

# Prison Rape Elimination Act (PREA) Audit Report Juvenile Facilities

Interim       Final

Date of Report 05-01-2019

## Auditor Information

Name: David "Will" Weir      Email: will@preaamerica.com

Company Name: PREA America, LLC

Mailing Address: P. O. Box 1473      City, State, Zip: Raton, NM 87740

Telephone: 405-945-1951      Date of Facility Visit: 3/21/2019

## Agency Information

Name of Agency: MDHHS Children Services Agency Juvenile Justice Program  
Governing Authority or Parent Agency (If Applicable): Michigan Department of Health and Human Services

Physical Address: 235 S. Grand Ave.      City, State, Zip: Lansing, MI 48909

Mailing Address: Click or tap here to enter text.      City, State, Zip: Click or tap here to enter text.

Telephone: 517-335-3489      Is Agency accredited by any organization?  Yes  No

The Agency Is:  Military       Private for Profit       Private not for Profit

Municipal       County       State       Federal

Agency mission: To lead statewide efforts to eliminate domestic and sexual violence in Michigan.

Agency Website with PREA Information: [http://www.michigan.gov/dhs/0,4562,7-124-5453\\_34044\\_39057---,00.html](http://www.michigan.gov/dhs/0,4562,7-124-5453_34044_39057---,00.html)

## Agency Chief Executive Officer

Name: Jennifer Wrayno      Title: MDHHS Children's Services Agency Executive Director

Email: SEMA Kelcy Williams, WilliamsK34@michigan.gov      Telephone: SEMA Kelcy Williams, 1-517-241-9859

## Agency-Wide PREA Coordinator

<b>Name:</b> Soleil Campbell	<b>Title:</b> Juvenile Justice Program Manager
<b>Email:</b> campbells6@michigan.gov	<b>Telephone:</b> 517-373-1570
<b>PREA Coordinator Reports to:</b> Stacie Bladen, Deputy Director of Children's Services Agency	<b>Number of Compliance Managers who report to the PREA Coordinator</b> 0

### Facility Information

<b>Name of Facility:</b>	Youth Opportunity Pathway of Hope		
<b>Physical Address:</b>	8835 Oak Road; Ewart, MI 48631		
<b>Mailing Address (if different than above):</b>	Click or tap here to enter text.		
<b>Telephone Number:</b>	231-734-3787		
<b>The Facility Is:</b>	<input type="checkbox"/> Military	<input checked="" type="checkbox"/> Private for Profit	<input type="checkbox"/> Private not for Profit
<input type="checkbox"/> Municipal	<input type="checkbox"/> County	<input type="checkbox"/> State	<input type="checkbox"/> Federal
<b>Facility Type:</b>	<input type="checkbox"/> Detention	<input type="checkbox"/> Correction	<input type="checkbox"/> Intake <input type="checkbox"/> Other
<b>Facility Mission:</b>	We are committed to bringing hope to hurting and troubled girls and their families.		
<b>Facility Website with PREA Information:</b>	<a href="http://www.youthopportunity.com/campuses/?lang=en">http://www.youthopportunity.com/campuses/?lang=en</a>		
<b>Is this facility accredited by any other organization?</b>	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		

### Facility Administrator/Superintendent

<b>Name:</b> Nicholas Bailey	<b>Title:</b> Program Manager
<b>Email:</b> pathway@gmail.com	<b>Telephone:</b> 810-241-0004

### Facility PREA Compliance Manager

<b>Name:</b> Lisa Salisbury	<b>Title:</b> Admin. Asst. PREA Compliance
<b>Email:</b> Lisa@mryh.org	<b>Telephone:</b> 231-734-3787

### Facility Health Service Administrator

<b>Name:</b> N/A	<b>Title:</b> Click or tap here to enter text.
<b>Email:</b> Click or tap here to enter text.	<b>Telephone:</b> Click or tap here to enter text.

### Facility Characteristics

<b>Designated Facility Capacity:</b> 14	<b>Current Population of Facility:</b> 6
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Number of residents admitted to facility during the past 12 months		13
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 10 days or more:		12
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 72 hours or more:		13
Number of residents on date of audit who were admitted to facility prior to August 20, 2012:		0
Age Range of Population:	10-17	
Average length of stay or time under supervision:		6-9 months
Facility Security Level:		Open Program
Resident Custody Levels:		Non-secure
Number of staff currently employed by the facility who may have contact with residents:		10
Number of staff hired by the facility during the past 12 months who may have contact with residents:		12
Number of contracts in the past 12 months for services with contractors who may have contact with residents:		0
<b>Physical Plant</b>		
Number of Buildings: 1		Number of Single Cell Housing Units: 0
Number of Multiple Occupancy Cell Housing Units:		4
Number of Open Bay/Dorm Housing Units:		0
Number of Segregation Cells (Administrative and Disciplinary):		0
Description of any video or electronic monitoring technology (including any relevant information about where cameras are placed, where the control room is, retention of video, etc.):		
Click or tap here to enter text.		
<b>Medical</b>		
Type of Medical Facility:		N/A
Forensic sexual assault medical exams are conducted at:		Big Rapids Spectrum Health (SANE, post-incident medical exams, and counseling); Advocacy through MOU with Oasis
<b>Other</b>		
Number of volunteers and individual contractors, who may have contact with residents, currently authorized to enter the facility:		0
Number of investigators the agency currently employs to investigate allegations of sexual abuse:		1

# Audit Findings

## Audit Narrative

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

The March 21, 2019, PREA audit of Youth Opportunity Pathway of Hope, formerly Muskegon River Pathway of Hope, was conducted by DOJ Certified PREA Auditor David "Will" Weir, MCJ. The audit team also included Project Manager Tom Kovach who assists in collecting documentation and conducts interviews. Mr. Weir and Mr. Kovach do their audit work through PREA America, LLC.

Introductory communication with the Michigan Department of Health and Human Services Juvenile Justice Programs PREA Coordinator to discuss the audit process, audit preparation, Pre-Audit Questionnaire (PAQ), and supporting documents and elements of the on-site visit, took place shortly after scheduling the on-site audit date, which occurred December 19, 2018. The Audit Notice Posting was sent with instructions to print on color paper and to ensure proper distribution of the posting. Alternative language posting was also made available. Proof of posting was verified by emailed photos of the various locations in the facility where the posting was placed. The date of the email was used to verify the minimum posting requirements of six weeks, along with observations of the posting during the physical plant tour.

During the Pre-Audit Phase an extensive desk audit of the facility/agency (PAQ, policies, procedures, as well as supporting documentation) was conducted, and several emails exchanged to clarify issues. This phase of the audit was used to collaborate with the facility staff on questions and concerns with documenting compliance. The communication with the facility staff was used to understand not only the policies and procedures unique to the facility but also to understand how PREA was put into practice. Internet research was done on the facility.

The PAQ had some unanswered questions which were later answered by Agency and Facility staff. The Coordinated Response Plan was updated to better reflect best practices. Policy revisions were recommended. The First Responder Duties were not stated in the Staff Response section of the facility's PREA policy. The Screening Policy enumerated all the risk factors that the standards require, except for the possible risk associated with "gender nonconforming appearance or manner or identification as lesbian, gay, bisexual, transgender, or intersex". These were added to the policy during the Pre-Audit Phase.

All documents received were reviewed, including logs, training files, and curriculum. Background checks and child abuse registry files were randomly selected of staff to verify the initial background check and the five-year recheck requirement. Resident files were randomly selected to verify PREA

education and PREA Screenings. Phone calls were made to listed advocates, to verify the advocacy required by the standards.

The on-site audit, conducted March 21, 2019, started with a briefing that confirmed the current population of six, agenda and logistics review, discussion of mandatory reporting, and clarification of the need to allow any staff or resident who requests an interview to get one. The audit team checked to see if there were questions or concerns.

The Site Review included obtaining and studying the facility diagram of the physical plant. The audit team observed staff and residents and the supervision and movement along with casual conversation to ascertain if observations made were of “normal” supervision and movement. Random checks were made to assure doors intended to be secured were locked. Random checks of PREA Hotline phones for functionality were made. All housing units and bathroom facilities were inspected for compliance for cross-gender supervision. This included a camera review for those areas with cameras; one camera was not working well, and a replacement has been requested. All areas of the physical plants were observed, with attention to those areas that are statistically high risk for sexual abuse. PREA Postings, including third-party reporting postings, in the visitation area were checked. Confirmation of the availability to staff of hardcopies of First Responder Duties was also a part of the tour. Blind spots were identified and procedures for checking them were verified.

Due to the size of this facility all residents were interviewed. Interviews were conducted in a conversational manner to gain the confidence of those interviewed and to put them at ease so the audit team could better understand their understanding of the PREA standards and the practice in the facility.

The following interviews of staff and administrators were conducted: Agency Head Designee, Agency PREA Coordinator, Agency Contract Compliance, Regional Director, human resources personnel, Local Investigator, PREA Compliance Manager, higher-level staff for unannounced rounds, staff who perform Screening and Intake, staff who monitor for Retaliation, and the Incident Review Team. Specialized Staff perform multiple functions at the facility, so they were interviewed regarding each role they play. An additional five staff members were interviewed, representing all staff working the day of the audit. They represented all stations and shifts. Some agency-level interviews were conducted by phone. A total of 13 unique interviews were conducted.

The Exit Briefing addressed all aspects of the audit to date. No determination of compliance was given. The recap of the aggregated information obtained and observed was summarized. A SWOT (Strengths, Weaknesses, Opportunities, and Threats) briefing was provided by request of the facility staff to assist in furthering the efforts of the facility to prevent and detect sexual abuse and harassment.

It was required that the Program Manager go through PREA training again since his interview indicated a need to better understand what the standards require. Additionally, during the the 30 days after the onsite audit the following documentation was received: PREA Training and Investigator Training completed by Program Manager, Updated CRP, New Staffing Plan Review, Updated PREA Policy, and two investigations.

## 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.*

This is a small residential facility for female youth. The single-story building sits on a large lot. There is a basement, which is for staff only and always remains locked. There is one room with bunk beds for residents. It has a bathroom with shower. A “one at a time rule” exists for the bathroom.

There is another bathroom next to the living quarters. A laundry room has a shower that is sometime used. Here too, a “one at a time rule” exists, along with a rule that the door be closed only during shower-time, due to a camera outside the laundry room.

There is a kitchen with a small dining area, along with three offices for the administration and case manager. A large room is used for visitation and other functions. There is a staff closet where the Coordinated Response Plan is posted. Also, a den or TV room is at the far end of the building.

Cameras have been upgraded recently. Most blind spots have been eliminated but there are a few areas without cameras. These are noted and checked as a part of regular rounds as well as unannounced rounds.

## Summary of Audit Findings

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

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

**Number of Standards Exceeded:** 0

**Number of Standards Met:** 43

**Number of Standards Not Met:** 0

## Summary of Corrective Action (if any)

Youth Opportunity Pathway of Hope did not require corrective action beyond the 30 days after the on-site audit.

## PREVENTION PLANNING

### Standard 115.311: Zero tolerance of sexual abuse and sexual harassment; PREA coordinator

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

#### 115.311 (a)

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

#### 115.311 (b)

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

#### 115.311 (c)

- If this agency operates more than one facility, has each facility designated a PREA compliance manager? (N/A if agency operates only one facility.)  Yes  No  NA
- Does the PREA compliance manager have sufficient time and authority to coordinate the facility's efforts to comply with the PREA standards? (N/A if agency operates only one facility.)  Yes  No  NA

#### Auditor Overall Compliance Determination

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

#### Instructions for Overall Compliance Determination Narrative

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

Youth Opportunity Pathway of Hope has a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment. The facility has a policy outlining how it will implement the agency's approach to preventing, detecting, and responding to sexual abuse and sexual harassment. The policy includes definitions of prohibited behaviors regarding sexual abuse and sexual harassment and includes sanctions for those found to have participated in prohibited behaviors. The policy includes a description of agency strategies and responses to reduce and prevent sexual abuse and sexual harassment of residents. Michigan Department of Health and Human Services (MDHHS) employs an upper-level, agency-wide PREA coordinator. MDHHS Children Services Agency Juvenile Justice Program Manager Soleil Campbell serves as the PREA Coordinator. She was appointed to the position in January 2019, taking over from outgoing PREA Coordinator Patrick Sussex, who was in the job until after the Audit Notices were posted. The agreement between MDHHS and their contract facilities, such as Pathway of Hope, allows close oversight regarding PREA, including policy writing and all aspects of PREA, although, technically the PREA Compliance Managers are not supervised by MDHHS, but by the command structure in their own organization. The PREA Compliance Manager at Pathway of Hope is Lisa Salisbury. The Program Manager is Nicholas Bailey.

**Analysis:** To show compliance, the facility provided the Youth Opportunity (Y.O.) PREA Policy and the Agency Organizational Chart. Also, during the 30 days after the on-site audit, the auditor was provided with additional verification of training, including PREA training by the Program Manager.

**Finding:** The facility is compliant with this standard.

## **Standard 115.312: Contracting with other entities for the confinement of residents**

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

### **115.312 (a)**

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

### **115.312 (b)**

- Does any new contract or contract renewal signed on or after August 20, 2012 provide for agency contract monitoring to ensure that the contractor is complying with the PREA standards? (N/A if the agency does not contract with private agencies or other entities for the confinement of residents OR the response to 115.312(a)-1 is "NO".)  Yes  No  NA

### **Auditor Overall Compliance Determination**



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

### Instructions for Overall Compliance Determination Narrative

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

This standard does not apply to Pathway of Hope, but to Michigan DHHS Juvenile Justices Programs, who are complying with this standard.

**Analysis:** To show compliance, the agency provided PREA Audit Final Reports for all facilities and the MDHHS Facilities’ Contract, page 27.

**Finding:** The facility is compliant with this standard.

## Standard 115.313: Supervision and monitoring

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

#### 115.313 (a)

- Does the agency ensure that each facility has developed a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse?  Yes  No
- Does the agency ensure that each facility has implemented a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse?  Yes  No
- Does the agency ensure that each facility has documented a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse?  Yes  No
- Does the agency ensure that each facility’s staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: The prevalence of substantiated and unsubstantiated incidents of sexual abuse?  Yes  No

- Does the agency ensure that each facility’s staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Generally accepted juvenile detention and correctional/secure residential practices?  Yes  No
- Does the agency ensure that each facility’s staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any judicial findings of inadequacy?  Yes  No
- Does the agency ensure that each facility’s staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any findings of inadequacy from Federal investigative agencies?  Yes  No
- Does the agency ensure that each facility’s staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any findings of inadequacy from internal or external oversight bodies?  Yes  No
- Does the agency ensure that each facility’s staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: All components of the facility’s physical plant (including “blind-spots” or areas where staff or residents may be isolated)?  Yes  No
- Does the agency ensure that each facility’s staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: The composition of the resident population?  Yes  No
- Does the agency ensure that each facility’s staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: The number and placement of supervisory staff?  Yes  No
- Does the agency ensure that each facility’s staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Institution programs occurring on a particular shift?  Yes  No
- Does the agency ensure that each facility’s staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any applicable State or local laws, regulations, or standards?  Yes  No
- Does the agency ensure that each facility’s staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any other relevant factors?  Yes  No

### 115.313 (b)

- Does the agency comply with the staffing plan except during limited and discrete exigent circumstances?  Yes  No

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

#### 115.313 (c)

- Does the facility maintain staff ratios of a minimum of 1:8 during resident waking hours, except during limited and discrete exigent circumstances? (N/A only until October 1, 2017.)  
 Yes  No  NA
- Does the facility maintain staff ratios of a minimum of 1:16 during resident sleeping hours, except during limited and discrete exigent circumstances? (N/A only until October 1, 2017.)  
 Yes  No  NA
- Does the facility fully document any limited and discrete exigent circumstances during which the facility did not maintain staff ratios? (N/A only until October 1, 2017.)  Yes  No  NA
- Does the facility ensure only security staff are included when calculating these ratios? (N/A only until October 1, 2017.)  Yes  No  NA
- Is the facility obligated by law, regulation, or judicial consent decree to maintain the staffing ratios set forth in this paragraph?  Yes  No

#### 115.313 (d)

- In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: The staffing plan established pursuant to paragraph (a) of this section?  Yes  No
- In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: Prevailing staffing patterns?  Yes  No
- In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: The facility's deployment of video monitoring systems and other monitoring technologies?  Yes  No
- In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: The resources the facility has available to commit to ensure adherence to the staffing plan?  Yes  No

#### 115.313 (e)

- Has the facility implemented a policy and practice of having intermediate-level or higher-level supervisors conduct and document unannounced rounds to identify and deter staff sexual abuse and sexual harassment? (N/A for non-secure facilities)  Yes  No  NA
- Is this policy and practice implemented for night shifts as well as day shifts? (N/A for non-secure facilities)  Yes  No  NA

- Does the facility have a policy prohibiting staff from alerting other staff members that these supervisory rounds are occurring, unless such announcement is related to the legitimate operational functions of the facility? (N/A for non-secure facilities)  Yes  No  NA

### Auditor Overall Compliance Determination

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

### Instructions for Overall Compliance Determination Narrative

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

Youth Opportunity Pathway of Hope has developed, documented, and made its best efforts to comply regularly with a staffing plan that considers all relevant factors and provides for adequate levels of staffing and video monitoring, to protect residents against abuse. Each time the staffing plan is not complied with, the facility documents and justifies all deviations from the staffing plan. According to the Pre-Audit Questionnaire, interviews, and other documentation received by the auditor, there were no deviations from the plan in the past year. At least once every year the agency and the facility, in collaboration with the PREA Coordinator, reviews the staffing plan for prevailing staffing patterns to see whether adjustments are needed to the staffing plan, and considers whether the deployment of monitoring technology or the reallocation of agency or facility resources to commit to the staffing plan are necessary to ensure compliance with the staffing plan. The Staffing Plan and Review was reviewed by the audit team. The facility requires that intermediate-level or higher-level staff conduct unannounced rounds to identify and deter staff sexual abuse and sexual harassment. These rounds are documented and cover all shifts, according to logs provided and interviews conducted.

**Analysis:** To verify compliance, the facility provided the Youth Opportunity (Y.O.) Staffing Plan and Staffing Plan Annual Review, Unannounced Rounds Logs for August 2018 through February 2019, and Y.O. PREA Policy I 5. This documentation, in addition to information received during interviews with residents and staff, indicate compliance with this standard.

**Finding:** The facility is compliant with this standard.

## Standard 115.315: Limits to cross-gender viewing and searches

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

#### 115.315 (a)

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

#### 115.315 (b)

- Does the facility always refrain from conducting cross-gender pat-down searches in non-exigent circumstances?  Yes  No  NA

#### 115.315 (c)

- Does the facility document and justify all cross-gender strip searches and cross-gender visual body cavity searches?  Yes  No
- Does the facility document all cross-gender pat-down searches?  Yes  No

#### 115.315 (d)

- Does the facility implement policies and procedures that enable residents to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks?  Yes  No
- Does the facility require staff of the opposite gender to announce their presence when entering a resident housing unit?  Yes  No
- In facilities (such as group homes) that do not contain discrete housing units, does the facility require staff of the opposite gender to announce their presence when entering an area where residents are likely to be showering, performing bodily functions, or changing clothing? (N/A for facilities with discrete housing units)  Yes  No  NA

#### 115.315 (e)

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

#### 115.315 (f)

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

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

### Auditor Overall Compliance Determination

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

### Instructions for Overall Compliance Determination Narrative

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

Youth Opportunity Pathway of Hope does not conduct cross-gender searches of residents, absent exigent circumstances. In the past 12 months, no cross-gender searches have been performed. If they are done, they must be documented. The facility has implemented policies and procedures that enable residents to shower, perform bodily functions, and change clothing without non-medical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine room checks (this includes viewing via video camera). Policies and procedures require staff of the opposite gender to announce their presence when entering a resident housing unit or area where residents are likely to be showering, performing bodily functions, or changing clothing. The facility has a policy prohibiting staff from searching or physically examining a transgender or intersex resident for the sole purpose of determining the resident's genital status. None of these searches have occurred in the past 12 months.

**Analysis:** To verify compliance, the facility provided the Y.O. Youth Body Search Policy and the Y.O. PREA Policy D 4-5, B. 8. Documentation and interviews indicate that all staff have been trained regarding searches and understand the training. The interviews with the residents also indicated compliance. When male staff need to enter the housing area, they either announce themselves and wait until it is verified that everyone knows they are coming in, or they ask the residents to step out of the area before they enter.

**Finding:** The facility is compliant with this standard.

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

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

### 115.316 (a)

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

- Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Are blind or have low vision?  Yes  No

### 115.316 (b)

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

### 115.316 (c)

- Does the agency always refrain from relying on resident interpreters, resident readers, or other types of resident assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the resident's safety, the performance of first-response duties under §115.364, or the investigation of the resident's allegations?  Yes  No

### Auditor Overall Compliance Determination

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

### Instructions for Overall Compliance Determination Narrative

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

Pathway of Hope has established procedures to provide disabled residents and residents with limited English proficiency 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.

**Analysis:** To verify compliance, the facility provided Y.O. PREA Policy A 2, and the Services for Residential or Family with Language, Hearing or Speech Barriers Memo. Questions asked to staff and administrators during interviews indicated an understanding of these policies and how to access services. Interviews with both staff and residents indicated Pathway of Hope residents will get the help they need.



**Finding:** The facility is compliant with this standard.

## Standard 115.317: Hiring and promotion decisions

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

### 115.317 (a)

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

### 115.317 (b)

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

### 115.317 (c)

- Before hiring new employees, who may have contact with residents, does the agency: Perform a criminal background records check?  Yes  No

- Before hiring new employees, who may have contact with residents, does the agency: Consult any child abuse registry maintained by the State or locality in which the employee would work?  Yes  No
- Before hiring new employees, who may have contact with residents, does the agency: Consistent with Federal, State, and local law, make its best efforts to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse?  Yes  No

#### 115.317 (d)

- Does the agency perform a criminal background records check before enlisting the services of any contractor who may have contact with residents?  Yes  No
- Does the agency consult applicable child abuse registries before enlisting the services of any contractor who may have contact with residents?  Yes  No

#### 115.317 (e)

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

#### 115.317 (f)

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

#### 115.317 (g)

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

#### 115.317 (h)

- Unless prohibited by law, does the agency provide information on substantiated allegations of sexual abuse or sexual harassment involving a former employee upon receiving a request from

an institutional employer for whom such employee has applied to work? (N/A if providing information on substantiated allegations of sexual abuse or sexual harassment involving a former employee is prohibited by law.)  Yes  No  NA

### Auditor Overall Compliance Determination

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

### Instructions for Overall Compliance Determination Narrative

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

The facility's policy prohibits hiring or promoting anyone who may have contact with residents, and prohibits enlisting the services of any contractor who may have contact with residents, who has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997); has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or has been civilly or administratively adjudicated to have engaged in any of these activities. Y.O. policy requires the consideration of any incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any contractor, who may have contact with residents. The facility's policy requires that before it hires any new employees who may have contact with residents, it conducts criminal background checks, consults the child abuse registry maintained by the state, and makes its best efforts to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse. Policy states that material omissions regarding such misconduct, or the provision of materially false information, shall be grounds for termination. Much of the above is also covered on the Employee Acknowledgment Form, required prior to employment, which is not limited to convictions, but also requires disclosure of any investigations, arrests, and administrative adjudications. Michigan Division of Child Welfare Licensing requires and monitors that criminal background checks and central registry abuse and neglect registry checks are done annually for all juvenile justice residential facilities. In addition, the MDHHS overarching policy that must be followed by public and contracted facilities requires this. MDHHS Juvenile Justice Residential Policy #100 (excerpt), "Pre-employment Screening: All applicants must complete pre-employment screening that includes:

- Submission of fingerprints; see AHP 629-9, Criminal History File Search by Fingerprints.
- Criminal history checks using the Law Enforcement Information Network (LEIN) or Internet Criminal History Access Tool (ICHAT).
- Testing for use of illegal substances.
- Checks of the central registry.
- The prospective employee must submit a written DHS-194, Request for Central Registry Clearance, which is available online.
- The facility director or designee must contact the local county office to verify

that a prospective employee is not listed as a perpetrator on the central registry. • The county office must provide a completed DHS-1910 which documents that there is no central registry record of the individual or that a record exists and lists the county that entered the record. • Checks of the Michigan Public Sex Offender Registry and the Dru Sjodin National Sex Offender Public Website.”

“Annual Checks: The facility director or designee must ensure the following annual checks are conducted and documented for all staff: • Central registry checks. • Criminal history checks using LEIN or ICHAT including checks for all interns and contractors. • Checks of staff for current driver’s licenses and the appropriate endorsements for duties performed. • Checks of the Michigan Public Sex Offender Registry and the Dru Sjodin National Sex Offender Public Website.”

**Analysis:** To verify compliance, the facility provided Employee File Check List; Application Form; Employee files, Y.P. Memo on Hiring Procedures, and policy quoted above.

**Finding:** The facility is compliant with this standard.

## Standard 115.318: Upgrades to facilities and technologies

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

#### 115.318 (a)

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

#### 115.318 (b)

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

### Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- 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.*

Youth Opportunity Pathway of Hope has not acquired a new confinement facility, but they added cameras in 2018.

**Analysis:** The facility on-site review, and the way interview questions were answered, verified PAQ documentation that no substantial changes have been made, but that safety will be the paramount consideration if and when changes occur in the future. The review of cameras indicated blind spots and the ways being utilized to address them.

**Finding:** The facility is compliant with this standard.

## RESPONSIVE PLANNING

### Standard 115.321: Evidence protocol and forensic medical examinations

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

#### 115.321 (a)

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

#### 115.321 (b)

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

#### 115.321 (c)

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

#### 115.321 (d)

- Does the agency attempt to make available to the victim a victim advocate from a rape crisis center?  Yes  No
- If a rape crisis center is not available to provide victim advocate services, does the agency make available to provide these services a qualified staff member from a community-based organization, or a qualified agency staff member?  Yes  No
- Has the agency documented its efforts to secure services from rape crisis centers?  Yes  No

#### 115.321 (e)

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

#### 115.321 (f)

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

#### 115.321 (g)

- Auditor is not required to audit this provision.

#### 115.321 (h)

- If the agency uses a qualified agency staff member or a qualified community-based staff member for the purposes of this section, has the individual been screened for appropriateness to serve in this role and received education concerning sexual assault and forensic examination issues in general? (Check N/A if agency attempts to make a victim advocate from a rape crisis center available to victims per 115.321(d) above.)  Yes  No  NA

### Auditor Overall Compliance Determination

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

### Instructions for Overall Compliance Determination Narrative

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

Youth Opportunity Pathway of Hope is responsible for conducting only administrative sexual abuse investigations (including resident-on-resident sexual abuse or staff sexual misconduct). Osceola County Sheriff's Department and Michigan Children's Protective Services coordinate on the criminal investigations. The facility offers all residents who experience sexual abuse access to forensic medical examinations off site, at no financial cost to the victim. Where possible, examinations are conducted by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs). When SANEs or SAFEs are not available, a qualified medical practitioner performs forensic medical examinations. The facility documents efforts to provide SANEs or SAFEs. During the past 12 months, there have been no forensic medical exams conducted. The facility attempts to make a victim advocate from a rape crisis center available to the victim, in person or by other means, and documents these efforts.

**Analysis:** To verify compliance, the facility provided Michigan Model Policy: The Law Enforcement Response to Sexual Assault; Memo to File on SANE Services verified by the Compliance Manager in May of 2018; MOU with Cadillac Oasis for Rape Crisis Services; and their MOU with Osceola Sherriff's Department. In addition, the audit team verified the MOU with Cadillac Rape Crisis Services by phone.

**Finding:** The facility is compliant with this standard.

## Standard 115.322: Policies to ensure referrals of allegations for investigations

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

### 115.322 (a)

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

### 115.322 (b)

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

### 115.322 (c)

- If a separate entity is responsible for conducting criminal investigations, does such publication describe the responsibilities of both the agency and the investigating entity? [N/A if the agency/facility is responsible for criminal investigations. See 115.321(a).]  
 Yes  No  NA

### 115.322 (d)

- Auditor is not required to audit this provision.

### 115.322 (e)

- Auditor is not required to audit this provision.

### Auditor Overall Compliance Determination

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

### Instructions for Overall Compliance Determination Narrative



*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.*

Youth Opportunity Pathway of Hope ensures that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment. The agency does have a policy that requires that allegations of sexual abuse or sexual harassment be referred for investigation to an agency with the legal authority to conduct criminal investigations, unless the allegation does not involve potentially criminal behavior. The agency's policy regarding the referral of allegations of sexual abuse or sexual harassment for a criminal investigation is published on the DHHS agency website. The agency documents all referrals of allegations of sexual abuse or sexual harassment for criminal investigation.

**Analysis:** To verify compliance, the facility provided Y.O. PREA Policy H and completed investigations. The investigations provide evidence of compliance in practice and interviews conducted also help to verify that the facility is fully compliant with this standard.

**Finding:** The facility is compliant with this standard.

## TRAINING AND EDUCATION

### Standard 115.331: Employee training

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

#### 115.331 (a)

- Does the agency train all employees who may have contact with residents on: Its zero-tolerance policy for sexual abuse and sexual harassment?  Yes  No
- Does the agency train all employees who may have contact with residents on: How to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures?  Yes  No
- Does the agency train all employees who may have contact with residents on: Residents' right to be free from sexual abuse and sexual harassment  Yes  No
- Does the agency train all employees who may have contact with residents on: The right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment?  Yes  No
- Does the agency train all employees who may have contact with residents on: The dynamics of sexual abuse and sexual harassment in juvenile facilities?  Yes  No

- Does the agency train all employees who may have contact with residents on: The common reactions of juvenile victims of sexual abuse and sexual harassment?  Yes  No
- Does the agency train all employees who may have contact with residents on: How to detect and respond to signs of threatened and actual sexual abuse and how to distinguish between consensual sexual contact and sexual abuse between residents?  Yes  No
- Does the agency train all employees who may have contact with residents on: How to avoid inappropriate relationships with residents?  Yes  No
- Does the agency train all employees who may have contact with residents on: How to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents?  Yes  No
- Does the agency train all employees who may have contact with residents on: How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities?  Yes  No
- Does the agency train all employees who may have contact with residents on: Relevant laws regarding the applicable age of consent?  Yes  No

#### 115.331 (b)

- Is such training tailored to the unique needs and attributes of residents of juvenile facilities?  Yes  No
- Is such training tailored to the gender of the residents at the employee's facility?  Yes  No
- Have employees received additional training if reassigned from a facility that houses only male residents to a facility that houses only female residents, or vice versa?  Yes  No

#### 115.331 (c)

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

#### 115.331 (d)

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

## Auditor Overall Compliance Determination

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

## Instructions for Overall Compliance Determination Narrative

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

Pathway of Hope trains all employees who may have contact with residents on the matters required by this standard.

**Analysis:** To verify compliance, the facility provided the Y.O. PREA Policy C, PREA Training outline, and all employee files for review. Staff indicated, during interviews, that they have received the training and understand it.

**Finding:** The facility is compliant with this standard.

## Standard 115.332: Volunteer and contractor training

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

#### 115.332 (a)

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

#### 115.332 (b)

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

#### 115.332 (c)

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

### Auditor Overall Compliance Determination

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

### Instructions for Overall Compliance Determination Narrative

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

Any volunteers and contractors who have contact with residents are to be trained on their responsibilities under the agency's policies and procedures regarding sexual abuse and sexual harassment prevention, detection, and response. The level and type of training provided to volunteers and contractors is to be based on the services they provide and the level of contact they have with residents. All volunteers and contractors who have contact with residents are to have been notified of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and informed about how to report such incidents.

**Analysis:** To verify compliance, the facility provided relevant policies and demonstrated an understanding of this standard during interviews, even though the facility does not utilize volunteers at this time.

**Finding:** The facility is compliant with this standard.

## Standard 115.333: Resident education

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

#### 115.333 (a)

- During intake, do residents receive information explaining the agency's zero-tolerance policy regarding sexual abuse and sexual harassment?  Yes  No
- During intake, do residents receive information explaining how to report incidents or suspicions of sexual abuse or sexual harassment?  Yes  No
- Is this information presented in an age-appropriate fashion?  Yes  No

**115.333 (b)**

- Within 10 days of intake, does the agency provide age-appropriate comprehensive education to residents either in person or through video regarding: Their rights to be free from sexual abuse and sexual harassment?  Yes  No
- Within 10 days of intake, does the agency provide age-appropriate comprehensive education to residents either in person or through video regarding: Their rights to be free from retaliation for reporting such incidents?  Yes  No
- Within 10 days of intake, does the agency provide age-appropriate comprehensive education to residents either in person or through video regarding: Agency policies and procedures for responding to such incidents?  Yes  No

**115.333 (c)**

- Have all residents received such education?  Yes  No
- Do residents receive education upon transfer to a different facility to the extent that the policies and procedures of the resident's new facility differ from those of the previous facility?  
 Yes  No

**115.333 (d)**

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

**115.333 (e)**

- Does the agency maintain documentation of resident participation in these education sessions?  
 Yes  No

**115.333 (f)**

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

### Auditor Overall Compliance Determination

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

### Instructions for Overall Compliance Determination Narrative

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

Residents receive information at time of intake about the zero-tolerance policy and how to report incidents or suspicions of sexual abuse or sexual harassment. All residents have been educated regarding their rights to be free from sexual abuse and sexual harassment and to be free from retaliation for reporting such incidents. The facility ensures that key information about the agency's PREA policies is continuously and readily available or visible through posters, resident handbooks, or other written formats. The agency provides resident education in formats accessible to all residents, including those who are limited English proficient, deaf, visually impaired, or otherwise disabled, as well as to residents who have limited reading skills.

**Analysis:** To verify compliance, the facility provided Y.O. PREA Policy A and B and provided all resident files for the auditor to review. Residents indicated that they have been educated regarding PREA.

**Finding:** The facility is compliant with this standard.

## Standard 115.334: Specialized training: Investigations

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

#### 115.334 (a)

- In addition to the general training provided to all employees pursuant to §115.331, does the agency ensure that, to the extent the agency itself conducts sexual abuse investigations, its investigators have received training in conducting such investigations in confinement settings? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).]  Yes  No  NA

### 115.334 (b)

- Does this specialized training include: Techniques for interviewing juvenile sexual abuse victims? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).]  Yes  No  NA
- Does this specialized training include: Proper use of Miranda and Garrity warnings? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).]  Yes  No  NA
- Does this specialized training include: Sexual abuse evidence collection in confinement settings? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).]  Yes  No  NA
- Does this specialized training include: The criteria and evidence required to substantiate a case for administrative action or prosecution referral? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).]  Yes  No  NA

### 115.334 (c)

- Does the agency maintain documentation that agency investigators have completed the required specialized training in conducting sexual abuse investigations? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).]  Yes  No  NA

### 115.334 (d)

- Auditor is not required to audit this provision.

### Auditor Overall Compliance Determination

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

### Instructions for Overall Compliance Determination Narrative

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

The facility investigator is trained in conducting sexual abuse investigations in confinement settings, as required by policy.

**Analysis:** To verify compliance, the facility provided NIC Investigator Training (by link to training) and Training Certificate for the local investigator. The investigator has experience conducting investigations, as evidenced by the investigations conducted in the past 12 months, and by her understanding of the investigative process during her interview.

**Finding:** The facility is compliant with this standard.

## Standard 115.335: Specialized training: Medical and mental health care

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

#### 115.335 (a)

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to detect and assess signs of sexual abuse and sexual harassment?  Yes  No
- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to preserve physical evidence of sexual abuse?  Yes  No
- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to respond effectively and professionally to juvenile victims of sexual abuse and sexual harassment?  Yes  No
- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How and to whom to report allegations or suspicions of sexual abuse and sexual harassment?  Yes  No

#### 115.335 (b)

- If medical staff employed by the agency conduct forensic examinations, do such medical staff receive appropriate training to conduct such examinations? (N/A if agency medical staff at the facility do not conduct forensic exams.)  Yes  No  NA

#### 115.335 (c)

- Does the agency maintain documentation that medical and mental health practitioners have received the training referenced in this standard either from the agency or elsewhere?  Yes  No

#### 115.335 (d)



- Do medical and mental health care practitioners employed by the agency also receive training mandated for employees by §115.331?  Yes  No
- Do medical and mental health care practitioners contracted by and volunteering for the agency also receive training mandated for contractors and volunteers by §115.332?  Yes  No

**Auditor Overall Compliance Determination**

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- 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 has a policy related to the training of medical and mental health practitioners who work regularly in the facility, but they do not do forensic exams. The agency maintains documentation showing that medical and mental health practitioners have completed required training. The training teaches how to detect and assess signs of sexual abuse and sexual harassment; how to preserve physical evidence of sexual abuse; how to respond effectively and professionally to juvenile victims of sexual abuse and sexual harassment; and how and to whom to report allegations or suspicions of sexual abuse and sexual harassment.

**Analysis:** To verify compliance, the facility provided the Y. O. Policy C 6 and a training Certificate from NIC. Also, when the medical and mental health practitioner was interviewed, she indicated a strong knowledge base in these areas.

**Finding:** The facility is compliant with this standard.

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

**Standard 115.341: Screening for risk of victimization and abusiveness**

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

**115.341 (a)**

- Within 72 hours of the resident's arrival at the facility, does the agency obtain and use information about each resident's personal history and behavior to reduce risk of sexual abuse by or upon a resident?  Yes  No
- Does the agency also obtain this information periodically throughout a resident's confinement?  Yes  No

#### 115.341 (b)

- Are all PREA screening assessments conducted using an objective screening instrument?  Yes  No

#### 115.341 (c)

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Prior sexual victimization or abusiveness?  Yes  No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Any gender nonconforming appearance or manner or identification as lesbian, gay, bisexual, transgender, or intersex, and whether the resident may therefore be vulnerable to sexual abuse?  Yes  No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Current charges and offense history?  Yes  No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Age?  Yes  No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Level of emotional and cognitive development?  Yes  No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Physical size and stature?  Yes  No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Mental illness or mental disabilities?  Yes  No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Intellectual or developmental disabilities?  Yes  No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Physical disabilities?  Yes  No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: The resident's own perception of vulnerability?  Yes  No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Any other specific information about individual residents that may

indicate heightened needs for supervision, additional safety precautions, or separation from certain other residents?  Yes  No

#### 115.341 (d)

- Is this information ascertained: Through conversations with the resident during the intake process and medical mental health screenings?  Yes  No
- Is this information ascertained: During classification assessments?  Yes  No
- Is this information ascertained: By reviewing court records, case files, facility behavioral records, and other relevant documentation from the resident's files?  Yes  No

#### 115.341 (e)

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

#### Auditor Overall Compliance Determination

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

#### Instructions for Overall Compliance Determination Narrative

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

Y.O. Pathway of Hope has policy and procedure that requires screening upon admission for risk of sexual abuse victimization or sexual abusiveness toward other residents using an objective screening instrument within 72 hours of arrival, and this screening instrument included all the requirements of the sub-standards of this standard. The facility also performs reassessments on all residents as indicated, and usually within 30 days.

**Analysis:** To verify compliance, the audit team reviewed Y.O. PREA Policy B and screenings on all residents and associated reassessments, and spoke with staff involved in the intake/admissions process. Interviews conducted during the onsite audit, including interviews with residents, indicate this screening and reassessment is being done.

**Finding:** The facility is compliant with this standard.

## Standard 115.342: Use of screening information

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

### 115.342 (a)

- Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Housing Assignments?  Yes  No
- Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Bed assignments?  Yes  No
- Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Work Assignments?  Yes  No
- Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Education Assignments?  Yes  No
- Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Program Assignments?  Yes  No

### 115.342 (b)

- Are residents isolated from others only as a last resort when less restrictive measures are inadequate to keep them and other residents safe, and then only until an alternative means of keeping all residents safe can be arranged?  Yes  No
- During any period of isolation, does the agency always refrain from denying residents daily large-muscle exercise?  Yes  No
- During any period of isolation, does the agency always refrain from denying residents any legally required educational programming or special education services?  Yes  No
- Do residents in isolation receive daily visits from a medical or mental health care clinician?  Yes  No
- Do residents also have access to other programs and work opportunities to the extent possible?  Yes  No

### 115.342 (c)

- Does the agency always refrain from placing: Lesbian, gay, and bisexual residents in particular housing, bed, or other assignments solely on the basis of such identification or status?  
 Yes  No
- Does the agency always refrain from placing: Transgender residents in particular housing, bed, or other assignments solely on the basis of such identification or status?  Yes  No
- Does the agency always refrain from placing: Intersex residents in particular housing, bed, or other assignments solely on the basis of such identification or status?  Yes  No
- Does the agency always refrain from considering lesbian, gay, bisexual, transgender, or intersex identification or status as an indicator or likelihood of being sexually abusive?  
 Yes  No

#### 115.342 (d)

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

#### 115.342 (e)

- Are placement and programming assignments for each transgender or intersex resident reassessed at least twice each year to review any threats to safety experienced by the resident?  
 Yes  No

#### 115.342 (f)

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

#### 115.342 (g)

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

#### 115.342 (h)

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

### 115.342 (i)

- In the case of each resident who is isolated as a last resort when less restrictive measures are inadequate to keep them and other residents safe, does the facility afford a review to determine whether there is a continuing need for separation from the general population EVERY 30 DAYS?  Yes  No

### Auditor Overall Compliance Determination

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

### Instructions for Overall Compliance Determination Narrative

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

Y.O. Pathway of Hope uses information from the risk screening required by §115.341 to inform housing, bed, work, education, and program assignments. This information is gleaned through conversations with the resident and during medical and mental health screenings; during classification assessments; and by reviewing court records, case files, facility behavioral records, and other relevant documentation from the resident's file. This is a non-secure facility, according to the Pre-Audit Questionnaire, and no residents are placed in isolation, so they cannot be isolated based on information obtained during this process. Placing lesbian, gay, bisexual, transgender, or intersex residents in particular housing, bed, or other assignments solely on the basis of such identification or status is prohibited. The facility also prohibits considering lesbian, gay, bisexual, transgender, or intersex identification or status as an indicator of likelihood of being sexually abusive. The agency makes housing and program assignments for transgender or intersex residents in the facility on a case-by-case basis.

**Analysis:** To verify compliance, the facility provided Y.O. PREA Policy B, B 4, 5. Policy and interviews indicate appropriate controls have been implemented on the dissemination of sensitive information obtained during the screening, reassessment, and therapeutic process, in order to ensure that the

information is not exploited to the resident's detriment by staff or other residents. Residents expressed a high degree of certainty and confidence when asked about the facility's ability to appropriately protect confidential information.

**Finding:** The facility is compliant with this standard.

## REPORTING

### Standard 115.351: Resident reporting

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

#### 115.351 (a)

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

#### 115.351 (b)

- Does the agency also provide at least one way for residents to report sexual abuse or sexual harassment to a public or private entity or office that is not part of the agency?  Yes  No
- Is that private entity or office able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials?  Yes  No
- Does that private entity or office allow the resident to remain anonymous upon request?  Yes  No
- Are residents detained solely for civil immigration purposes provided information on how to contact relevant consular officials and relevant officials at the Department of Homeland Security to report sexual abuse or harassment?  Yes  No

#### 115.351 (c)

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

## 115.351 (d)

- Does the facility provide residents with access to tools necessary to make a written report?  
 Yes  No
- Does the agency provide a method for staff to privately report sexual abuse and sexual harassment of residents?  Yes  No

### Auditor Overall Compliance Determination

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

### Instructions for Overall Compliance Determination Narrative

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

Youth Opportunity Pathway of Hope has established procedures allowing for multiple internal ways for residents to report privately to agency officials about sexual abuse and sexual harassment; retaliation by other residents or staff for reporting sexual abuse and sexual harassment; and staff neglect or violation of responsibilities that may have contributed to such incidents. Their staff are trained on these procedures. Residents can report verbally, through the grievance process, or through the outside reporting option of calling the Child Protective Services toll-free report line. The facility accepts reports of sexual abuse and sexual harassment made verbally, in writing, anonymously, and from third parties. Staff are required to document verbal reports by the end of their shift. Residents are provided with access to tools to make written reports of sexual abuse or sexual harassment, retaliation by other residents or staff for reporting sexual abuse and sexual harassment, and staff neglect or violation of responsibilities that may have contributed to such incidents.

As part of their ongoing effort to make improvements to their system and respond to corrective actions, the MDHHS Centralized Intake recently completed some training and changes, keeping this standard, and others, in mind. Here is the email, in part, that was sent to facilities in Michigan from the PREA Coordinator:

“From: MDHHS-PREA  
Sent: Monday, January 28, 2019 11:50 AM  
To: (All Public and Contracted JJ Residential Facilities in MI)

Dear Facility PREA Administrator(s):



Effective today, there is a new procedure in place whereby MDHHS Centralized Intake will provide immediate notification to a designated facility representative when a youth from the facility has placed a call to MDHHS Centralized Intake alleging sexual abuse or sexual harassment. Most juvenile justice residential facilities in Michigan use MDHHS Centralized Intake as the external reporting option for youth that want to report an allegation to someone outside of the facility. A recent facility audit identified a deficiency in this system whereby a facility might not be immediately notified that an allegation was made, so might be hampered in providing protection to youth(s) and instigating response and investigation protocols. The new procedure ensures that MDHHS Centralized Intake will provide immediate notification to the designated facility official that an allegation was phoned in, and provide as much information on the allegation as allowed by law....”

The email goes on to explain procedural details such as who will be contacted at the facility and what will happen if that person cannot be reached. The email also included instructions regarding protecting confidentiality, including the identity of the reporting person, while also acting to protect the youth. Also, there are instructions regarding how facilities can update their information and get other assistance.

**Analysis:** To demonstrate compliance, the facility provided the Y.O. PREA Policy E 1; Youth Orientation Packet; and Hotline Procedure. Also, staff, administrators, and residents seemed to understand reporting options.

**Finding:** The facility is compliant with this standard.

## Standard 115.352: Exhaustion of administrative remedies

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

#### 115.352 (a)

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

#### 115.352 (b)

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

#### 115.352 (c)

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

#### 115.352 (d)

- Does the agency issue a final agency decision on the merits of any portion of a grievance alleging sexual abuse within 90 days of the initial filing of the grievance? (Computation of the 90-day time period does not include time consumed by residents in preparing any administrative appeal.) (N/A if agency is exempt from this standard.)  Yes  No  NA
- If the agency determines that the 90-day timeframe is insufficient to make an appropriate decision and claims an extension of time [the maximum allowable extension of time to respond is 70 days per 115.352(d)(3)], does the agency notify the resident in writing of any such extension and provide a date by which a decision will be made? (N/A if agency is exempt from this standard.)  Yes  No  NA
- At any level of the administrative process, including the final level, if the resident does not receive a response within the time allotted for reply, including any properly noticed extension, may a resident consider the absence of a response to be a denial at that level? (N/A if agency is exempt from this standard.)  Yes  No  NA

#### 115.352 (e)

- Are third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, permitted to assist residents in filing requests for administrative remedies relating to allegations of sexual abuse? (N/A if agency is exempt from this standard.)  Yes  No  NA
- Are those third parties also permitted to file such requests on behalf of residents? (If a third party, other than a parent or legal guardian, files such a request on behalf of a resident, the facility may require as a condition of processing the request that the alleged victim agree to have the request filed on his or her behalf, and may also require the alleged victim to personally pursue any subsequent steps in the administrative remedy process.) (N/A if agency is exempt from this standard.)  Yes  No  NA
- If the resident declines to have the request processed on his or her behalf, does the agency document the resident's decision? (N/A if agency is exempt from this standard.)  Yes  No  NA
- Is a parent or legal guardian of a juvenile allowed to file a grievance regarding allegations of sexual abuse, including appeals, on behalf of such juvenile? (N/A if agency is exempt from this standard.)  Yes  No  NA
- If a parent or legal guardian of a juvenile files a grievance (or an appeal) on behalf of a juvenile regarding allegations of sexual abuse, is it the case that those grievances are not conditioned

upon the juvenile agreeing to have the request filed on his or her behalf? (N/A if agency is exempt from this standard.)  Yes  No  NA

#### 115.352 (f)

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

#### 115.352 (g)

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

#### Auditor Overall Compliance Determination

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

## Instructions for Overall Compliance Determination Narrative

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

Pathway of Hope has an administrative procedure for dealing with resident grievances regarding sexual abuse, which allows a resident to submit a grievance regarding an allegation of sexual abuse at any time, regardless of when the incident is alleged to have occurred. The policy includes all the minimum requirements of this standard.

**Analysis:** To verify compliance, the facility provided Y.O. PREA Policy A 1 g, E 1, 5, J 3, and grievance logs. Residents expressed, during interviews, that it is easy to file grievances and that they feel they can also easily speak with staff members about any problems they have. Staff and administrators interviewed indicate an understanding of the reality and the importance of the grievance process.

**Finding:** The facility is compliant with this standard.

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

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

### 115.353 (a)

- Does the facility provide residents with access to outside victim advocates for emotional support services related to sexual abuse by providing, posting, or otherwise making assessable mailing addresses and telephone numbers, including toll-free hotline numbers where available, of local, State, or national victim advocacy or rape crisis organizations?  Yes  No
- Does the facility provide persons detained solely for civil immigration purposes mailing addresses and telephone numbers, including toll-free hotline numbers where available of local, State, or national immigrant services agencies?  Yes  No
- Does the facility enable reasonable communication between residents and these organizations and agencies, in as confidential a manner as possible?  Yes  No

### 115.353 (b)

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

### 115.353 (c)

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

### 115.353 (d)

- Does the facility provide residents with reasonable and confidential access to their attorneys or other legal representation?  Yes  No
- Does the facility provide residents with reasonable access to parents or legal guardians?  Yes  No

### Auditor Overall Compliance Determination

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

### Instructions for Overall Compliance Determination Narrative

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

Residents are provided access to outside victim advocates for emotional support services related to sexual abuse. They are provided with phone numbers in their Orientation Packets, as well as by postings around the building. They are assisted in communicating with these organizations, in as confidential a manner as possible. The facility informs residents, prior to giving them access to outside support services, the extent to which such communications will be monitored. The facility informs residents, prior to giving them access to outside support services, of the mandatory reporting rules governing privacy, confidentiality, and/or privilege that apply to disclosures of sexual abuse made to outside victim advocates, including any limits to confidentiality under relevant federal, state, or local law.

**Analysis:** To demonstrate compliance, the facility provided Y.O. PREA Policy E 1-2; their MOU with Cadillac Oasis; and their Policy on Resident Contacting DHHS Worker, Probation Office, and/or Attorneys: Visitations On and Off Campus. Interviews also indicated a general understanding of this standard. There is an understanding among residents and staff that residents have access to outside confidential support services and legal representation.

**Finding:** The facility is compliant with this standard.

## Standard 115.354: Third-party reporting

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

#### 115.354 (a)

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

### Auditor Overall Compliance Determination

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

### Instructions for Overall Compliance Determination Narrative

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

The facility provides methods to make and receive third-party reports of resident sexual abuse or sexual harassment. Third-party reports can be made through the youth and family grievance system, through the Child Protective Services toll-free reporting line, or by verbal or written reporting to the facility.

**Analysis:** To verify compliance, the facility provided materials that they provide to residents and their families. Also, during the site review, third-party reporting posters were observed in visitation areas. When residents were interviewed about third-party reporting, they indicated that it would be easy for them to discretely inform family members, during face-to-face visits or phone calls, about any matter that might need to be reported. They also mentioned their ability to communicate with MDHHS caseworkers.

**Finding:** The facility is compliant with this standard.

## OFFICIAL RESPONSE FOLLOWING A RESIDENT REPORT

### Standard 115.361: Staff and agency reporting duties

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

#### 115.361 (a)

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

#### 115.361 (b)

- Does the agency require all staff to comply with any applicable mandatory child abuse reporting laws?  Yes  No

#### 115.361 (c)

- Apart from reporting to designated supervisors or officials and designated State or local services agencies, are staff prohibited from revealing any information related to a sexual abuse report to anyone other than to the extent necessary, as specified in agency policy, to make treatment, investigation, and other security and management decisions?  Yes  No

#### 115.361 (d)

- Are medical and mental health practitioners required to report sexual abuse to designated supervisors and officials pursuant to paragraph (a) of this section as well as to the designated State or local services agency where required by mandatory reporting laws?  Yes  No
- Are medical and mental health practitioners required to inform residents of their duty to report, and the limitations of confidentiality, at the initiation of services?  Yes  No

#### 115.361 (e)

- Upon receiving any allegation of sexual abuse, does the facility head or his or her designee promptly report the allegation to the appropriate office?  Yes  No

- Upon receiving any allegation of sexual abuse, does the facility head or his or her designee promptly report the allegation to the alleged victim's parents or legal guardians unless the facility has official documentation showing the parents or legal guardians should not be notified?  
 Yes    No
  
- If the alleged victim is under the guardianship of the child welfare system, does the facility head or his or her designee promptly report the allegation to the alleged victim's caseworker instead of the parents or legal guardians? (N/A if the alleged victim is not under the guardianship of the child welfare system.)  Yes    No    NA
  
- If a juvenile court retains jurisdiction over the alleged victim, does the facility head or designee also report the allegation to the juvenile's attorney or other legal representative of record within 14 days of receiving the allegation?  Yes    No

### 115.361 (f)

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

### Auditor Overall Compliance Determination

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

### Instructions for Overall Compliance Determination Narrative

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

Pathway of Hope requires all staff to report any knowledge, suspicion, or information they receive regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency; any retaliation against residents or staff who reported such an incident; and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. The agency requires all staff to comply with any applicable mandatory child abuse reporting laws. Apart from reporting to designated supervisors or officials and designated state or local service agencies, the policy prohibits staff from revealing any information related to a sexual abuse report to anyone other than to the extent necessary to make treatment, investigation, and other security and management decisions. Medical and mental health practitioners are mandated reporters and are required to inform residents at the initiation of services of their duty to report and the limitations of confidentiality. Upon



receiving any allegation of sexual abuse, the facility will promptly report the allegation to the appropriate agency office and to the alleged victim's parents or legal guardians, unless the facility has official documentation showing the parents or legal guardians should not be notified. If the alleged victim is under the guardianship of the child welfare system, the report will be made to the alleged victim's caseworker instead of to the parents or legal guardians. If a juvenile court retains jurisdiction over the alleged victim, the facility head or designee will also report the allegation to the juvenile's attorney or other legal representative of record within 14 days of receiving the allegation.

**Analysis:** To show compliance, the facility provided PREA Policy F 2, & 10. In addition, the investigations reviewed, as well as interviews conducted, indicated compliance with this standard.

**Finding:** The facility is compliant with this standard.

## Standard 115.362: Agency protection duties

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

#### 115.362 (a)

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

### Auditor Overall Compliance Determination

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

### Instructions for Overall Compliance Determination Narrative

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

When the facility learns that a resident is subject to a substantial risk of imminent sexual abuse, it takes immediate action to protect the resident.

**Analysis:** To verify compliance, the facility provided Y.O. PREA Policy G and demonstrated, during interviews, an understanding of what to do when a resident is at substantial risk of imminent sexual abuse. Although there have been no incidents of substantial risk of imminent sexual abuse identified during the past 12 months, the facility has acted to protect residents regarding less serious risks. Residents indicate a belief that they are safe at the facility.

**Finding:** The facility is compliant with this standard.

## Standard 115.363: Reporting to other confinement facilities

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

#### 115.363 (a)

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

#### 115.363 (b)

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

#### 115.363 (c)

- Does the agency document that it has provided such notification?  Yes  No

#### 115.363 (d)

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

### Auditor Overall Compliance Determination

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

### Instructions for Overall Compliance Determination Narrative

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

Youth Opportunity Pathway of Hope has a policy requiring that, upon receiving an allegation that a resident was sexually abused while confined at another facility, the head of the facility must notify the

head of the facility, or the appropriate office of the agency or facility where sexual abuse is alleged to have occurred, as soon as possible, but no later than 72 hours after receiving the allegation; and that this notification be documented.

**Analysis:** To demonstrate compliance, the facility provided Y.O. PREA Policy F 10 and H, and administrators indicated an understanding of this standard during interviews, even though they have not had allegations during the past year that were subject to this standard.

**Finding:** The facility is compliant with this standard.

## Standard 115.364: Staff first responder duties

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

### 115.364 (a)

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

### 115.364 (b)

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

### Auditor Overall Compliance Determination

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

- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

### Instructions for Overall Compliance Determination Narrative

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

Pathway of Hope has a first responder policy for allegations of sexual abuse consistent with this standard.

**Analysis:** To verify compliance, the facility provided their Coordinated Response Plan (CRP) and updated policies, putting the First Responder Duties in prominent locations in the text, and posting them where staff can find them when needed. Interviews with First Responders indicated an understanding of the duties and where to locate a hard copy for review.

**Finding:** The facility is compliant with this standard.

## Standard 115.365: Coordinated response

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

#### 115.365 (a)

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

### Auditor Overall Compliance Determination

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

### Instructions for Overall Compliance Determination Narrative

*The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's*

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

Youth Opportunity Pathway of Hope has developed a written institutional plan to coordinate actions taken in response to an incident of sexual abuse among staff first responders, medical and mental health practitioners, investigators, and facility leadership. During the audit process, the facility updated their Coordinated Response Plan and trained staff on the updates. SANE exams are at Big Rapids Spectrum Health, and the same hospital also provides post-incident medical exams, and counseling. Advocacy is provided through the facility's MOU with Oasis.

**Analysis:** To verify compliance, the facility provided their written CRP and demonstrated, during interviews, an understanding of the plan, and where hard copies of the plan are located.

**Finding:** The facility is compliant with this standard.

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

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

#### 115.366 (a)

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

#### 115.366 (b)

- Auditor is not required to audit this provision.

### Auditor Overall Compliance Determination

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

### Instructions for Overall Compliance Determination Narrative

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

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

The agency, facility, or any other governmental entity responsible for collective bargaining on the agency's behalf has not entered into or renewed any collective bargaining agreement or other agreement since August 20, 2012.

**Analysis:** All interviews and documentation reviewed indicates that the facility retains the ability to protect residents from abusers.

**Finding:** The facility is compliant with this standard.

## **Standard 115.367: Agency protection against retaliation**

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

#### **115.367 (a)**

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

#### **115.367 (b)**

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

#### **115.367 (c)**

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor the conduct and treatment of residents or staff who reported the sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff?  Yes  No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor the conduct and treatment of residents who were reported to have suffered sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff?  Yes  No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Act promptly to remedy any such retaliation?  Yes  No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor: Any resident disciplinary reports?  Yes  No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor: Resident housing changes?  Yes  No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor: Resident program changes?  Yes  No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor: Negative performance reviews of staff?  Yes  No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor: Reassignments of staff?  Yes  No
- Does the agency continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need?  Yes  No

#### 115.367 (d)

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

#### 115.367 (e)

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

#### 115.367 (f)

- Auditor is not required to audit this provision.

#### Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

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

### Instructions for Overall Compliance Determination Narrative

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

Youth Opportunity Pathway of Hope has a policy to protect all residents and staff who report sexual abuse or sexual harassment, or who cooperate with sexual abuse or sexual harassment investigations, from retaliation by other residents or staff.

**Analysis:** To show compliance, the facility provided Y.O. PREA policy F 11, which is consistent with all subsections of this standard. In addition, investigative documentation reviewed, and interviews conducted with the investigator and administrators, indicate this standard is being followed in practice.

**Finding:** The facility is compliant with this standard.

## Standard 115.368: Post-allegation protective custody

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

#### 115.368 (a)

- Is any and all use of segregated housing to protect a resident who is alleged to have suffered sexual abuse subject to the requirements of § 115.342?  Yes  No

### Auditor Overall Compliance Determination

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

### Instructions for Overall Compliance Determination Narrative

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Y. O. Pathway of Hope is a non-secure facility with no protective custody options. Law enforcement would be called if a child required this level of control.

**Analysis:** To verify compliance, the facility provided Y.O. PREA policy B 5, which is consistent with this standard. Interviews with youth verify that no protective custody or isolation is used, and also that, even when youth are being closely monitored, they always retain their rights to make reports, to have medical and mental health care, to get exercise, and to have access to education.

**Finding:** The facility is compliant with this standard.

## INVESTIGATIONS

### Standard 115.371: Criminal and administrative agency investigations

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

#### 115.371 (a)

- When the agency conducts its own investigations into allegations of sexual abuse and sexual harassment, does it do so promptly, thoroughly, and objectively? [N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations. See 115.321(a).]  Yes  No  NA
- Does the agency conduct such investigations for all allegations, including third party and anonymous reports? [N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations. See 115.321(a).]  Yes  No  NA

#### 115.371 (b)

- Where sexual abuse is alleged, does the agency use investigators who have received specialized training in sexual abuse investigations involving juvenile victims as required by 115.334?  Yes  No

#### 115.371 (c)

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

**115.371 (d)**

- Does the agency always refrain from terminating an investigation solely because the source of the allegation recants the allegation?  Yes  No

**115.371 (e)**

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

**115.371 (f)**

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

**115.371 (g)**

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

**115.371 (h)**

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

**115.371 (i)**

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

**115.371 (j)**

- Does the agency retain all written reports referenced in 115.371(g) and (h) for as long as the alleged abuser is incarcerated or employed by the agency, plus five years unless the abuse was committed by a juvenile resident and applicable law requires a shorter period of retention?  
 Yes  No

**115.371 (k)**

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

#### 115.371 (l)

- Auditor is not required to audit this provision.

#### 115.371 (m)

- When an outside entity investigates sexual abuse, does the facility cooperate with outside investigators and endeavor to remain informed about the progress of the investigation? (N/A if an outside agency does not conduct administrative or criminal sexual abuse investigations. See 115.321(a).)  Yes  No  NA

#### Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- 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.*

Y.O. Pathway of Hope has a policy related to criminal and administrative agency investigations that include all the minimum requirements of this standard. The Sheriff's Department conducts any criminal investigations.

**Analysis:** To verify compliance, the facility provided Y.O. PREA Policy H and their MOU with the Sheriff's Department. Investigations reviewed, as well as interviews with investigators and administrators, also indicate compliance with this standard. The auditor was able to interview some residents who had made complaints and they answered the interview questions in a way that indicates the facility is following this standard in practice, while also practicing respect and sensitivity to the various needs of the residents.

**Finding:** The facility is compliant with this standard.

## Standard 115.372: Evidentiary standard for administrative investigations

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

### 115.372 (a)

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

### Auditor Overall Compliance Determination

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

### Instructions for Overall Compliance Determination Narrative

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

As stated in policy and verified by the auditor during interviews, the facility imposes a standard of a preponderance of the evidence, or a lower standard of proof, when determining whether allegations of sexual abuse or sexual harassment are substantiated.

**Analysis:** To verify compliance, the facility provided Y.O. PREA Policy H and completed investigations. The investigator and other administrators indicated an understanding of this standard.

**Finding:** The facility is compliant with this standard.

## Standard 115.373: Reporting to residents

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

### 115.373 (a)

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

### 115.373 (b)

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

#### 115.373 (c)

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

#### 115.373 (d)

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

#### 115.373 (e)

- Does the agency document all such notifications or attempted notifications?  Yes  No

#### 115.373 (f)

- Auditor is not required to audit this provision.

## Auditor Overall Compliance Determination

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

## Instructions for Overall Compliance Determination Narrative

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

Policy requires that any resident who makes an allegation that he or she suffered sexual abuse in the facility is informed, verbally or in writing, as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded following an investigation. Following a resident's allegation that a staff member has committed sexual abuse against the resident, the facility subsequently informs the resident (unless the facility has determined that the allegation is unfounded) whenever: the staff member is no longer posted within the resident's unit; the staff member is no longer employed at the facility; the agency learns that the staff member has been indicted on a charge related to sexual abuse within the facility; or the agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility. Following a resident's allegation that she has been sexually abused by another resident in an agency facility, the agency subsequently informs the alleged victim whenever the agency learns that the alleged abuser has been indicted or convicted on a charge related to sexual abuse within the facility. The agency has a policy that all notifications to residents described under this standard are documented.

**Analysis:** To show compliance, the facility provided Y. O. PREA Policy E 3, 4 and documentation related to the two investigations completed in the past 12 months. Interviews also indicate a respect for keeping residents appropriately informed.

**Finding:** The facility is compliant with this standard.

## DISCIPLINE

### Standard 115.376: Disciplinary sanctions for staff

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

#### 115.376 (a)

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

#### 115.376 (b)

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

#### 115.376 (c)

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

#### 115.376 (d)

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

#### Auditor Overall Compliance Determination

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

#### Instructions for Overall Compliance Determination Narrative

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

Pathway of Hope staff are subject to disciplinary sanctions up to and including termination for violating sexual abuse or sexual harassment policies. Disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) are commensurate with the nature and circumstances of the acts committed, the staff member's disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar

histories. Termination is the presumptive disciplinary sanction for staff who have engaged in sexual abuse. All terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, are reported to law enforcement agencies, unless the activity was clearly not criminal, and to any relevant licensing bodies.

**Analysis:** To verify compliance, the facility provided Y.O. PREA Policy H 2d. Although no allegations or investigations have implicated staff in the past 12 months, all administrators interviewed indicated an understanding of, and commitment to, this standard and the related policies.

**Finding:** The facility is compliant with this standard.

## Standard 115.377: Corrective action for contractors and volunteers

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

### 115.377 (a)

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

### 115.377 (b)

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

### Auditor Overall Compliance Determination

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

### Instructions for Overall Compliance Determination Narrative

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



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

Any contractor or volunteer who engages in sexual abuse be reported to law enforcement agencies, unless the activity was clearly not criminal, and to relevant licensing bodies. Policy requires that any contractor or volunteer who engages in sexual abuse be prohibited from contact with residents. The facility takes appropriate remedial measures and considers whether to prohibit further contact with residents in the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer.

**Analysis:** To verify compliance, the facility provided Y.O. PREA Policy H 2d. Although the facility does not utilize volunteers or contractors at this time, administrators understands this standard, according to interviews, and will not employ volunteers unless they are properly trained and can be held accountable.

**Finding:** The facility is compliant with this standard.

## **Standard 115.378: Interventions and disciplinary sanctions for residents**

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

### **115.378 (a)**

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

### **115.378 (b)**

- Are disciplinary sanctions commensurate with the nature and circumstances of the abuse committed, the resident's disciplinary history, and the sanctions imposed for comparable offenses by other residents with similar histories?  Yes  No
- In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident is not denied daily large-muscle exercise?  Yes  No
- In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident is not denied access to any legally required educational programming or special education services?  Yes  No
- In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident receives daily visits from a medical or mental health care clinician?  Yes  No
- In the event a disciplinary sanction results in the isolation of a resident, does the resident also have access to other programs and work opportunities to the extent possible?  Yes  No

### **115.378 (c)**

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

#### 115.378 (d)

- If the facility offers therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse, does the facility consider whether to offer the offending resident participation in such interventions?  Yes  No
- If the agency requires participation in such interventions as a condition of access to any rewards-based behavior management system or other behavior-based incentives, does it always refrain from requiring such participation as a condition to accessing general programming or education?  Yes  No

#### 115.378 (e)

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

#### 115.378 (f)

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

#### 115.378 (g)

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

#### Auditor Overall Compliance Determination

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

#### Instructions for Overall Compliance Determination Narrative

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

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

Residents are subject to disciplinary sanctions only pursuant to a formal disciplinary process following an administrative finding that the resident engaged in resident-on-resident sexual abuse, or a criminal finding of guilt. Although the agency policy is consistent with this PREA standard regarding the isolation of residents, the facility does not practice isolation. The facility offers therapy, counseling, or other interventions designed to address and correct the underlying reasons or motivations for abuse and considers whether to require the offending resident to participate in such interventions as a condition of access to any rewards-based behavior management system or other behavior-based incentives. Access to general programming or education is not conditional on participation in such interventions. The agency disciplines residents for sexual contact with staff only upon finding that the staff member did not consent to such contact. Disciplinary action for making a report of sexual abuse, if the report is made in good faith based upon a reasonable belief that the alleged conduct occurred, is prohibited, even if an investigation does not establish evidence sufficient to substantiate the allegation.

**Analysis:** The facility provided Y.O. PREA Policy A 1g. Although no residents have been found to have engaged in sexual abuse during the past year, when interviewed, staff and administrators answered questions in such a way to indicate an understanding of this standard.

**Finding:** The facility is compliant with this standard.

## MEDICAL AND MENTAL CARE

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

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

#### 115.381 (a)

- If the screening pursuant to § 115.341 indicates that a resident has experienced prior sexual victimization, whether it occurred in an institutional setting or in the community, do staff ensure that the resident is offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening?  Yes  No

#### 115.381 (b)

- If the screening pursuant to § 115.341 indicates that a resident has previously perpetrated sexual abuse, whether it occurred in an institutional setting or in the community, do staff ensure that the resident is offered a follow-up meeting with a mental health practitioner within 14 days of the intake screening?  Yes  No

#### 115.381 (c)

- Is any information related to sexual victimization or abusiveness that occurred in an institutional setting strictly limited to medical and mental health practitioners and other staff as necessary to

inform treatment plans and security management decisions, including housing, bed, work, education, and program assignments, or as otherwise required by Federal, State, or local law?  
 Yes  No

#### 115.381 (d)

- Do medical and mental health practitioners obtain informed consent from residents before reporting information about prior sexual victimization that did not occur in an institutional setting, unless the resident is under the age of 18?  Yes  No

#### Auditor Overall Compliance Determination

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

#### Instructions for Overall Compliance Determination Narrative

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

Residents who have disclosed any prior sexual victimization during a screening pursuant to §115.341 are offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening, as per the facility's written policy and procedure.

**Analysis:** To verify compliance, the facility provided Y.O. PREA Policy B 2d and verified during interviews that these services are available and utilized. Residents interviewed with prior victimization stated that they have received care for their past traumas.

**Finding:** The facility is compliant with this standard.

### Standard 115.382: Access to emergency medical and mental health services

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

#### 115.382 (a)

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

### 115.382 (b)

- If no qualified medical or mental health practitioners are on duty at the time a report of recent sexual abuse is made, do staff first responders take preliminary steps to protect the victim pursuant to § 115.362?  Yes  No
- Do staff first responders immediately notify the appropriate medical and mental health practitioners?  Yes  No

### 115.382 (c)

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

### 115.382 (d)

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

### Auditor Overall Compliance Determination

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

### Instructions for Overall Compliance Determination Narrative

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

Resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services. SANE exams are conducted at Spectrum Health in Big Rapids. Also, the same hospital provides post-incident medical exams, and counseling. Advocacy is provided through the MOU with Oasis.

**Analysis:** To show compliance, the facility provided the Y.O. PREA Policy, updated their Coordinated Response Plan, and verified, through interviews, that they understand this standard and that there are no barriers to following the standard.

**Finding:** The facility is compliant with this standard.

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

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

### **115.383 (a)**

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

### **115.383 (b)**

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

### **115.383 (c)**

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

### **115.383 (d)**

- Are resident victims of sexually abusive vaginal penetration while incarcerated offered pregnancy tests? (N/A if all-male facility.)  Yes  No  NA

### **115.383 (e)**

- If pregnancy results from the conduct described in paragraph § 115.383(d), do such victims receive timely and comprehensive information about and timely access to all lawful pregnancy-related medical services? (N/A if all-male facility.)  Yes  No  NA

### **115.383 (f)**

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

### **115.383 (g)**

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

### **115.383 (h)**

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

### Auditor Overall Compliance Determination

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

### Instructions for Overall Compliance Determination Narrative

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

Y.O. Pathway of Hope offers medical and mental health evaluation and, as appropriate, and treatment to all residents who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility. This includes access to all lawful pregnancy-related services. Resident victims of sexual abuse are offered tests for sexually transmitted infections as medically appropriate. Treatment services are 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. Interviews indicate that the evaluation and treatment of victims shall 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. The facility attempts to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history, and it offers treatment when deemed appropriate by mental health practitioners.

**Analysis:** To verify compliance, the facility provided Y.O. PREA Policy F 6, their screenings of residents (and related mental health records), and their investigations, and made all staff available for interviews.

**Finding:** The facility is compliant with this standard.

## DATA COLLECTION AND REVIEW

### Standard 115.386: Sexual abuse incident reviews

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

### 115.386 (a)

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

### 115.386 (b)

- Does such review ordinarily occur within 30 days of the conclusion of the investigation?  Yes  No

### 115.386 (c)

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

### 115.386 (d)

- Does the review team: Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse?  Yes  No
- Does the review team: Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; gang affiliation; or other group dynamics at the facility?  Yes  No
- Does the review team: Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse?  Yes  No
- Does the review team: Assess the adequacy of staffing levels in that area during different shifts?  Yes  No
- Does the review team: Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff?  Yes  No
- Does the review team: Prepare a report of its findings, including but not necessarily limited to determinations made pursuant to §§ 115.386(d)(1) - (d)(5), and any recommendations for improvement and submit such report to the facility head and PREA compliance manager?  Yes  No

### 115.386 (e)

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

### Auditor Overall Compliance Determination

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



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

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

### Instructions for Overall Compliance Determination Narrative

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

The facility conducts a sexual abuse incident review at the conclusion of every sexual abuse criminal or administrative investigation, unless the allegation has been determined to be unfounded. The facility ordinarily conducts a sexual abuse incident review within 30 days of the conclusion of the criminal or administrative sexual abuse investigation. The sexual abuse incident review team includes upper-level management officials and allows for input from line supervisors, investigators, and medical or mental health practitioners. The review team considers whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse; and 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. The team examines the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse; and the team also assesses the adequacy of staffing levels in that area during different shifts. They assess whether monitoring technology should be deployed or augmented to supplement supervision by staff. They report their findings, and any recommendations they have for improvement, to the facility head and PREA Compliance Manager.

**Analysis:** To verify compliance, the facility provided their PREA policy. Additionally, the investigator and PREA Compliance Manager answered questions during interviews that indicated an understanding of this standard. The investigations provided did not require Incident Reviews.

**Finding:** The facility is compliant with this standard.

## Standard 115.387: Data collection

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

#### 115.387 (a)

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

#### 115.387 (b)

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

#### 115.387 (c)

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

#### 115.387 (d)

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

#### 115.387 (e)

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

#### 115.387 (f)

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

#### Auditor Overall Compliance Determination

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

#### Instructions for Overall Compliance Determination Narrative

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

Youth Opportunity Pathway of Hope collects accurate, uniform data for every allegation of sexual abuse, using a standardized instrument and set of definitions, and reports this annually. The facility maintains, reviews, and collects data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews.

**Analysis:** To show compliance, the facility provided their PREA Policy and Definitions. Also, the PREA Coordinator verifies compliance with this standard during interviews. Their published annual reports verify practice.

**Finding:** The facility is compliant with this standard.

## Standard 115.388: Data review for corrective action

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

### 115.388 (a)

- Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Identifying problem areas?  Yes  No
- Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Taking corrective action on an ongoing basis?  Yes  No
- Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Preparing an annual report of its findings and corrective actions for each facility, as well as the agency as a whole?  Yes  No

### 115.388 (b)

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

### 115.388 (c)

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

### 115.388 (d)

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

### Auditor Overall Compliance Determination

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

- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

### Instructions for Overall Compliance Determination Narrative

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

Both MDHHS and Youth Opportunity Pathway of Hope reviews data collected and aggregated pursuant to §115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies and training, including: identifying problem areas; taking corrective action on an ongoing basis; and preparing an annual report of its findings from its data review and any corrective actions for each facility, as well as the agency as a whole. The annual report provides an assessment of the agency's progress in addressing sexual abuse. The annual reports are approved by the agency head, as per protocol.

**Analysis:** To verify compliance, the facility provided the agency and facility websites, MDHHS Umbrella Policy #560, pages 6-7, and explained their data collection systems.

**Finding:** The facility is compliant with this standard.

## Standard 115.389: Data storage, publication, and destruction

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

#### 115.389 (a)

- Does the agency ensure that data collected pursuant to § 115.387 are securely retained?  
 Yes  No

#### 115.389 (b)

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

#### 115.389 (c)

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

#### 115.389 (d)

- Does the agency maintain sexual abuse data collected pursuant to § 115.387 for at least 10 years after the date of the initial collection, unless Federal, State, or local law requires otherwise?  Yes  No

### Auditor Overall Compliance Determination

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

### Instructions for Overall Compliance Determination Narrative

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

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

<http://www.youthopportunity.com/campuses/?lang=en>  
[https://www.michigan.gov/mdhhs/0,5885,7-339-73971\\_34044\\_39057---,00.html](https://www.michigan.gov/mdhhs/0,5885,7-339-73971_34044_39057---,00.html)

**Analysis:** To verify compliance, the facility provided MDHHS Umbrella Policy #560, pages 6-7, and Annual Reports.

**Finding:** The facility is compliant with 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 inmates, residents, and detainees?  Yes  No

#### 115.401 (n)

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

#### Auditor Overall Compliance Determination

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

## Instructions for Overall Compliance Determination Narrative

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

The Michigan Department of Health and Human Services Juvenile Justice Programs PREA Coordinator coordinates the PREA audits of their facilities, and most of the facilities they contract with statewide. They initiate PREA audits every year in keeping with this standard and remain compliant in material ways with this standard. Additional and specific information regarding this work can be viewed at [https://www.michigan.gov/mdhhs/0,5885,7-339-73971\\_34044\\_39057---,00.html](https://www.michigan.gov/mdhhs/0,5885,7-339-73971_34044_39057---,00.html)

**Analysis and Finding:** To verify compliance, the audit team studied the website and reports. The agency is compliant with 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, all Final Audit Reports within 90 days of issuance by auditor. The review period is for prior audits completed during the past three years PRECEDING THIS AGENCY AUDIT. In the case of single facility agencies, the auditor shall ensure that the facility's last audit report was published. The pendency of any agency appeal pursuant to 28 C.F.R. § 115.405 does not excuse noncompliance with this provision. (N/A if there have been no Final Audit Reports issued in the past three years, or in the case of single facility agencies that there has never been a Final Audit Report issued.)  Yes  No  NA

#### Auditor Overall Compliance Determination

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

## Instructions for Overall Compliance Determination Narrative

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

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

For annual reports and audits: <http://www.youthopportunity.com/campuses/?lang=en>

**Analysis and Finding:** To verify compliance, the audit team verified that the previous report is available online. The facility is compliant with 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.<sup>1</sup> Auditors are not permitted to submit audit reports that have been scanned.<sup>2</sup> See the PREA Auditor Handbook for a full discussion of audit report formatting requirements.

D. Will Weir

05-01-2019

**Auditor Signature**

**Date**

<sup>1</sup> See additional instructions here: <https://support.office.com/en-us/article/Save-or-convert-to-PDF-d85416c5-7d77-4fd6-a216-6f4bf7c7c110>.

<sup>2</sup> See *PREA Auditor Handbook*, Version 1.0, August 2017; Pages 68-69.