Employee Policy and Procedure Manual-Hiring and Promotion” specifically details the agency will not hire anyone who has engaged in abuse within a confinement facility of any kind, has been convicted of engaging or attempting to engage in forceable sexual activity in the community, has been civilly or administratively adjudicated to have engaged in any of the aforementioned activities. Furthermore, the policy clearly states the agency shall consider any incident of sexual harassment in determining whether to hire or promote anyone, or enlist contractual services when resident contact may be present.

Agency employment applications ask applicants directly about this behavior on the applications ensuring they capture any instances of abuse or harassment prior to making any offer of employment. Furthermore, the agency indicates on their applications that any omission of such information shall result in termination.

.217(c)(d) Agency policy, titled “Employee Policy and Procedure Manual” specifically states, before hiring new employees who may have resident contact, the agency shall conduct criminal background checks and make its best effort, consistent with local, State, and Federal law, to contact all prior institutional employers for information about any allegations of, or resignations in lieu of sexual abuse or harassment while employed with the institutional employer. Agency policy requires these same efforts before enlisting any contractual services if the contractor may have contact with residents.

Consistent with their own policy, and as a requirement within their contract with the Michigan Department of Corrections (MDOC), the Agency requests from the MDOC a scan of every employee’s criminal history through the Law Enforcement Information Network (LEIN). A LEIN check discloses any and all involvement with law enforcement. The MDOC has authorized persons available to run LEIN checks for facilities they contract with. The MDOC is a PREA compliant state agency who requires these checks annually of their contracted facilities in order to remain compliant with the PREA standards themselves. Short of a 27/7 live scan, this audit team cannot think of a more thorough method of ensuring the agency keeps close watch of their existing and newly hired staff.

A thorough review of staff files verified that every staff member currently employed with the agency had a LEIN check completed within the past 12 months. Furthermore, every employee whose employment with the facility was greater than 2 years had multiple LEIN check verifications in their file demonstrating the agency is requesting from and receiving LEIN checks on their staff on an annual basis.

.217(e) Agency policy Agency policy, titled “Employee Policy and Procedure Manual” requires the conduction of either criminal background checks or other means of capturing this information at least every 5 years. The agency contracts with the Michigan Department of Corrections (MDOC) who require annual Law Enforcement Information Network (LEIN) checks be run on all employees of contracted facilities. The MDOC conducts the LEIN checks on behalf of the contracted facility but the facility needs to provide lists of employees (and new hires) for the MDOC to run. There is a standardized form the agency utilizes to track this process and the form is retained by the HR manager at the agency. A review of employee files verified that every employee does have a LEIN check within the past 12 months and any employee with 2 or more years with the agency has multiple.

.217(f)(g) Agency policy states it shall ask all applicants and employees who may have contact with residents directly about previous misconduct regarding sexual abuse and sexual harassment outlined in this standard. The policy states this is conducted in applications for new hires or interviews for new hires and promotions. The policy also requires the agency to request this information through interviews or self-evaluations of current employees. The policy also imposes upon its employees and contractors the continuing requirement to disclose such misconduct. Furthermore, agency policy clearly states any material omission or materially false information shall be grounds for termination from employment.

In addition to policy, job applications clearly state any omission of information on the application shall result in termination. A review of employee files verifies the actual applications completed by current employees has the required language on the application. Furthermore, the audit team verified during employee interviews that they were well aware of the requirement to disclose such information, that they have a continuous requirement to report such information, and that failure to do so may result in termination of their employment.

The agency as met every aspect of this standard and goes well beyond the requirement of conducting background checks once every five years by conducting LEIN checks annually. For this reason, the audit team has determined the agency exceeded this standard.

**Standard 115.218: Upgrades to facilities and technologies**

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

**115.218 (a)**

* If the agency designed or acquired any new facility or planned any substantial expansion or modification of existing facilities, did the agency consider the effect of the design, acquisition, expansion, or modification upon the agency’s ability to protect residents from sexual abuse? (N/A if agency/facility has not acquired a new facility or made a substantial expansion to existing facilities since August 20, 2012, or since the last PREA audit, whichever is later.) ☒ Yes ☐ No ☐ NA

**115.218 (b)**

* If the agency installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology, did the agency consider how such technology may enhance the agency’s ability to protect residents from sexual abuse? (N/A if agency/facility has not installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology since August 20, 2012, or since the last PREA audit, whichever is later.) ☒ Yes ☐ No ☐ NA

**Auditor Overall Compliance Determination**

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

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

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

**Instructions for Overall Compliance Determination Narrative**

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

.218(a) Agency policy, titled “Employee Policy and Procedure Manual-Upgrades to Facilities and Technologies” requires the agency to consider the effect of any design, acquisition, expansion, or modification upon the agency’s ability to protect residents from sexual abuse.

.218(b) The same policy requires the agency to consider how any technology installations or upgrades have an effect on enhancing the agency’s ability to protect residents from sexual abuse.

While conducting the on-site visit, the audit team’s first stop inside the facility was the control center. The audio and video technology was immediately evident by the large screen monitors on the wall showing footage from cameras placed throughout the facility, including resident rooms, hallways, class rooms, conference rooms, utility rooms, kitchen, dining facility, back docks, the parking lots, and outdoor recreation arears. Aside from the bathroom, drug test room, and shower area, every inch of the facility is covered by camera footage. The agency assured the audit team that no cameras were placed in any bathroom/shower area. While touring the facility the audit team took note that every bathroom/shower area, resident and staff, were void of cameras. While reviewing camera footage and capability, it was noted that no cameras were placed at such an angle that one viewing footage from a remote location could gain a view into the bathroom/shower areas ensuring the privacy of residents while changing clothing, showering, or performing other bodily functions. It was noted the agency took full advantage of the technology available to record sound in all areas where cameras were not allowed. When conducing resident interviews, every resident was aware of the facility’s technological abilities and indicated it enhanced their sense of security and safety while at the facility.

During the tour, the audit team gained access to a maintenance room. The room was the location of several of the facility’s mechanicals as well as doubling as dry storage for the kitchen where some of the most desirable food goods were kept, such as soda and candy. The audit team did note that no camera existed within the maintenance room and inquired as to why. The agency indicated this is an area that residents would seldom visit, and only with a staff member. After discussing why such a secluded area may pose a place of opportunity for an assault, including sexual assault could occur, the agency immediately enacted a plan to pace a camera in that location. The camera was installed and functional before the audit team completed the facility visit two days later. This is yet another example of the agency’s commitment to continuously update/upgrade their efforts to ensure the safety of their residents.

Due to the extensive camera and audio technology already installed at the facility, and the agency’s willingness to immediately address any lack of coverage by installing additional cameras within 48 hours, the audit team has found this facility not only takes the safety of its residents seriously, they have invested a significant amount to time, money, and research to ensure their safety. For these reasons, the audit team has found the agency to have exceeded this standard.

**RESPONSIVE PLANNING**

**Standard 115.221: Evidence protocol and forensic medical examinations**

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

**115.221 (a)**

* If the agency is responsible for investigating allegations of sexual abuse, does the agency follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.) ☐ Yes ☐ No ☒ NA

**115.221 (b)**

* Is this protocol developmentally appropriate for youth where applicable? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.) ☐ Yes ☐ No ☒ NA
* Is this protocol, as appropriate, adapted from or otherwise based on the most recent edition of the U.S. Department of Justice’s Office on Violence Against Women publication, “A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents,” or similarly comprehensive and authoritative protocols developed after 2011? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.) ☐ Yes ☐ No ☒ NA

**115.221 (c)**

* Does the agency offer all residents who experience sexual abuse access to forensic medical examinations, whether on-site or at an outside facility, without financial cost, where evidentiarily or medically appropriate? ☒ Yes ☐ No
* Are such examinations performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) where possible? ☒ Yes ☐ No
* If SAFEs or SANEs cannot be made available, is the examination performed by other qualified medical practitioners (they must have been specifically trained to conduct sexual assault forensic exams)? ☒ Yes ☐ No
* Has the agency documented its efforts to provide SAFEs or SANEs? ☒ Yes ☐ No

**115.221 (d)**

* Does the agency attempt to make available to the victim a victim advocate from a rape crisis center? ☒ Yes ☐ No
* If a rape crisis center is not available to provide victim advocate services, does the agency make available to provide these services a qualified staff member from a community-based organization, or a qualified agency staff member? (N/A if agency *always* makes a victim advocate from a rape crisis center available to victims.) ☐ Yes ☐ No ☒ NA
* Has the agency documented its efforts to secure services from rape crisis centers? ☒ Yes ☐ No

**115.221 (e)**

* As requested by the victim, does the victim advocate, qualified agency staff member, or qualified community-based organization staff member accompany and support the victim through the forensic medical examination process and investigatory interviews? ☒ Yes ☐ No
* As requested by the victim, does this person provide emotional support, crisis intervention, information, and referrals? ☒ Yes ☐ No

**115.221 (f)**

* If the agency itself is not responsible for investigating allegations of sexual abuse, has the agency requested that the investigating agency follow the requirements of paragraphs (a) through (e) of this section? (N/A if the agency/facility is responsible for conducting criminal AND administrative sexual abuse investigations.) ☒ Yes ☐ No ☐ NA

**115.221 (g)**

* Auditor is not required to audit this provision.

**115.221 (h)**

* If the agency uses a qualified agency staff member or a qualified community-based staff member for the purposes of this section, has the individual been screened for appropriateness to serve in this role and received education concerning sexual assault and forensic examination issues in general? (N/A if agency *always* makes a victim advocate from a rape crisis center available to victims.) ☐ Yes ☐ No ☒ NA

**Auditor Overall Compliance Determination**

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

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

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

**Instructions for Overall Compliance Determination Narrative**

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.221(a) The agency does not conduct investigations into allegations of sexual abuse or sexual harassment. Rather, the agency has entered into a Memorandum of Agreement (MOA) with the Three Rivers Police Department to conduct all allegations into sexual harassment and sexual abuse and therefore any and all allegations are referred for criminal investigation by Three Rivers Police.

.221(b) This portion of the standard is not applicable to this audit as the agency does not conduct its own investigations.

.221(c) Agency policy, titled “Employee Policy and Procedure Manual-” requires all victims have access to community-based forensic medical examinations at Three Rivers Hospital, the Kalamazoo YMCA, or other free community service that offers examinations by SAFE or SANE certified personnel.

At the time of this audit, there have been no allegations of sexual abuse requiring the agency to ensure the alleged victim received services from SAFE or SANE certified personnel.

.221(d Agency policy, titled “Employee Policy and Procedure Manual-Responsive Planning” requires a victim advocate from a rape crisis center be made available, at no cost to anyone making an allegation of sexual abuse/harassment. Agency policy also requires the crisis center offering the victim advocacy services NOT be are part of the criminal justice system (such as a law enforcement agency).

The agency has partnered with Domestic And Sexual Abuse Services (DASAS) in Three Rivers, Michigan to provide these services. A detailed and lengthy in-person interview with a DASAS and an intern revealed that DASAS is not only capable of providing the services required under PREA, they are capable of offering services to all residents for any trauma related care they may need, sexually related or otherwise. Furthermore, DASAS conducts weekly rounds at the facility. While conducting the interview with DASAS, they assured the audit team that they were more than capable of providing any services requested by the agency 24/7 and without charge to the resident.

.221(e) Agency policy requires the allowance of a victim advocate accompanying and supporting a victim through the forensic examination process, including investigatory interviews and providing emotional support, crisis intervention, information and referrals.

The audit team called 1-800-828-2023 and verified DASAS is willing to provide rape crisis services to residents of Twin County Probation Center. An in-person interview with representatives from the agency verified they are willing and able to provide all the necessary services for TCCPC to be fully complaint with this standard.

.221(f) The agency has elected to refer each and every allegation of sexual abuse or harassment to an outside law enforcement agency for investigation. The agency has entered into a signed agreement (Memorandum of Agreement) with the Three Rivers Police Department to conduct these services. The MOU was signed by the Three Rivers Police Chief, Chief Bringman, and Twin County Community Probation Center Director, Tom Miles. The MOU specifically states the Three Rivers Police Department will fully investigate all sexual abuse complaints in accordance with PREA Standards 115.221 and 115.234.

.221(g) The agency being audited is not a State entity or Department of Justice component. Therefore, this portion of the standard is not applicable to this audit.

There have been no allegations of sexual abuse occurring at this facility. Therefore, the agency has no documentation available to demonstrate compliance other than the Memorandum of Agreement with Three Rivers Police, verification by the audit team that outside services are ready and available to provide services if and when needed, detailed policy requirements implemented meeting the tenants of this standard and awareness of staff to provide such services. For these reasons, the audit team finds the agency meets this standard.

**Standard 115.222: Policies to ensure referrals of allegations for investigations**

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

**115.222 (a)**

* Does the agency ensure an administrative or criminal investigation is completed for all allegations of sexual abuse? ☒ Yes ☐ No
* Does the agency ensure an administrative or criminal investigation is completed for all allegations of sexual harassment? ☒ Yes ☐ No

**115.222 (b)**

* Does the agency have a policy and practice in place to ensure that allegations of sexual abuse or sexual harassment are referred for investigation to an agency with the legal authority to conduct criminal investigations, unless the allegation does not involve potentially criminal behavior? ☒ Yes ☐ No
* Has the agency published such policy on its website or, if it does not have one, made the policy available through other means? ☒ Yes ☐ No
* Does the agency document all such referrals? ☒ Yes ☐ No

**115.222 (c)**

* If a separate entity is responsible for conducting criminal investigations, does the policy describe the responsibilities of both the agency and the investigating entity? (N/A if the agency/facility is responsible for conducting criminal investigations. See 115.221(a).) ☒ Yes ☐ No ☐ NA

**115.222 (d)**

* Auditor is not required to audit this provision.

**115.222 (e)**

* Auditor is not required to audit this provision.

**Auditor Overall Compliance Determination**

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

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

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

**Instructions for Overall Compliance Determination Narrative**

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.222(a)(b) Agency policy, titled “Employee Policy and Procedure Manual-Responsive Planning” requires an administrative or criminal investigation be conducted for all allegations of sexual abuse or sexual harassment. Furthermore, the same policy requires all allegations of sexual abuse or harassment be referred for investigation by an agency with the legal authority to conduct criminal investigations. Policy has outlined the agency will refer such allegations to either local law enforcement, the Michigan Department of Corrections, or the Federal Bureau of Prisons.

.222(c) The agency has elected to refer each and every allegation of sexual abuse or harassment to an outside law enforcement agency for investigation. The agency has entered into a signed agreement (Memorandum of Agreement) with the Three Rivers Police Department to conduct these services. The MOU was signed by the Three Rivers Police Chief, Chief Bringman, and Twin County Community Probation Center Director, Tom Miles. The MOU specifically states the Three Rivers Police Department will fully investigate all sexual abuse complaints in accordance with PREA Standards 115.221 and 115.234 and outlines the duties and responsibilities of each party. Specifically, the police department is responsible for conducting a thorough investigation in accordance with law and these standards and the agency is responsible for producing any documentation/evidence necessary to conduct such an investigation. Furthermore, the agency is responsible to contact the police department in a timely manner to initiate an investigation due to the time sensitive nature of potential evidence in a sexual abuse case.

.222(d)(e) The agency being audited is not a State entity or Department of Justice component. Therefore, this portion of the standard is not applicable to this audit.

The audit team has determined the agency has sufficient language in policy and has a suitable agreement, in writing, with a local law enforcement agency to conduct investigations into Sexual Abuse and Sexual Harassment allegations. At the time of this audit, there have been no allegations of Sexual Abuse nor Sexual Harassment. Therefore, the agency does not have documentation to verify this arrangement is sufficient to handle all cases, even those which appear to not be criminal in nature. That said, the audit team has found the minim requirements of this standard to be met and therefore has found the agency meets the standard.

The audit team feels it is worth nothing here, but not a condition of compliance with the standard, that the agency could go a bit further in the future by sufficiently training supervisory staff to conduct investigations as well.

**TRAINING AND EDUCATION**

**Standard 115.231: Employee training**

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

**115.231 (a)**

* Does the agency train all employees who may have contact with residents on: Its zero-tolerance policy for sexual abuse and sexual harassment? ☒ Yes ☐ No
* Does the agency train all employees who may have contact with residents on: How to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures? ☒ Yes ☐ No
* Does the agency train all employees who may have contact with residents on: Residents’ right to be free from sexual abuse and sexual harassment ☒ Yes ☐ No
* Does the agency train all employees who may have contact with residents on: The right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment? ☒ Yes ☐ No
* Does the agency train all employees who may have contact with residents on: The dynamics of sexual abuse and sexual harassment in confinement? ☒ Yes ☐ No
* Does the agency train all employees who may have contact with residents on: The common reactions of sexual abuse and sexual harassment victims? ☒ Yes ☐ No
* Does the agency train all employees who may have contact with residents on: How to detect and respond to signs of threatened and actual sexual abuse? ☒ Yes ☐ No
* Does the agency train all employees who may have contact with residents on: How to avoid inappropriate relationships with residents? ☒ Yes ☐ No
* Does the agency train all employees who may have contact with residents on: How to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents? ☒ Yes ☐ No
* Does the agency train all employees who may have contact with residents on: How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities? ☒ Yes ☐ No

**115.231 (b)**

* Is such training tailored to the gender of the residents at the employee’s facility? ☒ Yes ☐ No
* Have employees received additional training if reassigned from a facility that houses only male residents to a facility that houses only female residents, or vice versa? ☒ Yes ☐ No

**115.231 (c)**

* Have all current employees who may have contact with residents received such training? ☒ Yes ☐ No
* Does the agency provide each employee with refresher training every two years to ensure that all employees know the agency’s current sexual abuse and sexual harassment policies and procedures? ☒ Yes ☐ No
* In years in which an employee does not receive refresher training, does the agency provide refresher information on current sexual abuse and sexual harassment policies? ☒ Yes ☐ No

**115.231 (d)**

* Does the agency document, through employee signature or electronic verification, that employees understand the training they have received? ☒ Yes ☐ No

**Auditor Overall Compliance Determination**

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

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

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

**Instructions for Overall Compliance Determination Narrative**

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.231(a) Agency policy, titled “Employee Policy and Procedure Manual-Training and Education” clearly states, as part of the agency’s initiative to promote zero tolerance for sexual abuse and sexual harassment, all staff who work for the agency shall be advised of resident rights to be free from sexual abuse and harassment, shall be trained the prevention, detection, and responding to sexual conduct within its facility. The same policy mandates all staff be trained in how to recognize sexual abuse or misconduct, fulfill their (staff) responsibility under agency policy and procedure regarding the prevention of sexual abuse and harassment, ways residents may report incidents, staff and resident right to be free from retaliation for making reports, the dynamics of sexual abuse and harassment, common reactions of sexual abuse, crisis intervention and treatment options, crime scene and evidence preservation, how to avoid inappropriate relationships, how to effectively communicate with all residents, duties of first responders, and cultural competency regarding lesbian, gay, bisexual, transgender, intersex, and gender non-conforming residents.

While reviewing policy, the audit team did not find the requirement for staff to be trained in accordance with sub-section 10 of this portion of the standard which requires training on how to comply with relevant laws regarding mandatory reporting. Furthermore, while conducting interviews with staff, it was apparent the majority of staff were unaware of what “mandatory reporting” was nor the laws covering them.

In order for the agency to be fully compliant with this portion of the standard, training regarding mandatory reporting of sexual abuse/harassment must be provided to staff in accordance with this standard. Once the training has been developed, provided, documented and relevant documentation provided to the audit team, the agency will be fully compliant with this portion of the standard.

The audit team provides the following links as a reference to Michigan law governing mandatory reporting. Furthermore, the audit team has provided a PDF file titled “A Guide to Detailed Reporting” that can be used as a training aid.

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

<https://apps.rainn.org/policy/policy-state-laws.cfm?state=Michigan&group=5&_ga=2.190487595.1293268936.1624115940-251053022.1624115940>

.231(b) Agency policy requires all training pertaining to sexual abuse or harassment be tailored to the gender of the resident population at the facility. Furthermore, policy requires additional specialized training be provided to medical staff using the DOC (Department of Corrections) PREA training materials for medical practitioners.

The agency participated in detailed training provided by DASAS, an outside sexual assault victim advocacy and support agency, that covered the details of sexual assault specific to males and females, the response of sexual assault victims following an assault, consent, and how to appropriately respond to cases of assault. The training was detailed, appropriate, and exceeds the requirements of this standard. All staff were required to attend and the agency documented attendance with a staff sign-in roster.

.231(c) Agency policy requires, in addition to new employee orientation, an annual training module consisting of identifying, responding to, and preventing sexual conduct is required for all staff. This annual refresher shall include reviews of information from the new employee orientation, training on guidelines for female staff announcing their presence before entering the sleeping and bathroom facilities of male residents, and any additional information deemed appropriate or required.

Furthermore, the agency has developed an employee Policy and Procedure Manual which is provided to every employee upon hire and is reviewed with each employee at orientation. In addition, each employee is required to sign for the Manual indicating they have received and understand the information contained within. The manual includes, among other employee rights/responsibilities,

1. Employee standards of conduct
2. Employee discipline
3. PREA Coordinator Responsibilities
4. Incident and Major Misconduct Reporting
5. Critical Incident Reporting
6. Evidence Preservation
7. Pat Searches
8. Strip Searches
9. Adequate Staffing
10. Sexual Harassment
11. Sexual Misconduct
12. Emergency Plan
13. PREA Standards

This manual is used as a guide to conduct staff training and is but one of the many tools used to train and document staff understanding of training received.

In addition to the manual, staff are also trained utilizing the MDOC Vendor Handbook. This is a contractual obligation with the Michigan Department of Corrections for all vendors to training their staff on various topics, including Overfamiliarity, Sexual Harassment of Offenders (Residents), Sexual Conduct with Offenders (Residents), Humane Treatment, Discrimination, Physical Contact with Residents, Reporting Violations, and Workplace Safety. Again, each employee is required to verify they have been trained, and understand they must abide by the information they have received, by signing acknowledgement of the training received. The signed documents verifying training receipt are maintained in the employee’s file.

A careful review of employee files by the audit team verified that all employees have signed verification of training received and all employee interviews verified at least a basic understanding the training.

The agency once again has gone above and beyond the minimum requirements to meet the standard by requiring training annually for all staff. A review of staff files has indicated that all staff are trained and all training has occurred within the past 12 months. Considering this is the agency’s first audit, there are not multiple years of documentation available to review. However, considering the detail in which the agency has documented training requirements within their policy, documented by signature that every employee has received training, and continues to make additional efforts, such as contracting with experts to provide additional staff training, the audit team is fully confident of the agency’s willingness and ability to continue to meet this standard.

.231(d) Agency policy requires all staff training to be documented, including that the employee understood the training and maintained in the employee’s personnel file. The agency has developed a detailed training verification document that outlines the title of each training course, the date of the course, and the percentage obtained on the post training quiz for every employee. Furthermore, the document requires the employee to sign acknowledging they have completed the training modules listed with a minimum passing score, or better. They employee’s signature also verifies the employee is aware they must direct any questions regarding the training material to their supervisor/manager. By requiring a minimum passing score of 70% and requiring employees to direct questions to supervisory staff verifies the agency is sufficiently ensuring each and every employee is not only receiving the appropriate training but has fully understood the training as well.

A full review of staff files, as well as verification of training completed while conducting interviews with staff have verified staff have received, and signed documentation of annual training.

However, the one aspect of training regarding that of mandatory reporting is missing and will need to be completed before the audit team can find the agency is compliant with the full intent of this standard. Therefore, the audit team finds the agency does not meet the standard at this time.

Post Interim Report Update:

During the corrective action period, the agency successfully developed and implement training for all staff addressing the requirements under mandatory reporting guidelines. Specifically, the agency used the information outlined by the Michigan Department of Health and Human Services which details those professionals who are mandatory reports. This training was provided to all staff and staff were required to sign verification of receiving and understanding the training. The agency provided sufficient documentation to the audit team demonstrating all staff have received and understand the training provided. Therefore, the audit team now finds the agency meets this standard.

**Standard 115.232: Volunteer and contractor training**

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

**115.232 (a)**

* Has the agency ensured that all volunteers and contractors who have contact with residents have been trained on their responsibilities under the agency’s sexual abuse and sexual harassment prevention, detection, and response policies and procedures? ☒ Yes ☐ No

**115.232 (b)**

* Have all volunteers and contractors who have contact with residents been notified of the agency’s zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents (the level and type of training provided to volunteers and contractors shall be based on the services they provide and level of contact they have with residents)? ☒ Yes ☐ No

**115.232 (c)**

* Does the agency maintain documentation confirming that volunteers and contractors understand the training they have received? ☐ Yes ☒ No

**Auditor Overall Compliance Determination**

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

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

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

**Instructions for Overall Compliance Determination Narrative**

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.232(a Agency policy, titled “Employee Policy and Procedure Manual-Volunteer and Contractor Training and Education” states all volunteers, interns, and contractors shall be advised that any form of sexual conduct with a resident, whether consensual or not, is strictly prohibited and any volunteer, intern, or contractor found to have engaged in such conduct shall be removed from the facility and not allowed to return and my subject to criminal prosecution.

.232(b) Agency policy requires that all volunteers, interns, and contractors who have regular contact with residents shall be provided with a copy of the same brochure provided to staff regarding sexual behavior and receive the same information and training materials provided to staff about sexual abuse and harassment. The level and type of training required of volunteers is the same as staff, exceeding the minimum requirement.

The audit team conducted interviews with multiple volunteers during the on-site visit. Without exception, every volunteer indicated they have received training specific to the agency’s expectations regarding contact with residents. When probed, all of the volunteers recalled receiving specific training regarding the prohibition of sexual conduct with residents and reporting requirements, however could not recall if that was training provided by the agency or general training they’ve received as a result of their line of work.

It is recommended by the audit team that all volunteers and contractors be refreshed on the training they received from the agency with an emphasis on resident rights and their (volunteer or contractor) duty regarding reporting.

.232(c) Again, agency policy requires all PREA related training received by volunteers, interns, and contractors be documented, including documenting they understand the training they received. The documentation shall be maintained by the volunteer coordinator, and/or the Human Resources Department.

However, the agency was unable to provide any written documentation that volunteers and contractors have completed the required training. At depth discussions with the agency’s PREA Coordinator were had about the types of training required to meet the standard. The audit team has provided a training packet that sufficiently educates volunteers and contractors of their responsibilities under the agency’s and the Michigan Department of Corrections’ requirements regarding sexual abuse and sexual harassment prevention. The packet includes a signature sheet for each contractor/volunteer to complete indicating s/he has received and understands the training.

In order to be compliant with this standard, the agency must document, and maintain the documentation that each volunteer and contractor has received training regarding the responsibilities regarding sexual abuse and sexual harassment prevention. Therefore, it is required by the audit team that the agency provide the training to every volunteer and contractor providing services directly to residents at its facility and maintain documentation confirming that each has received and understood the training.

Once completed and provided to the audit team, the agency will be compliant with this standard. However, at the time of this report, the audit team has found the agency does not meet the standard.

Post Interim Report Update:

The agency provided detailed training to all volunteers and contractors who may have contact with residents. The agency PREA Coordinator developed a signature form for every volunteer and contractor to sign indicating they acknowledge they received a copy of, have read, and understand and agree to abide by the agency’s policies, procedures, and PREA Federal Register. The form is signed and dated by each member receiving the training.

The agency provided the audit team with copies of every volunteer and contractor providing services at the facility verifying each as received the training. Therefore, the audit team has now found the agency to be fully compliant and meets this standard.

**Standard 115.233: Resident education**

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

**115.233 (a)**

* During intake, do residents receive information explaining: The agency’s zero-tolerance policy regarding sexual abuse and sexual harassment? ☒ Yes ☐ No
* During intake, do residents receive information explaining: How to report incidents or suspicions of sexual abuse or sexual harassment? ☒ Yes ☐ No
* During intake, do residents receive information explaining: Their rights to be free from sexual abuse and sexual harassment? ☒ Yes ☐ No
* During intake, do residents receive information explaining: Their rights to be free from retaliation for reporting such incidents? ☒ Yes ☐ No
* During intake, do residents receive information regarding agency policies and procedures for responding to such incidents? ☒ Yes ☐ No

**115.233 (b)**

* Does the agency provide refresher information whenever a resident is transferred to a different facility? ☒ Yes ☐ No

**115.233 (c)**

* Does the agency provide resident education in formats accessible to all residents, including those who: Are limited English proficient? ☒ Yes ☐ No
* Does the agency provide resident education in formats accessible to all residents, including those who: Are deaf? ☒ Yes ☐ No
* Does the agency provide resident education in formats accessible to all residents, including those who: Are visually impaired? ☒ Yes ☐ No
* Does the agency provide resident education in formats accessible to all residents, including those who: Are otherwise disabled? ☒ Yes ☐ No
* Does the agency provide resident education in formats accessible to all residents, including those who: Have limited reading skills? ☒ Yes ☐ No

**115.233 (d)**

* Does the agency maintain documentation of resident participation in these education sessions? ☒ Yes ☐ No

**115.233 (e)**

* In addition to providing such education, does the agency ensure that key information is continuously and readily available or visible to residents through posters, resident handbooks, or other written formats? ☒ Yes ☐ No

**Auditor Overall Compliance Determination**

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

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.233(a) Agency policy, titled “Employee Policy and Procedure Manual-Resident Education and Training” requires all residents housed with the agency receive, as part of their orientation to the facility, education regarding sexual conduct. All residents shall be provided oral and written information regarding the agency’s zero tolerance toward all forms of sexual conduct, prevention and intervention methods, self-protection, reporting incidents of sexual abuse including the resident’s right to be free from retaliation for making such reports, and how the agency responds to allegations.

.233(b) This agency operates a single facility. Therefore, providing resident education and training to each and every resident assigned to this single facility meets the requirement of this portion of the standard. While performing the on-site visit, the audit team inquired about the frequency of resident training for those who leave the facility. Because the agency is primarily a probation center, most of the residents have requirements to maintain jobs and attend other programming off grounds. Residents who leave the facility on a regular basis do not receive additional training on a daily basis, nor should they unless there is good cause to believe the resident would require, or otherwise benefit from additional education. The agency did verify that any resident leaving the facility for an extended period of time would be treated as a new incoming resident receiving the same benefit as any new resident in regard to screening and education.

.233(c) The agency has teamed with Vivian J. Montero, president and founder of Enlaces Language Solutions LLC, and translation and interpretation services agency locally available. This is the same organization utilized by the local court house to provide translation and interpretation services for court hearings to individuals who are limited English, deaf, visually impaired, or otherwise in need of translation or interpretive services. The audit team reached out to Ms. Montero via phone call to inquire about the scope of services provided and verified the organization provided interpretive services both receptively and expressively in multiple languages. Furthermore, she confirmed her organization was in contact with TCCPC and ready and able to provided services as need. Detailed interviews with staff verified they were aware of the services offered by Enlaces Language Solutions, LLC and the agency’s requirement to make contact with the organization if and when needed.

Furthermore, the agency utilizes a language identification card which can be shown to incoming residents who speak no English in order to successfully identify the language they understand. The agency also prints, in Spanish (the most likely non-English language of a resident attending TCCPC) that interpreter services are available.

.233(d) Agency policy requires all resident training be documented in each resident’s file including a signed receipt indicating the resident is verifying they have received training and information regarding the agency’s zero tolerance policy, how to report incidents, and how to obtain treatment if needed.

The receipt states the resident has received a copy of the agency’s written policy mandating zero tolerance toward all forms of sexual abuse and harassment, that the resident has read these policies, or has had them read aloud if necessary, and understand them, and that the resident has a right to be free from sexual abuse, sexual harassment, and retaliation for reporting such incidents.

A careful review of resident files revealed that all files reviewed contained the signed receipt that the resident has received and understands their rights as well as agency policy regarding their sexual safety. Furthermore, the audit team conducted 26 resident interviews, all of which indicated they had received the training. Every resident interviewed answered interview questions in a manner which revealed they had a good understanding of their rights as well as the agency’s duty to protect them from any type of sexual abuse, harassment, or retaliation.

.233(e) In addition to new resident orientation, the agency has included all the pertinent information provided during the orientation in a resident handbook for ready reference by residents at any time. Furthermore, residents are provided with brochures addressing the potential dangers of sexual conduct and the agency’s zero tolerance policy regarding the matter. The agency’s NO MEANS NO poster is also posted throughout the agency informing residents of how to report, everyone’s right to report, and contact information for victim support services available to residents.

Based off agency policy, staff and resident interviews, and verification of more than sufficient postings throughout the facility, the audit team is fully convinced the agency has provided ample means of educating its residents in a manner that develops a full understanding of resident rights regarding their safety and the agency’s responsibility to act when necessary. For these reasons, the audit team finds the agency has met this standard.

**Standard 115.234: Specialized training: Investigations**

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

**115.234 (a)**

* In addition to the general training provided to all employees pursuant to §115.231, does the agency ensure that, to the extent the agency itself conducts sexual abuse investigations, its investigators receive training in conducting such investigations in confinement settings? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).)

☐ Yes ☐ No ☒ NA

**115.234 (b)**

* Does this specialized training include: Techniques for interviewing sexual abuse victims? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).) ☐ Yes ☐ No ☒ NA
* Does this specialized training include: Proper use of Miranda and Garrity warnings? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).) ☐ Yes ☐ No ☒ NA
* Does this specialized training include: Sexual abuse evidence collection in confinement settings? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).) ☐ Yes ☐ No ☒ NA
* Does this specialized training include: The criteria and evidence required to substantiate a case for administrative action or prosecution referral? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).) ☐ Yes ☐ No ☒ NA

**115.234 (c)**

* Does the agency maintain documentation that agency investigators have completed the required specialized training in conducting sexual abuse investigations? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).) ☐ Yes ☐ No ☒ NA

**115.234 (d)**

* Auditor is not required to audit this provision.

**Auditor Overall Compliance Determination**

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

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

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

**Instructions for Overall Compliance Determination Narrative**

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

.234(a)(b)(c) The agency does not conduct investigations into allegations of sexual abuse. Rather, the agency has entered into a Memorandum Of Agreement (MOA) with the local police department (Three Rivers Police Department) to conduct all investigations on behalf of the agency. The Three Rivers Police Department has agreed to provided offers skilled in conducting these types of investigations and the MOA states Three Rivers Police Department will comply with all aspects of the PREA standards regarding investigations into allegations of sexual abuse.

.234(d) The agency being audited is not a State entity or Department of Justice component. Therefore, this portion of the standard is not applicable to this audit.

The agency has sufficiently meant the intent of this standard by contracting, though a signed agreement, with a law enforcement agency with the legal authority to conduct investigations into sexual abuse allegations. Furthermore, the law enforcement agency has agreed, through said written agreement, to fully comply with all aspects of the PREA standards regarding investigations into allegations of sexual abuse. Therefore, the audit team is finding the agency has met the standard.

**Standard 115.235: Specialized training: Medical and mental health care**

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

**115.235 (a)**

* Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to detect and assess signs of sexual abuse and sexual harassment? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)

☐ Yes ☐ No ☒ NA

* Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to preserve physical evidence of sexual abuse? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.) ☐ Yes ☐ No ☒ NA
* Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to respond effectively and professionally to victims of sexual abuse and sexual harassment? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.) ☐ Yes ☐ No ☒ NA
* Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How and to whom to report allegations or suspicions of sexual abuse and sexual harassment? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.) ☐ Yes ☐ No ☒ NA

**115.235 (b)**

* If medical staff employed by the agency conduct forensic examinations, do such medical staff receive appropriate training to conduct such examinations? (N/A if agency does not employ medical staff or the medical staff employed by the agency do not conduct forensic exams.)

☐ Yes ☐ No ☒ NA

**115.235 (c)**

* Does the agency maintain documentation that medical and mental health practitioners have received the training referenced in this standard either from the agency or elsewhere? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.) ☐ Yes ☐ No ☒ NA

**115.235 (d)**

* Do medical and mental health care practitioners employed by the agency also receive training mandated for employees by §115.231? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners employed by the agency.) ☐ Yes ☐ No x NA
* Do medical and mental health care practitioners contracted by and volunteering for the agency also receive training mandated for contractors and volunteers by §115.232? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners contracted by or volunteering for the agency.) ☐ Yes ☐ No ☒ NA

**Auditor Overall Compliance Determination**

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

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

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

**Instructions for Overall Compliance Determination Narrative**

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

.235(a) The agency does not employ the services of medical nor mental health care workers in its facilities. Rather, the agency refers any resident in need of medical or mental health care to outside facilities capable of providing these services. Therefore, no documentation exists, no interviews were possible, and no means of observation of medical nor mental health staff was possible during this audit. This portion of the standard is not applicable to this audit.

.235(b)(c) All medical procedures, including forensic examinations are provided by the local hospital and not be staff employed by the agency. Therefore, this portion of the standard is not applicable to this audit.

.235(d) No medical nor mental health care practitioners are employed by the agency rendering this portion of the stand not applicable to this audit.

The audit process does not allow for a finding of “Not Applicable” and a finding of “Does Not Meet Standard” is inappropriate considering the agency does not employ medical nor mental health professionals. Furthermore, the agency has assured the audit team a practice is in place ensuring appropriate medical and mental health care is readily available to all residents in need at local facilities. Therefore, the audit team has found the agency is in full compliance with the intent of this standard and has found the agency meets the standard.

**SCREENING FOR RISK OF SEXUAL VICTIMIZATION AND ABUSIVENESS**

**Standard 115.241: Screening for risk of victimization and abusiveness**

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

**115.241 (a)**

* Are all residents assessed during an intake screening for their risk of being sexually abused by other residents or sexually abusive toward other residents? ☒ Yes ☐ No
* Are all residents assessed upon transfer to another facility for their risk of being sexually abused by other residents or sexually abusive toward other residents? ☒ Yes ☐ No

**115.241 (b)**

* Do intake screenings ordinarily take place within 72 hours of arrival at the facility? ☒ Yes ☐ No

**115.241 (c)**

* Are all PREA screening assessments conducted using an objective screening instrument? ☒ Yes ☐ No

**115.241 (d)**

* Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has a mental, physical, or developmental disability? ☒ Yes ☐ No
* Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: The age of the resident? ☒ Yes ☐ No
* Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: The physical build of the resident? ☒ Yes ☐ No
* Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has previously been incarcerated? ☒ Yes ☐ No
* Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident’s criminal history is exclusively nonviolent? ☒ Yes ☐ No
* Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has prior convictions for sex offenses against an adult or child? ☒ Yes ☐ No
* Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident is or is perceived to be gay, lesbian, bisexual, transgender, intersex, or gender nonconforming (the facility affirmatively asks the resident about his/her sexual orientation and gender identity AND makes a subjective determination based on the screener’s perception whether the resident is gender non-conforming or otherwise may be perceived to be LGBTI)? ☒ Yes ☐ No
* Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has previously experienced sexual victimization? ☒ Yes ☐ No
* Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: The resident’s own perception of vulnerability? ☒ Yes ☐ No

**115.241 (e)**

* In assessing residents for risk of being sexually abusive, does the initial PREA risk screening consider, when known to the agency: prior acts of sexual abuse? ☒ Yes ☐ No
* In assessing residents for risk of being sexually abusive, does the initial PREA risk screening consider, when known to the agency: prior convictions for violent offenses? ☒ Yes ☐ No
* In assessing residents for risk of being sexually abusive, does the initial PREA risk screening consider, when known to the agency: history of prior institutional violence or sexual abuse? ☒ Yes ☐ No

**115.241 (f)**

* Within a set time period not more than 30 days from the resident’s arrival at the facility, does the facility reassess the resident’s risk of victimization or abusiveness based upon any additional, relevant information received by the facility since the intake screening? ☒ Yes ☐ No

**115.241 (g)**

* Does the facility reassess a resident’s risk level when warranted due to a: Referral? ☒ Yes ☐ No
* Does the facility reassess a resident’s risk level when warranted due to a: Request? ☒ Yes ☐ No
* Does the facility reassess a resident’s risk level when warranted due to a: Incident of sexual abuse? ☒ Yes ☐ No
* Does the facility reassess a resident’s risk level when warranted due to a: Receipt of additional information that bears on the resident’s risk of sexual victimization or abusiveness? ☒ Yes ☐ No

**115.241 (h)**

* Is it the case that residents are not ever disciplined for refusing to answer, or for not disclosing complete information in response to, questions asked pursuant to paragraphs (d)(1), (d)(7), (d)(8), or (d)(9) of this section? ☒ Yes ☐ No

**115.241 (i)**

* Has the agency implemented appropriate controls on the dissemination within the facility of responses to questions asked pursuant to this standard in order to ensure that sensitive information is not exploited to the resident’s detriment by staff or other residents? ☒ Yes ☐ No

**Auditor Overall Compliance Determination**

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

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

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

**Instructions for Overall Compliance Determination Narrative**

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

.241(a)(b) Agency policy, titled “Employee Policy and Procedure Manual-Screening for Risk of Sexual Victimization and Abusiveness” requires all residents be screened within 72 hours of admission to a TCCPC facility. Considering TCCPC operates a single facility, the requirement under this portion of the standard to ensure residents are screened upon transfer to another facility is not applicable for this audit.

A thorough review of resident files revealed that every resident residing at TCCPC at the time of the audit had been properly screened within 72 hours of arrival at the facility. In fact, more than 95% of the files reviewed by the audit team revealed that residents are screened within 24 hours of arrival at the facility.

Detailed interviews with staff and residents confirmed the agency has a practice of screening residents the same day they arrive, far exceeding the requirement of this portion of the standard.

.241(c)(d)(e) Agency policy mandates staff conduct thorough interviews and reviews of resident files and any other available information in order to determine whether the resident may be a potential aggressor or potential victim of sexual abuse or harassment while incarcerated. The policy requires, in addition to interviewing residents and completing a review of their file and criminal history, the use of the Prison Rape Elimination Act (PREA) Risk Assessment sheet. The risk assessment sheet is an objective tool staff use to guide them through the evaluation process in making a determination whether or not to classify a resident as victim or aggressor. The assessment tool covers all nine aspects required by this portion of the standard as well as considering past acts of sexual abuse, prior convictions for violent offenses, and history of prior institutional violence or sexual abuse. The assessment directs staff when to review past history, when to ask the resident their view/response to a topic and includes an opportunity for staff to override a resident’s score if they feel it is necessary to keep all residents safe and secure. Any override requires a detailed explanation of the rationale as to why the screening staff person chose to override the findings of the assessment.

.241(f)(g) Agency policy requires a reassessment within 30 days of the resident’s arrival at the facility in order to reassess the resident’s risk for abusiveness or victimization based upon any additional information that may be known to the facility since the initial assessment. The same portion of policy requires a new assessment whenever warranted or requested by staff or the resident based off new information.

During the course of interviewing staff and residents, and while conducting reviews of resident files, the audit team discovered the agency was conducting reviews of resident risk assessments every 30 days as a part of their monthly file reviews. Each of these monthly reassessments require an in-person interview with the resident in order to gain the residents perspective of their assessment and to inquire about any additional information may wany to disclose that they had not revealed in the past. This monthly reassessment goes well above and beyond the requirement of the standard.

.241(h) Agency policy explicitly states a resident’s refusal to provide information related to a risk assessment will not result in any form of discipline. Interviews with staff and residents revealed everyone was aware of the agency’s standard on this matter and all residents revealed they felt comfortable answering the questions of the assessment.

.241(i) Agency policy states the information obtained during an assessment and the results of an assessment are confidential and strict controls are put into place to ensure the information is not made public. All assessments are kept as part of a resident’s counselor’s file and only counselors and their supervisors have access to the locked cabinets and locked offices where the assessments are kept.

After determining the depth to which the agency goes in order to ensure an accurate and unbiased assessment is conducted of every resident, discovering that assessments are more likely than not completed upon a resident’s first day of arrival at the facility, and the facility’s practice to reassess every resident on a monthly basis, it is without a doubt the agency is far exceeding this standard. Based of the information obtained during the file review, interviews with staff and residents, and a thorough review of resident files, the audit team has determined the agency exceeds this standard.

**Standard 115.242: Use of screening information**

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

**115.242 (a)**

* Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Housing Assignments? ☒ Yes ☐ No
* Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Bed assignments? ☒ Yes ☐ No
* Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Work Assignments? ☒ Yes ☐ No
* Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Education Assignments? ☒ Yes ☐ No
* Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Program Assignments? ☒ Yes ☐ No

**115.242 (b)**

* Does the agency make individualized determinations about how to ensure the safety of each resident? ☒ Yes ☐ No

**115.242 (c)**

* When deciding whether to assign a transgender or intersex resident to a facility for male or female residents, does the agency consider on a case-by-case basis whether a placement would ensure the resident’s health and safety, and whether a placement would present management or security problems (NOTE: if an agency by policy or practice assigns residents to a male or female facility on the basis of anatomy alone, that agency is not in compliance with this standard)? ☒ Yes ☐ No
* When making housing or other program assignments for transgender or intersex residents, does the agency consider on a case-by-case basis whether a placement would ensure the resident’s health and safety, and whether a placement would present management or security problems? ☒ Yes ☐ No

**115.242 (d)**

* Are each transgender or intersex resident’s own views with respect to his or her own safety given serious consideration when making facility and housing placement decisions and programming assignments? ☒ Yes ☐ No

**115.242 (e)**

* Are transgender and intersex residents given the opportunity to shower separately from other residents? ☒ Yes ☐ No

**115.242 (f)**

* Unless placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting lesbian, gay, bisexual, transgender, or intersex residents, does the agency always refrain from placing: lesbian, gay, and bisexual residents in dedicated facilities, units, or wings solely on the basis of such identification or status? (N/A if the agency has a dedicated facility, unit, or wing solely for the placement of LGBT or I residents pursuant to a consent decree, legal settlement, or legal judgement.) ☒ Yes ☐ No ☐ NA
* Unless placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting lesbian, gay, bisexual, transgender, or intersex residents, does the agency always refrain from placing: transgender residents in dedicated facilities, units, or wings solely on the basis of such identification or status? (N/A if the agency has a dedicated facility, unit, or wing solely for the placement of LGBT or I residents pursuant to a consent decree, legal settlement, or legal judgement.) ☒ Yes ☐ No ☐ NA
* Unless placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting lesbian, gay, bisexual, transgender, or intersex residents, does the agency always refrain from placing: intersex residents in dedicated facilities, units, or wings solely on the basis of such identification or status? (N/A if the agency has a dedicated facility, unit, or wing solely for the placement of LGBT or I residents pursuant to a consent decree, legal settlement, or legal judgement.)

☒ Yes ☐ No ☐ NA

**Auditor Overall Compliance Determination**

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

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

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

**Instructions for Overall Compliance Determination Narrative**

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

.242(a)(b) Agency policy, titled “Employee Policy and Procedure Manual-Screening Results” states housing and bed assignments are made based upon results of resident risk assessments. Options available to the agency include placing residents in an individual room or placing residents on more frequent security checks in order to ensure the safety of all residents. Any resident screened as victim/potential victim is placed as far from any resident screening as aggressor/potential aggressor. This is easily accomplished due to have multiple rooms, with multiple bed assignments available at the facility.

Upon conducting rounds of the facility, the audit team found that not potential victims were placed within the same rooms as any resident classified as a potential aggressor. Every resident interviewed indicated they felt safe at the facility and anyone coming to TCCPC with an aggressor’s mentality usually didn’t last long as they were generally not suitable for the programming available at the facility. This was the general perspective of every resident interviewed by the audit team.

While conducting interviews with staff, including supervisor staff responsible for making bed assignments, all staff indicated that risk assessments were a part of making bed assignments, however, each bed assignment was made considering a totality of the circumstances and each assignment was an individualized determination based off those circumstances.

.242(c)(d)(e) Agency policy outlines their approach to housing transgender or intersex residents based upon the resident’s own views with respect to their own safety. Policy also requires a method by which transgender and intersex residents be allowed to shower separately.

Although the agency has sufficiently addressed this portion of the standard in their policy, they have yet to find a need to implement it as they have never had a known transgender or intersex resident partake in their program.

Upon observing the showering facilities at TCCPC, the audit team noticed the showers, although separate for males and females, were open bay showers located within the only resident bathroom on each side of the facility. This set up is not conducive to allowing anyone the opportunity to shower separately. Due to the frequent movement by residents throughout the facility, it would be difficult to allow a single resident the specified showering time that limited the use of the only bathroom facility for the entire male/female side of the facility.

When discussing this during the staff interview with supervisors and facility heads, the agency head concluded they do not have the facilities conducive to meeting the specific needs of transgender nor intersex residents. Therefore, the agency would not allow a known transgender nor intersex resident to reside at TCCPC in the immediate future. Because the standard requires the agency make provisions for this specific population, but does not require a Community Confinement facility to allow specific populations access to their facilities, the agency is currently in compliance with this portion of the standard. However, should the agency find itself deciding to accept transgender and intersex residents in the future, deliberate actions must be made to ensure this portion of the standard if fully complied with.

.242(f) Agency policy does not specifically address the prohibition of placing residents in specific rooms or wings based upon their status as lesbian, gay, bisexual, transgender, or intersex. However, the audit team was able to discern the agency does not place residents in rooms, wings, or dedicated portions of the facility based off such information. This was determined through a thorough tour of the facility, conducting informal interviews with residents and staff, as well as during formal interviews with residents and staff. Furthermore, the facility does not have an adequate number of rooms to break down housing assignments based off such criteria.

Based off a detailed review of agency policy, a thorough tour of the agency’s facility, and informal and formal interviews with staff and residents, the audit team is confident the agency is utilizing the information derived from resident risk assessments in full compliance with the standards and in doing so is insuring the sexual safety of all residents in their care. For these reasons, the audit team has found the agency meets this standard.

**REPORTING**

**Standard 115.251: Resident reporting**

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

**115.251 (a)**

* Does the agency provide multiple internal ways for residents to privately report: Sexual abuse and sexual harassment? ☒ Yes ☐ No
* Does the agency provide multiple internal ways for residents to privately report: Retaliation by other residents or staff for reporting sexual abuse and sexual harassment? ☒ Yes ☐ No
* Does the agency provide multiple internal ways for residents to privately report: Staff neglect or violation of responsibilities that may have contributed to such incidents? ☒ Yes ☐ No

**115.251 (b)**

* Does the agency also provide at least one way for residents to report sexual abuse or sexual harassment to a public or private entity or office that is not part of the agency? ☒ Yes ☐ No
* Is that private entity or office able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials? ☒ Yes ☐ No
* Does that private entity or office allow the resident to remain anonymous upon request? ☒ Yes ☐ No

**115.251 (c)**

* Do staff members accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously, and from third parties? ☒ Yes ☐ No
* Do staff members promptly document any verbal reports of sexual abuse and sexual harassment? ☒ Yes ☐ No

**115.251 (d)**

* Does the agency provide a method for staff to privately report sexual abuse and sexual harassment of residents? ☒ Yes ☐ No

**Auditor Overall Compliance Determination**

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

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

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

**Instructions for Overall Compliance Determination Narrative**

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.251(a)(b) Agency policy, titled “Employee Policy and Procedure Manual-Resident Reporting” outlines the various methods in which residents of TCCPC are able to report sexual abuse, sexual harassment, or retaliation from staff or other residents. Specifically, policy states it is the goal of TCCPC to make reporting incidents or retaliation as convenient and safe as possible for residents and staff alike. Policy requires all staff and residents to be informed of the following methods of reporting:

1. Calling the PREA Coordinator directly at (269) 278-1375
2. Contacting the PREA Coordinator by email at [sschmitt@tccpc.comcastbiz.net](mailto:sschmitt@tccpc.comcastbiz.net)
3. Meeting with PREA Coordinator in person
4. Calling 911 from any phone in the facility
5. Calling the local Domestic and Sexual Abuse Hotline at (800) 828-2023
6. Any report made to any staff verbally, in writing, anonymously
7. Any third party can utilize the same methods outlined above

While conducting the tour of the facility, the audit team observed the DASAS hotline printed on every telephone in the facility. Attempts to reach DASAS from within the facility were successful verifying this was a viable option to everyone, staff, residents, volunteers, or contractors, while inside the facility. It was also verified this was a toll-free call for anyone utilizing it. Furthermore, while conducting both staff and resident interviews, everyone, without exception was aware of the services DASAS provided as well as the toll-free number they could call if the wanted to file a report.

Upon conducting interviews with DASAS volunteers, the audit team confirmed that DASAS would accept reports from staff, residents, and third-parties and would immediately pass along the report to appropriate staff (agency PREA Coordinator) if a complaint was received.

.251(c) Agency policy requires staff to accept reports of sexual abuse, harassment, or retaliation in whatever form the report is made. The audit team confirmed, through staff interviews, that every staff member was well aware of this requirement. At the time of this report, no allegations of abuse, harassment, or retaliation had been made, therefore no documentation is available to support this portion of the standard. However, that does not prevent the agency from being found compliant with the standard.

.251(d) As outlined in sub-section (a) of this standard above, all staff receive the same information as residents in regard to reporting options and staff are authorized and encouraged to report by which ever means they are most comfortable.

Based off the detailed policy outlining the various methods of reporting and the requirement of staff to accept any report regardless of how the report was made/received, the audit team is assured appropriate administrative measures are in place to fully comply with this standard. Furthermore, while conducting the tour, the audit team witnessed sufficient postings/documentation placed throughout the facility to keep staff, residents, and volunteers well informed of the various options available to report. Interviews with staff, residents, and volunteers confirmed everyone was well aware of the options available. Although the agency has yet to receive a report, interviews with residents revealed that every resident seemed fully confident agency staff would accept and appropriately respond to any allegation of abuse, harassment, or retaliation regardless of the method in which it was reported. For these reasons, the audit team finds the agency meets this standard.

**Standard 115.252: Exhaustion of administrative remedies**

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

**115.252 (a)**

* Is the agency exempt from this standard? NOTE: The agency is exempt ONLY if it does not have administrative procedures to address resident grievances regarding sexual abuse. This does not mean the agency is exempt simply because a resident does not have to or is not ordinarily expected to submit a grievance to report sexual abuse. This means that as a matter of explicit policy, the agency does not have an administrative remedies process to address sexual abuse. ☒ Yes ☐ No

**115.252 (b)**

* Does the agency permit residents to submit a grievance regarding an allegation of sexual abuse without any type of time limits? (The agency may apply otherwise-applicable time limits to any portion of a grievance that does not allege an incident of sexual abuse.) (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA
* Does the agency always refrain from requiring a resident to use any informal grievance process, or to otherwise attempt to resolve with staff, an alleged incident of sexual abuse? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

**115.252 (c)**

* Does the agency ensure that: A resident who alleges sexual abuse may submit a grievance without submitting it to a staff member who is the subject of the complaint? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA
* Does the agency ensure that: Such grievance is not referred to a staff member who is the subject of the complaint? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

**115.252 (d)**

* Does the agency issue a final agency decision on the merits of any portion of a grievance alleging sexual abuse within 90 days of the initial filing of the grievance? (Computation of the 90-day time period does not include time consumed by residents in preparing any administrative appeal.) (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA
* If the agency determines that the 90-day timeframe is insufficient to make an appropriate decision and claims an extension of time (the maximum allowable extension of time to respond is 70 days per 115.252(d)(3)) , does the agency notify the resident in writing of any such extension and provide a date by which a decision will be made? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA
* At any level of the administrative process, including the final level, if the resident does not receive a response within the time allotted for reply, including any properly noticed extension, may a resident consider the absence of a response to be a denial at that level? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

**115.252 (e)**

* Are third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, permitted to assist residents in filing requests for administrative remedies relating to allegations of sexual abuse? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA
* Are those third parties also permitted to file such requests on behalf of residents? (If a third-party files such a request on behalf of a resident, the facility may require as a condition of processing the request that the alleged victim agree to have the request filed on his or her behalf, and may also require the alleged victim to personally pursue any subsequent steps in the administrative remedy process.) (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA
* If the resident declines to have the request processed on his or her behalf, does the agency document the resident’s decision? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

**115.252 (f)**

* Has the agency established procedures for the filing of an emergency grievance alleging that a resident is subject to a substantial risk of imminent sexual abuse? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA
* After receiving an emergency grievance alleging a resident is subject to a substantial risk of imminent sexual abuse, does the agency immediately forward the grievance (or any portion thereof that alleges the substantial risk of imminent sexual abuse) to a level of review at which immediate corrective action may be taken? (N/A if agency is exempt from this standard.). ☐ Yes ☐ No ☒ NA
* After receiving an emergency grievance described above, does the agency provide an initial response within 48 hours? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA
* After receiving an emergency grievance described above, does the agency issue a final agency decision within 5 calendar days? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA
* Does the initial response and final agency decision document the agency’s determination whether the resident is in substantial risk of imminent sexual abuse? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA
* Does the initial response document the agency’s action(s) taken in response to the emergency grievance? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA
* Does the agency’s final decision document the agency’s action(s) taken in response to the emergency grievance? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

**115.252 (g)**

* If the agency disciplines a resident for filing a grievance related to alleged sexual abuse, does it do so ONLY where the agency demonstrates that the resident filed the grievance in bad faith? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

**Auditor Overall Compliance Determination**

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

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

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

**Instructions for Overall Compliance Determination Narrative**

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

Twin County Community Probation Center, Inc. does not have administrative procedures to address resident grievances specifically regarding sexual abuse and is therefore exempt from this standard. However, because the audit process does not allow for a not applicable finding of a particular standard and a finding of Does Not Meet Standard would not be appropriate in this case, the audit team has found the facility Meets the Standard.

**Standard 115.253: Resident access to outside confidential support services**

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

**115.253 (a)**

* Does the facility provide residents with access to outside victim advocates for emotional support services related to sexual abuse by giving residents mailing addresses and telephone numbers, including toll-free hotline numbers where available, of local, State, or national victim advocacy or rape crisis organizations? ☒ Yes ☐ No
* Does the facility enable reasonable communication between residents and these organizations and agencies, in as confidential a manner as possible? ☒ Yes ☐ No

**115.253 (b)**

* Does the facility inform residents, prior to giving them access, of the extent to which such communications will be monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws? ☒ Yes ☐ No

**115.253 (c)**

* Does the agency maintain or attempt to enter into memoranda of understanding or other agreements with community service providers that are able to provide residents with confidential emotional support services related to sexual abuse? ☒ Yes ☐ No
* Does the agency maintain copies of agreements or documentation showing attempts to enter into such agreements? ☒ Yes ☐ No

**Auditor Overall Compliance Determination**

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

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

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

**Instructions for Overall Compliance Determination Narrative**

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

.253(a) Agency policy, titled “Employee Policy and Procedure Manual-Resident Access To Outside Confidential Support Services” states residents will be given access to outside victim advocates for emotional support services related to sexual abuse by giving residents mailing addresses and telephone numbers, including toll-free numbers, and enabling reasonable communication between residents and these organizations. Residents are informed, prior to being given access, of the extent such communication will be monitored and the extent to which reports of abuse will be forwarded to authorities.

The facility has provided all residents with information on how to contact a local domestic and sexual abuse service center named Domestic And Sexual Abuse Services (DASAS) in response to this standard.

While conducting the facility tour, the audit team verified that DASAS contact information was readily available throughout the facility, including a toll-free hotline number posted on every phone available to residents. Furthermore, the audit team confirmed that, without exception, every resident interviewed was fully aware of who DASAS was and the services they provide. The audit team made contact, via the toll-free number and during an in-person interview with a DASAS staff member, verifying their full support of TCCPC and willingness to provide any services necessary to address the needs of their residents.

.253(b) In addition to agency policy outlining that privacy may by limited, all residents are informed at intake of the limitations of privacy while on the phone or otherwise communicating with staff or volunteers while at TCCPC. Upon conducting interview with residents, the audit team verified that all residents were well aware of the fact that anything they report while at the facility was limited in scope of privacy due to mandatory reporting obligations of staff and volunteers.

.253(c) The agency has entered into an agreement with DASAS by way of a signed Memorandum of Understanding (MOU). The MOU outlines the activities and professional services provided by DASAS, including a full range of Sexual Assault Supportive Services.

TCCPC has agreed to allow a DASAS counselor to make rounds and provide additional services, beyond the scope of the MOU and broader than sexual abuse/harassment, to all residents on a weekly basis. The audit team was awarded the opportunity to conduct an interview with a DASAS counselor while conducting the on-site portion of this audit. The audit team verified the counselors from DASAS were all licensed and willing to provide any sexual abuse/harassment services requested by a TCCPC resident 24/7.

Based off the detailed policy requirements addressing this standard, the training provided to residents, the MOU between TCCPC and DASAS, as well as the agency’s willingness to allow DASAS counselors access to the facility on a weekly basis, the audit team has concluded the agency goes beyond the scope required to be found compliant with this standard. Furthermore, the audit team found, during interview with staff, residents, and volunteers, that services offered in support of this standard are common knowledge and access is readily available. For these reasons, the audit team finds the agency exceeds this standard.

**Standard 115.254: Third-party reporting**

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

**115.254 (a)**

* Has the agency established a method to receive third-party reports of sexual abuse and sexual harassment? ☒ Yes ☐ No
* Has the agency distributed publicly information on how to report sexual abuse and sexual harassment on behalf of a resident? ☒ Yes ☐ No

**Auditor Overall Compliance Determination**

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

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

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

**Instructions for Overall Compliance Determination Narrative**

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

.254(a) Agency policy, titled “Employee Policy and Procedure Manual-Third Party Reporting” states any third party can report sexual abuse or harassment allegations on behalf of a resident directly to the PREA Coordinator by either phone or email. The PREA Coordinator contact information will be posted on the agency’s website at TCCPC.net.

In addition to the what agency policy has outlined, facility practice allows for any third party to report through any of the means outlined in PREA Standard 115.251 Resident Reporting. The No Means No poster posted throughout the facility reemphasizes this information and makes residents, volunteers, and visitors aware of the methods in which a third-party report can be made.

While conducting rounds of the facility, the audit team verified there were more than enough No Means No posters hung in common areas readily available to volunteers and visitors, including meeting rooms, class rooms, visiting rooms, and vestibules and entry ways. This assures anyone entering the facility can benefit from the information. Furthermore, this information is part of the training provided to residents at intake insuring they are aware of how third-party reports are made as well.

Detailed interviews with staff, residents, and volunteers confirmed all parties are fully aware of the agency’s willingness to accept third-party reports and how they can be made.

For the reasons outlined above, the audit team has found the agency meets this standard.

**OFFICIAL RESPONSE FOLLOWING A RESIDENT REPORT**

**Standard 115.261: Staff and agency reporting duties**

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

**115.261 (a)**

* Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency? ☒ Yes ☐ No
* Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding retaliation against residents or staff who reported an incident of sexual abuse or sexual harassment? ☒ Yes ☐ No
* Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding any staff neglect or violation of responsibilities that may have contributed to an incident of sexual abuse or sexual harassment or retaliation? ☒ Yes ☐ No

**115.261 (b)**

* Apart from reporting to designated supervisors or officials, do staff always refrain from revealing any information related to a sexual abuse report to anyone other than to the extent necessary, as specified in agency policy, to make treatment, investigation, and other security and management decisions? ☒ Yes ☐ No

**115.261 (c)**

* Unless otherwise precluded by Federal, State, or local law, are medical and mental health practitioners required to report sexual abuse pursuant to paragraph (a) of this section? ☒ Yes ☐ No
* Are medical and mental health practitioners required to inform residents of the practitioner’s duty to report, and the limitations of confidentiality, at the initiation of services? ☒ Yes ☐ No

**115.261 (d)**

* If the alleged victim is under the age of 18 or considered a vulnerable adult under a State or local vulnerable persons statute, does the agency report the allegation to the designated State or local services agency under applicable mandatory reporting laws? ☒ Yes ☐ No

**115.261 (e)**

* Does the facility report all allegations of sexual abuse and sexual harassment, including third-party and anonymous reports, to the facility’s designated investigators? ☒ Yes ☐ No

**Auditor Overall Compliance Determination**

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

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

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

**Instructions for Overall Compliance Determination Narrative**

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

.261(a) Agency policy, titled “Employee Policy and Procedure Manual-Official Response Following a Report” requires all staff to immediately report to the Agency Director any knowledge, suspicion, or information regarding an incident of sexual abuse or harassment occurring in a facility, whether or not it is a part of the agency, retaliation against reporting in such incidents, and any staff neglect or violation of responsibility that may have contributed to an incident or to retaliation.

There have been no reports of incidents of sexual abuse or sexual harassment to facility staff, therefore, no documentation exists to demonstrate compliance. However, detailed interviews with staff reveal that every staff member, without exception, understands their duty to report and that failure to do so will result in disciplinary action. The audit team is fully convenience agency staff understand their duty and will exercise it when necessary.

.261(b) Agency policy requires staff to not reveal any information related to a sexual abuse or harassment report to anyone other than to the extent necessary, to make treatment, investigative, and other necessary security management decisions.

Again, the audit team is dependent upon feedback from staff as to whether they understand this requirement and determine their willingness to comply. It is the opinion of this audit team that the staff at TCCPC are compassionate to the needs and rights of the residents under their care. This, coupled with responses from detailed staff interviews regarding this standard assured the audit team the agency has sufficiently informed and trained staff to comply with this standard. Furthermore, the agency has a practice of maintaining any documentation that may come up regarding such reporting behind locked doors in an administrator’s or PREA Coordinator’s office preventing unauthorized access to such information.

.261 (c) Agency policy requires medical and mental health practitioners to report sexual abuse pursuant to this standard. However, the agency does not currently employ medical nor mental health staff. Therefore, compliance with this portion of the standard is dependent upon compliance with PREA standard 115.232 Volunteer and Contractor Training. Because the agency is not currently compliant with 115.232, the audit team cannot find the agency is in full compliance with this standard.

The primary reason for this finding is that while conducting in-person interviews with the medial volunteers during the on-site portion of the audit, it was discovered that the medical professionals volunteering were well aware of their duty to report any know allegation of sexual abuse or sexual harassment, however, they were not informing residents at the initiation of services their duty to report and that confidentiality is limited. Once the agency fully trains all of their volunteers, including medical and mental health volunteers, including this requirement, the agency will be compliant with this portion of the standard.

.261(d) Agency policy requires reporting to a the Michigan Adult Protective Agency in accordance with law and this standard if an allegation is made affecting a person considered a vulnerable adult. Once again, there have been no allegations reported at this facility requiring the audit team to rely heavily on the responses gained from staff interviews. Staff, and medical/mental health volunteers all responded appropriately when asked about reporting requirements under this standard. Therefore, the audit team is assured, should an incident occur involving a vulnerable adult, agency staff and/or volunteer staff would respond appropriately.

.261(e) Agency policy, as noted in sub-section (a) above requires any and all reports or knowledge of incidents be immediately reported to the Agency Director. The same policy requires the Agency Director to notify the agency’s PREA Coordinator of such incidents or knowledge as an additional measure to ensure all response requirements are followed appropriately, including reporting such information to local law enforcement in accordance with the agency’s MOU with Three Rivers Police.

Based off the information outlined above, the agency has successfully fulfilled nearly every aspect of this standard. Because the agency does not employ medical nor mental health staff, but relies on volunteers to perform these services, the agency must ensure those individuals are properly trained in regard to their duty to report and their duty to notify residents, at the onset of services, the limits to privacy regarding sexual abuse and harassment. The agency can simply add this information and requirement to the volunteer training packet already provided as a suitable training aid for all volunteers, provide and document the training, and follow through with ensuring compliance to the requirement to come into full compliance with this standard.

Once all medical and mental health caretakers entering the facility and providing services to the residents have been trained in these requirements, and signed documentation verifying completion of this training is provided to the audit team, the agency will be fully compliant with this standard. In the meantime, the audit team has found the agency does not meet this standard.

Post Interim Report Update:

The agency provided detailed training to all medical volunteers/contractors who may have contact with residents. The agency PREA Coordinator developed a signature form for every volunteer and contractor to sign indicating they acknowledge they received a copy of, have read, and understand and agree to abide by the agency’s policies, procedures, and PREA Federal Register. The form is signed and dated by each medical volunteer/contractor receiving the training.

The agency provided the audit team with copies of every volunteer and contractor providing services at the facility verifying each as received the training. Therefore, the audit team has now found the agency to be fully compliant and meets this standard.

**Standard 115.262: Agency protection duties**

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

**115.262 (a)**

* When the agency learns that a resident is subject to a substantial risk of imminent sexual abuse, does it take immediate action to protect the resident? ☒ Yes ☐ No

**Auditor Overall Compliance Determination**

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

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

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

**Instructions for Overall Compliance Determination Narrative**

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.262 Agency policy, titled “Employee Policy and Procedure Manual-Agency Protection Duties” states when any staff learns that a resident is subject to a substantial risk of imminent sexual abuse, they shall take immediate action to protect the resident.

While conducting interviews with various staff, it was apparent that every staff member was aware of this requirement. Most, in fact, acted as though this was common sense and the primary reason they were at the facility. That said, when probed, all staff responded appropriately indicating they would immediately separate the resident from the threat, ensuring continued safety of the resident while reporting the circumstances to supervisory staff and the PREA Coordinator who would provide follow on instructions appropriate for the specific situation. When asked, every staff member indicated they would not leave a resident alone whom they thought was at risk.

While conducting the facility tour, the audit team noticed several resources available to the agency to ensure the safety of an individual resident, even if temporarily, while the situation was investigated and more permanent or long-term plans could be made. Options noted include empty rooms where no other residents currently resided, holding areas where new residents where in-processed, and chairs in the hallways of the administrative wing, among others. These all made excellent choices for staff to temporarily place a resident whom they thought was at imminent risk.

For these reasons, the audit team has determined the agency meets this standard.

**Standard 115.263: Reporting to other confinement facilities**

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

**115.263 (a)**

* Upon receiving an allegation that a resident was sexually abused while confined at another facility, does the head of the facility that received the allegation notify the head of the facility or appropriate office of the agency where the alleged abuse occurred? ☒ Yes ☐ No

**115.263 (b)**

* Is such notification provided as soon as possible, but no later than 72 hours after receiving the allegation? ☒ Yes ☐ No

**115.263 (c)**

* Does the agency document that it has provided such notification? ☒ Yes ☐ No

**115.263 (d)**

* Does the facility head or agency office that receives such notification ensure that the allegation is investigated in accordance with these standards? ☒ Yes ☐ No

**Auditor Overall Compliance Determination**

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

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

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

**Instructions for Overall Compliance Determination Narrative**

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.263(a) Agency policy, titled “Employee Policy and Procedure Manual-Reporting to Other Confinement Facilities” states upon receiving an allegation that a resident was sexually abused while confined at another facility, the Agency Director that received the allegation shall notify the Agency Director of the facility where the alleged abuse occurred. Agency policy requires such notification be provided as soon as possible, but no later than 72 hours after receiving the allegation and requires the Agency Director to document they have provided such notification.

While conducting resident interviews, the audit team uncovered that a resident had allegedly been sexual assaulted while he was at the county jail prior to arriving at TCCPC. The audit team did its best to offer supportive services immediately upon discovering the resident had been previously assaulted at another facility due to the resident being noticeably disturbed by admitting to such an incident. However, the resident adamantly refused any such services. The resident refused to provide any details about the incident other than to inform the audit team of the name of the facility, approximate location of the incident and approximate date it occurred.

The audit team promptly informed the Agency Director and PREA Coordinator who both reacted sympathetically and appropriately. The agency continued to offer supportive services form outside professionals well after the audit team had completed its visit. Furthermore, the Agency Director immediately contacted the county jail administrator where the alleged incident occurred. In addition, he followed up with a formal Incident Report detailing, in writing, as much information as the resident was willing to offer. This report was forwarded to the county jail administrator where the alleged incident occurred the same day. A response from the jail stated the allegation was being forwarded to appropriate staff further disposition and/or investigation.

The immediate response to this allegation demonstrates what the audit team had already determined about TCCPC and its staff. They are in this business because they are compassionate to the needs of its residents and will react swiftly and appropriately to any incident that jeopardizes resident safety or the good order of their facility.

For the reasons noted above, emphasizing the quick response of the Agency Director and PREA Coordinator regarding the allegation of abuse occurring at a local jail, the audit team finds the agency meets this standard.

**Standard 115.264: Staff first responder duties**

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

**115.264 (a)**

* Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Separate the alleged victim and abuser? ☒ Yes ☐ No
* Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Preserve and protect any crime scene until appropriate steps can be taken to collect any evidence? ☒ Yes ☐ No
* Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Request that the alleged victim not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating, if the abuse occurred within a time period that still allows for the collection of physical evidence? ☒ Yes ☐ No
* Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Ensure that the alleged abuser does not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating, if the abuse occurred within a time period that still allows for the collection of physical evidence? ☒ Yes ☐ No

**115.264 (b)**

* If the first staff responder is not a security staff member, is the responder required to request that the alleged victim not take any actions that could destroy physical evidence, and then notify security staff? ☒ Yes ☐ No

**Auditor Overall Compliance Determination**

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

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

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

**Instructions for Overall Compliance Determination Narrative**

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.264(a)(b) Agency policy, titled “Employee Policy and Procedure Manual-Staff First Responder Duties” lays out the requirements for staff to follow in response to becoming aware of an incident of sexual abuse. The policy outlines that staff shall:

1. Separate the alleged victim from the alleged abuser.
2. Preserve and protect any crime scene until appropriate steps can be taken to collect any evidence.
3. If the abuse occurred within a time period that still allows for the collection of physical evidence, request that the alleged victim not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating.
4. If the abuse occurred within a time period that allows for the collection of physical evidence, ensure that the alleged abuser does not take any action that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating.
5. If the first staff person to respond is not a security staff member, the responder shall be required to request the alleged victim not take any actions that could destroy physical evidence and then notify security staff.

In addition to outlining these requirements in policy, the agency has developed on one-page reference sheet titled TCCPC First Response Plan which outlines all the requirements of first responders. This document is easy to understand and is an easy reference for staff when faced with a stressful situation of an alleged abuse. It was recommended to the agency PREA Coordinator by the audit team, but not a requirement for compliance, that this one-page reference be laminated and posted at every work station as a quick reference for staff.

The audit team conducted detailed interviews regarding the requirements of staff who may find themselves as the first to respond to an incident of sexual abuse. Most staff readily provided the team with appropriate responses. However, a few staff, those who were visibly nervous to be interviewed by the audit team struggled to recall all the steps from memory. This is the reason for the recommendation to post the First Response Plan for staff to reference at their work stations.

That said, when probed with additional questions, all staff were able to articulate appropriate responses to the questions asked of the audit team. Because there have been no instances of sexual abuse occurring at the facility the audit team is not able to verify compliance through documentation of the incident. Therefore, the audit team must rely on agency policy, tools developed, and responses from staff regarding their duties as a first responder in making a determination of compliance. Due to the detailed policy, the development of the First Response Plan, and appropriate responses from staff during interviews, the audit team finds the agency meets this standard.

**Standard 115.265: Coordinated response**

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

**115.265 (a)**

* Has the facility developed a written institutional plan to coordinate actions among staff first responders, medical and mental health practitioners, investigators, and facility leadership taken in response to an incident of sexual abuse? ☒ Yes ☐ No

**Auditor Overall Compliance Determination**

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

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

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

**Instructions for Overall Compliance Determination Narrative**

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

.265 Agency policy, titled “Employee Policy and Procedure Manual-Coordinated Response” states the PREA Coordinator shall develop a written institutional plan to coordinate actions taken in response to every incident of sexual abuse, among first responders, mental health staff practitioners, investigators, and facility leadership.

The agency developed a one-page reference as their facility plan titled TCCPC First Response Plan. The plan outlines, step-by-step every action required of staff including what to do with alleged victims and abusers, how to protect any physical evidence, who to contact, including law enforcement and medical staff, reports to complete, and facility leadership to contact. The checklist is exhaustive and appropriate.

While conducting interviews with staff, everyone was aware of the checklist and knew where they could find a copy if and when necessary. Furthermore, as mentioned the auditor’s response to PREA Standard 115.264, staff response to their duties during an incident were appropriate and demonstrated a thorough understanding of their duties and responsibilities following an incident.

For these reasons, the audit team has found the agency meets this standard.

**Standard 115.266: Preservation of ability to protect residents from contact with abusers**

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

**115.266 (a)**

* Are both the agency and any other governmental entities responsible for collective bargaining on the agency’s behalf prohibited from entering into or renewing any collective bargaining agreement or other agreement that limits the agency’s ability to remove alleged staff sexual abusers from contact with any residents pending the outcome of an investigation or of a determination of whether and to what extent discipline is warranted? ☒ Yes ☐ No

**115.266 (b)**

* Auditor is not required to audit this provision.

**Auditor Overall Compliance Determination**

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

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

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

**Instructions for Overall Compliance Determination Narrative**

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The agency is a privately operated non-profit providing services, under contract, with the Michigan Department of Corrections and other local courts and jails to provide community probation services. Staff employed by TCCPC are not unionized nor are they subject to any collective bargaining agreements. Furthermore, upon conducting staff interviews with the Agency Director, he indicated there are no current unions or bargaining agreements, however, if the time came that this was ever the case, he would ensure agreements are NOT in violation of PREA.

Therefore, because the PREA audit process does not allow for a finding of not applicable, the audit team finds the agency meets this standard.

**Standard 115.267: Agency protection against retaliation**

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

**115.267 (a)**

* Has the agency established a policy to protect all residents and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other residents or staff? ☒ Yes ☐ No
* Has the agency designated which staff members or departments are charged with monitoring retaliation? ☒ Yes ☐ No

**115.267 (b)**

* Does the agency employ multiple protection measures, such as housing changes or transfers for resident victims or abusers, removal of alleged staff or resident abusers from contact with victims, and emotional support services for residents or staff who fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations? ☒ Yes ☐ No

**115.267 (c)**

* Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor the conduct and treatment of residents or staff who reported the sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff? ☒ Yes ☐ No
* Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor the conduct and treatment of residents who were reported to have suffered sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff? ☒ Yes ☐ No
* Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Act promptly to remedy any such retaliation? ☒ Yes ☐ No
* Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor any resident disciplinary reports? ☒ Yes ☐ No
* Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor resident housing changes? ☒ Yes ☐ No
* Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor resident program changes? ☒ Yes ☐ No
* Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor negative performance reviews of staff? ☒ Yes ☐ No
* Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor reassignments of staff? ☒ Yes ☐ No
* Does the agency continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need? ☒ Yes ☐ No

**115.267 (d)**

* In the case of residents, does such monitoring also include periodic status checks? ☒ Yes ☐ No

**115.267 (e)**

* If any other individual who cooperates with an investigation expresses a fear of retaliation, does the agency take appropriate measures to protect that individual against retaliation? ☒ Yes ☐ No

**115.267 (f)**

* Auditor is not required to audit this provision.

**Auditor Overall Compliance Determination**

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

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

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

**Instructions for Overall Compliance Determination Narrative**

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

.267(a) The agency has established a policy, titled “Employee Policy and Procedure Manual-Agency Protection Against Retaliation” which establishes the agency’s response to ensuring the protection against retaliation of any resident or staff who report sexual abuse or harassment, or who cooperate with an investigations into these reports.

Agency policy states it is the responsibility of the Agency Director to ensure retaliation monitoring is being conducted. During the on-site visit, when the audit team inquired about the duty/responsibility of retaliation monitoring, it was discovered this responsibility was delegated to the agency’s PREA Coordinator.

.267(b) Agency policy outlines multiple protection measures to be taken to ensure retaliation is not occurring. Policy outlines the following measures:

1. Housing changes,
2. Transfers for residents (abusers or victims),
3. Removal of staff,
4. Emotional support services.

.267(c)(d) Agency policy states retaliation monitoring shall occur for a least 90 days following a report. For these 90 days, the Agency Director shall ensure monitoring of the conduct and treatment of residents or staff who reported the abuse and the resident victim(s) of the abuse to see if there are changes that may suggest possible retaliation is taking place. The policy requires prompt action to remedy any such retaliation if discovered. Policy states the following should be looked for while monitoring for retaliation:

1. Resident disciplinary reports,
2. Housing changes,
3. Program assignment changes,
4. Negative performance reviews for staff,
5. Work reassignments of staff.

Policy requires and extension beyond 90 days if the initial monitoring indicates a continued need, and periodic status checks during the monitoring period.

.267(e)(f) Agency policy also requires the same implementation of monitoring for anyone individual who cooperates with an investigation who expresses fear of retaliation. All monitoring obligations terminate if an investigation determines the allegation is unfounded.

The agency has met all the policy requirements to meet this standard. There have been no allegations of abuse nor harassment at the facility preventing the audit team from verifying compliance through documentation. Therefore, the audit team must rely upon the agency’s policy and staff interviews in order to determine compliance.

While conducting interviews with staff, the audit team was assured by the Agency Director and PREA Coordinator that they were aware of and ready to implement retaliation monitoring efforts in compliance with their policy and these standards should they receive an allegation of abuse in the future. The PREA Coordinator inquired as to any best practices to document such retaliation monitoring for future audits. The audit team provided a PREA retaliation monitoring check list which the agency has agreed to use.

Based off the detailed policy implemented by the agency and staff ability to articulate accurately the need for retaliation monitoring, the audit team has found the agency meets this standard.

**INVESTIGATIONS**

**Standard 115.271: Criminal and administrative agency investigations**

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

**115.271 (a)**

* When the agency conducts its own investigations into allegations of sexual abuse and sexual harassment, does it do so promptly, thoroughly, and objectively? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations. See 115.221(a).) ☐ Yes ☐ No ☒ NA
* Does the agency conduct such investigations for all allegations, including third party and anonymous reports? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations. See 115.221(a).) ☐ Yes ☐ No ☒ NA

**115.271 (b)**

* Where sexual abuse is alleged, does the agency use investigators who have received specialized training in sexual abuse investigations as required by 115.234? ☒ Yes ☐ No

**115.271 (c)**

* Do investigators gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data? ☒ Yes ☐ No
* Do investigators interview alleged victims, suspected perpetrators, and witnesses? ☒ Yes ☐ No
* Do investigators review prior reports and complaints of sexual abuse involving the suspected perpetrator? ☒ Yes ☐ No

**115.271 (d)**

* When the quality of evidence appears to support criminal prosecution, does the agency conduct compelled interviews only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution? ☒ Yes ☐ No

**115.271 (e)**

* Do agency investigators assess the credibility of an alleged victim, suspect, or witness on an individual basis and not on the basis of that individual’s status as resident or staff? ☒ Yes ☐ No
* Does the agency investigate allegations of sexual abuse without requiring a resident who alleges sexual abuse to submit to a polygraph examination or other truth-telling device as a condition for proceeding? ☒ Yes ☐ No

**115.271 (f)**

* Do administrative investigations include an effort to determine whether staff actions or failures to act contributed to the abuse? ☒ Yes ☐ No
* Are administrative investigations documented in written reports that include a description of the physical evidence and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings? ☒ Yes ☐ No

**115.271 (g)**

* Are criminal investigations documented in a written report that contains a thorough description of the physical, testimonial, and documentary evidence and attaches copies of all documentary evidence where feasible? ☒ Yes ☐ No

**115.271 (h)**

* Are all substantiated allegations of conduct that appears to be criminal referred for prosecution? ☒ Yes ☐ No

**115.271 (i)**

* Does the agency retain all written reports referenced in 115.271(f) and (g) for as long as the alleged abuser is incarcerated or employed by the agency, plus five years? ☒ Yes ☐ No

**115.271 (j)**

* Does the agency ensure that the departure of an alleged abuser or victim from the employment or control of the agency does not provide a basis for terminating an investigation? ☒ Yes ☐ No

**115.271 (k)**

* Auditor is not required to audit this provision.

**115.271 (l)**

* When an outside entity investigates sexual abuse, does the facility cooperate with outside investigators and endeavor to remain informed about the progress of the investigation? (N/A if an outside agency does not conduct administrative or criminal sexual abuse investigations. See 115.221(a).) ☒ Yes ☐ No ☐ NA

**Auditor Overall Compliance Determination**

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

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

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

**Instructions for Overall Compliance Determination Narrative**

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

.271(a)(b)(c)(d)(l) Agency policy, titled “Employee Policy and Procedure Manual-Investigations” states all investigations shall be done promptly, thoroughly, and objectively, including allegations received anonymously or from third-parties. This policy establishes the criteria for the agency to meet this standard if and when they would conduct their own investigations. However, at the time of the audit, the agency has elected to refer each and every allegation of sexual abuse to an outside law enforcement agency for investigation. Police departments, by nature of the required training peace officers receive by law, have sufficient authority and training to conduct sexual abuse and harassment investigations in accordance with the PREA standards.

The agency has entered into a signed agreement (Memorandum of Agreement) with the Three Rivers Police Department to conduct these investigations. The MOU was signed by the Three Rivers Police Chief, Chief Bringman, and Twin County Community Probation Center Director, Tom Miles. The MOU specifically states the Three Rivers Police Department will fully investigate all sexual abuse complaints in accordance with PREA standards and outlines the duties and responsibilities of each party. Specifically, the police department is responsible for conducting a thorough investigation in accordance with law and these standards. The agency is responsible for producing any documentation/evidence necessary to conduct such an investigation, including gathering and preserving direct and circumstantial evidence, including any physical evidence, and DNA evidence as well as any electronic monitoring as outlined in agency policy. Thorough interviews with staff revealed all staff are well aware of their duty and responsibility regarding contacting the police department in a timely manner to initiate an investigation as well as the collection and safe guarding any evidence that may aid in the investigation.

.271(e) Agency policy states the credibility of an alleged victim, suspect, or witness shall be assessed on an individual basis and shall not be determined by the persons status as resident or staff. Furthermore, agency policy strictly prohibits the use of polygraph or other truth detecting device in conjunction with an investigation. Thorough interviews with staff reaffirmed to the audit team that everyone employed by TCCPC was aware of the stance the agency has regarding the assessment of credibility assuring the auditors that, if an allegation were made, the credibility of those involved would be based upon the circumstances of the incident and not the status of the individual.

.271(f) Agency policy requires administrative investigations to include a determination whether staff actions or failures contributed to abuse, must be documented in written reports, and a review completed within 30 days of conclusion of the investigation. Policy language meets the requirements of this standard.

However, the agency has indicated that all investigations, criminal and administrative are referred out to the Three Rivers Police Department. Furthermore, no allegations have been made upon the writing of this report, therefore no documentation is available to review for compliance. This however, does not prevent the agency from being fully compliant with the standard. Rather, the audit team has derived, through interviews with agency staff, that should an allegation occur, the agency would meet the requirements set forth her for administrative investigations. Upon completing staff interviews, the audit team is assured the agency has a thorough understanding of what is expected and is aware of the requirement to meet this standard, with supporting documentation should an allegation be made before their next PREA audit.

.271(g)(h)(i)(j) At the time of this report, there have been no allegations of sexual abuse or harassment to report and investigate. However, the audit team made contact with the Three Rivers Police Department and fully discussed the MOU and investigative requirements with agency leadership resulting in full confidence all parties involved are ready and able to fulfill the requirements of this standard.

.271(k) The agency being audited is not a State entity or Department of Justice component. Therefore, this portion of the standard is not applicable to this audit.

It is worth noting here, that should the agency choose to undertake any investigatory roles in the future, a detailed training program must be implemented in order to sufficiently train the appropriate staff on how to conduct investigations appropriately.

Due to the detail contained in the MOU with the local police department and full awareness of all agency staff to immediately contact law enforcement upon knowledge of abuse or harassment. Interviews with staff and law enforcement confirmed everyone is aware and supportive of their roles. For these reasons, the audit team finds the agency meets this standard.

**Standard 115.272: Evidentiary standard for administrative investigations**

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

**115.272 (a)**

* Is it true that the agency does not impose a standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated? ☒ Yes ☐ No

**Auditor Overall Compliance Determination**

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

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

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

**Instructions for Overall Compliance Determination Narrative**

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.272 Agency policy, titled “Employee Policy and Procedure Manual-Evidentiary Standard for Administrative Investigations” states the agency shall impose no standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated.

The agency has indicated that any allegation is referred outside the agency for investigation. However, the agency head has confirmed, during the staff interviews with the audit team, then any investigation with results indicating staff were more likely than not to have engaged in misconduct shall be held administratively responsible and disciplined, including dismissal, even if insufficient evidence exist to be found criminally responsible.

At the time of this report, no allegations have been made at this facility resulting in documentation to verify compliance. Therefore, for the reasons outlined above, the audit team is convinced the agency would fully meet the requirements of the standard if or when an allegation is made. Therefore, the audit team finds the agency meets this standard.

**Standard 115.273: Reporting to residents**

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

**115.273 (a)**

* Following an investigation into a resident’s allegation that he or she suffered sexual abuse in an agency facility, does the agency inform the resident as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded? ☒ Yes ☐ No

**115.273 (b)**

* If the agency did not conduct the investigation into a resident’s allegation of sexual abuse in the agency’s facility, does the agency request the relevant information from the investigative agency in order to inform the resident? (N/A if the agency/facility is responsible for conducting administrative and criminal investigations.) ☒ Yes ☐ No ☐ NA

**115.273 (c)**

* Following a resident’s allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The staff member is no longer posted within the resident’s unit? ☒ Yes ☐ No
* Following a resident’s allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The staff member is no longer employed at the facility? ☒ Yes ☐ No
* Following a resident’s allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The agency learns that the staff member has been indicted on a charge related to sexual abuse in the facility? ☒ Yes ☐ No
* Following a resident’s allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility? ☒ Yes ☐ No

**115.273 (d)**

* Following a resident’s allegation that he or she has been sexually abused by another resident, does the agency subsequently inform the alleged victim whenever: The agency learns that the alleged abuser has been indicted on a charge related to sexual abuse within the facility? ☒ Yes ☐ No
* Following a resident’s allegation that he or she has been sexually abused by another resident, does the agency subsequently inform the alleged victim whenever: The agency learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility? ☒ Yes ☐ No

**115.273 (e)**

* Does the agency document all such notifications or attempted notifications? ☒ Yes ☐ No

**115.273 (f)**

* Auditor is not required to audit this provision.

**Auditor Overall Compliance Determination**

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

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

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

**Instructions for Overall Compliance Determination Narrative**

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.273(a)(b) Agency policy, titled “Employee Policy and Procedure Manual-Reporting to Residents” states following an investigation into a resident’s allegation of sexual abuse suffered in a TCCPC facility, the PREA Coordinator is responsible for informing the resident as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded. The Offender Notification Form is used to accomplish this task and is required to occur within 30 days of concluding the investigation according to agency policy. It was clarified that the agency employs the services of the local law enforcement agency to conduct these investigations and both the Agency Director and PREA Coordinator are aware they may need to be proactive in gaining the outcome of the investigation from the police department.

.273(c) Agency policy requires notification of the following for cases where a staff member were involved:

1. The staff member is no longer posted within the resident’s unit,
2. The staff member is no longer employed at the facility,
3. TCCPC learns that the staff member has been indicted on a charge of sexual abuse within a facility, or
4. TCCPC learns that the staff member has been convicted on a charge related to sexual abuse within a facility.

.273(d) Agency policy requires notification of the following for cases where another resident where the aggressor:

1. TCCPC learns the alleged abuser has been indicted on a charge related to sexual abuse within a facility, or
2. TCCPC learns that the alleged abuser has been convicted on a charge related to sexual abuse within a facility.

.273(e) Agency policy requires all such notifications to be documented, as stated in sub-section (a) above, the agency has determined the Offender Notification Form is used to document this. Furthermore, agency policy allows for the obligation to notify to terminate if the resident victim is released from TCCPC’s custody.

Once again, due to the nature that no allegations have been reported, the audit team is forced to make a determination of compliance based off agency policy and staff awareness/knowledge of the requirements. The agency has a policy in place that sufficiently addresses the standard and detailed interviews with the Agency Director and PREA Coordinator reveal they are fully aware of the requirements set forth in this standard, have a plan to ensure implementation when needed, and developed the necessary tools to fulfill compliance. For these reasons, the audit team has determined the agency meets this standard.

**DISCIPLINE**

**Standard 115.276: Disciplinary sanctions for staff**

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

**115.276 (a)**

* Are staff subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies? ☒ Yes ☐ No

**115.276 (b)**

* Is termination the presumptive disciplinary sanction for staff who have engaged in sexual abuse? ☒ Yes ☐ No

**115.276 (c)**

* Are disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) commensurate with the nature and circumstances of the acts committed, the staff member’s disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories? ☒ Yes ☐ No

**115.276 (d)**

* Are all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, reported to: Law enforcement agencies unless the activity was clearly not criminal? ☒ Yes ☐ No
* Are all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, reported to: Relevant licensing bodies? ☒ Yes ☐ No

**Auditor Overall Compliance Determination**

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

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

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

**Instructions for Overall Compliance Determination Narrative**

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.276(a)(b) Agency policy, titled “Employee Policy and Procedure Manual-Discipline” states staff shall be subject to discipline sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies and that termination is the presumptive disciplinary sanction for staff who engage in sexual abuse.

.276(c) Agency policy continues addressing sexual abuse and sexual harassment allegations by outlining that sanctions for violations of TCCPC policies regarding abuse and harassment, aside from actually engaging in abuse, shall be 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.

.276(d) Agency policy requires all terminations, including resignations in lieu of termination, shall be reported to local law enforcement, unless clearly not a criminal act, and to any relevant licensing body.

Once again, due to the nature that no allegations have been reported, the audit team is forced to make a determination of compliance based off agency policy and staff awareness/knowledge of the requirements. The agency has a policy in place that sufficiently addresses the standard and detailed interviews with the Agency Director and PREA Coordinator reveal they are fully aware of the requirements set forth in this standard and fully support the implementation of these sanctions if ever necessary.

The Agency Director provided documentation and history of a staff member who violated agency policy, not related to sexual abuse or harassment. In short, once it was verified the staff member did violate agency policy be allowing a resident to accompany him into an unauthorized area of the facility, the staff member was immediately terminated. This demonstrates the agency’s willingness to act swiftly and appropriately to instances that may place the sexual safety of its residents in jeopardy.

Furthermore, upon conducting staff interviews, the audit team discovered that, without exception, all staff were well aware of the agency’s stance on this matter and were fully supportive of the immediate termination of any staff member found to be violating these policies further demonstrating the overall attitude and culture of the agency and its staff. For these reasons, the audit team has determined the agency meets this standard.

**Standard 115.277: Corrective action for contractors and volunteers**

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

**115.277 (a)**

* Is any contractor or volunteer who engages in sexual abuse prohibited from contact with residents? ☒ Yes ☐ No
* Is any contractor or volunteer who engages in sexual abuse reported to: Law enforcement agencies unless the activity was clearly not criminal? ☒ Yes ☐ No
* Is any contractor or volunteer who engages in sexual abuse reported to: Relevant licensing bodies? ☒ Yes ☐ No

**115.277 (b)**

* In the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer, does the facility take appropriate remedial measures, and consider whether to prohibit further contact with residents? ☒ Yes ☐ No

**Auditor Overall Compliance Determination**

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

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

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

**Instructions for Overall Compliance Determination Narrative**

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.277(a)(b) Agency policy, titled “Employee Policy and Procedure Manual-Corrective Action for Contractors and Volunteers states any contractor or volunteer who engages in sexual abuse shall be prohibited from contact with residents and shall be reported to law enforcement agencies, unless clearly not a criminal act, and to relevant licensing bodies. Policy continues with the requirement for the agency to take appropriate remedial measures, and shall consider whether to prohibit further contact with residents, in the case where any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer.

Fortunately, the agency does not have any documentation to support this standard. In other words, the agency has never experienced an allegation of sexual abuse or harassment for which they would have to demonstrate compliance. However, upon conducting detailed interviews with volunteers at the facility during the on-site visit, the audit team was fully convinced that every volunteer was aware of not only the prohibition for such conduct but also the consequences of doing so.

Furthermore, all relevant staff responded appropriately regarding the facility’s requirement to hold volunteers and contractors accountable and the reporting requirements to both law enforcement and appropriate licensing bodies. For these reasons, the audit team has found the agency meets this standard.

**Standard 115.278: Interventions and disciplinary sanctions for residents**

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

**115.278 (a)**

* Following an administrative finding that a resident engaged in resident-on-resident sexual abuse, or following a criminal finding of guilt for resident-on-resident sexual abuse, are residents subject to disciplinary sanctions pursuant to a formal disciplinary process? ☒ Yes ☐ No

**115.278 (b)**

* Are sanctions commensurate with the nature and circumstances of the abuse committed, the resident’s disciplinary history, and the sanctions imposed for comparable offenses by other residents with similar histories? ☒ Yes ☐ No

**115.278 (c)**

* When determining what types of sanction, if any, should be imposed, does the disciplinary process consider whether a resident’s mental disabilities or mental illness contributed to his or her behavior? ☒ Yes ☐ No

**115.278 (d)**

* If the facility offers therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse, does the facility consider whether to require the offending resident to participate in such interventions as a condition of access to programming and other benefits? ☒ Yes ☐ No

**115.278 (e)**

* Does the agency discipline a resident for sexual contact with staff only upon a finding that the staff member did not consent to such contact? ☒ Yes ☐ No

**115.278 (f)**

* For the purpose of disciplinary action does a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred NOT constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation? ☒ Yes ☐ No

**115.278 (g)**

* If the agency prohibits all sexual activity between residents, does the agency always refrain from considering non-coercive sexual activity between residents to be sexual abuse? (N/A if the agency does not prohibit all sexual activity between residents.) ☒ Yes ☐ No ☐ NA

**Auditor Overall Compliance Determination**

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

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

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

**Instructions for Overall Compliance Determination Narrative**

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

.278(a)(b) Agency policy, titled “Employee Policy and Procedure Manual-Disciplinary Sanctions for Residents” states residents shall be subject to disciplinary sanctions pursuant to a formal disciplinary process following an administrative or criminal finding that resident engaged in sexual abuse. Furthermore, agency policy requires the sanctions to be commensurate with the nature and circumstances of the abuse committed, the resident aggressor’s disciplinary history, and sanctions imposed for comparable offenses by other residents with similar histories.

.278 (c) Agency policy requires the disciplinary process to consider whether mental disability or mental illness contributed to the aggressor’s behavior when determining what type of sanction, if any, should be imposed.

.278(d) Agency policy, titled “Employee Policy and Procedure Manual-Medical and Mental Health Treatment addresses sub-section (d) of this standard. The policy states, TCCPC will make referrals for the mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners.

While conducting interviews with TCCPC staff, they indicated that the agency would offer such services by way of referring an alleged abuser to medical and mental health volunteers who routinely make rounds at the facility. When the audit team probed further, the PREA Coordinator indicated DASAS staff and medical professionals from a local doctor’s office visit the facility weekly in order to conduct rounds to visit with, engage, and if applicable, provide services to residents. If an allegation of abuse were to occur at the facility, the agency would ensure these volunteers engage with the alleged abuser in order to determine the appropriateness and willingness of the resident to receive such services. The audit team is convinced this practice is suitable given the dynamics of the community confinement environment and is sufficient in meeting this section of the standard.

.278(e) Agency policy is clear that disciplinary sanctions for residents engaged in sexual conduct with staff are only administered upon a finding the staff member did not consent to the contact.

.278(f) Regarding making reports of allegations and disciplinary action for making false reports, agency policy is clear that any report made in good faith will not be considered a false report resulting in disciplinary action. Staff response to interviews verifies staff do not discipline residents for reporting misconduct of any type.

.278(g) TCCPC has elected to prohibit any and all types of sexual activity among its resident population and policy requires for disciplinary action to be taken against any residents found to be engaging in such activity. Interviews with staff verify that staff will engage all parties involved in order to determine if coercion was a factor before initiating any disciplinary action regarding consensual sexual acts between residents.

At the time of the audit, no residents have been sanctioned for any sexual misconduct. Therefore, no documentation is available for the audit team to review. However, detailed interviews with staff and residents verify sufficient training and information regarding this matter has been distributed throughout the agency and its populace assuring the audit team that awareness in this instance is akin to compliance. Furthermore, as noted in other standards throughout this audit, the agency has a detailed policy governing all relevant factors of this standard. For these reasons, the audit team has found the agency meets this standard.

**MEDICAL AND MENTAL CARE**

**Standard 115.282: Access to emergency medical and mental health services**

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

**115.282 (a)**

* Do resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services, the nature and scope of which are determined by medical and mental health practitioners according to their professional judgment? ☒ Yes ☐ No

**115.282 (b)**

* If no qualified medical or mental health practitioners are on duty at the time a report of recent sexual abuse is made, do security staff first responders take preliminary steps to protect the victim pursuant to § 115.262? ☒ Yes ☐ No
* Do security staff first responders immediately notify the appropriate medical and mental health practitioners? ☒ Yes ☐ No

**115.282 (c)**

* Are resident victims of sexual abuse offered timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate? ☒ Yes ☐ No

**115.282 (d)**

* Are treatment services provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident? ☒ Yes ☐ No

**Auditor Overall Compliance Determination**

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

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

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

**Instructions for Overall Compliance Determination Narrative**

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.282(a) Agency policy, titled “Employee Policy and Procedure Manual-Medical and Mental Health Care” states resident victims of sexual abuse shall receive timely and unimpeded access to emergency medical treatment and crisis intervention. The policy states these services are provided by the local hospital emergency room or the local rape crisis center.

While conducting interviews with relevant staff regarding this process, the audit team was informed that the local hospital might not have a SANE/SAFE on staff, depending on when the incident occurs. The local rape crisis center, however, has contracted with hospital in another community to provide these services. In order to insure all resident victims of sexual abuse are awarded the most relevant medical treatment possible, policy includes both options. Policy also allows the medical professionals the authority to determine the type and scope of treatment rendered.

.282(b) Agency policy does not speak directly to this portion of the standard. However, the agency does not employ medical nor mental health professionals. Therefore, any medical emergency requires staff to immediately contact the local hospital or call ‘911’ in order to ensure timely services are rendered. Interviews with staff reveal that everyone is well aware of this practice.

Furthermore, the agency has implemented, within their First Response Plan, the requirement for staff to ensure the victim is made safe, separate from the abuser, and to immediately call ‘911’ and request medical treatment.

The combination of staff understanding derived from interviews along with the agency’s First Response Plan more than sufficiently address this portion of the standard.

.282(c)(d) Agency policy requires the timely offering of information and access to emergency contraception and sexually transmitted infections prophylaxis and all services covered under this standard are provided at no cost to the resident.

Agency policy sufficiently addresses this standard in its entirety. However, much like previous standards addressed in this audit, the lack of allegations at this facility require the audit team to deifier understanding of the agency’s requirements to ensure compliance if or when an incident occurs. Upon conducting detailed interviews with staff, it was apparent to the audit team that the agency had done an excellent job of communicating the requirements of this policy, in practice, to everyone. Every staff member interviewed understood the requirement to contact medical emergency services by dialing ‘911’ and to allow all medically appropriate services in accordance with the assessment of the medical professionals. For these reasons, the audit team has determined the agency meets this standard.

**Standard 115.283: Ongoing medical and mental health care for sexual abuse victims and abusers**

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

**115.283 (a)**

* Does the facility offer medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility? ☒ Yes ☐ No

**115.283 (b)**

* Does the evaluation and treatment of such victims include, as appropriate, follow-up services, treatment plans, and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody? ☒ Yes ☐ No

**115.283 (c)**

* Does the facility provide such victims with medical and mental health services consistent with the community level of care? ☒ Yes ☐ No

**115.283 (d)**

* Are resident victims of sexually abusive vaginal penetration while incarcerated offered pregnancy tests? (N/A if “all-male” facility. *Note: in “all-male” facilities, there may be residents who identify as transgender men who may have female genitalia. Auditors should be sure to know whether such individuals may be in the population and whether this provision may apply in specific circumstances.*) ☒ Yes ☐ No ☐ NA

**115.283 (e)**

* If pregnancy results from the conduct described in paragraph § 115.283(d), do such victims receive timely and comprehensive information about and timely access to all lawful pregnancy-related medical services? (N/A if “all-male” facility. *Note: in “all-male” facilities, there may be residents who identify as transgender men who may have female genitalia. Auditors should be sure to know whether such individuals may be in the population and whether this provision may apply in specific circumstances.*) ☒ Yes ☐ No ☐ NA

**115.283 (f)**

* Are resident victims of sexual abuse while incarcerated offered tests for sexually transmitted infections as medically appropriate? ☒ Yes ☐ No

**115.283 (g)**

* Are treatment services provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident? ☒ Yes ☐ No

**115.283 (h)**

* Does the facility attempt to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners? ☒ Yes ☐ No

**Auditor Overall Compliance Determination**

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

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

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

**Instructions for Overall Compliance Determination Narrative**

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

.283(a) Agency policy, titled “Employee Policy and Procedure Manual-Medical and Mental Health Care” requires the agency to ensure access to community-based medical and mental health evaluations and treatment where necessary. Furthermore, agency policy requires the facility to develop and maintain a list of all community-based entities offering services. At the time of the audit, the following entities were on the facility’s list:

1. For Medical:
   1. Urgent Care of Three Rivers
   2. Three Rivers Hospital ER
2. For Dental:
   1. Three Rivers Dental Clinic
3. For Substance Abuse:
   1. Community healing Center
4. For Mental Health:
   1. Community Mental Health

.283(b) Agency policy continues with the requiring the evaluation and treatment of victims including follow-up services, treatment plans, and referrals for continued care following transfer or discharge.

.283(c) Agency policy addresses the requirement for the agency to ensure services provided are consistent with the community level of care. Considering the agency only provides services rendered by providers from the community, this is more of a reminder to staff and the agency as a whole of the requirement to allow services as directed by community providers.

.283(d)(e)(f) Agency policy requires the following for resident victims of sexual abuse:

1. Tests for sexually transmitted infections
2. Free pregnancy tests
3. Comprehensive information about pregnancy related medical services
4. Access to all lawful pregnancy related medical services

.283(g)(h) Agency policy indicates all services provided to victims of sexual abuse shall be offered at no cost to the victim. The same policy also states the agency will make a referral for the mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by the mental health professionals.

The audit team has closely reviewed agency policy pertaining to this standard and is satisfied policy appropriately addresses the requirements of this standard. Due to the lack of incidents requiring these services which also means there is no documentation to review, the audit team is left with determining compliance based off staff understanding of the requirements. Like several standards before, the agency has done an excellent job putting into place the training, tools, and insuring staff understanding in order to meet compliance. Therefore, the audit team has determined the agency meets this standard.

**DATA COLLECTION AND REVIEW**

**Standard 115.286: Sexual abuse incident reviews**

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

**115.286 (a)**

* Does the facility conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation, including where the allegation has not been substantiated, unless the allegation has been determined to be unfounded? ☒ Yes ☐ No

**115.286 (b)**

* Does such review ordinarily occur within 30 days of the conclusion of the investigation? ☒ Yes ☐ No

**115.286 (c)**

* Does the review team include upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners? ☒ Yes ☐ No

**115.286 (d)**

* Does the review team: Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse? ☒ Yes ☐ No
* Does the review team: Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; gang affiliation; or other group dynamics at the facility? ☒ Yes ☐ No
* Does the review team: Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse? ☒ Yes ☐ No
* Does the review team: Assess the adequacy of staffing levels in that area during different shifts? ☒ Yes ☐ No
* Does the review team: Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff? ☒ Yes ☐ No
* Does the review team: Prepare a report of its findings, including but not necessarily limited to determinations made pursuant to §§ 115.286(d)(1) - (d)(5), and any recommendations for improvement and submit such report to the facility head and PREA compliance manager? ☒ Yes ☐ No

**115.286 (e)**

* Does the facility implement the recommendations for improvement, or document its reasons for not doing so? ☒ Yes ☐ No

**Auditor Overall Compliance Determination**

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

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

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

**Instructions for Overall Compliance Determination Narrative**

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

.286(a)(b) Agency policy, titled “Employee Policy and Procedure Manual-Data Collection and Review” states the agency shall conduct sexual abuse incident reviews at the conclusion of every sexual abuse investigation, including where the allegation has not been substantiated, unless the allegation has been determined to be unfounded. The policy also requires the review be conducted within 30 days of the conclusion of the investigation.

.286(c)(d) Agency policy requires the review be conducted by upper-level management with input from the Director, Administrative Case Manager, Chief of Security, Case Managers, Investigators, and Medical/Mental Health Practitioners. Policy goes on to include the review team consider the following:

1. Whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse.
2. Whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; or gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility.
3. Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse.
4. Assess the adequacy of staffing levels in that area during different shifts.
5. Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff.
6. Prepare a report of findings, including any recommendations for improvement, and submit such report to the Executive Director.

.286(e) Agency policy states TCCPC shall implement the recommendations provided by the review team or document reasons for not doing so.

The agency has not received any allegations for which it needs to conduct such reviews. However, the audit team witnessed the facility’s response to recommendations to enhance monitoring technology within the facility following recommendations from the team. Specifically, the audit team revealed a location within the facility that posed a potential blind spot where sexual abuse could occur undetected. The agency immediately responded by adding a camera to the maintenance room in question and had it operational before the audit team completed the on-site visit.

Agency policy does not require the a copy of the sexual abuse incident review report be provided to the PREA Coordinator, as required in subsection (d)(6) of this standard. However, upon conducting interviews with both the Agency Director and PREA Coordinator, when the time comes that a review needs to be conducted in accordance with agency policy, the PREA Coordinator will be responsible for developing the report effectively obtaining a copy by virtue of being the author.

Based off several interviews with staff affected by this standard and a detailed review of agency policy, the audit team is convinced the agency has in place the tools, training, and understanding necessary to meet full compliance. In addition, the audit team provided the agency’s PREA Coordinator with a template to use for completing sexual abuse incident reviews in a manner that sufficiently address the standard to use as a guide if and when the time comes they need to complete one.

For these reasons, the audit team has found the agency meets this standard.

**Standard 115.287: Data collection**

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

**115.287 (a)**

* Does the agency collect accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions? ☒ Yes ☐ No

**115.287 (b)**

* Does the agency aggregate the incident-based sexual abuse data at least annually? ☒ Yes ☐ No

**115.287 (c)**

* Does the incident-based data include, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice? ☒ Yes ☐ No

**115.287 (d)**

* Does the agency maintain, review, and collect data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews? ☒ Yes ☐ No

**115.287 (e)**

* Does the agency also obtain incident-based and aggregated data from every private facility with which it contracts for the confinement of its residents? (N/A if agency does not contract for the confinement of its residents.) ☐ Yes ☐ No ☒ NA

**115.287 (f)**

* Does the agency, upon request, provide all such data from the previous calendar year to the Department of Justice no later than June 30? (N/A if DOJ has not requested agency data.) ☒ Yes ☐ No ☐ NA

**Auditor Overall Compliance Determination**

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

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

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

**Instructions for Overall Compliance Determination Narrative**

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

.287(a)(b)(c) Agency policy, titled “Employee Policy and Procedure Manual-Data Collection” requires the agency to collect accurate, uniform data for every allegation of sexual abuse occurring at its facility utilizing a standardized instrument and set of definitions. Policy requires the agency to aggregate the data at least annually, and shall include, at a minimum, information necessary to complete the Survey of Sexual Violence (now called the Survey of Sexual Victimization).

.287(d) Agency policy requires the PREA Coordinator to maintain, review, and collect data as needed from all available incident-based documents including reports, investigations, and sexual abuse incident reviews.

.287(e) Agency policy does not address this portion of the standard because it does not contract for the confinement of its residents and therefore this portion is not applicable to this audit.

.287(f) Agency policy does not sufficiently address this requirement of the standard. However, the audit team has provided the agency with the tools necessary to ensure compliance when necessary. It is recommended by the audit team that the agency include this requirement in policy especially considering the audit team has no other means in which to determine compliance.

The agency has not collected any data regarding allegations of sexual abuse occurring at its facility. This is because there have been no allegations of sexual abuse occurring at the facility. Simply not completing the data collection in circumstance like this does not mean non-compliance with the standard. Especially if an agency has a detailed plan and tools in place to demonstrate full compliance when the time comes that an allegation has occurred.

The audit team suggested the agency complete the SSV-IV for each year of the audit cycle to demonstrate during future audits the awareness and ability of the agency to be compliant. However, this is not a requirement for compliance considering there have been no allegations from which to collect data.

The audit team does require additional guidance in the agency’s policy ensuring compliance by future staff, especially when there is no documentation to review. Therefore, as mentioned in sub-section (f) above, the agency must add the requirement to provide aggregate data to the Department of Justice no later than June 30, upon request, in order to be fully compliant with this standard. Once the policy change has been implemented and provided to the audit team, the agency will be fully complaint with this standard.

For the reasons mentioned above, the audit team has found the agency does not meet this standard.

Post Interim Report Updates:

The agency elected to utilize the most current version of the SSV-4 to collect and record accurate, uniform data for every allegation of sexual abuse/harassment occurring under its control. This process sufficiently addresses all elements of this standard. Furthermore, the agency has included in its updated PREA Policy (Twin County Community Probation Center, Policies and Procedures Manual – Revised 1 August, 2021) to include the following requirements:

a. TCCPC shall collect accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions.

b. The TCCPC PREA coordinator shall aggregate the incident-based sexual abuse data at least annually by completing the Survey of sexual Victimization (SSV-4) and uploaded it to website.

c. The incident-based data collected will include the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice.

d. The TCCPC PREA coordinator will maintain, review, and collect data as needed from all available incident-based documents including reports, investigation files, and sexual abuse incident reviews.

The agency’s updated policy is now effective and the PREA Coordinator is aware of the requirement to track the data necessary to be compliant with this standard. Furthermore, the agency as completed the SSV-4 for this year and provided it to the audit team demonstrating an understanding and willingness to comply.

For the reasons mentioned above, the audit team has determined the agency now meets this standard.

**Standard 115.288: Data review for corrective action**

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

**115.288 (a)**

* Does the agency review data collected and aggregated pursuant to § 115.287 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Identifying problem areas? ☒ Yes ☐ No
* Does the agency review data collected and aggregated pursuant to § 115.287 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Taking corrective action on an ongoing basis? ☒ Yes ☐ No
* Does the agency review data collected and aggregated pursuant to § 115.287 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Preparing an annual report of its findings and corrective actions for each facility, as well as the agency as a whole? ☒ Yes ☐ No

**115.288 (b)**

* Does the agency’s annual report include a comparison of the current year’s data and corrective actions with those from prior years and provide an assessment of the agency’s progress in addressing sexual abuse ☒ Yes ☐ No

**115.288 (c)**

* Is the agency’s annual report approved by the agency head and made readily available to the public through its website or, if it does not have one, through other means? ☒ Yes ☐ No

**115.288 (d)**

* Does the agency indicate the nature of the material redacted where it redacts specific material from the reports when publication would present a clear and specific threat to the safety and security of a facility? ☒ Yes ☐ No

**Auditor Overall Compliance Determination**

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

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

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

**Instructions for Overall Compliance Determination Narrative**

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Agency policy, titled “Employee Policy and Procedure Manual-Data Review for Corrective Action” fulfills all the necessary requirements for this standard. However, due to the language in standard 115.287(a) requiring the agency to collect data from actual allegations of sexual abuse occurring at its facility, there is no data to review for corrective action. Once again, the audit team must rely on policy language and staff understanding of the requirements in order to make a determination of compliance. That said, the audit team has found the policy language and staff understanding of the requirements is sufficient to find the agency in compliance. For these reasons, the audit team finds the agency meets this standard.

Again, the audit team recommends the agency conduct an annual review of itself addressing the questions outlined in the most recent SSV-IV as well as considering it’s continued effectiveness of its sexual abuse prevention, detection, response, policies, practices, and training in order to demonstrate the agency’s willingness and ability to comply with the provisions of this standard. This is not a requirement for compliance, simply and observation and recommendation by the audit team.

**Standard 115.289: Data storage, publication, and destruction**

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

**115.289 (a)**

* Does the agency ensure that data collected pursuant to § 115.287 are securely retained? ☒ Yes ☐ No

**115.289 (b)**

* Does the agency make all aggregated sexual abuse data, from facilities under its direct control and private facilities with which it contracts, readily available to the public at least annually through its website or, if it does not have one, through other means? ☒ Yes ☐ No

**115.289 (c)**

* Does the agency remove all personal identifiers before making aggregated sexual abuse data publicly available? ☒ Yes ☐ No

**115.289 (d)**

* Does the agency maintain sexual abuse data collected pursuant to § 115.287 for at least 10 years after the date of the initial collection, unless Federal, State, or local law requires otherwise? ☒ Yes ☐ No

**Auditor Overall Compliance Determination**

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

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

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.289(a)(b)(c)(d) Agency policy, titled “Employee Policy and Procedure Manual-Data Storage, Publication, and Destruction states the agency shall ensure data, when collected, will be kept in locked offices, that all aggregated sexual abuse data will be readily available to the public, at least annually, through its website, and all personal identifies will be removed before being made public. Furthermore, policy requires retention for at least 10 years after the date of the initial collection.

The agency has yet to have a report of abuse or harassment in which to aggregate, review and report. Furthermore, this is the agency’s initial year working toward full compliance and elected to undergo a certified audit. Going forward, the agency will need to provide documentation demonstrating they are reviewing annually, comparing data, and completing annual reports to be compliant with future audits.

Based off the detailed policy language and the PREA Coordinator’s thorough understanding of this standard, the audit team has found the agency meets this standard.

**AUDITING AND CORRECTIVE ACTION**

**Standard 115.401: Frequency and scope of audits**

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

**115.401 (a)**

* During the prior three-year audit period, did the agency ensure that each facility operated by the agency, or by a private organization on behalf of the agency, was audited at least once? (*Note: The response here is purely informational. A "no" response does not impact overall compliance with this standard.*) ☒ Yes ☐ No

**115.401 (b)**

* Is this the first year of the current audit cycle? (*Note: a “no” response does not impact overall compliance with this standard*.) ☒ Yes ☐ No
* If this is the second year of the current audit cycle, did the agency ensure that at least one-third of each facility type operated by the agency, or by a private organization on behalf of the agency, was audited during the first year of the current audit cycle? (N/A if this is **not** the *second* year of the current audit cycle.) ☐ Yes ☐ No ☒ NA
* If this is the third year of the current audit cycle, did the agency ensure that at least two-thirds of each facility type operated by the agency, or by a private organization on behalf of the agency, were audited during the first two years of the current audit cycle? (N/A if this is **not** the *third* year of the current audit cycle.) ☐ Yes ☐ No ☒ NA

**115.401 (h)**

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

**115.401 (i)**

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

**115.401 (m)**

* Was the auditor permitted to conduct private interviews with residents? ☒ Yes ☐ No

**115.401 (n)**

* Were residents permitted to send confidential information or correspondence to the auditor in the same manner as if they were communicating with legal counsel? ☒ Yes ☐ No

**Auditor Overall Compliance Determination**

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

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

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

**Instructions for Overall Compliance Determination Narrative**

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

This is the first year of the current audit cycle and the agency’s first audit for PREA compliance. The agency does not contract for the confinement of its residents but does house residents on behalf of the Michigan Department of Corrections. The agency’s willingness to undergo a certified audit makes them compliant and therefore meets this standard.

**Standard 115.403: Audit contents and findings**

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

**115.403 (f)**

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

**Auditor Overall Compliance Determination**

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

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

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

**Instructions for Overall Compliance Determination Narrative**

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

This is the agency’s first certified PREA audit. Therefore, there have been no final audit reports to publish. However, the agency will be required to publish this report, once finalized, in order to be in compliance for subsequent audits.

For the purposes of this audit, a finding of not applicable is not an option. Therefore, the audit team must find the agency meets this standard.

**AUDITOR CERTIFICATION**

I certify that:

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

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

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

**Auditor Instructions:**

Type your full name in the text box below for Auditor Signature. This will function as your official electronic signature. Auditors must deliver their final report to the PREA Resource Center as a searchable PDF format to ensure accessibility to people with disabilities. Save this report document into a PDF format prior to submission.[[1]](#footnote-1) Auditors are not permitted to submit audit reports that have been scanned.[[2]](#footnote-2) See the PREA Auditor Handbook for a full discussion of audit report formatting requirements.

Todd W. Butler 9/14/2021

**Auditor Signature Date**

1. See additional instructions here: <https://support.office.com/en-us/article/Save-or-convert-to-PDF-d85416c5-7d77-4fd6-a216-6f4bf7c7c110> . [↑](#footnote-ref-1)
2. See *PREA Auditor Handbook*, Version 1.0, August 2017; Pages 68-69. [↑](#footnote-ref-2)