Prison Rape Elimination Act (PREA) Audit Report
Juvenile Facilities

☐ **Interim** ☒ **Final**

Date of Report 05-27-2019

Auditor Information

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Company Name: PREA America, LLC	
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Telephone: 405-945-1951	**Date of Facility Visit:** 10-29-2018

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 (MDHHS)	
Physical Address: 235 S. Grand Avenue		**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: Child welfare professionals will demonstrate an unwavering commitment to engage and partner with families we serve to ensure safety, permeance and well-being.

Agency Website with PREA Information: 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; 517-241-9859

Agency-Wide PREA Coordinator

Name: Soleil Campbell	**Title:** Juvenile Justice Program Manager

Email: campbells6@michigan.gov	**Telephone:** 517-373-1570
PREA Coordinator Reports to: Stacie Bladen, Deputy Director of Children's Services Agency	**Number of Compliance Managers who report to the PREA Coordinator** 0

Facility Information

Name of Facility:	Calumet Center			
Physical Address:	330 Glendale St.; Highland Park, MI 48203			
Mailing Address (if different than above):	Click or tap here to enter text.			
Telephone Number:	313-852-7500			
The Facility Is:	☐ Military	☐ Private for Profit	☒ Private not for Profit	
☐ Municipal	☐ County	☐ State	☐ Federal	
Facility Type:	☐ Detention	☐ Correction	☐ Intake	☒ Other
Facility Mission:	Rehabilitate chronically delinquent youthful offenders.			
Facility Website with PREA Information:	www.spectrumhuman.org/index_sjjs.html			
Is this facility accredited by any other organization?	☒ Yes ☐ No			

Facility Administrator/Superintendent

Name:	Kirpheous Stewart	**Title:**	Center Director
Email:	kstewart@spectrumhuman.org	**Telephone:**	313-852-7505

Facility PREA Compliance Manager

Name:	Rema Mourad	**Title:**	Clinical Service Manager
Email:	rmourad@spectrumhuman.org	**Telephone:**	313-852-7532

Facility Health Service Administrator

Name:	Dr. Steven Teitel	**Title:**	Medical Doctor
Email:	steitel@spectrumhuman.org	**Telephone:**	313-852-7518

Facility Characteristics

Designated Facility Capacity: 88	**Current Population of Facility:** 66
Number of residents admitted to facility during the past 12 months	80
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 10 days or more:	80

Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 72 hours or more:	80
Number of residents on date of audit who were admitted to facility prior to August 20, 2012:	0
Age Range of Population:	11-20 years old
Average length of stay or time under supervision:	12 months
Facility Security Level:	High-Secure
Resident Custody Levels:	Secure
Number of staff currently employed by the facility who may have contact with residents:	65
Number of staff hired by the facility during the past 12 months who may have contact with residents:	41
Number of contracts in the past 12 months for services with contractors who may have contact with residents:	0

Physical Plant

Number of Buildings: 1	**Number of Single Cell Housing Units:** 88
Number of Multiple Occupancy Cell Housing Units:	0
Number of Open Bay/Dorm Housing Units:	0
Number of Segregation Cells (Administrative and Disciplinary:	8

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.):

90 cameras are deployed in Admissions, Cafeteria, Day Area, Sleeping Quarters, Kitchen, Laundry, Outside Perimeter, Confinement Rooms, Recreation Area, Visitation, Gym and Medical.

Medical

Type of Medical Facility:	On-site for routine medical
Forensic sexual assault medical exams are conducted at:	Detroit Medical Ctr. Children's Hospital

Other

Number of volunteers and individual contractors, who may have contact with residents, currently authorized to enter the facility:	7
Number of investigators the agency currently employs to investigate allegations of sexual abuse:	3

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.

PREA America LLC was retained on March 12, 2018 to perform the Calumet Center PREA Audit. Michigan DHHS PREA Juvenile Coordinator and Program Manager Patrick Sussex facilitated the process. The on-site audit was conducted on October 29, 2018, as planned. As described in more detail below, the audit team (consisting of DOJ Certified PREA Auditor Will Weir and Project Manager Tom Kovach) met with Agency Juvenile PREA Coordinator Patrick Sussex and Calumet Center administrators Melissa Fernandez, Kirpheous Stewart, Jenny Sloan, PREA Compliance Manager Rema Mourad, and others, that day, participating in a site review, random interviews with residents and staff, document reviews, and an exit conference at the conclusion of the on-site audit. It is important to note that the Michigan Department of Health and Human Services (MDHHS) is the agency contracting Spectrum Juvenile Justice Services (SJJS) and their Calumet Facility to house youth who are in state custody. References will be made to policy from all three entities. SJJS and their Calumet facility must adhere, by contract, to the MDHHS polices. SJJS has policies, as does the facility. The Calumet facility is required to follow each of these policies.

Introductory communication with the PREA Coordinator started on March 12, 2018, to discuss the audit process, audit preparation, the Pre-Audit Questionnaire (PAQ), and supporting documents and elements of the on-site visit. The Audit Notice Posting was sent, with instructions to print on colored paper, and regarding the proper distribution of the posting. Alternative-language postings were also made available. Proof of posting was verified by emailed photos of the various locations within the facility in which the postings were placed. The date of the email was used to verify the minimum posting requirement of six weeks prior to the on-site audit, along with observations of the posting during the physical plant tour.

The Pre-Audit Phase for this facility began with a Pre-Audit Questionnaire (PAQ) and supporting documentation, which was received by the auditor on October 5, 2018. An extensive desk audit was conducted at that time. The PAQ, policies, procedures, as well as supporting documentation, were reviewed. Then several emails were 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 not only to understand the policies and procedures unique to the facility, but also to understand how PREA was put into practice.

All documents received were reviewed, including logs, training files, and curricula. The personnel files of randomly selected staff, contractors, and volunteers were reviewed, to verify that each contained both sufficient documentation to meet the initial background check requirements, and the 5-year recheck requirement. As is noted in this report throughout the narratives associated with investigations, the facility was very slow to provide information regarding the sexual abuse allegations and investigations of the past 12 months, and they had not yet provided complete information or documentation as of the auditor's Interim Report, which was issued 12-04-2018.

The on-site audit started with a briefing, which included confirmation of current population, 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. Present were: Pat Sussex, PREA Coordinator; Courtney Praski, Agency PREA Analyst; Rema Mourad, PREA Compliance Manager; Melissa Fernandez, SJJS Executive Director; and the audit team.

The Site Review included obtaining and studying the facility diagram of the physical plant. The supervision and movement of staff and residents were observed, and casual conversations were held to ascertain whether the 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 were made to assess their functionality. All housing units and bathroom facilities were inspected for compliance with regulations regarding cross-gender supervision. This included a camera review for those areas with cameras. All areas of the physical plants were observed, with attention to those areas which statistically are high-risk for sexual abuse. PREA Postings in the visitation area, including third-party reporting postings, were checked. Confirmation of the availability to staff of written First Responder Duties was also a part of the tour. Blind spots were identified, and procedures for checking them were verified. Among the observations made were: A third-party reporting poster from the visitation area was missing, and most of the audit notice posters were gone. The camera review showed a violation of cross-gender supervision, due to cameras viewing the toilets in one housing unit and in the isolation cells.

The auditor attempted to make random selections of residents to interview in accordance with the guidance of the PREA Auditor Handbook, with random selections of residents to ensure diversity of geographic location (from each housing unit), race, and those with risk factors. Random Staff interviews were made to include: gender, shift, and posting diversity. Interviews were 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 comprehension of the PREA policies and practice in the facility. 16 of the 66 residents were interviewed. Although a request had been made in advance for the facility to provide a list of residents with risk factors (as recognized by PREA) for possible targeted interviews, none was provided. This helped indicate a problem with the facility's screening system for risks, which was later addressed. (See the narrative for Standard 341.) In the absence of a targeted list, the PREA Compliance Manager remembered one youth with a history of abuse and assisted the auditor in selecting 4 youth who were younger than the other youth; so, these composed the targeted interviews. Interviews were conducted of the following staff: Agency Head Designee; Agency PREA Coordinator; Agency Contract Manager; Superintendent; Human Resources; Local Investigator; PREA Compliance Manager; Higher-Level Staff for Unannounced Rounds; Medical Staff; Mental Health Staff; Staff who Perform Screening and Intake; Staff who Monitor for Retaliation; Incident Review Team; Staff who Monitor Isolation; and a contractor. The auditor also interviewed an Agency CPS Administrator. An additional twelve staff were selected randomly, representing various stations, housing units, shifts, and genders. Some specialized staff perform multiple duties, so these staff were interviewed regarding all their PREA-related duties. During the CAP, an additional three administrators were interviewed, bringing the total of staff and administrators interviewed to 28.

The Exit Briefing addressed all aspects of the audit to date. No determination of compliance was given, but it was clear that much more work would be done by the facility to show compliance. The aggregate of the information observed and obtained was summarized. At the request of the facility staff, the the recap included a SWOT briefing, assessing for Strengths, Weaknesses, Opportunities, and Threats in order to assist in furthering the efforts of the facility to prevent and detect sexual abuse and harassment. Present at the Exit Briefing were Pat Sussex, PREA Coordinator; Courtney Praski, Agency PREA Analyst; Rema Mourad, PREA Compliance Manager; Melissa Fernandez, SJJS Executive Director; Kirpheous Stewart, Facility Superintendent; Jenny Sloan, Mental Health Director; and the audit team.

An Interim Report was issued 12-04-2018, which triggered a corrective action period. The facility and the agency worked with the audit team to devise a Corrective Action Plan (CAP) that would address all the outstanding compliance issues. Most of the documentation was provided by February 14, 2019. However, the agency and facility continued to attempt to establish an MOU, and to follow up on investigative work to show full compliance with the few remaining Standards. On May 8, 2019, it was determined that the facility had no additional verification to provide, and that due diligence had been demonstrated regarding all PREA Standards.

Documents reviewed for this audit include:
Spectrum Juvenile Justice Services Policy (mirrors MDHHS umbrella policy); Calumet PREA Policy; Spectrum Organizational Chart; Organizational Chart for Michigan Department of Health and Human Services (DHHS); SJJS Staffing Plan and Annual Review; SJJS Staffing Plan Review; SJJS Shift Supervisors' Daily Report; verbal MOU Wayne County SAFE; MOU between SJJS and Highland Park Police; Certificate of Completion from NIC for BHC for Sexual Assault Victims in a Confinement Setting; SJJS Student Handbook Treatment; MDHHS website for reporting; Coordinated Response Plan; Blank Annual Report Form; MDHHS Website Annual Reports; Floor Plan Schematic with cameras; LEP Policy; Staff Training Curriculum; Blank Training Test Form; Investigation; Incident Reviews; All Staff Training Records; All Contractor and Volunteer Training Records; 16 Background Checks; 16 Child Abuse Registry Checks for Staff and Contractors; Employment Applications; Staff List; List of staff hired in past 12 months; "End Silence" PREA Training Comic; Investigator Training Certificates; Intake Records, including Risk Screenings and Reassessments for 17 of 66 youth; and numerous emails answering questions and making clarifications.

Documents reviewed after Onsite Audit include: Updated Screening Form; Updated Incident Review Form; Updated Retaliation Monitoring Sheet; Third Party postings in Arabic, Spanish, and English; postings to remind to staff to make gender announcements; and additional emails. Additional documentation reviewed during the CAP is detailed in each section where corrective action is described.

Facility Characteristics

Calumet Center is a one-building, High-Security facility built in 1999. It has 8 housing units, 7 of which were in use the day of the audit. The housing units consist of single cells, with a security office observing the cells, and two dayrooms, a classroom, and staff offices. There are four housing areas that surround the interior gymnasium and outdoor recreation courtyard. The gymnasium has storage and two multi-purpose rooms, as well as a toilet and two offices. There are multipurpose rooms and storage adjacent to the Outdoor Recreation Area.

Halls connect the housing areas to the front offices, Intake, and Medical. Additionally, areas include a visitation area and a control center for security. All areas have multiple cameras, which have several days of memory and cover any potential blind spots.

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: 22 in Interim Report; 43 in Final Report

Number of Standards Not Met: 21 in Interim Report; 0 in Final Report

Standards resolved during the CAP, by number: 315, 321, 322, 334, 351, 353, 364, 365, 367, 371, 372, 373, 376, 377, 378, 382, 383, 386, 387, 388, & 389.

Summary of Corrective Action (if any)

The facility/agency had not shown full compliance with the following Standards at the time the Interim Report was issued by the auditor, which was 12-04-2019. This triggered corrective action, and the agency, and the facility, responded expeditiously, showing compliance with all standards prior to the 180 days allowed.

§ 115.315 Limits to cross-gender viewing and searches. (Resolved)
During interviews, many residents stated they are not told when female staff are working, but upon further inquiry it was determined that Calumet staff announce their presence by giving their names instead of saying "female" on duty. A higher rate of residents stated that females announce their presence when the auditor asked the question in a way that reflected the practice at Calumet. However, there were still 6 residents that stated they do not always know when female staff are on duty. During the on-site audit, and in emails afterward, the auditor requested the facility to provide their own assessment regarding how well their staff are following this standard. The Executive Director provided the following response, "All staff were retrained on this standard (staff members of the opposite gender shall announce their presence upon entering the housing units). Posters stating 'Staff members of the opposite gender shall announce their presence upon entering the housing units' have been posted on all doors entering the living units where youth may be showering, changing clothing or using bathroom." She provided digital photos of the posted signs, and this was accepted by the auditor as addressing this issue prior to the Interim Report being issued. However, the audit team identified a problem that required a correction, rather than just a clarification. Pod 3 and protective segregation cells have cameras in all rooms, with the toilets in full view. The Executive Director stated, " . . . Operations Management discussed the cameras in the pod 3 day[room] with our cabling provider. Cabling Concepts representatives confirmed that they can pixilate the view over the toilets; however upgrades to the system will need to occur. A date of 12/15/18 has been scheduled to complete this project. In the meantime, all cameras in rooms 2-10 on pod 3 have been disabled." This item was on the CAP until verification of completion could be provided.

Corrective Action: Verification of cross-gender announcement staff training was provided 01-24-2019. Digital photos of camera views were provided 02-14-2019.

§ 115.321 Evidence protocol and forensic medical examinations. (Resolved)
Two allegations regarding staff-on-resident sexual abuse were substantiated during the 12 months prior to the PAQ, of which one included sexual assault. Although the alleged incident of sexual assault happened one week before it was reported, and although the allegation involved oral to genital sexual

assault, the documentation provided to the audit team did not document that any medical examination, testing, advocacy, or follow-up care was offered to the victim. Part "D" of this standard states, "The agency shall attempt to make available to the victim a victim advocate from a rape crisis center. If a rape crisis center is not available to provide victim advocate services, the agency shall make available to provide these services a qualified staff member from a community-based organization or a qualified agency staff member. Agencies shall document efforts to secure services from rape crisis centers. . . ." Therefore, this standard was indicated as "Does Not Meet Standard" in the Interim Report and included in the CAP.

Corrective Action: The facility made additional changes to their Coordinated Response Plan and trained on the plan, which includes these responses, and posted it where all staff can see it. They updated their Youth Orientation Packet to include additional information about the availability of this care to residents. They provided additional First Responder Training and retrained on PREA basics. They also did a training called, "PREA: Access to Emergency and Medical and Mental Health Services". They provided complete investigations that followed all applicable parts of the Standards. The facility made additional attempts to enter into an MOU with Wayne County SAFE. Although they were unable to get that MOU established, they did establish one with the police department that is tasked with doing their criminal investigations, and this agreement requires specialized training for the police investigators.

§ 115.322 Policies to ensure referrals of allegations for investigations. (Resolved)
During the on-site audit, the audit team was provided a "PREA Incident Review Report" regarding an investigation of sexual harassment. Despite requests, the facility did not provide an actual PREA investigation for the auditor to review. They provided the allegation on the "Unusual Incident Report Summary" form, which indicated that First Responder Duties had been initiated; and they provided the investigation that was completed by the MDHHS Division of Child Welfare Licensing, which is not a sexual harassment investigation, but an investigation regarding whether the facility violated licensing requirements. Therefore, this standard was listed in the Interim Report as "Does Not Meet Standard" and included in the CAP.

Corrective Action: The Center Director stated in CAP materials, in part, that, "An administrative investigation will be conducted on each incident, regardless of whether the Department of Child Welfare Licensing (DCWL) investigates. (Incidents that appear to involve criminal behavior will be referred to law enforcement)." The CAP went on to say, "Evidence that Spectrum Human Services is already applying these protocols can be found in the facility's Corrective Action Plan, PREA standards 115.334, 115.367, 115.371, 115.772. Calumet currently has two investigations occurring . . . . Spectrum Human Services will provide the auditor with all documentation of these investigations. Spectrum will provide documentation of any new allegations of sexual abuse or harassment received by 04-04-2019, and of any new investigations completed by that date. Also, provide documentation of what has been done to implement the items . . . . For example, any staff meeting notes, policy updates, emailed instructions or training completion acknowledgement." The facility provided verification of practice as agreed.

§ 115.334 Specialized training: Investigations. (Resolved)
Although the training received, and policies reviewed, seem to be consistent with this standard, the documents reviewed associated with investigations did not seem consistent with the policy and training. The Executive Director stated, in response to the audit team's observations, "All PREA managers will re-take the investigator training by November 30th, 2018."

Corrective Action: Spectrum Human Services has retrained all investigative staff through the National Institute of Corrections. Four investigators took the course entitled, "PREA: Investigating Sexual Abuse in a Confinement Setting". By taking this course, all investigators received knowledge, components, and considerations that an investigator must use to perform a successful sexual abuse or sexual harassment investigation consistent with PREA standards. Certificates of completion were provided.

§ 115.351 Resident reporting. (Resolved)
During interviews with administrators regarding reporting and investigations, a concern was raised that CPS (the outside entity designated to meet 351 (b) of this standard) might not report back to the facility as required by this standard, leaving the facility not knowing what to investigate.

Corrective Action: A new procedure was developed that ensures that MDHHS Centralized Intake will provide immediate notification to the designated facility official that an allegation was phoned in, and that they will provide as much information on the allegation as allowed by law.

§ 115.353 Resident access to outside support services and legal representation. (Resolved)
The standard requires facilities to provide residents with access to outside victim advocates for emotional support services related to sexual abuse. This is not just about residents who are taken for a forensic exam. The concern, at the time of the Interim Report, was that other sexual abuse survivors at Calumet that do not report for a forensic exam may not be made aware of available advocacy.

Corrective Action: Spectrum Human Services made additional attempts with Wayne County SAFE to enter into an MOU with the agency, without success. However, they did succeed in entering into an MOU with the police department tasked with investigating criminal sexual abuse allegations. In order to educate clients on their access to resources outside the facility, the facility has added this additional language to the youth orientation packet: “This facility has policies that require that a victim of sexual assault receive medical attention, counseling, is kept safe from further victimization, is protected from retaliation and is supported in helping to hold perpetrators accountable. PREA also states that you have the right to speak to someone outside of this facility, if an outside service is available, to help you heal from past sexual abuse, and/or to be with you during any medical examinations and investigative interviews as related to sexual victimization. If you request these services, a facility counselor or administrator will contact an outside advocate for you. If at the time the request is made an outside advocate is not available, a qualified person from the facility will provide those services.” Additional PREA education was provided to current facility residents informing them that they can be provided outside advocacy if requested.

§ 115.364 Staff first responder duties. (Resolved)
Although policies are consistent with this standard, the pre- and on-site audit work indicated that staff seem to rely on their superiors to understand the duties, and that not all their superiors demonstrated an understanding of the duties during interviews. Refresher training was scheduled, and this Standard was included in the CAP. Out of all interviews with staff, supervisors, and directors who were asked about advocacy, only one was found who understood advocacy. Some staff thought First Responders should do investigative work, and they did not know how to secure interpreters when needed.

Corrective Action: Staff were retrained regarding First Responder Duties. Also, they received their PREA Basics training again. In addition, they took the course: “PREA: Access to Emergency and Medical and Mental Health Services (115.382)”, and they learned about advocacy and how to secure interpreters. Furthermore, they took trainings entitled, “Juvenile Detention: Completing a PREA Incident Report” and “Juvenile Detention: Professional Communication and Boundaries”. Administration at Calumet updated the First Responder Duties (see Standard 115.365), and these updated First Responder Duties were re-printed and placed on the back of all staff identification cards. Additionally, Calumet has posted their Coordinated Response Plan in all staffing areas and control rooms.

§ 115.365 Coordinated response. (Resolved)
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; except that it did not adequately include the steps to take regarding making sure forensic evidence is collected from an alleged perpetrator.

Corrective Action:
Calumet Center updated their Coordinated Response Plan to correct the language relative to victims and perpetrators and protecting evidence, and in other areas pertinent to this audit as well. All staff were retrained in the month of December on First Responder Duties, and all employee identification cards have First Responder Duties upon them, to which the requirement that they do not allow a perpetrator to wash, change clothes, etc. (pending forensic exam) was added. Also, the Coordinated Response Plans were posted for easy access by staff.

§ 115.367 Agency protection against retaliation. (Resolved)
Although policies appear to cover all aspects of the PREA standards, not all sub-sections of the Standards appear to have been followed in practice regarding investigations performed during the past 12 months. Retaliation monitoring did not appear to have been adequately documented, if completed, so this Standard was included in the CAP.

Corrective Action: Verification was provided, both of training regarding retaliation monitoring, and of the practice of retaliation monitoring.

§ 115.371 Criminal and administrative agency investigations. (Resolved)
Since SJJS had not provided complete investigations for all allegations, the Interim Report indicated that the facility had not shown compliance with this Standard.

Corrective Action: The facility provided complete administrative investigations regarding each incident and reported to law enforcement as required. They followed up with law enforcement as required.

§ 115.372 Evidentiary standard for administrative investigations. (Resolved)
The interview with the investigator indicated that the investigator was not well-informed about the basics of investigations, such as the standards of evidence, so this Standard was marked “Does Not Meet Standard” in the Interim Report.

Corrective Action: The facility provided the training and documentation required by the CAP and it provided verification of compliance with this Standard in practice, as well as training which included a review of the standards of evidence, given to four investigators.

§ 115.373 Reporting to residents. (Resolved)
Since Calumet Center had not provided complete investigations for all allegations at the time of the Interim Report, the facility had not provided verification that alleged victims are informed appropriately regarding the outcome of investigations, and the other requirements, regarding the alleged perpetrator, nor the other sub-sections of this standard. The facility had provided two documents showing that alleged victims were notified regarding the outcomes of two investigations. However, without all the full investigative documentation to review, it was unclear if the notifications included all required information, or if there might have been other alleged victims.

Corrective Action: Investigative documentation was provided in accordance with the CAP. The documentation showed compliance with this Standard in practice.

§ 115.376 Disciplinary sanctions for staff. (Resolved)
The facility had only provided partial documentation, at the time of the Interim Report, regarding how employees who were alleged perpetrators were sanctioned.

Corrective Action: Copies of the Letters of Termination were provided. In accordance with facility policy, both terminations were reported to law enforcement, CPS and licensing. These staff have not been and are not eligible to be re-hired.

§ 115.377 Corrective action for contractors and volunteers. (Resolved)
Although policy appeared to be consistent with this standard, the facility had not provided verification of practice at the time of the Interim Report. Without reviewing the documentation auditors are required to review, the auditor did not know whether there had been any offending contractors or volunteers.

Corrective Action: The facility provided the required investigative documentation. The documentation did not reveal any accusations against contractors or volunteers. That is to say, the documentation did not indicate any violations of this Standard.

§ 115.378 Interventions and disciplinary sanctions for residents. (Resolved)
Although policy appeared to be consistent with this standard, the facility had not provided verification of practice at the time of the Interim Report. Without reviewing the documentation auditors are required to review, the auditor did not know whether any offending residents had been sanctioned within the requirements of this Standard.

Corrective Action: The facility provided the required investigative documentation. The documentation did not reveal any incidents of resident-on-resident sexual abuse or findings that triggered the regulations and safeguards detailed in the Standard. That is to say, the documentation did not indicate any violations of this Standard.

§ 115.382 Access to emergency medical and mental health services. (Resolved)
Once again, in the absence of SJJS providing complete investigations for all allegations, the auditor could not verify, when writing the Interim Report, whether the investigations were conducted sufficiently well, nor even that emergency services were provided appropriately. The auditor did not know whether follow-up care was provided as per the requirements of this standard and agency policy.

Corrective Action: Investigative documentation provided during the CAP was not inconsistent with the practice of this Standard. The facility provided training verification for training entitled, “PREA: Access to Emergency and Medical and Mental Health Services (115.382)” and “PREA: Behavioral Health Care for Sexual Assault Victims in a Confinement Setting” In addition, the new MOU with Parkland Police Department supports compliance with this Standard.

§ 115.383 Ongoing medical and mental health care for sexual abuse victims and abusers. (Resolved)
Since SJJS had not provided complete investigations for all allegations, the auditor could not verify whether victims received appropriate care at the time of the Interim Report. Although agency policies appeared to be consistent with this standard, the facility had not provided verification that they follow this standard in practice.

Corrective Action: The facility provided the documentation required in the CAP, showing evidence of youth being offered services as required by this Standard, and documentation of when ongoing care was not indicated.

§ 115.386 Sexual abuse incident reviews. (Resolved)
As above, because SJJS had not yet sent the audit team complete investigations for all allegations, at the time of the Interim Report, the auditor was not able to verify whether the investigations were conducted appropriately, nor even that the number of them was accurate; nor whether corrective actions and incident reviews had been fully followed through.

Corrective Action: During the course of the CAP, additional incident reviews were completed as investigations were completed, showing practice of this Standard. As investigative information was provided to the auditor, and reviewed, the auditor could see that the Incident Reviews addressed the

circumstances surrounding the incidents as required. Three Incident Review Reports were found to be consistent with this standard after all the investigative information was received.

§ 115.387 Data collection. (Resolved)
Since the facility had not yet provided complete investigations for all allegations, the auditor could not verify whether the investigations had been done well, nor even that they are counted well; nor whether corrective actions and incident reviews were fully followed through. The absence of the sharing of this documentation called both the facility's data collection and its annual reports into question, so these Standards were marked "Does Not Meet Standard" in the Interim Report, and placed in the CAP.

Corrective Action: The facility provided the documentation required in the CAP showing their data collection matches their incidents, allegations, and investigations.

§ 115.388 Data review for corrective action. (Resolved)
Since SJJS had not yet sent the audit team the entire investigations for all allegations, the auditor could not verify whether the investigations had been done sufficiently well, nor even that they are counted sufficiently well; nor whether corrective actions and incident reviews had been followed through fully. Sans such information, the facility's data and its annual reports were are called into question.

Corrective Action: These concerns were resolved with documentation and analysis provided during the CAP.

§ 115.389 Data storage, publication, and destruction. (Resolved)
Because SJJS had not yet provided complete investigations for all allegations, at the time that the Interim Report was written, the auditor could not yet verify whether the investigations had been done well, nor even that they had been counted well, nor whether corrective actions and incident reviews had been followed through fully. The absence of the complete set of completed investigations called the data and the annual reports into question.

Corrective Action: The facility provided all their investigative documentation and explained their logging system, indicating an accurate method of tracking and reporting their allegations and investigations. The facility's annual statistics were adjusted to reflect the "new" accurate count of allegations made during the audit period.

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.

Calumet Center has a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment, and a policy outlining how it will implement the agency's approach to preventing, detecting, and responding to sexual abuse and sexual harassment. Spectrum Juvenile Justice Services (SJJS) Clinical Services Manager Rema Mourad, housed onsite at Calumet Center, is the PREA Compliance Manager. She reports to the Executive Director Melissa Fernandez, who takes an active role regarding PREA compliance at the facility. 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 Interim Report was issued regarding this audit. The agreement between MDHHS and their contract facilities, such as Calumet Center, 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.

Analysis: Due to a triangulation of evidence, the auditor is able to determine that the facility has shown compliance with this standard. This evidence is divided into the following types: policy, interviews, and

proof of practice. According to interviews with Executive Director Melissa Fernandez, Facility Director Kirpheous Stewart, PREA Coordinator Rema Mourad, and MDHHS PREA Coordinator Patrick Sussex, as well as interviews with staff and residents, Calumet's Policy represents an ongoing commitment to zero tolerance and safety. The policy update, effective April 2, 2015, states on page 1, "Spectrum Juvenile Services has zero-tolerance for sexual abuse and/or harassment of residents." The agency employs and designates an upper-level, agency-wide PREA coordinator who has sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards in the facility. This is further detailed in SJJS Policy part 3, page 2. Despite the facility not showing full PREA compliance yet, PREA coordination work was observed in practice throughout the pre-audit process, on-site audit, and in the 30 days after the on-site review.

Finding: The facility has shown compliance 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.

SJJS/Calumet does not contract out for the confinement of its residents. The State of Michigan DHHS contracts with SJJS for the confinement of its residents. DHHS requires all contractors, such as SJJS, to adopt and comply with PREA Standards.

Analysis: Due to a triangulation of evidence, the facility has shown compliance with this standard. The evidence is as follows: The policies of both agencies, interviews with administrators in both agencies, and the contracts as verified through contract monitoring.

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.

Calumet Center provided documentation that it develops, documents, and makes its best efforts to comply with a staffing plan that provides for adequate levels of staffing, and, where applicable, video monitoring, to protect residents against abuse. At least once every year, the agency, in collaboration with the PREA Coordinator, reviews the staffing plan to see whether adjustments are needed to: the

staffing plan; prevailing staffing patterns; the deployment of monitoring technology; or the allocation of agency or facility resources to commit to the staffing plan, to ensure compliance with the staffing plan. The facility requires that intermediate-level or higher-level staff conduct unannounced rounds to identify and deter staff sexual abuse and sexual harassment. Calumet Center documents unannounced rounds on all shifts, with a prohibition of staff alerting other staff of the conduct of the rounds. Documentation of these rounds was reviewed by the audit team. On paper, the Calumet Center seems to exceed both DHHS and PREA minimum requirements for staffing by having a staff-to-youth ratio of 2:10 during waking hours and 1:10 during sleeping hours. However, there has been a high rate of staff turnover, and it has been a challenge to get everyone fully trained. One high-ranking administrator stated the ratios are 1 to 10 during the day and 1 to 11 at night. It was determined that the administrator mis-spoke, and no evidence was found that indicated that the facility does not meet the requirements of this standard in practice. 30 staff were hired in the 6 months leading up to the audit. The facility has 65 staff. The staffing plan was based on the facility having the maximum of 88 residents, but it has been operating with an average of about 65 residents.

Analysis: Due to a triangulation of evidence, the facility has shown compliance with this standard. The evidence which combines to show compliance with this standard is as follows: Staffing plans and staffing plan reviews, staff and resident rosters, supervisory logs, policies, and interviews.

Finding: The facility appears to be 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.

During interviews, many residents stated they are not told when female staff are working, but upon further inquiry it was determined that Calumet staff announce their presence by giving their names instead of saying "female" on duty. A higher rate of residents stated that females announce their presence when the auditor asked the question in a way that reflected the practice at Calumet. However, there were still 6 residents who stated they do not always know when female staff are on duty. During

the on-site audit, and in emails afterward, the auditor requested the facility to provide their own assessment regarding how well their staff are following this standard. The Executive Director provided the following response: “All staff were retrained on this standard (staff members of the opposite gender shall announce their presence upon entering the housing units). Posters stating ‘Staff members of the opposite gender shall announce their presence upon entering the housing units’ have been posted on all doors entering the living units where youth may be showering, changing clothing or using bathroom.” She provided digital photos of the posted signs, and this was accepted by the auditor as addressing this issue prior to the Interim Report being issued. However, the audit team identified a problem that required a correction, rather than just a clarification. Pod 3 and protective segregation cells have cameras in all rooms, with the toilets in full view. The Executive Director states, “ . . . Operations Management discussed the cameras in the pod 3 day[room] with our cabling provider. Cabling Concepts representatives confirmed that they can pixilate the view over the toilets; however upgrades to the system will need to occur. A date of 12/15/18 has been scheduled to complete this project. In the meantime, all cameras in rooms 2-10 on pod 3 have been disabled.” This item was on the CAP until verification of completion could be provided.

Corrective Action: Verification of cross-gender announcement staff training was provided 01-24-2019. Digital photos of camera views were provided 02-14-2019.

Analysis: The facility has shown compliance with all parts of this standard through a triangulation of evidence, now that the solutions proposed by the agency have been implemented and verified. In addition to written policy and training curriculum being consistent with the standard, interviews verified the parts of the Standard not subject to corrective action.

Finding: The facility has demonstrated full compliance 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.

Prior audits, interviews with experienced staff and administrators, and policy reviews indicate the facility and agency have had most of the sub-sections of this standard entrenched in their culture for many years. However, there have been a number of new staff hired and trained recently. Calumet administrators encouraged the audit team to provide feedback from interviews, so they can re-train or address issues expeditiously. Due to the way some staff answered the questions posed to them during interviews, it was clear that many of them rely heavily on their supervisors and, for example, did not yet know how to access interpreters for residents, or families of residents, with limited English proficiency. Residents did not know how to access these services confidentially. PREA reporting posters in visitation were only in English. The Executive Director stated, "Per policy, SJJS youth are allowed to have private visitation and calls. During visitation, which occurs at least twice a week, locked, private visitation rooms are utilized that are free of any audio monitoring. A security officer is stationed in the common area with visual observation for security purposes. A resident may also have private calls. Although a youth cannot pick up a phone as they please and place an external call, requests for private calls to outside workers, advocates, counselors, attorneys are dialed by a staff and the youth then is allowed a confidential call. In cases of a resident requesting to call the PREA hotline, a supervisor or manager is contacted and the youth is allowed to make the call using the numbers that are posted by each and every unit telephone. The call is confidential and not monitored. On the day of the audit, Third Party posters were immediately posted in the lobby of the facility and also in the visitation area at the recommendation of the PREA auditors. Posters were created in English, Spanish and Arabic. Posters in additional languages will be created, as the need arises." She provided photos of the postings, thereby addressing this issue quickly before the Interim Report was issued. (Minor issues that are addressed and resolved during the audit, or in the 30 days after the on-site review, are not required to be on CAPs, according to the guidance of the Department of Justice.)

Analysis: Due to a triangulation of evidence, the facility has shown compliance with this standard without corrective action. The evidence is as follows: Calumet PREA Policies A-2 and A-1-6; interviews with staff and residents; and evidence of practice as described above.

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 audit team verified compliance with all subsections of this standard during the Pre-Audit and on-site audit process, except one. The Human Resources designee did not know that the agency provides 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. This was addressed in the 30 days after the on-site audit. The Executive Director states, "This standard has been reviewed with the Human Resources Department. They are aware that they must disclose sexual abuse/harassment to new employers, however if there is a history, they will ask the employer to obtain a signed release in order to discuss the history."

Analysis: Due to a triangulation of evidence, the facility has shown compliance with this standard. The evidence is as follows: Spectrum personnel policies including but not limited to Conditional Job Offer, Contractual Employees, Good Moral Character, and Disciplinary Action; interviews with HR and other administrators; All Staff Training Records; All Contractor Volunteer Training Records; 16 Background Checks; 16 Child Abuse Registry Checks for Staff and Contractors; and Employment applications.

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.

Calumet has not acquired a new facility, nor made a substantial expansion or modification to existing facilities, since the last audit. The facility has neither installed nor updated a video monitoring system, electronic surveillance system, nor other monitoring technology, since the last audit. Documentation provided, as well as interviews with administrators, indicates PREA will be considered when updates occur in the future. The video monitoring system was demonstrated during the facility tour, and it is extensive and expandable.

Analysis: By a triangulation of evidence, the facility has shown compliance with this standard. The evidence is as follows: demonstration of practice during the audit tour; facility schematic; and interviews with administrators and staff who utilize video monitoring to perform their duties.

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.

Two allegations regarding staff-on-resident sexual abuse were substantiated during the 12 months prior to the PAQ, of which one included sexual assault. Although the alleged incident of sexual assault happened one week before it was reported, and although the allegation involved oral-to-genital sexual assault, the documentation provided to the audit team did not document that any medical examination, testing, advocacy, or follow-up care was offered to the victim. Part "D" of this standard states, "The agency shall attempt to make available to the victim a victim advocate from a rape crisis center. If a rape crisis center is not available to provide victim advocate services, the agency shall make available to provide these services a qualified staff member from a community-based organization or a qualified agency staff member. Agencies shall document efforts to secure services from rape crisis centers. . . ." Therefore, this standard was indicated as "Does Not Meet Standard" in the Interim Report and included in the CAP.

Corrective Action: The facility made additional changes to their Coordinated Response Plan and trained on the plan, which includes these responses, and posted it where all staff can see it. They updated their Youth Orientation Packet to include additional information about the availability of this care to residents. They provided additional First Responder Training and retrained on PREA basics. They also did a training called, "*PREA: Access to Emergency and Medical and Mental Health Services."* They provided complete investigations that followed all applicable parts of the Standards. The facility made additional attempts to enter into an MOU with Wayne County SAFE. Although they were unable to get that MOU established, they did establish one with the police department that is tasked with doing their criminal investigations, and this agreement requires specialized training for the police investigators.

Analysis: The facility has shown compliance with all parts of this standard in policy and in practice. They provided verification of training, including the parts identified for improvement in the Interim Report.

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.

During the on-site audit, the audit team was provided with a "PREA Incident Review Report," regarding an investigation of sexual harassment. Despite requests, the facility did not provide an actual PREA investigation for the auditor to review. They provided the allegation on the "Unusual Incident Report Summary" form, which indicated that First Responder Duties were initiated; and they provided the investigation that was completed by the MDHHS Division of Child Welfare Licensing, which is not a sexual harassment investigation, but an investigation regarding whether the facility violated licensing requirements. Therefore, this standard was listed in the Interim Report as "Does Not Meet Standard" and included in the CAP.

Corrective Action: The Center Director stated in CAP materials, in part, that, "An administrative investigation will be conducted on each incident, regardless of whether the Department of Child Welfare Licensing (DCWL) investigates. (Incidents that appear to involve criminal behavior will be referred to law enforcement)." The CAP went on to say, "Evidence that Spectrum Human Services is already applying these protocols can be found in the facility's Corrective Action Plan, PREA standards 115.334, 115.367, 115.371, 115.772. Calumet currently has two investigations occurring . . . . Spectrum Human Services will provide the auditor with all documentation of these investigations. Spectrum will provide documentation of any new allegations of sexual abuse or harassment received by 04-04-2019, and of any new investigations completed by that date. Also, provide documentation of what has been done to implement the items . . . . For example, any staff meeting notes, policy updates, emailed instructions or training completion acknowledgement." The facility provided verification of practice as agreed.

Analysis: The facility has now shown that sexual abuse or sexual harassment investigations are completed for every allegation. Verification was received during the CAP, as described above. During the audit, the audit team also reviewed policies and conducted interviews, which also indicated compliance 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.

Calumet trains all employees who may have contact with residents on all matters required by this standard. The agency documents that employees understand the training they have received through employee signature.

Analysis: By a triangulation of evidence, the facility has shown compliance with this standard. The evidence supporting compliance is as follows: PREA Policy cross-referenced with SOP; staff training rosters and acknowledgements; and interviews with staff conducted during the audit.

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

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Volunteers and contractors who will have contact with residents have been trained on their responsibilities under the agency policies and procedures regarding sexual abuse and sexual harassment prevention, detection, and response. According to interviews and documentation provided, 4 interns and 3 contractors were being utilized at the time of the audit. The level and type of training provided to volunteers and contractors is based on the services they will provide and the level of contact they will have with residents. All volunteers and contractors who will have contact with residents will have at least been notified of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents. The agency maintains documentation confirming that volunteers/contractors understand the training they have received

Analysis: By a triangulation of evidence, the facility has shown compliance with this standard. The evidence is as follows: SJJS Policy -Part 3 II; training documentation review; and interviews with staff who sign up volunteers.

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

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Calumet residents receive information at the time of intake about the zero-tolerance policy and how to report incidents or suspicions of sexual abuse or sexual harassment. The facility provides resident education as required by all sub-sections of this standard. All residents admitted during the past 12 months have received this information in an age-appropriate fashion, according to interviews and information provided. Many have received the information at previous placements, as well. The agency maintains documentation of resident participation in PREA education sessions, and this documentation was provided to the auditor. The agency ensures that key information about the agency's PREA policies is continuously and readily available or is visible through posters, resident handbooks, or other written formats, as verified in interviews of staff and residents, and as observed by the audit team during the site review.

Analysis: By triangulation of evidence, the facility has shown compliance with this standard. The evidence is as follows: Calumet PREA Policies A, A-2; documentation of individual residents' participation in PREA education sessions; and PREA policies that are continuously and readily available or visible through posters, resident handbooks, or other written formats, as verified in interviews of staff and residents, and as observed by the audit team during the site review.

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.

Although the training received, and policies reviewed, seemed to be consistent with this Standard, the documents reviewed associated with investigations did not seem consistent with the policy and training. The interview with the investigator also did not seem consistent with a full understanding of this Standard. The Executive Director stated, in response to the audit team's observations, "All PREA managers will re-take the investigator training by November 30th, 2018."

Corrective Action: Spectrum Human Services has retrained all investigative staff through the National Institute of Corrections. Four investigators took the course entitled, "PREA: Investigating Sexual Abuse in a Confinement Setting." By taking this course, all investigators received knowledge, components, and considerations that an investigator must use to perform a successful sexual abuse or sexual harassment investigation consistent with PREA standards. Certificates of completion were provided.

Analysis: Investigations provided during the CAP were consistent with this Standard and with policies reviewed. In addition, verification has been received that investigators have been re-trained regarding investigations, and regarding the other issues raised during this audit.

Finding: The facility is compliant with this Standard after corrective action.

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.

Calumet has written policies related to the training of both medical and mental health practitioners who work regularly in its facilities, as required by this standard. Calumet employs 7 clinical staff. During interviews, these staff, including the PREA Coordinator, demonstrated an understanding of the processes utilized by medical and forensic professionals.

Analysis: By a triangulation of evidence, the facility has shown compliance with this standard. SJJS SOP 3-1 is consistent with MDHHS policies. Calumet employs 7 clinical staff. 3 of these staff were interviewed, and they demonstrated an understanding of the processes utilized by medical and forensic professionals. Training documentation/verification was reviewed.

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.

Calumet has a policy that requires screening for risk of sexual abuse victimization, or sexual abusiveness toward other residents, upon admission to the facility or transfer from another facility. This policy meets all the sub-sections of this standard. These screenings have been done for a number of years, and they are engrained in the facility culture and routines. However, after conducting interviews with residents and staff, and after reviewing 17 randomly selected resident screenings, the audit team had some questions for the facility administration based on the following observations. (1) 3 of the 16 residents interviewed did not remember being screened. (2) 7 residents did not remember being asked all the questions on the screening form, but said they were only asked some of the questions. (3) 4

interviewed residents volunteered risk factors to the auditor that were not recorded on the screening forms and/or reassessment forms when cross-referenced, although these residents indicated they had previously shared the risk factors with staff at the facility. (4) On a few of the screening forms, there appeared to be a question that the screener misunderstood, documenting the answer of the question from the perspective of the screener rather than noting the perspective of the resident being screened. Although none of these observations prove lack of compliance with this standard, the conversation that ensured when these questions were addressed by the facility were very enlightening and constructive. The audit team learned that the facility was not using the latest and greatest screening form suggested by MDHHS. These updated versions of the screening forms are not only superior in the way they cover the risk factors for vulnerability and abusiveness, but they also flow better and come with better instructions for staff conducting the screenings. These better forms were implemented into practice during the 30 days after the on-site audit. It is expected that these updates will greatly improve the effectiveness of the screenings and reassessments. The Executive Director of SJJS summarizes their renewed commitment to the screening process this way: “We have revised our initial assessment form and have adopted the State of Michigan PREA intake questionnaire to utilize with all youth. All initial assessments are currently reviewed in the weekly management meeting within one week of intake for formal discussion. All youth with identified risk factors will be re-assessed at 3 and 6 months post admission. Any youth who discloses a risk factor at any time during his stay at the Calumet Center will immediately be reassessed. The process of reviewing re-assessments of youth in weekly management meeting will begin immediately. Any youth who discloses a risk factor will be re-assessed immediately and reviewed in the weekly management meeting.”

Analysis: By a triangulation of evidence, the facility has shown compliance with this standard. The evidence is as follows: 17 completed screenings, new screening forms and instructions, policies (including Calumet Policies B-1 and B-4), and interviews with screeners and administrators.

Finding: The facility has showed compliance with the minimum requirements of this standard and has plans in place to continue to increase the effectiveness of the screening process.

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.

Calumet uses information from the risk screening required by ß115.341 to inform housing, bed, work, education, and program assignments. All residents are in single-occupancy rooms. The facility prohibits placing lesbian, gay, bisexual, transgender, or intersex residents in particular housing, bed, or other assignments solely on the basis of such identification or status. The facility prohibits considering lesbian, gay, bisexual, transgender, or intersex identification or status as an indicator of likelihood of being sexually abusive. The facility makes housing and program assignments for transgender or intersex residents in the facility on a case-by-case basis. The facility uses all information obtained pursuant to § 115.341, and subsequently, to make housing, bed, program, education, and work assignments for residents, with the goal of keeping all residents safe and free from sexual abuse. Residents may be 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. Placement and programming assignments for each transgender or intersex resident are reassessed at least twice each year, to review any threats to safety experienced by the resident. A transgender or intersex resident's own views with respect to his or her own safety shall be given serious consideration. Transgender and intersex residents have the opportunity to shower separately from other residents. Residents at Calumet have a high degree of confidence that staff and therapists maintain confidentiality appropriately.

Analysis: By a triangulation of evidence, the auditor can determine that the facility has shown compliance with this standard. The evidence is as follows: Interviews with staff and administrators; interviews with residents with various risk factors, including LGBTI residents; interviews with staff who do screenings and make placement decisions; reviews of applicable policies (Calumet Policy B-3,B-4, B-5); and reviews of screenings.

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.

During the audit, some residents did not know that private visits or calls are possible, making confidential and anonymous third-party reporting impossible for them until they know better. 4 residents thought they can never have a private face-to-face visit with family. Also, during their interview with an auditor, a resident who desired to make a report could not figure out how to make an outside call. The

auditor tried to put the call through, following the directions located next to the phone, but could not get it to work, either. Also, in the visitation area, third-party reporting posters were only in English, despite some families having limited English proficiency. Although having some residents with a low level of understanding is not proof of lack of compliance with this standard, the audit team brought these issues up to the facility, and the issues were addressed. The Executive Director stated, “Per policy, SJJS youth are allowed to have private visitation and calls. During visitation, which occurs at least twice a week, locked, private visitation rooms are utilized that are free of any audio monitoring. A security officer is stationed in the common area with visual observation for security purposes. A resident may also have private calls. Although a youth cannot pick up a phone as they please and place an external call, requests for private calls to outside workers, advocates, counselors, attorneys are dialed by a staff and the youth then is allowed a confidential call. In cases of a resident requesting to call the PREA hotline, a supervisor or manager is contacted and the youth is allowed to make the call using the numbers that are posted by each and every unit telephone. The call is confidential and not monitored. On the day of the audit, Third Party posters were immediately posted in the lobby of the facility and also in the visitation area at the recommendation of the PREA auditors. Posters were created in English, Spanish and Arabic. Posters in additional languages will be created [as] the need arises.”

During interviews with administrators regarding reporting and investigations, a concern was raised that CPS, the outside entity designated to meet 351 (b) of this standard, might not report back to the facility as required by this standard, leaving the facility not knowing what to investigate. This concern was being addressed by DHHS at the time of the Interim Report, and a solution was expected soon. The auditor had communication with the DHHS PREA Coordinator, as well as with the Director of Maltreatment in Care Unit at CPS, who were both working with other high-level officials to get approval for the Centralized Intake Unit to notify the facility of complaints that come in, honoring confidentiality, anonymity, and the integrity of investigations. In addition to the facility needing to know what to investigate, the SJJS Executive Director stated, “The state of Michigan has agreed to meet regarding this concern. If a youth makes a PREA complaint and the complaint is not accepted, there is no notification to the youth that this was the case.” She went on to state that, “Effective immediately, if a youth utilizes the PREA hotline to make a complaint, SJJE will increase monitoring of the youth over the next three days to ensure that there are no immediate threats to his safety without asking the youth about the call and breaching his right to confidential disclosure.” In addition to this new precaution, it can be pointed out that SJJS PREA Policy D already includes the following note, “Calls to CPS are confidential; however, it could occur that a Resident also volunteers information to Staff about sexual abuse. If at any time a Resident discloses information about sexual abuse to any Spectrum Juvenile Justice Services Staff, Staff must respond in accordance with the Procedures listed under Section F: *Staff Response to Sexual Abuse/Rape*.”

Corrective Action: MDHHS Centralized Intake recently completed some training and changes as a result of concerns brought up during this audit. Here is the email, in part, that went out 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 can't 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: Calumet PREA Policy D, E-1-3 seems consistent with this standard. The one issue that remained to be addressed during the CAP, regarding Standard 351(b) being followed in practice, was resolved during the CAP. Compliance with this Standard, other than the part addressed in the CAP, was also verified through interviews, the site review, and other documentation received during the audit.

Finding: The agency has shown full compliance with all sub-standards of 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.

The facility has an administrative procedure for dealing with resident grievances regarding sexual abuse consistent with this standard. Interviews conducted, and documentation received, indicate that in the past 12 months, there have been no grievances filed alleging substantial risk of imminent sexual abuse.

Analysis: By a triangulation of evidence, the facility has shown compliance with this standard. The evidence is as follows: Interviews with facility administrators who handle grievances; interviews with youth who verify their ability to file grievances; interviews with agency administrators; review of PAQ and investigative documentation; observation of grievance postings throughout the facility; and a review of policies (Calumet PREA Policies E-1, D-e , D-h, J, and J-3).

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 assessible mailing addresses and telephone numbers, including toll-free hotline numbers where available, of local, State, or national victim advocacy or rape crisis organizations? ☒ Yes ☐ No

- Does the facility provide persons detained solely for civil immigration purposes mailing addresses and telephone numbers, including toll-free hotline numbers where available of local, State, or national immigrant services agencies? ☒ Yes ☐ No

- Does the facility enable reasonable communication between residents and these organizations and agencies, in as confidential a manner as possible? ☒ Yes ☐ No

115.353 (b)

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

115.353 (c)

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

- Does the agency maintain copies of agreements or documentation showing attempts to enter into such agreements? ☒ Yes ☐ No

115.353 (d)

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

- Does the facility provide residents with reasonable access to parents or legal guardians?
  ☒ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The standard requires facilities to provide residents with access to outside victim advocates for emotional support services related to sexual abuse. This is not just about residents who are taken for a forensic exam. The auditor spoke with Glenda Cook, Victim Advocate, at Wayne County Sexual Assault Forensic Examiner's Program (wcsafe.org). Ms. Cook verifies that when WC SAFE responds to a page from one of the 5 sites they cover (which includes 4 hospitals) to do a forensic exam, the SANE/SAFE is accompanied by an advocate for the victim. The pager number to activate WC SAFE is on the Coordinated Response Plan for Calumet, so the auditor was satisfied that advocacy will be provided during an exam, regardless of the hospital utilized. Not all sexual abuse calls for a SANE exam, and some abuse is reported so long after the fact that a SANE exam is not indicated. The concern, at the time of the Interim Report, was that other sexual abuse survivors at Calumet, who do not report for a forensic exam, may not be made aware of available advocacy. During the audit, staff and residents did not seem to understand advocacy, nor remember being told about outside services that sexual abuse victims can utilize. Some residents did not know that private visits or calls are possible, making confidential communication with advocates impossible for them until they know better.

Although having some residents with a low level of understanding is not proof of lack of compliance with this standard, the audit team brought these issues up to the facility. The Executive Director stated, "Per policy, SJJS youth are allowed to have private visitation and calls. During visitation, which occurs at least twice a week, locked, private visitation rooms are utilized that are free of any audio monitoring. A security officer is stationed in the common area with visual observation for security purposes. A resident may also have private calls. Although a youth cannot pick up a phone as they please and place an external call, requests for private calls to outside workers, advocates, counselors, attorneys are dialed by a staff and the youth then is allowed a confidential call. . . ." Ms. Cook stated that all residents can be given the general number for WC SAFE (313-964-9701). Trained advocates will either be assigned to them when they call, or they will be referred appropriately. So, the Interim Report stated that providing residents with this number and educating them about their ability to make confidential calls will easily address part of the problem in short order. The Interim Report also stated that this needs to be ongoing, and that the agency needs a relationship with WC SAFE. Ms. Cook indicated the organization is open to being more "PREA aware" and entering into more MOU's. At the time of the Interim Report, the facility had not provided documentation of a signed MOU with any advocacy organization, nor of any recent attempts to enter into one. Despite at least three allegations of sexual

abuse or harassment during the 12 months prior to the audit, the audit team had not been made aware of any examples of anyone having an outside advocate or counselor for any purpose, nor being offered one. This constellation of factors, combined with the residents who do not know about their right to make outside calls that are not monitored, demonstrated that corrective action was needed to remove potential barriers to residents having full access to advocacy.

Corrective Action: The facility made additional attempts with Wayne County SAFE to enter into an MOU with the agency, without success. However, they did succeed in entering into an MOU with the police department tasked with investigating criminal sexual abuse allegations. In order to educate clients on their access to resources outside the facility, the facility has added this additional language to the youth orientation packet: "This facility has policies that require that a victim of sexual assault receive medical attention, counseling, is kept safe from further victimization, is protected from retaliation and is supported in helping to hold perpetrators accountable. PREA also states that you have the right to speak to someone outside of this facility, if an outside service is available, to help you heal from past sexual abuse, and/or to be with you during any medical examinations and investigative interviews as related to sexual victimization. If you request these services, a facility counselor or administrator will contact an outside advocate for you. If at the time the request is made an outside advocate is not available, a qualified person from the facility will provide those services." Additional PREA education was provided to current facility residents informing them that they can be provided outside advocacy if requested.

Analysis: Calumet PREA Policy D-3, and postings observed during the site review, seem consistent with this standard. The facility provided verification of completing the CAP as agreed, which sought to increase the understanding of the availability of advocacy within the facility, and which increased the written reminders that residents have reasonable and confidential access to advocacy.

Finding: The facility has shown full compliance 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.

During the audit, some residents did not know that private visits or calls are possible, rendering confidential and anonymous third-party reporting inaccessible, even impossible for them, until they were to become informed. Also, in the visitation area, third-party reporting posters were only in English, despite some families having limited English proficiency. Although having some residents with a low level of understanding is not proof of lack of compliance with this standard, the audit team brought these issues up to the facility, and the issues were addressed. The Executive Director stated, "Per policy, SJJS youth are allowed to have private visitation and calls. During visitation, which occurs at least twice a week, locked, private visitation rooms are utilized that are free of any audio monitoring. A security officer is stationed in the common area with visual observation for security purposes. A resident may also have private calls. Although a youth cannot pick up a phone as they please and place an external call, requests for private calls to outside workers, advocates, counselors, attorneys are dialed by a staff and the youth then is allowed a confidential call. In cases of a resident requesting to call the PREA hotline, a supervisor or manager is contacted and the youth is allowed to make the call using the numbers that are posted by each and every unit telephone. The call is confidential and not monitored. On the day of the audit, Third Party posters were immediately posted in the lobby of the facility and also in the visitation area at the recommendation of the PREA auditors. Posters were created in English, Spanish and Arabic. Posters in additional languages will be created [as] the need arises."

Analysis: By a triangulation of evidence, the facility has shown compliance with this standard. The evidence is as follows: Third-party postings were verified during the site review. Additional postings were added during the 30 days after the on-site audit, which were verified through digital photos sent by email to the audit team. SJJS and MDHHS policies reviewed are consistent with this standard. Staff training covers this issue well, and staff interviews indicate staff generally have a good understanding of the requirements of this standard.

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.

Policy and training reviewed are consistent with all sub-sections of this standard. Also, interviews with staff indicate that they know they are required 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. They also must report any retaliation against residents or staff who reported such an incident. They must report 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, agency policy prohibits staff from revealing any information related to a sexual abuse report to anyone, other than to the extent necessary to make treatment, investigation, and other security and management decisions.

Analysis: By a triangulation of evidence, the facility has shown compliance with this standard. The evidence is as follows: Documentation provided, as well as interviews conducted, indicates reports are made according to this standard in practice. Also, agency and facility policies and procedures (including Calumet PREA policy E) are consistent 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

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When the agency or facility learns that a resident is subject to a substantial risk of imminent sexual abuse, it takes immediate action to protect the resident. Interviews indicate staff take this responsibility seriously. In the 12 months prior to the on-site audit, there were no times the agency or facility determined that a resident was subject to substantial risk of imminent sexual abuse.

Analysis: By a triangulation of evidence, the facility has shown compliance with this standard. The evidence is as follows: Calumet PREA Policy E and related MDHHS policies; contractual obligations to MDHHS; interviews with administrators and residents; and a review of other documentation provided, such as PAQ and documentation associated with investigations.

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.

SJJS Calumet Center policy requires that, upon receiving an allegation that a resident was sexually abused while confined at another facility, the Director must notify the head of the facility where sexual abuse is alleged to have occurred, as well as notifying the appropriate investigative agency. In the 12 months prior to the on-site audit, no allegations were received that a resident was abused while confined at another facility. The agency policy requires that the facility head provides such notification as soon as possible, but no later than 72 hours after receiving the allegation. The agency or facility documents that it has provided such notification within 72 hours of receiving the allegation. Policy also requires that allegations received from other facilities/agencies are investigated in accordance with the PREA standards.

Analysis: By a triangulation of evidence, the facility has shown compliance with this standard. The evidence is as follows: Policies (Calumet PREA Policy E-12); interviews; and PAQ and supporting documentation provided.

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.

Although policies are consistent with this standard, the pre- and on-site audit work indicated that staff seem to rely on their superiors to understand the duties, and that not all their superiors demonstrated an understanding of the duties during interviews. Refresher training was scheduled, and this Standard was included in the CAP. Out of all interviews with staff, supervisors, and directors who were asked about advocacy, only one was found who understood advocacy. Some staff thought First Responders should do investigative work, and they did not know how to secure interpreters when needed.

Corrective Action: Staff were retrained regarding First Responder Duties. Also, they received their PREA Basics training again. In addition, the took the course: "*PREA: Access to Emergency and Medical and Mental Health Services (115.382*)", and they learned about advocacy and how to secure interpreters. Furthermore, they took trainings entitled, "Juvenile Detention: Completing a PREA Incident Report" and "Juvenile Detention: Professional Communication and Boundaries". Administration at Calumet updated the First Responder Duties (see Standard 115.365), and these updated first responder duties were re-printed and placed on the back of all staff identification cards. Additionally, Calumet has posted their Coordinated Response Plan in all staffing areas and control rooms.

Analysis: After trainings conducted during the CAP, the auditor believes all concerns were addressed. The trainings match the policy, which matches the Standard. Also, when investigative materials are

reviewed, there are clear indications that the First Responder Duties are followed in practice when needed.

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.

The facility developed a written institutional plan, among staff first responders, medical and mental health practitioners, investigators, and facility leadership, to coordinate actions taken in response to an incident of sexual abuse, except that it did not adequately include the steps to take regarding making sure forensic evidence is collected from an alleged perpetrator.

Corrective Action: Calumet Center updated their Coordinated Response Plan to correct the language relative to victims and perpetrators and protecting evidence, as well as in other areas pertinent to this audit. All staff were retrained in the month of December on First Responder Duties, and all employee identification cards were imprinted with a list of First Responder Duties, to which was added a reminder of the requirement to not allow a perpetrator to wash, change clothes, etc., pending forensic exam. Also, the Coordinated Response Plans were posted for easy access by staff.

Analysis: Interviews, the updated Coordinated Response Plan, and documentation of training verify compliance with this Standard.

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.

Calumet Center is not part of a collective bargaining contract and maintains its ability to protect its residents and employees from abusers.

Analysis: By a triangulation of evidence, the facility has shown compliance with this standard. The evidence is as follows: Personnel policies; contractual obligations with MDHHS; and interviews with administrators, including HR.

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

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Although policies appear to cover all aspects of the PREA standards, not all sub-sections of the Standards appear to have been followed in practice regarding investigations performed during the past 12 months. Retaliation monitoring did not appear to have been adequately documented, if completed, so this Standard was included in the CAP.

Corrective Action: The facility provided verification, both of training regarding Retaliation Monitoring, and about the practice of retaliation monitoring.

Analysis: Policies were provided, including Calumet PREA Policy E-13, consistent with this standard. Verification of compliance in practice was achieved during the CAP, through the combination of additional training and documentation of actual retaliation monitoring, with alleged victims and those who cooperated with investigations.

Finding: The facility is compliant with this Standard following corrective action.

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

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 has a policy that residents who have alleged to have suffered sexual abuse may only be placed in isolation as a last resort, if less restrictive measures are inadequate to keep them and other residents safe, and only until an alternative means of keeping all residents safe can be arranged. The facility policy requires that residents who are placed in isolation because they allege to have suffered sexual abuse have access to legally required educational programming, special education services, and daily large-muscle exercise. A few residents, who had been randomly interviewed by the auditor, coincidentally happened to have required close management and observation during the past 12 months. These residents seem to have been provided full health services and uninterrupted programming. Since residents each already have single-occupancy rooms, seclusion typically happens in the resident's own, familiar room for 5 minutes; like a time-out; then the resident returns, perhaps gradually, to join the peers in the pod for small group activities and processing. The therapeutic process takes over from there. The peers assist each other in acknowledging feelings and moving past anger.

Analysis: By a triangulation of evidence, the facility has shown compliance with this standard. The evidence is as follows: Calumet PREA Policy b-5; interviews with staff, administrators and residents; and documentation of practice, as evidenced in the investigative materials that were provided.

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.

Since SJJS had not provided complete investigations for all allegations, the Interim Report indicated that the facility had not shown compliance with this Standard. In addition, since the investigator was not well-informed about basics, such as the standard of evidence, it appeared that investigators needed additional oversight and/or training. The audit team had requested additional information and documentation, such as follow-up with law enforcement during the audit process prior to the Interim Report. The documentation provided to the auditor regarding one investigation contained documentation that the investigation was initiated promptly, and that thorough, objective, documented interviews were completed with the alleged victims, with the alleged perpetrators, and with the witnesses. Prior actions and inactions by staff were assessed, and confidentiality seemed to be well-maintained. Documentation not yet provided when the Interim Report was due included consultation and updates from the law enforcement investigation, whether services of any kind were offered to the alleged victim, and whether monitoring was in place to detect potential retaliation. Also, there were two narratives of findings that seemed inconsistent with each other, as to which exact allegations were substantiated and which were unsubstantiated and unfounded.

Corrective Action: The facility provided complete administrative investigations regarding each incident and reported to law enforcement as required. They followed up with law enforcement as required. Monitoring for retaliation was provided and findings were clear.

Analysis: Upon completing the CAP, the audit team has received verification of full compliance with this standard. Policies and training match the investigative documentation.

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.

The interview with the investigator indicated that the investigator was not well-informed about the basics of investigations, such as the standards of evidence, so this Standard was marked "Does Not Meet Standard" in the Interim Report.

Corrective Action: The facility provided the training and documentation required by the CAP and it provided verification of compliance with this Standard in practice, as well as training regarding standards of evidence.

Analysis: Spectrum PREA Policy H is consistent with this standard, and documentation of training received during the CAP, along with investigations completed using preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated, completes the verification of compliance with this Standard.

Finding: The facility is compliant 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.

Since Calumet Center had not provided complete investigations for all allegations at the time of the Interim Report, the facility had not provided verification that alleged victims are informed appropriately regarding the outcome of investigations, and the other requirements, regarding the alleged perpetrator, nor the other sub-sections of this standard. The facility had provided two documents showing that alleged victims were notified regarding the outcomes of two investigations. However, without all the full investigative documentation to review, it was unclear if the notifications included all required information, or if there might have been other alleged victims.

Corrective Action: Investigative documentation was provided in accordance with the CAP. The documentation showed compliance with this Standard in practice.

Analysis: Spectrum PREA Policy Sections E and F are consistent with this standard. In addition, with the documentation and training provided during the CAP, the facility now shows full compliance with the Standard.

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.

The facility had only provided partial documentation, at the time of the Interim Report, regarding how employees who were alleged perpetrators were sanctioned.

Corrective Action: Copies of the Letters of Termination were provided. In accordance with facility policy, both terminations were reported to law enforcement, CPS, and licensing. These staff have not been and are not eligible to be re-hired.

Analysis: The policy review, interviews, and actual documented practice of employee terminations, provide strong verification of compliance with this Standard.

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.

Although policy appeared to be consistent with this standard, the facility had not provided verification of practice at the time of the Interim Report. Without reviewing the documentation auditors are required to review, the auditor did not know whether there had been any offending contractors or volunteers.

Corrective Action: The facility provided the required investigative documentation. The documentation did not reveal any accusations against contractors or volunteers. That is to say, the documentation did not indicate any violations of this Standard.

Analysis: Calumet PREA Policies E 1 & 2 seem consistent with this standard, and interviews with administrators indicate a knowledge of how to apply this Standard and associated policies. Finally, the additional training received during the CAP, including training related to this Standard, also lends support to a finding that the facility is fully compliant.

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.

Although policy appeared to be consistent with this standard, the facility had not provided verification of practice at the time of the Interim Report. Without reviewing the documentation auditors are required to review, the auditor did not know whether any offending residents had been sanctioned within the requirements of this Standard.

Corrective Action: The facility provided the required investigative documentation. The documentation did not reveal any incidents of resident-on-resident sexual abuse or findings that triggered the regulations and safeguards detailed in the Standard. That is to say, the documentation did not indicate any violations of this Standard.

Analysis: Not only is policy consistent with this Standard, interviews with administrators indicate a knowledge of how to apply this Standard and associated policies. Finally, the additional training received during the CAP, including training related to this Standard, also lends support to a finding that the facility is fully compliant.

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.

All residents at this facility who have disclosed any prior sexual victimization during a screening pursuant to ß115.341 are offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening. In the past 12 months, all residents, regardless of disclosure for prior victimization during screening, were offered a follow-up meeting with a medical or mental health practitioner. Medical and mental health staff maintain secondary materials documenting compliance with the above required services. All residents who have previously perpetrated sexual abuse, as indicated during the screening pursuant to ß 115.341, are offered a follow-up meeting with a mental health practitioner within 14 days of the intake screening. Mental health staff maintain secondary

materials, documenting compliance with the above-required services. The information shared with other staff is strictly limited to informing security and management decisions, including treatment plans, housing, bed, work, education, and program assignments, or as otherwise required by federal, state, or local law.

Analysis: By a triangulation of evidence, the facility has shown compliance with this standard. The evidence is as follows: Calumet PREA Policy B-1, as well as MDHHS policies; interviews with screeners and administrators; and screening documentation.

Finding: The facility is compliant.

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.

Once again, in the absence of SJJS providing complete investigations for all allegations, the auditor could not verify, when writing the Interim Report, whether the investigations were conducted sufficiently well, nor even that emergency services were provided appropriately. The auditor did not know whether follow-up care was provided as per the requirements of this standard and agency policy.

Corrective Action: Investigative documentation provided during the CAP was consistent with the practice of this Standard. The facility provided training verification for training entitled, "PREA: Access to Emergency and Medical and Mental Health Services (115.382)" and "PREA: Behavioral Health Care for Sexual Assault Victims in a Confinement Setting" In addition, the new MOU with Parkland Police Department supports compliance with this Standard.

Analysis: Policy and training are consistent with interviews conducted and investigative documentation received.

Finding: The facility has shown compliance 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.

Since SJJS had not provided complete investigations for all allegations, the auditor could not verify whether victims received appropriate care at the time of the Interim Report. Although agency policies appeared to be consistent with this standard, the facility had not provided verification that they follow this standard in practice.

Corrective Action: The facility provided the documentation required in the CAP, showing evidence of youth being offered services as required by this Standard, and documentation of when ongoing care was not indicated.

Analysis: Policy and training are consistent with interviews conducted, investigative documentation received, and documentation regarding youth who have been sexual abuse victims and abusers

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

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As above, because SJJS had not yet sent the audit team complete investigations for all allegations, the auditor was not able to verify whether the investigations were conducted appropriately, nor even that the number of them was accurate; nor whether corrective actions and incident reviews had been fully followed through.

Corrective Action: During the course of the CAP, additional incident reviews were completed as investigations were completed, showing practice of this Standard. As investigative information was provided to the auditor, and reviewed, the auditor could see that the Incident Reviews addressed the circumstances surrounding the incidents as required.

Analysis: SJJS policy Part 3 B appears to be consistent with this standard. The facility provided three Incident Review Reports that were found to be consistent with this standard after all the investigative information was received. In addition, interviews with administrators indicated an understanding of this Standard in a general way, and this was supported by additional training being received during the course of the CAP.

Finding: The facility is compliant.

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.

Since the facility had not yet provided complete investigations for all allegations, the auditor could not verify whether the investigations had been done well, nor even that they are counted well; nor whether corrective actions and incident reviews were fully followed through. The absence of the sharing of this documentation called both the facility's data collection and its annual reports into question, so these Standards were marked "Does Not Meet Standard" in the Interim Report, and placed in the CAP.

Corrective Action: The facility provided the documentation required in the CAP showing their data collection matches their incidents, allegations, and investigations.

Analysis: SJJS PREA Policy Section I, #8, appears to be consistent with this standard, and, with the investigative documentation provided during the CAP, the facility has shown that the information required by this Standard is being accurately collected. The interview with the Executive Director, and other administrators, also lend support to this finding.

Finding: The facility is compliant.

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.

Since SJJS had not yet sent the audit team the entire investigations for all allegations, the auditor could not verify whether the investigations had been done sufficiently well, nor even that they are counted sufficiently well; nor whether corrective actions and incident reviews had been followed through fully. Sans such information, the facility's data and its annual reports were are called into question.

Corrective Action: These concerns were resolved with documentation and analysis provided during the CAP.

Analysis: The facility has engaged in data review for corrective action, made adjustments, and demonstrated ongoing data management during the CAP.

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.

Calumet Center ensures that incident-based and aggregate data are securely retained. Agency policy requires that aggregated sexual abuse data be made readily available to the public, at least annually. Before making aggregated sexual abuse data publicly available, the agency removes all personal identifiers. The agency maintains sexual abuse data collected pursuant to ß115.387 for at least 10 years after the date of initial collection, unless Federal, State or local law requires otherwise. However, because SJJS had not yet provided complete investigations for all allegations, at the time the Interim Report was written, the auditor could not yet verify whether the investigations had been done well, nor even that they had been counted well, nor even whether corrective actions and incident reviews had been followed through fully. The absence of the full set of completed investigations called the data and the annual reports into question.

Corrective Action: The facility provided all their investigative documentation and explained their logging system, indicating an accurate method of tracking and reporting their allegations and investigations. The facility's annual statistics were adjusted to reflect the "new" accurate count of allegations made during the audit period. One investigation had been divided into two, and new allegations came in and were added.

Analysis: After reviewing the annual reports and the current investigations and logs, the auditor believes the system is accurate and reliable. In addition, agency and facility policies are consistent with the standard. Interviews with the PREA Coordinator and the facility administrators indicate compliance as well. The facility has updated its Annual Report and it can be viewed at: https://www.spectrumhuman.org/forms/2018_PREA_annual_report.pdf

Finding: The facility has shown compliance.

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.

MDHHS schedules approximately 1/3 of its facilities for audits each year of the 3-year audit cycles.

Analysis: By a triangulation of evidence, the agency has shown compliance with this standard. The evidence is as follows: Interviews with administrators; verification of audits being completed in a timely fashion; and policies which require the audits to be conducted according to PREA standards.

Finding: 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.

The reports were first posted on the Michigan DHHS website, but the State no longer provides this service for its contractors. Currently the previous report can be located at: http://spectrumhuman.org/forms/Calument_Center_PREA_Audit_Final_Report_2015.pdf

Analysis: By a triangulation of evidence, the facility has shown compliance with this standard. The evidence is as follows: The auditor visually observed the reports to be on the DHHS website several times during the past 3 years, and now has seen it on the Spectrum site. The agency policy requires these reports be made public. In addition, interviews and email exchanges with the agency officials indicate this standard is understood and followed.

Finding: The facility has shown compliance 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.[1] Auditors are not permitted to submit audit reports that have been scanned.[2] See the PREA Auditor Handbook for a full discussion of audit report formatting requirements.

D. Will Weir 05-27-2019

Auditor Signature **Date**

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

[2] See *PREA Auditor Handbook*, Version 1.0, August 2017; Pages 68-69.