PREA AUDIT REPORT ☐ **INTERIM** ☒ **FINAL**

JUVENILE FACILITIES

Date of report: May 18, 2017

Auditor Information			
Auditor name: Louis A. Goodman			
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Telephone number: (602) 904-2851			
Date of facility visit: April 17 - 18, 2017			
Facility Information			
Facility name: Lincoln Center (Spectrum Human Services)			
Facility physical address: 1961 Lincoln, Highland Park, Michigan 48203			
Facility mailing address: *(if different from above)*			
Facility telephone number: (313) 868-8300			
The facility is:	☐ Federal	☐ State	☐ County
	☐ Military	☐ Municipal	☒ Private for profit
	☐ Private not for profit		
Facility type:	☒ Correctional	☐ Detention	☐ Other
Name of facility's Chief Executive Officer: Melissa Fernandez			
Number of staff assigned to the facility in the last 12 months: 90			
Designed facility capacity: 90			
Current population of facility: 80			
Facility security levels/inmate custody levels: Secure			
Age range of the population: 11-20			
Name of PREA Compliance Manager: Lauren Skinner		**Title:** Clinical Services Manager	
Email address: lskiner@spectrumhuman.org		**Telephone number:** 313-868-8308	
Agency Information			
Name of agency: Michigan Department of Health and Human Services			
Governing authority or parent agency: *(if applicable)*			
Physical address: 235 S. Grand Ave., Lansing, Michigan 48909			
Mailing address: *(if different from above)*			
Telephone number: (517) 335-3489			
Agency Chief Executive Officer			
Name: Nick Lyon		**Title:** Director	
Email address: Nancy Grijalva, AA to Director GrijalvaN@michigan.gov		**Telephone number:** Nancy Grijalva (517) 241-1193	
Agency-Wide PREA Coordinator			
Name: Patrick Sussex		**Title:** PREA Juvenile Coordinator / Program Manager	
Email address: sussexp@michigan.gov		**Telephone number:** (517) 648-6503	

AUDIT FINDINGS

NARRATIVE

The Michigan Department of Health and Human Resources (MDHHS) contracted with Goodman Consulting, LLC, to conduct an audit of Lincoln Center (LC), which is operated by Spectrum Human Services (SHS), for compliance with the Prison Rape Elimination Act (PREA). SHS is a private for-profit agency with which MDHHS contracts for the placement of juveniles committed through the juvenile justice system. Juveniles are placed at LC both by county juvenile courts and by the MDHHS. SHS operates Lincoln Center as a secure juvenile correctional facility for male juveniles with felony adjudications. Louis A. Goodman, an auditor certified by the United States Department of Justice (DOJ), conducted the audit. The facility site visit occurred on April 17-18, 2017.

The auditor provided the facility an announcement of the upcoming audit on February 7, 2017, and the notice was posted at LC on February 12, 2017, more than six weeks prior to the site visit, as verified by a photograph provided the auditor. During the site visit, the auditor observed the notices to be posted throughout the facility. On March 14, 2017, the auditor received a flash drive containing LC's completed Pre-Audit Questionnaire, along with numerous SHS policies and procedures and other documents. Prior to the site visit, the auditor comprehensively reviewed all of the materials the facility provided, including the responses to the Pre-Audit Questionnaire, SHS policies and procedures, and other documents responsive to the Questionnaire.

At the outset of the site visit on April 17, 2017, the auditor held an informational meeting with the MDHHS PREA Coordinator, SHS's Executive Director of Juvenile Justice Services, LC's Center Director, who serves in the facility's "superintendant" role, and LC's PREA Compliance Manager. The meeting was followed by an extensive tour of the facility, during which the auditor was given access to all areas of the facility, including the unlocking and opening of all doors as requested. The tour also included the facility's outdoor recreation area. Residents of the facility were in school on the premises at the time of the tour, and the auditor was able to observe classes in progress.

Over the course of the the two-day audit, the auditor conducted interviews of administrators, staff, a contractor, and residents. All interviews were conducted in accordance with the protocols established by the DOJ. There were a total of 26 interviews, which covered all of the positions and roles required by the DOJ protocols. Some staff and administrators perform multiple functions, including intake, screening, first responder duties, and membership on the incident review team. Nine residents were interviewed, including at least one resident from each of the 8 treatment pods. The residents were selected at random from a roster the facility provided on first day of the site visit, with the exception of residents specifically selected because they identified as LGBTI or had disclosed prior sexual victimization during risk screening. There were no residents who fell into the other special catagories set out in the audit prototcols. There were no residents in isolation, and there were no residents still in the facility who had made reports of sexual abuse or harassment in the facility in the past 12 months. Neither were there any limited English proficient residents. The auditor also conducted interviews of six line staff, who were selected at random and represented all three shifts, security, and child care staff.

During the site visit the auditor randomly selected five staff personnel files to review for background check documentation and signature sheets reflecting PREA training and an understanding of the material presented in them. The facility also provided and the auditor reviewed extensive additional documentation over the course of the site visit, including risk assessment forms for likelihood of sexual aggressiveness or vulnerablily completed at intake, and resident signature sheets indicating receipt of PREA information.

At the conclusion of the site visit on April 18, 2017, the auditor held a debriefing attended by the same administrators who attended the initial briefing. During that meeting the auditor reported preliminary findings, including both strengths and weaknesses observed over the course of the visit.

The auditor wishes to acknowledge and thank the administrators and staff of LC for the hospitality extended him during the site visit and their cooperation throughout the audit process.

DESCRIPTION OF FACILITY CHARACTERISTICS

Lincoln Center is a secure facility housed in a modern 70,000 square foot building constructed in 2008. Its design capacity is 90, and there were 80 residents at the time of the on-site audit. Residents are housed on eight pods, each of which holds ten single-bunk rooms. A ninth pod, which also contains ten rooms, is known as the "life safety" pod and is used for the isolation of residents who pose a threat to themselves or others. It may also be used for the protection of residents whose safety cannot be assured by less restrictive measures. Each room contains a bunk, a desk, and a a toilet/sink unit. The pods are arranged along a single hallway in pairs, each of which shares a control room. Classroooms are along the opposite side of the same hallway.

Each pod's floor plan is identical. The primary space consists of a large day room, along two walls of which are five rooms each. Along a third, angled wall is the control room behind large windows, from which the entire area can be observed. Each control room serves two pods. A short hallway off of each pod's day room holds two shower stalls with solid doors that are open at the top so that only a resident's head can be seen from outside. Each pod also contains a large therapy room, a therapy office, and its own separate dining room, where all meals are eaten.

Besides the housing pods, the building contains a facility control room at the front entrance, a visitation area consisting of several small, windowed rooms where residents can individually meet with their families or attorneys. The building also contains a health unit, classrooms, a gym, and a large multi-purpose room in which assemblies and other programs are held. There is a large outdoor recreation yard holding a basketball court, several tables, and a grassy area. The recreation yard is surrounded by the building on two sides, and the remaining perimeter consists of a tall fence. The facility also has an administrative wing, which residents never enter. The entire building, including the recreation yard, is surrounded by a fence topped with razor wire.

The facility was designed to minimize blind spots, and staff use a line-of-sight approach to maintaining safety and security. Direct staff observation is augmented by the placement of 116 cameras throughout the facility. The cameras cover virtually every area of the facility other than the residents' rooms and the showers. Cameras also cover the recreation yard and the perimeter of the facility. Security staff monitor the cameras, and video can also be viewed by administrators and supervisors. The videos also include audio.

The mission of the Spectrum Juvenile Justice Services Residential Treatment Programs, including Lincoln Center, is "to rehabilitate chronically delinquent youthful offenders." The residents of Lincoln Center range from 12 to 20 years old, and the typical length of stay is 12 to 15 months. Residents have indeterminate sentences. Release, based on completion of program, is recommended by the facility and must be granted by the court. The treatment programs at LC serve chronic offenders, substance abusers, sex offenders, and violent offenders. Residents are placed on pods based on their committing offenses.

LC utilizes a cognitive behavioral treatment program known as the SJJS (Spectrum Juvenile Justice Services) Chronic Offender Treatment Model. Residents must complete seven treatment stages in order to earn a recommendation to the court for release. Administrators describe the approach as holistic and focused on adolescent development, in addition to the cognitive behavioral programming specifically directed to changing delinquent thinking and behaviors. Program services include anger management, coping skills training, social living skills and life management training, non-denominational religious services, and on-site medical, dental and psychiatric services. Services also include group and individual counseling, as well as family therapy. Other programs and activities available to residents include yoga, pet care, and a YMCA-sponsored program. The facility employs a level-based behavioral management system that awards privileges for appropriate behavior.

School is provided on-site year around by Ace Academy, a charter school operated by Central Michigan University. The school offers a standard curriculum for grades 6-12, as mandated by the Michigan Department of Education. Students earn high school credits, and diplomas are awarded. Students attend school by pods.

SUMMARY OF AUDIT FINDINGS

Number of standards exceeded: 0

Number of standards met: 38

Number of standards not met: 0

Number of standards not applicable: 3

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Lincoln Center operates under the Spectrum Juvenile Justice Services (SJJS) policy entitled Zero Tolerance of Sexual Harassment, Assault, and/or Abuse of Residents (hereinafter referred to as "Zero Tolerance Policy"). It mandates zero tolerance towards all forms of sexual abuse and harassment in the facility and outlines the facility's approach to preventing, detecting and responding to sexual abuse and harassment. The policy includes the required definitions of prohibited behaviors and outlines the facility's approach to preventing sexual abuse and harassment of residents.

The Michigan Department of Health and Human Services employs a PREA Coordinator who reports sufficient time and authority to develop and implement policy and practices related to the implementation of the PREA requirements. Lincoln Center employs a PREA Compliance Manager who reports to the SJJS Executive Director and likewise reports sufficient time and authority to carry out her PREA responsibilities.

Standard 115.312 Contracting with other entities for the confinement of residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

NA. The facility does not contract with other entitites for the confinement of residents.

Standard 115.313 Supervision and monitoring

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

LC operates under the SJJS Staffing Plan, which provides for a staff to youth ratio of 2:10 during waking hours and 1:10 during sleeping hours. The plan reflects the consideration of all of the factors set forth in paragraph (a) of this standard. When interviewed, administrators and staff alike articulated the facility's "line of sight" approach to supervising youth. The facility itself, having been built recently, was designed to minimize blind spots. In addition,

the facility employs video technology throughout, utilizing 116 cameras to cover all areas of the facility. The cameras are monitored by security staff in the facility control room. Doors generally have windows, so that staff and residents are not isolated in an area or room out of view of others.

According to both the Lincoln Center Director and the PREA Compliance Manager, there are no instances when the facility's required staffing ratios are not met. If necessary, the facility requires staff to work overtime to cover unanticipated absence on a shift.

The agency annually reviews its staffing plan in accordance with the requirements of this standard. The facility provided its 2017 Annual Assessment Form, which reflects the review of all of the required factors.

Standard 115.315 Limits to cross-gender viewing and searches

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The facility provided its Resident Search Policy, which prohibits cross-gender searches of any type, except in exigent circumstances. All staff who were interviewed confirmed the policy, and each resident interviewed stated that he had never been searched by a female staff, nor was he aware of that having occurred with any other resident. The policy requires documenting and justifying any cross-gender pat-down search that occurs, but the facility reported that none had been conducted in the past 12 months.

The facility has implemented policies and practices to prevent female staff from viewing residents who are showering, changing clothes, or using the toilet. The Zero Tolerance Policy requires that female staff announce their presence when entering the housing area. However, interviews of staff and residents alike reflected that this requirement is not consistently being followed. At the conclusion of the site visit, the auditor communicated his concern over these comments. As a result, the Facility Director issued instructions to staff, all of whom were retrained on this requirement. Supervisors are now documenting that female staff adhere to the requirement that they announce their presence when entering the housing pod.

The two individual showers on each pod have solid doors that do not permit viewing by any staff. Residents change and use the toilets in their own rooms, the doors to which have windows. In order to assure privacy, youth are permitted to place white paper, which they refer to as "blinders," over the lower portion of those windows when changing or using the toilet. Each interviewed resident reported that he had never been viewed by female staff while showering, changing, or using the toilet, and that he was unaware of any occasion where any other resident had been observed naked by a female staff member.

The Resident Search Policy prohibits conducting searches of transgender or intersex residents to determine genital status, and the agency reports that, in any event, residents come to the facility with thorough files that would make such inquiries unnecessary. The agency reports that all of its female staff were trained on conducting cross-gender pat searches and all staff have been trained on conducting searches of transgender and intersex residents.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The SJJS Zero Tolerance Policy provides that the facility shall present information regarding sexual assault and harassment verbally and in written form, and in a language and format that each resident can understand. LC does not accept residents who are blind or deaf, and SJJS operates another facility at which youth with significant intellectual or psychiatric disabilities are placed. The facility reports not having received residents who are limited English proficient, but it has translated its brochure for residents regarding sexual assault and harassment into both Spanish and Arabic. If the facility were to receive a resident who needed the services of an interpreter, one would be engaged, according to facility administrators. Agency policy does prohibit the use of resident interpreters.

Standard 115.317 Hiring and promotion decisions

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

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

The facility has enacted a policy entitled "Hiring, Staffing and Monitoring to Prevent and Effectively Address Ssexual Harassment, Sexual Assault and/or Sexual Abuse of Residents." That policy sets forth the prohibitions on hiring and promotion set forth in paragraph (a) of this standard. The policy does not explicitly state that the facility will consider incidents of sexual harassment in considering whether to hire or promote anyone or engage a volunteer or contractor who will have contact with residents, but SHS' human resources administrated gave assurances that the facility follows this requirement. This standard does not explicitly require policy on that provision.

The facility hiring policy requires both a criminal background check and a check of child abuse registries prior to hiring any employee or engaging a volunteer or contractor who will have contact with residents. Policy also requires that those checks be made annually for each such employee, contractor, or volunteer. During the site visit the auditor randomly selected five employees, whose personnel files were reviewed. Each of those files contained documentation that the required checks, both pre-employment and annual, were made.

The facility hiring policy requires that all prospective employees be asked if they had ever committed the misconduct described in paragraph (a) of this standard. LC has complied with that provision by the development of a form containing three questions addressing the prohibited conduct. A prospective employee is given the form for completion when a conditional offer of employment is made. During the review of randomly selected personnel files, the auditor found the completed form in the files of the more recently hired employees. The hiring policy also provides that material omissions regarding such misconduct, or the provision of materially false information, is grounds for termination.

Finally, the hiring policy explicitly provides that the agency shall 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. In his interview, the HR administrator confirmed that facility practice is consistent with this provision.

Standard 115.318 Upgrades to facilities and technologies

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

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These

recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

NA. Since its last PREA audit, the facility has not designed or constructed a new facility nor made a substantial addition or modification. Neither has it installed or substantially modified its video monitoring system.

Standard 115.321 Evidence protocol and forensic medical examinations

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

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

Lincoln Center has an investigator who conducts administrative investigations of allegations of sexual abuse. Criminal investigations are the responsibility of the Highland Park Police Department, and Children's Protective Services also conducts administrative investigations. No one from LC would conduct a forensic medical examination of the alleged victim. The Lincoln Center investigator states that a uniform evidence protocol is utilized. The investigator has completed a course offered by the National Institute of Corrections that is specific to investigating sexual abuse allegations involving adolescents in a confinement setting. As a result, he is able to conduct investigations that are developmentally appropriate.

There were no allegations of sexual abuse involving a resident of LC during this reporting period. However, the facility reports that any alleged victim would receive a forensic medical examination performed by a Sexual Assault Forensic Examiner (SAFE) or Sexual Assault Nurse Examiner, without cost, at Detroit Medical Center Children's Hospital. In addition, any victim would have access to a victim's advocate through a community agency called WC Safe. LC has unsuccessfully attemted to enter into a written agreement with WC Safe and provided email evidence of those attempts. Although WC Safe declined to enter into a written agreement, LC administrators stated that they received verbal assurances that the agency would provide services for any victim in Wayne County, including any residing at LC. Upon request of the victim, an advocate would accompany a victim through the forensic examination process.

LC administrators and its investigator report a good relationship with the Highland Park Police Department (HPPD). The facility provided email evidence of its request that the HPPD follow the requirements of paragraphs (a) through (e) of this standard, but the HPPD has not entered into such an agreement.

Standard 115.322 Policies to ensure referrals of allegations for investigations

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

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

The SJJS Zero Tolerance Policy mandates the referral of allegations of sexual abuse or sexual harassment to outside law enforcement, unless the allegation does not involve potentially criminal behavior. The policy is published on the facility's website, and the auditor was able to review it there. During the reporting period there were two allegation of sexual harassment on the part of staff. The allegations did not involve potential criminal activity, but rather involved inappropriate remarks by staff. The allegations were investigated internally and by the Michigan Department of Licensing and Regulatory Affairs. The auditor reviewed the investigation reports. In each case the allegations of sexual harassment were found to be unsubstantiated.

Standard 115.331 Employee training

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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Paragraph (a) of this standard spells out 11 topics on which all employees who may have contact with residents must be trained. The SJJS Zero Tolerance policy explicitly requires that each of those topics be covered in staff training. The facility also provided a list of its training modules for pre-service trainng. That listing includes a module on PREA. Each of the line staff interviewed affirmed that all of the required topics were covered in training, and staff were able to summarize the training.

Although this standard requires refresher training every two years, LC provides it to all staff annually. The auditor randomly selected five employees' personnel files for review. Each of them showed PREA training to have been completed as the facility described.

Staff PREA training at LC is tailored to the needs and attributes of residents of juvenile facilities and to male residents. Enployees receive the training in their initial orientation, so that any employee coming from a facility that houses females would receive the training specific to male juveniles.

Employees affirm by signature that they understand the PREA-related training they have received. Employee signature sheets were reviewed.

Standard 115.332 Volunteer and contractor training

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The SJJS Zero Tolerance Policy requires that all volunteers and contractors who have contact with residents be trained on their responsibilities under its sexual abuse and sexual harassment prevention, detection, and response policies. The facility states in the pre-audit questionnaire that it provides such training. The auditor interviewed a teacher, an employee of the Ace Academy charter school, who verified that such training is provided and was able to articulate the zero tolerance policy regarding sexual abuse and sexual harassment and the proper procedure for reporting incidents. The auditor was able to review signature sheets for contractors who completed PREA training.

Standard 115.333 Resident education

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The facility reports that all youth receive information at intake explaining the facility's zero tolerance policy regarding sexual abuse and sexual harassment and how to report incidents or suspicion of incidents. Intake staff corroborated this when interviewed during the on-site audit. The auditor also interviewed randomly selected residents, who confirmed that the information was presented to them both verbally and in a handbook. There was some variation in when the residents reported receiving the information, but most stated that they received it the day they arrived.

The agency also reports providing more comprehensive education to residents regarding their right to be free from sexual abuse and sexual harassment and to be free from retaliation for reporting such incidents, and regarding agency policies and procedures for responding to such incidents. The materials provided at intake, including a portion of the resident handbook, a brochure, and short informational comic books/graphic novels satisfy that requirement.

The facility demonstrated that it could provide education to limited English proficient residents by way of brochures available in Spanish and Arabic, the two most common languages of immigrants in the area, although administraters reported never having housed a limited English proficient resident. The facility does not accept residents who are deaf or visually impaired. It is able to present the information to residents with limited reading skills by explanation during intake when it was presented. All of the residents interviewed were able to articulate their understanding of the zero tolerance policy and the ways to report any incidents.

During the site visit, the auditor reviewed documentation of resident participation in information sessions in the form of signature sheets. Additionally, while touring the facility, the auditor observed posters in the pods and in common areas that provided basic PREA-related information, including the right to be free of sexual abuse and sexual harassment and the ways any incidents could be reported.

Standard 115.334 Specialized training: Investigations

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

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

The facility reported that its designated administrative investigators have each completed the National Institute of Corrections course, "Investigating Sexual Abuse in a Confinement Setting." The facility also provided the auditor certificates of completion reflecting completion of that course.

Standard 115.335 Specialized training: Medical and mental health care

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

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

The SJJS poicy entitled "Specialized Training for Medical and Mental Health Professionals " requires the specialized training mandated by this standard.

When interviewed during the site visit, medical and mental health professionals confirmed that they had received both the specialized training required by this standard and the general training given employees regarding PREA and its requirements. Facility medical staff do not conduct forensic examinations.

Paragraph (c) of this standard requires maintendance of documentation that facility medical and mental health professionals received the specialized training the standard mandates. The facility provided signature sheets to document the completion of that training.

Standard 115.341 Screening for risk of victimization and abusiveness

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

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

Lincoln Center utilizes an objective screening instrument to reduce the risk of sexual abuse by or upon a resident. The Zero Tolerance policy requires that the instrument be administered within 72 hours of a resident's arrival at the facility and periodically throughout their confinement. The auditor reviewed the screening instrument and found it to contain each of the eleven elements required by paragraph (c) of this standard. In addition to the elements dictated by the standard, the screening tool notes the highest school grade the resident has completed and specifically inquires as to prior adjucation or conviction on a charge of sexual abuse and, if so, whther there were multiple charges of sexual abuse.

During the site visit, the auditor reviewed completed screening instruments for residents in the facility and confirmed in the interviews of intake staff and residents that the instrument is administered within 72 hours of arrival, as required. Specifically, it is completed by a supervisor or manager at intake on the day of arrival. Interviews also confirmed the periodic reassessment of residents. Finally, interviews confirmed that the instrument is available only to administrators, supervisors, managers and medical and mental health professionals, with information being shared with line staff only as needed for the treatment of the resident, safety or security.

Standard 115.342 Use of screening information

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

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

The facility's Zero Tolerance Policy provides for use of the information obtained in screening residents for risk of victimization or abusiveness to make housing, bed, program, education, and work assignments for residents. In practice, residents are assigned to pods based upon their committing offenses and attend education and programming with the other residents of their pods. However, there are two pods assigned to each category of offense used for housing assignments, thus permitting flexibility. Youth are further protected in that they are single-bunked. As a last resort, the facility has the flexibility to move a resident to another secure facility operated by SHS.

The Zero Tolerance Policy also provides that residents may be isolated from others only as a last resort to keep them and other residents safe and only until an alternative means of keeping all residents safe can be arranged. The policy further provides that while in isolation, residents may not be denied any legally required education programming or special education services, that they shall recive daily visits from a medical or mental health care clinician, and that they have access to other programs to the extent possible. When interviewed, agency administrators stated that isolation is used only when a resident poses an immediate risk to himself or others. Medical and mental health providers confirmed that a youth in isolation is seen daily by one of

them.

The Zero Tolerance Policy prohibits placement of gay, bisexual, transgender, and intersex (GBTI) residents in particular housing based upon that status, and in any event, all housing placements are made according to committing offense. The policy also reflects that GBTI identification or status is not to be considered an indicator of likelihood of being sexually abusive.

The facility reports having received two transgender residents and no intersex residents during the reporting period. Placement of such residents, while generally made according to committing offense, considers the resident's health and safety, is reconsidered at least twice annually, and is made taking a transgender or intersex resident's own views with respect to his or her safety. All residents, including transgender and intersex residents, shower separately from other residents.

The facility reports no resident having been isolated for protection from sexual assault during the reporting period. However, policy provides that the basis for any such isolation be documented along with the reason why no alternative means of protection can be arranged, and that a review of the continuing need for isolation be afforded every 30 days.

Standard 115.351 Resident reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Lincoln Center provides multiple internal mechanisms for residents to privately report sexual abuse and harassment, retaliation for reporting, and staff neglect or violation of responsibilities that may have contributed to such incidents. Residents may verbally tell a trusted staff member or administrator, may file a written grievance, or may write a note, signed or unsigned, for a staff member or administator. Residents were also aware that they could inform a parent, guardian, or casworker, who could in turn make a report to the facility. All of the residents interviewed during the site visit expressed an awareness of these reporting methods. Residents stated that they have access to writing materials for making such reports. Residents were also aware that they can report abuse to the hotline operated by Children's Protective Services (CPS), the number for which is found on posters throughout the facility and in each pod's therapy room, where such a call would be made. Staff may also report sexual abuse and sexual harassment of residents privately by means of the CPS hotline.

The Zero Tolerance Policy not only spells out the means for reporting described above, but also mandates that staff must accept reports made verbally, in writing, anonymously, and from third parties and shall promptly document any verbal reports. All line staff interviewed during the site visit stated that verbal reports would be immediately documented in an incident report.

Standard 115.352 Exhaustion of administrative remedies

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

corrective actions taken by the facility.

LC addresses resident grievances both in its Zero Tolerance Policy and in its Youth Grievance Policy. Read together, those policies state that there is no time limit on when a resident may submit a grievance regarding an allegation of sexual abuse, and a resident is not required to use any informal grievance process, or to otherewise attempt to resolve with staff, an incident of sexual abuse. Residents alleging sexual abuse may submit a grievance without submitting it to a staff member who is the subject of the complaint, and the grievance is not referred to the staff member who is subject to the complaint.

The Zero Tolerance Policy provides that the facility must issue a final decision on the merits of any grievance alleging sexual abuse within 90 days of the initial filing of the grievance and that the facility may claim an extension of up to 70 days if necessary to make an appropriate decision.The policy states that a resident must be notified of any such extension and the date by which a decision will be made. There were no grievances alleging sexual abuse of a resident filed during the reporting period.

The Zero Tolerance Policy also provides that third parties are permitted to assist residents in filing requests for administrative remedies relating to allegations of sexual abuse and are permitted to file such requests on behalf of residents. If a parent or legal guardian of juvenile files a grievance alleging sexual abuse, that grievance is not to be conditioned upon the juvenile agreeing to have the request filed on his behalf.

LC's Youth Grievance Policy allows for the filing of an emergency grievance alleging a resident to be at substantial risk of imminent sexual abuse and requires that the response to the grievance be within the time frame established by this standard. No such emergency grievances were filed during this reporting period.

Lincoln Center's policy entitled "Interventions and Disciplinary Sanctions for Residents Related to Sexual Harassment, Sexual Assault and/or Sexual Abuse of Residents" provides that the agency may not discipline a resident for filing a grievance related to alleged sexual abuse unless an allegation is made in bad faith.

Standard 115.353 Resident access to outside confidential support services

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

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

Residents are provided contact information for WC Safe, an agency that provides outside victim advocates for emotional support related to sexual abuse. The number for WC Safe is listed on posters throughout the facility. The facility permits a resident who asks to contact WC Safe to speak to that agency in the therapy rooms on each pod. Staff dial the number for WC Safe but then leave the therapy room and observe the resident through a window, allowing privacy for the call. Residents interviewed expressed awarencss that both facility staff and personnel at WC Safe are mandatory reporters who must report any allegatgion of sexual abuse to CPS.

The auditor reviewed email communications that evidence an effort to establish a written agreement with WC Safe to provide residents with confidential emotional support services related to sexual abuse. WC Safe has not entered into any such agreement with the facility, but administrators are assured that, as residents of Wayne County, Lincoln Center residents would receive services.

Confidential access to their attorneys are provided residents, either by telephone calls taken in the therapy rooms, where staff can observe through windows from outside the room, or in person in the individual visitation rooms at the facility. Access to parents is provided by way of weekly phone calls, to which all residents are entitled, and a minimum of two visits per week. Additionally, families participate in family therapy once per month.

Standard 115.354 Third-party reporting

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

☐ Does Not Meet Standard (requires corrective action)

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

Lincoln Center accepts third-party reports of sexual abuse and sexual harassment no matter who makes such reports and no matter the reporting method, according to facility administrators. Formal means of making such reports include reporting to CPS or, in the case of families, guardians, or caseworkers for residents in the child welfare system, filing a family grievance. The facility website posts the agency PREA (Zero Tolerance) policy, which contains the telephone number of the Michigan DHHS Hotline (CPS) for reporting incidents of sexual abuse. While that posting satisfies the requirements of this section, it is noted that the auditor could not locate reference to the family grievance process on the website, and it is recommended that a description of the process be posted along with other PREA-related information.

Standard 115.361 Staff and agency reporting duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The Zero Tolerance Policy requires that staff immediately report any knowledge, suspicion or information they receive regarding an incident of sexual abuse or sexual harassment that occurred in a facility, retaliation against residents or staff who reported an incident, and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. All of the staff interviewed expressed awareness of the immediate reporting requirement. Similarly, interviewed staff were aware of their responsibility to report to the MDHHS hotline under Michigan's mandatory reporting statute, a responsibility that was also spelled out in the Zero Tolerance Policy. The policy additionally provides that apart from reporting to designated supervisors and the MDHHS hotline, staff are prohibited from revealing any information related to a sexual abuse report other than as specified in the facility policy, to make treatment, investigation, and other security and management decisions. Medical and mental health practitioners are subject to the same reporting requirements and are required to inform residents at the initiation of services of their duty to report and the corresponding limitations of confidentiality. Medical and mental health staff interviewed during the site visit stated that they inform residents accordingly.

The Zero Tolerance Policy spells out reporting duties for the facility head, which include reporting any allegation of sexual assault promptly to the appropriate agency office and to the alleged victim's parents, legal guardian, or child welfare system caseworker. In Michigan, the juvenile court retains jurisdiction over juveniles it has committed to facilities such as Linclon Center. Further the LC policy has recently been amended to require reporting any allegation of sexual abuse to an alleged victim's attorney within 14 days of receiving the allegation, as required by paragraph (e)(3) of this standard.

The reporting provisions of the Zero Tolerance Policy require that all allegations of of sexual abuse or harassment, including anonymous and third-party reports, be reported to Lincoln Center's designated investigators.

Standard 115.362 Agency protection duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

The facility's Zero Tolerance Policy requires that when a staff member learns that a resident is subject to a substantial risk of of imminent sexual abuse, the facility shall take immediate action to protect the resident. Administrators and staff alike, in interviews during the site visit, expressed awareness of that requirement and articulated that the victim would be immediately physically separated from a potential perpetrator and placed on staff watch. Moving either the potential victim or potential perpetrator to another pod or another facility would also be considered in such circumstances.

Standard 115.363 Reporting to other confinement facilities

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

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

The facility Zero Tolerance Policy requires that upon the receipt of an allegation that a resident was sexually abused while confined at another facility, the Center Director shall notify the head of the facility where the abuse is alleged to have occurred and shall also notify the appropriate investigative agency. Such notification is to be made within 72 hours after receiving the allegation. The policy states that all other reporting requirements for allegations of sexual abuse apply. Any such reports are documented. Conversely, any allegation of sexual abuse while a resident was at Lincoln Center subsequently received from the head of another faciilty are to be investigated in the same manner as any other such allegation.

Standard 115.364 Staff first responder duties

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

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

The faciilty Zero Tolerance Policy addresses the duties of staff first responders to incidents of alleged sexual abuse, including separation of the alleged victim and abuser, preservation of the crime scene for outside law enforcement, and if the abuse occurred within a time period that allows for the collection of personal physical evidence, requesting that the victim and requiring that the abuser not take any actions that could destroy evidence, such as washing, brushing teeth, changing clothes, eating, drinking, or using the bathroom. All of the line staff interviewed, including security staff, are potential first responders, and each one demonstrated a knowledge of these requirements when interviewed during the site visit.

Standard 115.365 Coordinated response

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

☐ Does Not Meet Standard (requires corrective action)

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

Lincoln Center has developed a written institutional plan to coordinate actions taken in response to an incident of sexual abuse among staff first responders, medical and mental health practitioners, investigators, and facility leadership. The auditor was provided a copy of and reviewed that plan.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

NA. The facility does not enter into collective bargaining agreements with its employees.

Standard 115.367 Agency protection against retaliation

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The facility's Zero Tolerance Policy provides for protection of all residents and staff who report sexual abuse or harassment or cooperate with sexual abuse or harassment investigations from retaliation. Lincoln Center has designated its PREA Compliance Manager to be responsible for monitoring retaliation. According to the interviews of administrators and the PREA Compliance Manager, the facility could employ various protection measures, including housing changes for resident victims or abusers, removal of alleged staff or resident abusers from contact with victims, and emotional support for residents or staff who fear retaliation. The reporting resident or staff member would be subject to periodic status checks. When interviewed, the PREA Compliance Manager stated that montoring for retaliation would continue for at least 90 days after a report of sexual abuse. Monitoring would include resident disciplinary reports or program changes and any negative performance reviews or reassignments of reporting staff. Monitoring would continue beyond 90 days where circumstances reflected a continuing need.

Standard 115.368 Post-allegation protective custody

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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

LC would only place a resident alleged to have suffered sexual abuse in isolation as a last resort to keep all residents safe and only until an alternative means of preserving safety could be arranged, as mandated by the policy entitled " Interventions and Disciplinary Sanctions for Residents Related to Sexual Harassment, Sexual Assault and/or Sexual Abuse of Residents." There were no instances of such a use of isolation during this reporting period. While in isolation, such a resident would be subject to all of the requirements for residents in isolation, which are spelled out in Standard 115.342 and in the Interventions and Disciplinary Sanctions Policy.

Standard 115.371 Criminal and administrative agency investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

As noted in the discussion of Standard 115.334, above, the personnel who conduct administrative investigations into allegations of sexual abuse and sexual harassment at Lincoln Center have completed the National Institute of Corrections course on conducting such investigations in a confinement facility. Criminal investigations are conducted by the Highland Park Police Department (HPPD). Additional administrative investigations could be conducted by the MDHHS (CPS) and by Michigan's licensing agency. The Zero Tolerance Policy addresses internal investigations and provides for prompt, thorough investigations into all allegations, including third-party and anonymous reports. Interviews of staff and of one of the agency investigators confirmed that this is the facility's practice, and a review of the investigation of an allegation of sexual harassment further corroborates adherence to policy and this standard. When conducting an administrative investigation, investigators gather and preserve direct and circumstantial evidence, although collecting and preserving evidence would be the responsibility of the HPPD in the event of sexual abuse. The facility's investigation would not be terminated solely because the source of the allegation recanted the allegation.

When the evidence appears to support criminal prosecution, the agency would cooperate with the HPPD, which would take the lead. LC's investigator would not compel interviews if doing so might be an obstacle to criminal prosecution. The credibility of an alleged victim, suspect, or witness is assessed on an individual basis, regardless of the person's status as resident or staff. LC would not require a resident alleging sexual abuse to submit to a polygraph examination. LC's administrative investigation would include an effort to determine if staff actions or failures to act contributed to an incident of sexual abuse. The investigations are documented in written reports that include a description of the evidence, the reasoning behind credibility assessments, and findings. The agency would retain all written reports for as long as the alleged abuser was confined or employed by the facility, plus five years.

Standard 115.372 Evidentiary standard for administrative investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

During his interview, the LC investigator confirmed that in administrative investigations the facility imposes a standard of preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated.

Standard 115.373 Reporting to residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The facility's Zero Tolerance Policy mandates that, following an investigation into a resident's allegation of sexual abuse in the facility, the facility must inform the resident whether the allegation has been found to be substantiated, unsubstantiated, or unfounded. The facility requests information from the HPPD, in the event of a criminal investigation, in order to inform the resident. The Zero Tolerance Policy also provides that, if a resident alleges that a staff member has committed sexual abuse against him, the facility will inform the resident whenever the staff member is no longer posted within the resident's pod; the staff member is no longer employed at the facility; or the agency learns that the staff member has been indicted or convicted on a charge related to sexual abuse. If a resident alleges that he has been sexually abused by another resident, the facility will inform the alleged victim whenever it learns that the alleged abuser has been indicted or convicted on a charge related sexual abuse. All such notifications or attempted notifications would be documented.

Standard 115.376 Disciplinary sanctions for staff

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The SJJS policy entitled "Disciplinary Sanctions For Employees, Contractors and Volunteers Related to Sexual Harasment, Sexual Assault and/or Sexual Abuse of Residents" provides that staff are subject to discipinary sanctions up to and including terminiatioin for violating agency sexual abuse or harassment policies. Termination is the presumptive disciplinary sanction for staff who have engaged in sexual abuse. Disciplinary sanctions for violations of policies related to sexual abuse or harassment, other than actually engaging in sexual abuse, are commensurate with the nature and circumstances of the acts committed, the staff member's disciplinary history, and sanctions imposed against other staff for comparable offenses. Terminations for violations of agency sexual abuse or harassment policies, or resignations by staff who would have been terminated, are reported to law enforcement unless the the activity was clearly not criminal, and to any relevant licensing bodies.

Standard 115.377 Corrective action for contractors and volunteers

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

In accordance with the policy entitiled "Disciplinary Sanctions For Employees, Contractors and Volunteers Related to Sexual Harasment, Sexual Assault and/or Sexual Abuse of Residents," a contractor or volunteer who engages in sexual abuse would be prohibited from contact with residents and reported to law enforcement agencies, unless the activity was clearly not criminal, and to relevant licensing bodies. The facility would take remedial measures and consider whether to prohibit further contact with residents, in the case of any other violation of sexual abuse or harassment policies. There were no instances of allegations of violation of sexual abuse or harassment policies by a contractor or volunteer during this reporting period.

Standard 115.378 Disciplinary sanctions for residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

During this reporting period there were no allegations or administrative findings of resident-on-resident sexual abuse. Discipline of abusers in such instances would be governed by the policy entitled "Interventions and Disciplinary Sanctions for Residents Related to Sexual Harassment, Sexual Assault and/or Sexual Abuse of Residents." A resident is subject to disciplinary sanctions only pursuant to a formal disciplinary process followig an admistrative or criminal finding that the resident engaged in resident-on-resident sexual abuse. Sanctions imposed are commensurate with the nature and circumstances of the abuse committed, the resident's disciplinary history, and sanctions imposed for comparable offenses by other residents. In the event of isolation, a resident is entitled to daily large-muscle exercise and access to legally required educational programming or special education services. Residents in isolation receive daily visits from a medical or mental health clinician and have access to other programs to the extent possible.

The determination of disciplinary sanctions for a resident who engaged in resident-on-resident sexual abuse considers whether a resident's mental disabilities or mental illness contributed to his behavior. The facility would offer therapy, counseling or other interventions to a resident who commits sexual abuse on another resident. Mental health providers, interviewed during the site visit, stated that participation in such interventions would not be a condition of access to general programming or education. The facility's policy provides that a resident may be disciplined for sexual contact with staff only upon a finding that the staff member did not consent to the contact. It further provides that a resident who makes a report of sexual abuse in good faith cannot be disciplined for making the allegation, even if an investigation does not establish evidence sufficient to substantiate it.

Lincoln Center prohibits all sexual activity between residents, but the facility does not deem such activity to be sexual abuse unless the activity is coerced.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance

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

The SJJS Zero Tolerance Policy provides that, should a resident's initial risk screening indicate that the resident has experienced prior sexual victimization, or has previously perpetrated sexual abuse, staff shall ensure that the resident is offered a follow-up meeting with a mental health practitioneer within 14 days of the risk screening. A staff member who conducts the initial risk screening confirmed that follow-up meetings are in fact offered. Any information related to sexual victimization or abusiveness that occurred in an institutional setting is limited to medical and mental health practitioners and other staff, as necessary, to inform treatment plans and safety and security management decisions. For residents who are 18 or older, medical and mental health practitioners obtain informed consent before reporting information about prior sexual victimization that did not occur in an institutional setting.

Standard 115.382 Access to emergency medical and mental health services

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

There were no incidents of sexual abuse of a resident during the reporting period. However, were such an incident to occur, the victim would receive timely access to emergency medical treatment and crisis intervention services, the nature and scope of which would be determined by medical and mental health practitioners according to their professional judgment. When interviewed during the site visit, medical staff stated that resident victims of sexual abuse while in the facility would be offered timely information about and timely access to sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate. All treatment services would be provided the victim without cost and regardless of whether the victim names the abuser or cooperates with the investigation of the incident.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The SJJS Zero Tolerance Policy provides that the facility shall offer medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse, whether it occurred while confined in any facility or in the community. When interviewed during the site visit, medical and mental health practitioners at the facility stated that the evaluation and treatment of any victims would include, as appropriate, follow-up services, treatment plans, and, when necessary, referrals for continued care following transfer to another facility or release from custody. Resident victims of sexual abuse while incarcerated would be offered tests for sexually transmitted infections as medically apprpriate. All medical and mental health services are provided without charge and regardless of whether the victim names the abuser or cooperates with any investigation. The facility would 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.

Standard 115.386 Sexual abuse incident reviews

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The SJJS policy entitled "Sexual Abuse and/or Assault Incident Data Collection, Review, Reporting and Storage Policy" requires that the facility conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation, including when the allegation has not been substantiated, unless the allegation has been determined to be unfounded. Such review is to occur within 30 days of the conclusion of the investigation. The review team includes upper-level management officials, and input is sought from line supervisors, investgators, and medical and mental health practitioners. Policy dictates that the incident review team comply with each of the six requirements spelled out in paragraph (d) of this standard, and when interviewed, the Center Director and incident review team member confirmed that the review team would comply with those requirements. Upon completion of an incident review process, the facility implements its recommendations for improvement or documents its reasons for not doing so.

Standard 115.387 Data collection

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The MDHHS's umbrella PREA policy requires collection of accurate, uniform data for every allegation of sexual abuse, sufficient to satisfy the annual Survey of Sexual Violence conducted by the United States Department of Justice. The MDHHS provided a link to its 2016 annual data and annual report on its website. The annual data reflected in the report separately aggregates allegations of sexual abuse and sexual harassment at the facilities under its control and all such allegations at private facilities with which it contracts for the confinement of juveniles. The incident-based data reflected in the report include the data necessary to answer all questions on the Survey of Sexual Violence.

The SJJS Sexual Abuse and/or Assault Incident Data Collection, Review, Reporting and Storage Policy mandates that the facility collect comprehensive data reflecting all allegation of sexual abuse or harassment against a resident, using the Survey of Sexual Violence tool. Both Lincoln Center administrators and the MDHHS PREA coordinator confirmed that LC collects accurate, uniform data for every allegation of sexual abuse at the facility using a standardized instrument and set of definitions and provides this information to the Michigan DHHS. The agency maintains, reviews, and collects data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews. Lincoln Center has not been requested to provide its collected data to the United States Department of Justice.

Standard 115.388 Data review for corrective action

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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

The MDHHS provided a link to its 2016 annual data and annual report on its website. The annual report contains a review of of its data in order to improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training. The report compares the 2016 data with data for previous years. The report was approved by the agency head.

Standard 115.389 Data storage, publication, and destruction

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The MDHHS endures that the aggregated data it collects are securely retained, in accordance with the relevant provisions of its umbrella PREA policy. It makes all aggregated sexual abuse data, from facilities under its direct control and private facilities with which it contracts, available to the public on its website and provided the link to that information. The published data did not incude any personal identifiers. The MDHHS maintains the sexual abuse data it collects pursualt to Standard 115.387 for at least 10 years after the date of its collection. The agency's PREA Coordinator is responsible for that data.

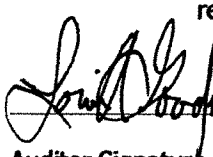
AUDITOR CERTIFICATION

I certify that:

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

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

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



Auditor Signature

May 18, 2017

Date