

UNITED STATES DISTRICT COURT  
FOR THE EASTERN DISTRICT OF MICHIGAN  
SOUTHERN DIVISION

TOCARRA MCMULLIN, NEXT OF  
FRIEND TO T. M., a minor,

Plaintiff,

v.

WAYNE COUNTY, d/b/a Wayne County  
Juvenile Detention Center, a political  
subdivision of the State of Michigan;  
WARREN EVANS, in his individual and  
official capacity as Wayne County  
Executive; ASSAD TURFE, Deputy  
Wayne County Executive, in his individual  
capacity; MELISSA FERNANDEZ, in her  
individual capacity as Division Director of  
Wayne County Juvenile and Youth  
Services and Chief Administrator of  
Wayne County Juvenile Detention Center;  
MARK ROLAND, in his individual  
capacity as Deputy Director of  
Administration for the Wayne County  
Juvenile Detention Facility; BRANDON  
BARBER, in his individual capacity as  
Facility Director of the Wayne County  
Juvenile Detention Facility; DOE 1, in her  
capacity as Operations Director of the JDF;  
KIRPHEOUS STEWART, in his  
individual capacity as the Wayne County  
Juvenile Detention Center Deputy Director  
of Operations; JDF STAFF MEMBER 1, in  
his individual capacity; JDF STAFF  
MEMBER 2, in his individual capacity;  
JDF STAFF MEMBER 3, in his individual  
capacity; JDF STAFF MEMBER 4, in his

Case no.  
Hon.  
Mag.

individual capacity; JDF STAFF MEMBER 5, in his individual capacity; JDF SUPERVISOR 1, in his individual capacity; JDF SUPERVISOR 2, in his individual capacity; DOE 2 (JDF Juvenile Detention Specialist) in his or her individual capacity; DOE 3 (JDF Team Leader/Supervisor), in his/her individual capacity; ELIZABETH HERTEL, in her individual capacity as the Director of the Michigan Department of Health and Human Services; DEMETRUIS STARLING, in his individual capacity as Senior Deputy Director of the Department of Health and Human Services; STEVE YAGER, in his individual capacity as the Executive Director of the Division of Child Welfare Licensing of the Michigan Department of Health and Human Services; ASHLEIGH BROTHERSON, in her individual capacity as the Division Director of Child Welfare Licensing for the Michigan Department of Health and Human Services; VIVIAN MALLECK, in her individual capacity as a Licensing Consultant for the Michigan Department of Health and Human Services; CHRISTOPHER BARR, in his individual capacity as a Licensing Consultant for the Michigan Department of Health and Human Services.

Jointly and severally,

Defendants.

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**COMPLAINT AND JURY DEMAND**

Plaintiff, Tocarra McMullin, as Next of Friend of T.M. a minor, by and

through her attorneys, Pitt McGehee Palmer Bonanni & Rivers P.C., states in support of her Complaint the following:

**I.**  
**INTRODUCTORY STATEMENT**

1. This a case brought by Plaintiff Tocarra McMullin, mother and legal guardian and as Next Friend to T.M., a twelve-year-old minor, arising out of the unconstitutionally deplorable and inhumane conditions that T.M. was subjected to while detained within the Wayne County Juvenile Detention Facility/William Dickerson Juvenile Detention Facility (collectively referred to as JDF)<sup>1</sup>. T.M. was detained while he was 11 and 12 years old, leading to him being viciously beaten and anally gang raped by 5 JDF residents on March 14<sup>th</sup> and 15<sup>th</sup>, 2023.

2. It is clearly established as a matter of constitutional law that detention officials must ensure that detainees receive adequate food, clothing, shelter, and medical care, and must take reasonable measures to guarantee the safety of the youthful detainees. *Farmer v. Brennan*, 511 U.S. 825, 832–33, 114 S. Ct. 1970, 1976, 128 L. Ed. 2d 811 (1994)(citations omitted)(Holding that the Eighth Amendment “imposes duties on these officials, who must provide humane conditions of confinement; prison officials must ensure that inmates receive adequate food, clothing, shelter, and medical care, and must “take reasonable

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<sup>1</sup> The Wayne County Juvenile Detention Facility moved from downtown Detroit to the William Dickerson Facility located in Hamtramck in October of 2023.

measures to guarantee the safety of the inmates[.]”) This clearly established constitutional duty includes “a duty...to protect prisoners from violence at the hands of other prisoners.” *Id.* (quoting *Cortes-Quinones v. Jimenez-Nettleship*, 842 F.2d 556, 558 (CA1), cert. denied, 488 U.S. 823 (1988) and *Wilson v. Seiter*, 501 U.S. 294, 303 (1991)).

3. Thus, at the time of the events giving rise to this action, all reasonable officials in Defendants’ position would understand, and the Defendants in this action did in fact understand that their actions as alleged in this complaint violated Plaintiff’s clearly established constitutional rights.

4. The Wayne County Juvenile and Youth Services Department administers the County's juvenile justice system of care from prevention to adjudication of juveniles and includes community re-integration of returning juveniles. The Department's responsibilities include detention custody and care, residential treatment, and community-based services for Wayne County youth who have had formal contact with the Family Division of the Wayne County Third Circuit Court.

5. The Wayne County Defendants, sued in their individual capacities for actions taken under color of law, are responsible for the operations of the JDF and ensuring the protection, safety, health, and well-being of the youth housed in the facility.

6. The MDHHS Defendants, sued in their individual capacities for actions taken under color of law, are charged with overseeing the JDF, licensing the facility, and monitoring the facility to ensure that the JDF provides proper care, education, health, and protection to the youths housed in it.

7. At all times relevant hereto, the MDHHS Defendants had actual and/or constructive knowledge of the conditions inside the JDF, as well as the power, authority, and resources to have access to the JDF and to oversee it to ensure that it provides proper care to the youthful detainees.

8. During T.M.'s detention at the Detroit JDF from February of 2022 to March of 2022, from April of 2022 to July of 2022, and from August of 2022 to October of 2022, and during his detention at the William Dickerson JDF from October of 2022 to March 16<sup>th</sup>, 2023, the conditions of the JDF were deplorable such that T.M. and other youth were denied:

- a. Showers and basic hygiene;
- b. Adequate change of clothes;
- c. Recreational time;
- d. Ability to leave their rooms for 22 to 24 hours a day;
- e. Educational programming;
- f. Necessary medication; and
- g. Sufficient food and sustenance.<sup>2</sup>

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<sup>2</sup> On September 29, 2023, the MDHHS issued a Special Investigation Report (SIR) - No. 2023C0000340 - placing the JDF on a provisional license, MCL section 722.117(a), finding that every possible form of neglect and inhumane conditions exists for the JDF youth, including, but not limited to:

1. A failure to provide showers and basic hygiene;

9. During T.M.'s detention within the JDF, Defendants had a policy, custom, and practice of:

- a. While at the JDF in Detroit facility, locking youthful detainees in their rooms for 22 to 24 hours a day;
- b. While at the JDF Dickerson facility, allowing youthful detainees to be out of their rooms unsupervised, outside the line of vision of JDF staff;
- c. Maintaining an inadequate and dangerous staff to resident ratio in violation of the Prison Rape Elimination Act (PREA);
- d. Hiring and retaining staff who have a history of child abuse and/or neglect;
- e. Directing JDF staff not to intervene when youthful detainees are being sexually and/or physically assaulted;
- f. Not maintaining 15-minute checks on the detainees;
- g. Not securing vacant rooms;
- h. Directing supervision to remain in the Unit Control Room which does not have direct visual contact with all rooms in a housing Unit;
- i. Placing younger juveniles, including Plaintiff, in confinement with older detainees; and
- j. Placing juveniles, including Plaintiff, in confinement with detainees who have a history of sexual misconduct.

10. Defendants, including the municipal defendant Wayne County and the State Defendant MDHHS, were on notice that detaining youth without regard to their vulnerable status subjects youthful detainees to heightened and substantial risk of

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2. A failure to provide an adequate change of clothes;
  3. A failure to provide recreational time;
  4. A failure to provide educational programming;
  5. A failure to provide necessary medication;
  6. A failure to provide sufficient food and sustenance.

(See September 29, 2023, SIR, No. 2023C0000340, attached hereto as Exhibit 1)

harm, including but not limited to, physical and sexual violence and abuse and sexual harassment by other youthful detainees, but did nothing to abate the risk and in fact disregarded the risk with deliberate indifference to Plaintiff's health and welfare.

11. Defendants' policies, customs, and practices as set forth above and below constituted deliberate indifference to Plaintiff's health, wellbeing and safety and were implemented with the express intent to punish T.M. and/or created detention conditions not rationally related to a legitimate governmental objective, and/or constituted punishment that was excessive in relation to that purpose.

12. Defendants' policies, customs, and practices and their actions and inactions, created a sexually hostile detention environment where the predictable but preventable happened when on March 14<sup>th</sup> and 15<sup>th</sup>, 2023 T.M. was brutally beaten and anally gang raped by five JDF residents while JDF staff did nothing to stop it.

13. On January 3, 2024, MDHHS issued a report identified as SIR- No. 2023C0000325, investigating the circumstances of T.M.'s March 2023 physical and sexual assault, and finding that the Wayne County Defendants engaged in deliberately indifferent conduct and maintained practices, policies and customs that violated numerous rules promulgated by the Department of Consumer and Industry Service Division of Child Welfare Licensing for Juvenile Facilities, and set forth in the Juvenile Justice Residential Policy Manual including:

- a. CCI Rule 400.4126- Sufficient Staff;

- b. CCI Rule 400.4127- Staff to Resident Ratio;
- c. CCI Rule 400.4112 - Criminal history check, subject to requirements, staff qualifications; and
- d. CCI Rule 400.4158- Intervention Standards and Prohibitions. (See January 3, 2024, SIR 2023C0000325, attached hereto as Exhibit 2)

14. Defendants' policies, customs, and practices and their actions and inactions constitute deliberate indifference to the welfare, health and safety of T.M. and a violation of his constitutional rights.

15. At all times relevant hereto, all Defendants were acting under color of law, and, in doing so, deprived T. M. of his rights under the 8<sup>th</sup> Amendment and 14<sup>th</sup> Amendment of the United States Constitution.

16. As a result of Defendants' policies, customs, and practices, actions and inactions, gross negligence, and deliberate indifference to T. M.'s health and safety, T.M. has suffered irreparable harm, including but not limited to physical injuries, sexual violence and abuse, including anal rape, severe emotional distress and mental trauma, degrading treatment, lengthened periods of detention, solitary confinement and deprivation of educational, medical and rehabilitative services.

17. After T.M.'s physical and sexual assaults, Wayne County Executive, Warren Evans, issued a Public Emergency Order regarding the conditions at JDF on March 22, 2023, stating:

"The situation has become untenable for nearly 140 youth that are currently residing there," Evans said in his remarks. "Extraordinary action has become necessary, which is why today I'm calling for a public health state emergency.

"This order, under the powers of the county health officer, will allow us to establish an incident command structure reporting directly to me, which will expedite action to adequately staff and provide therapeutic services in the facility. But in the end, the most important action needed to address the situation is for the state to provide long-term residential beds."

18. It is unconscionable that the conditions that existed for T.M. at the JDF continued to exist after his release and to date.

## **II.** **JURISDICTION AND VENUE**

19. This is a civil action brought pursuant to 42 U.S.C. § 1983, seeking monetary damages against Defendants for violations of his right to be free from cruel and unusual punishment under the 8<sup>th</sup> Amendment, as applied to Defendants through the Due Process Clause of the 14<sup>th</sup> Amendment, as well as his due process rights under the 14<sup>th</sup> Amendment of the United States Constitution.

20. This Court has jurisdiction pursuant to 28 U.S.C. § 1331, which authorizes federal courts to decide cases concerning federal questions, and 28 U.S.C. § 1343(a)(3) and (4), which authorizes federal courts to hear civil rights cases. This Court has personal jurisdiction over the Defendants named herein as public officials of Wayne County, Michigan and the State of Michigan sued in their official and individual capacities for violations of Plaintiffs' statutory and constitutional rights.

21. Venue is proper in this Court as the events giving rise to the action occurred in the Eastern District of Michigan, Defendants conduct their business across the State, including in the Eastern District of Michigan, and the named Plaintiff resides in Wayne County, Michigan.

### **III. PARTIES**

#### **A. Plaintiff**

22. Plaintiff Tocarra McMullin, next of friend of T.M., currently resides in Wayne County, Michigan. At all times relevant to this Complaint, T. M. was in the joint custody of the Wayne County Defendants and MDHHS Defendants.

23. T. M. is a minor, born in June 2010, and at all times relevant to this Complaint, was 11 and 12 years old and in the custody of Defendants within the Wayne County Juvenile Detention Center (JDF) located in Wayne County, Michigan, from February of 2022 to March of 2022, from April of 2022 to July of 2022, and from August of 2022 to March 16, 2023.

#### **B. Wayne County Defendants**

24. Defendant WAYNE COUNTY is a political subdivision of the State of Michigan that can be sued in its own name. Wayne County is responsible for all acts of the Wayne County's Executive Office. The Wayne County Executive's Office oversees and administers the Wayne County Juvenile Detention Center (JDF) and is responsible for custody and care and ensuring the protection, safety, health,

and well-being of the youth housed in the facility, and had custody over T. M. from February of 2022 to March of 2022, from April of 2022 to July of 2022, and from August of 2022 to March 16, 2023..

25. Defendant WARREN EVANS is the Executive of Wayne County and is and was at all times relevant hereto, responsible for operating the JDF, making policies and procedures related to the JDF, ensuring that policies and procedures were followed, disciplining employees who violated policies and procedures and rules, maintaining the care and custody of youth confined at the JDF and ensuring the protection, safety, health, and well-being of the youth housed in the facility. He had and has full power, control and authority to have access to the facility and to oversee the facility in the supervision and control of JDF affairs to ensure that the staff is providing proper care to the juveniles residents in the JDF. He is also responsible for ensuring that the JDF abides by the laws, policies, and regulations of the State of Michigan and of the United States of America. He is being sued in his individual capacity for actions taken under color of law.

26. Defendant ASSAD TURFE is the Deputy Wayne County Executive and is and was at all times relevant hereto, responsible for operating the JDF, making policies and procedures related to the JDF, ensuring that policies and procedures were followed, disciplining employees who violated policies and procedures and rules, maintaining the care and custody of juveniles confined at the JDF and

ensuring the protection, safety, health, and well-being of the youth housed in the facility. He had and has full power, control and authority to have access to the facility and to oversee the facility in the supervision and control of JDF affairs to ensure that the staff is providing proper care to the juveniles residents in the JDF. He is also responsible for ensuring that the JDF abides by the laws, policies, and regulations of the State of Michigan and of the United States of America. He is being sued in his individual capacity for actions taken under color of law.

27. Defendant MELISSA ANN FERNANDEZ, was at all times relevant hereto the Division Director of Wayne County Juvenile and Youth Services and Chief Administrator of JDF, and is and was at all times relevant hereto, responsible for operating the JDF, making policies and procedures related to the JDF, ensuring that policies and procedures were followed, disciplining employees who violated policies and procedures and rules, maintaining the care and custody of juveniles confined at the JDF and ensuring the protection, safety, health, and well-being of the youth housed in the facility. She had and has full power, control and authority to have access to the facility and to oversee the facility in the supervision and control of JDF affairs to ensure that the staff is providing proper care to the juveniles residents in the JDF. She is also responsible for ensuring that the JDF abides by the laws, policies, and regulations of the State of Michigan and of the United States of

America. She is being sued in her individual capacity for actions taken under color of law.

28. Defendant MARK ROLAND was the Deputy Director of Administration for the JDF and was at all times relevant hereto, responsible for operating the JDF, making policies and procedures related to the JDF, ensuring that policies and procedures were followed, disciplining employees who violated policies and procedures and rules, maintaining the care and custody of juveniles confined at the JDF and ensuring the protection, safety, health, and well-being of the youth housed in the facility. He had full power, control and authority to have access to the facility and to oversee the facility in the supervision and control of JDF affairs to ensure that the staff is providing proper care to the juveniles residents in the JDF. He is also responsible for ensuring that the JDF abides by the laws, policies, and regulations of the State of Michigan and of the United States of America. He is being sued in his individual capacity for actions taken under color of law.

29. Defendant BRANDON BARBER was the Facility Director of the JDF and was at all times relevant hereto, responsible for operating the JDF, making policies and procedures related to the JDF, ensuring that policies and procedures were followed, disciplining employees who violated policies and procedures and rules, maintaining the care and custody of juveniles confined at the JDF and ensuring the protection, safety, health, and well-being of the youth housed in the

facility. He had full power, control and authority to have access to the facility and to oversee the facility in the supervision and control of JDF affairs to ensure that the staff is providing proper care to the juveniles residents in the JDF. He is also responsible for ensuring that the JDF abides by the laws, policies, and regulations of the State of Michigan and of the United States of America. He is being sued in her individual capacity for actions taken under color of law.

30. Defendant KIRPHEOUS STEWART, was at all times relevant hereto, the Deputy Director of Operations of the JDF, and responsible for being the liaison between the Child Protective Services and the Bureau of Child Care and oversaw the daily operations of the JDF, including programming, staffing and training the staff and supervisors on how to manage the residents (Michigan State Police Investigative Report, June 13, 2023, Supplemental Date page 2 of 3, attached hereto as Exhibit 3) . He had full power, control and authority to have access to the facility and to oversee the facility in the supervision and control of JDF affairs to ensure that the staff is providing proper care to the juveniles residents in the JDF. He is also responsible for ensuring that the JDF abides by the laws, policies, and regulations of the State of Michigan and of the United States of America. He is being sued in her individual capacity for actions taken under color of law.

31. Defendant DOE 1 was at all times relevant hereto the Operations Director of the JDF and was responsible for overseeing the daily operations of the

JDF, including programming, staffing and training the staff and supervisors on how to manage the residents. (Michigan State Police Investigative Report, June 16, 2023, Supplemental Date page 1 of 4, attached hereto as Exhibit 3). She had full power, control and authority to have access to the facility and to oversee the facility in the supervision and control of JDF affairs to ensure that the staff is providing proper care to the juveniles residents in the JDF. She is also responsible for ensuring that the JDF abides by the laws, policies, and regulations of the State of Michigan and of the United States of America. She is being sued in her individual capacity for actions taken under color of law.

32. Defendant, STAFF PERSON 1 <sup>3</sup>was at all times relevant hereto an employee of Wayne County and acting within the scope of his employment and responsible for overseeing the youth housed in the JDF and ensuring the protection, safety, health, and well-being of the youth housed in the facility. He is being sued in his individual capacity for actions taken under color of law.

33. Defendant, STAFF PERSON 2 was at all times relevant hereto an employee of Wayne County and acting within the scope of his employment with responsibility for overseeing the youth housed in the JDF and ensuring the

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<sup>3</sup> The designation of Staff Persons 1 through 5 and Supervisors 1 through 2 is based on how they have been designated by the MDHHS in is Special Investigative Report (SIR) dated January 3, 2024, No. 2023C0000325, attached hereto as Exhibit 2)

protection, safety, health, and well-being of the youth housed in the facility. He is being sued in his individual capacity for actions taken under color of law.

34. Defendant, STAFF PERSON 3 was at all times relevant hereto an employee Wayne County and acting within the scope of his employment with responsibility for overseeing the youth housed in the JDF and ensuring the protection, safety, health, and well-being of the youth housed in the facility. He is being sued in his individual capacity for actions taken under color of law.

35. Defendant, STAFF PERSON 4 was at all times relevant hereto an employee Wayne County and acting within the scope of his employment with responsibility for overseeing the youth housed in the JDF and ensuring the protection, safety, health, and well-being of the youth housed in the facility. He is being sued in his individual capacity for actions taken under color of law.

36. Defendant, STAFF PERSON 5 was at all times relevant hereto an employee Wayne County and acting within the scope of his employment and with responsibility for overseeing the youth housed in the JDF and ensuring the protection, safety, health, and well-being of the youth housed in the facility. He is being sued in his individual capacity for actions taken under color of law.

37. Defendant, SUPERVISOR 1, was at all times relevant hereto an employee of Wayne County and acting within the scope of his employment in a supervisory capacity with responsibility for making and implementing policies and

procedures related to the JDF, ensuring that policies and procedures were followed, disciplining employees who violated policies and procedures and rules, overseeing the youth housed in the JDF and ensuring the protection, safety, health, and well-being of the youth housed in the facility. He is being sued in his individual capacity for actions taken under color of law.

38. Defendant, SUPERVISOR 2, was at all times relevant hereto an employee of Wayne County and acting within the scope of his employment in a supervisory capacity with responsibility for making and implementing policies and procedures related to the JDF, ensuring that policies and procedures were followed, disciplining employees who violated policies and procedures and rules, overseeing the youth housed in the JDF and ensuring the protection, safety, health, and well-being of the youth housed in the facility. He is being sued in his individual capacity for actions taken under color of law.

39. Defendant, DOE 2, identified as a JDF Juvenile Detention Specialist (Michigan State Police Investigation March 29<sup>th</sup>, 2023, Supplemental Date, page 6 of 10, Exhibit 3) was at all times relevant hereto an employee of Wayne County and acting within the scope of his employment in a supervisory capacity with responsibility for making and implementing policies and procedures related to the JDF, ensuring that policies and procedures were followed, disciplining employees who violated policies and procedures and rules, overseeing the youth housed in the

JDF and ensuring the protection, safety, health, and well-being of the youth housed in the facility. He is being sued in his individual capacity for actions taken under color of law.

40. Defendant, DOE 3, identified as a JDF Team Leader/Supervisor (Michigan State Police Investigation March 29<sup>th</sup>, 2023, Supplemental Date, page 8 of 10, Exhibit 3) was at all times relevant hereto an employee of Wayne County and acting within the scope of his employment in a supervisory capacity with responsibility for making and implementing policies and procedures related to the JDF, ensuring that policies and procedures were followed, disciplining employees who violated policies and procedures and rules, overseeing the youth housed in the JDF and ensuring the protection, safety, health, and well-being of the youth housed in the facility. He is being sued in his individual capacity for actions taken under color of law.

**C. Michigan Department of Health and Human Services (MDHHS) Defendants**

41. Defendant ELIZABETH HERTEL is and was at all times relevant hereto, the Director of the MDHHS, charged with overseeing the JDF, licensing the facility, and monitoring the facility to ensure that the JDF provides proper care, education, health, and protection to the youths housed in it. She is responsible for developing and implementing policies and procedures for the operation and management of the JDF and its employees, including the care, custody, and

protection of residents under the JDF jurisdiction. In her capacity as the Director of the MDHHS, she has full power, control and authority to have access to the facility and to oversee the facility in the supervision and control of JDF affairs to ensure that the staff is providing proper care to the juvenile residents in the JDF. She is also responsible for providing state residential treatment facilities for adjudicated youth to obtain mental health care and other services necessary to complete their sentences. She is also responsible for ensuring that the JDF abides by the laws, policies, and regulations of the State of Michigan and of the United States of America. HERTEL was directly involved in concerns related to the JDF as early as the fall of 2022.<sup>4</sup> She is being sued in her individual capacity for actions taken under color of law.

42. Defendant DEMETRUIS STARLING is and was at all times relevant hereto, the Senior Deputy Director of the MDHHS, charged with overseeing the JDF, licensing the facility, and monitoring the facility to ensure that the JDF provides proper care, education, health, and protection to the youths housed in it. He is and was responsible for developing and implementing policies and procedures for the operation and management of the JDF and its employees, including the care, custody, and protection of residents under the JDF jurisdiction. In her capacity as the Senior Deputy Director of the MDHHS, he has full power, control and authority

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<sup>4</sup> <https://www.detroitnews.com/story/news/local/wayne-county/2023/11/02/wayne-county-juvenile-detention-center-loses-full-license-from-state/71422844007>

to have access to the facility and to oversee the facility in the supervision and control of JDF affairs to ensure that the staff is providing proper care to the juveniles residents in the JDF. He is also responsible for providing state residential treatment facilities for adjudicated youth to obtain mental health care and other services necessary to complete their sentences. He is also responsible for ensuring that the JDF abides by the laws, policies, and regulations of the State of Michigan and of the United States of America. He is being sued in her individual capacity for actions taken under color of law.

43. Defendant STEVE YAGER is and was the Executive Director of the Division of Child Welfare Licensing (CWL) for the MDHSS and was at all times relevant hereto responsible for overseeing and monitoring onsite inspections of the JDF to determine compliance with state law and licensing rules, providing technical assistance and consultation to improve the quality of service and investigating complaints alleging violations of licensing rules or law, and ensuring the protection to children who are receiving care from the JDF by enforcing rules and laws such as the Child Care Organizations Act (1973 PA 116) and revoking the license if the JDF was failing to do so and jeopardizing the safety, health, and well-being of the youth housed in the facility. He is being sued in his individual capacity for actions taken under color of law.

44. Defendant ASHLEIGH BROTHERTON is and was at all times relevant hereto the Division Director of CLW for the MDHSS and was at all times relevant hereto responsible for overseeing and monitoring onsite inspections of the JDF to determine compliance with state law and licensing rules, providing technical assistance and consultation to improve the quality of service and investigating complaints alleging violations of licensing rules or law, and ensuring the protection to children who are receiving care from the JDF by enforcing rules and laws such as the Child Care Organizations Act (1973 PA 116) and revoking the license if the JDF was failing to do so and jeopardizing the safety, health, and well-being of the youth housed in the facility. She is being sued in her individual capacity for actions taken under color of law.

45. Defendant CHRIS BARR, is and was at all times relevant hereto, a CWL Consultant for the MDHHS Division of Child Welfare Licensing and was responsible for conducting onsite inspections of the JDF to determine compliance with state law and licensing rules, providing technical assistance and consultation to improve the quality of service and investigating complaints alleging violations of licensing rules or law, and ensuring the protection to children who are receiving care from the JDF by enforcing rules and laws such as the Child Care Organizations Act (1973 PA 116). He is being sued in his individual capacity for actions taken under color of law.

46. Defendant VIVIAN MALLECK, is and was at all times relevant hereto, a CWL Consultant for the MDHHS Division of Child Welfare Licensing and was responsible for conducting onsite inspections of the JDF to determine compliance with state law and licensing rules, providing technical assistance and consultation to improve the quality of service and investigating complaints alleging violations of licensing rules or law, and ensuring the protection to children who are receiving care from the JDF by enforcing rules and laws such as the Child Care Organizations Act (1973 PA 116). He is being sued in his individual capacity for actions taken under color of law.

#### **IV. STATEMENT OF FACTS**

##### **A. The Deplorable Conditions of Detention for Youth at the JDF**

47. Defendant Wayne County operates the JDF, which is the largest of the state's 26 county or court-operated juvenile detention facilities.

48. The JDF houses boys and girls between the ages of 9 and 18.

49. Most of the children housed in the JDF are children of color who have been detained for alleged offenses resulting from life conditions of poverty, mental illness, substance abuse, and parental neglect.

50. Some children are housed in the JDF facility while they are waiting adjudication related to juvenile charges. After adjudication, the child is supposed to

be either released from the facility with or without sentencing/probationary terms, or they are sentenced and ordered by a judge to be transferred to a state residential treatment facility to serve out their sentence and undergo special health care treatment and counseling before they are released.

51. While children who are adjudicated are supposed to be released from the JDF facility with or without sentencing/probationary terms, or they are sentenced and ordered by a judge to be transferred to a state residential treatment facility to serve out their sentence and undergo special health care treatment and counseling, at all times relevant hereto, a large percentage of the children housed in the JDF had already been adjudicated but were required to stay in the JDF because of a lack of state residential treatment facilities.

52. The MDHHS is responsible for securing residential treatment facilities to which the children are sent after they are adjudicated, sentenced and ordered into treatment.

53. For years, the MDHSS has failed to provide a sufficient number of state-licensed placement beds for adjudicated children.

54. In the spring of 2022, the JDF struggled with understaffing and overcrowding so severe that it was operating under a “temporary disaster” plan.<sup>5</sup>

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<sup>5</sup> <https://www.freep.com/story/news/local/michigan/wayne/2022/09/23/jdf-wayne-county-juvenile-jail-complaints/69510344007/>

55. While housed in the JDF, children are supposed to be provided with basic care, including recreational time out of their rooms, daily showers, education, mental health care, medical care, and vital medication.

56. For years prior to T.M.'s detention at JDF, numerous complaints were made to the JDF that it was confining youths to their rooms for extended periods of time, depriving them of basic care, including daily showers, recreation time and vital medication.<sup>6</sup>

57. In April of 2022, the MDHHS approved the JDF's request for a waiver of licensing rules – variance-allowing the JDF to operate with fewer staff and allowing the JDF to lock up children in their rooms facility-wide when there were not enough workers.<sup>7</sup>

58. Pursuant to the federal Prison Rape Elimination Act (PREA), which applies to JDF, the resident to staff ratio in a juvenile detention facility is required to be no less than 10 to 1. The ratio at the JDF was 20 to 1.<sup>8</sup>

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<sup>6</sup> <https://www.freep.com/story/news/local/michigan/wayne/2022/09/23/jdf-wayne-county-juvenile-jail-complaints/69510344007/>

<sup>7</sup> <https://www.freep.com/story/news/local/michigan/wayne/2022/09/23/jdf-wayne-county-juvenile-jail-complaints/69510344007/>

<sup>8</sup> Michigan Senate Appropriations Subcommittee Emergency Hearing on March 22, 2023. <https://committees.senate.michigan.gov/details?com=DHHS&sessionId=15>

59. Licensing rules prohibit seclusion except in narrow, special circumstances, and when seclusion is imposed, it must not be for more than three days.

60. Placing children in seclusion/solitary confinement which involves isolating them in small cells between 22 and 24 hours a day, as a way of discipline, behavior control and sometimes even for administrative convenience, has been shown to cause significant neurological and psychological damage, and can even lead to suicide in the most serious cases.

61. Under PREA, detention centers must afford youths the opportunity for daily large-muscle exercise, and to take part in special education services, programs and work opportunities. *PREA Standard § 115.14.*

62. Secluding a child to a small room for over 20 hours a day amounts to solitary confinement and cruel and unusual treatment.

63. After the variance was granted, JDF confined children to their rooms for days with no recreation time, educational services, or showers.<sup>9</sup>

64. After being confined to their rooms for days without showers, education, and recreation time, JDF youths predictably became distraught and angry and began to act out.

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<sup>9</sup> <https://www.freep.com/story/news/investigations/2022/10/28/wayne-county-juvenile-jail-jdf/69597822007/>

65. In May of 2022, after the rules variance was granted, police were called to JDF to control a group of 18 residents who had gotten out of their secured rooms after a youth had popped a lock and snagged a staffer's set of keys. The residents then destroyed property and fought each other.<sup>10</sup>

66. After the MDHHS granted the variances, multiple complaints regarding the conditions of the JDF were lodged with the MDHHS about the abysmal conditions for youth at the JDF which resulted in multiple licensing violation investigations by the state commencing as early as August of 2022.

67. The MDHHS's failure to take appropriate steps to address the lack of state-licensed placement beds for adjudicated youths resulted in youth residents at the JDF languishing in the facility for months after their cases had been adjudicated, while waiting to serve out their sentences and receive the necessary health care treatment and counseling ordered by the judge required before they could be released back to their home. This situation has unjustly extended the youths' sentencing and punishment.

68. In September of 2022, nearly half of the 140 youths held in the JDF were ordered by judges into residential treatment and counseling but were awaiting

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<sup>10</sup> <https://www.freep.com/story/news/local/michigan/wayne/2022/09/23/jdf-wayne-county-juvenile-jail-complaints/69510344007/>

placement, some on standby for months. In one instance, a child was in JDF custody for 800 days.<sup>11</sup>

69. Other children for whom no placement could be found were sent out-of-state at taxpayer expense.

70. In October 2022, Wayne County transferred the JDF Detroit population to the William Dickerson Juvenile Detention Facility (Dickerson) located in Hamtramck, Michigan.

71. Dickerson was built to house 80 adults, was never designed or modified to safely hold children, and was never designed or modified to handle a greater number of residents of any age.

72. As of December 2022, 138 juveniles were housed at Dickerson JDF with 65 of those 138 children waiting to be placed in a treatment facility.<sup>12</sup>

73. Since October of 2022, youth housed in the Dickerson JDF were largely left to educate themselves because the school that was providing services to the JDF in Detroit was not authorized to operate in locations other than Detroit.

74. Even before the move to Dickerson, the JDF was providing inadequate education to the youth residents- a teacher's presence in the facility was sporadic,

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<sup>11</sup> <https://www.freep.com/story/news/local/michigan/2022/10/20/whitmer-juvenile-treatment-shortage-michigan/69577383007/>

<sup>12</sup> <https://www.freep.com/story/news/investigations/2022/12/16/teachers-absent-wayne-county-juvenile-jail/69728001007/>

and youth were not given writing instruments with which to complete schoolwork packets.<sup>13</sup>

75. In January of 2023, Wayne County and the MDHHS continued to point fingers at one another for the overcrowded and understaffed conditions at the JDF and the lack of state residential treatment facilities resulting in adjudicated youths being housed at the JDF after they had been ordered into residential treatment facilities to receive treatment and counseling as part of their sentence before they could be released into the community.

76. In a letter dated January 24, 2023, from Wayne County Executive, Defendant Warren C. Evans to Governor Gretchen Whitmer, Warren wrote:

“I write to express to you my ongoing concern regarding the state’s refusal to accept youths that are rightfully yours.... The severe shortage of state-licensed placement beds for adjudicated delinquent youth and the state’s own failure to take adequate steps to address this problem has now directly impacted the operations of the WCJDF. As of this writing, 150 youth are housed at the WCJDF. Seventy of these youths are your wards awaiting placement in a state-licensed child-caring institution. The state’s ...inability to execute a plan to increase capacity for adjudicated youth, has created and subsequently exacerbated the crisis at our JDF.”

“The present shortage of juvenile justice services was foreseeable and avoidable...”

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“... We understand that there is a nearly two-year waiting list for secure residential placement. **This is completely unacceptable condition**

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<sup>13</sup> <https://www.freep.com/story/news/investigations/2022/12/16/teachers-absent-wayne-county-juvenile-jail/69728001007/>

**that requires action from your administration....** However, the state must lead the state licenses Child Caring institutions and is responsible for ensuring that children adjudicated delinquent by a Michigan court have reasonable, assured access to critical services. Children should not be left to languish in detention facilities that were never intended to house them on long-term basis. **However, through the collective inaction of MDHHS, this is the reality we now face.**" (emphasis added)

77. MDHHS responded to Defendant Evans' letter via email written by Defendant Demetrius Starling, Senior Deputy Director Children's Services Administration MDHHS, basically directing Wayne County to implement more community-based treatment and supervision options.

78. Defendant Evans responded to Defendant Starling's email in a letter dated February 9, 2023, writing:

"Disappointingly, your email to Court and County officials completely misses the central problem Wayne County faces-a lack of secure and non-secure residential placement beds, which has caused an unprecedented number of adjudicated youths to languish in detention, waiting for a placement that may never materialize..."

79. Further objecting to the state placing the blame and burden of taking action to address the problems on Wayne County, Evans emphasized in his February 9, 2023 letter to Defendant Starling:

"the vast majority of the adjudicated youths detained at the JDF require out-of-home placement because of the severity of the offense for which they were adjudicated or for complex treatment needs....**the State has played a large part in creating( the problem) but has done nothing tangible to fix.**"( emphasis added)

80. As of March of 2023, there were only 160 therapeutic beds in the entire

state. Previously there were 500.<sup>14</sup>

81. As a result of the overcrowding and understaffing conditions at the JDF and complaints that youths were being locked in their rooms for extended periods of time, the Wayne County Defendants implemented a policy, custom and practice of allowing the youths to be out of their rooms without supervision.

82. In 2023, Wayne County Defendants also implemented a policy, custom, and practice and custom of no longer requiring JDF staff responsible to monitor the JDF youth, to keep the youth within their line of sight or to make rounds every 15 minutes to check on the location of the youth and instead stay in the Control Room and monitor the youth from inside the room although the staff did not have direct visual contact to all the rooms from the Control Room.

83. The Michigan Welfare Act, MCL 400.115, et seq. promulgates the Licensing Rules for Child Caring Institutions governing the conditions of the juvenile detention facilities. These Michigan Administrative Rules are set forth in the MDHHS's Juvenile Justice Residential Policy Manual (JJPM) and the Department of Consumer and Industry Service Division of Child Welfare Licensing for Juvenile Facilities. As set forth in the JJPM:

The purpose of this policy is to ensure facility staff, including contractors, sub-contractors, interns and volunteers avoid exposing youth to actual or potentially negative influences in compliance with the Prison Rape Elimination Act National Standards Subpart D,

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<sup>14</sup> <https://cloud.castus.tv/vod/misenate/video/641c5bded3cb3b00089b4009?page=HOME>

Standards for Juvenile Facilities, Child Caring Institution licensing rules and the Michigan Department of Health and Human Services (MDHHS)/State of Michigan hiring guidelines and rules.

84. At all times relevant hereto, Defendants engaged in repeated and egregious violations of the Michigan Administrative Code, including but not limited to violations of:

- a. Sufficiency of Staff- R 400.4126;
- b. Staff to Resident Ratio- R 400.4127;
- c. Criminal History Check- R 400.4112;
- d. Intervention Standards and Prohibitions- R 400.4158; and
- e. Performing variable eye-on 15 interval checks on youth.

**B. T.M. Inhumane Treatment and Sexual and Physical Assault While Housed at the JDF**

85. Plaintiff's Next Friend, T. M., was at all times relevant hereto 11 and 12 years old and a youthful resident at the JDF from February 2022 to March of 2022, from April of 2022 to July of 2022, and from August of 2022 to March 16, 2023.

86. During T.M.'s detention within the JDF, he was subjected to the following inhumane conditions of detention, among others, which constituted cruel and unusual punishment:

- a. Prolonged time locked up in his room for 22 to 24 hours a day;
- b. Overcrowding of the facility;
- c. Extended periods of solitary confinement;
- d. Denial of mental health care;
- e. Denial of behavioral treatment;
- f. Denial of medical health care;

- g. Denial of education;
- h. Denial of proper hygiene, including regular showers;
- i. Denial of sufficient food and sustenance;
- j. Denial of proper supervision;
- k. Denial of physical exercise;
- l. Denial of access to recipient rights;
- m. Denial of visitation rights;
- n. Denial of attorney visits;
- o. Sexual harassment;
- p. Sexual assault by residents;;
- q. Physical assault by residents;
- r. Failure to perform risk assessments and separate him from substantially older residents and or separation based on risk assessment ;
- s. Failure to provide required staff/resident ratios as required by Prison Rape Elimination Act (PREA);
- t. Failure to obtain information from T.M. and other residents necessary for proper placement in housing, beds, programs, education, and work assignments in violation of PREA;
- u. Failure to properly train and educate staff in violation of PREA;
- v. Failure to provide adequate reporting mechanisms for threatened harm; and
- w. Failure to provide adequate monitoring and supervision.

87. On March 14, 2023, T.M. was being housed in Unit A of the Health and Wellness Pod. The Health and Wellness Pod has three units- Unit A, B and C.

88. On March 14, 2023, T.M. complained to JDF staff that he was being physically threatened by another resident.

89. Following T.M.'s complaint, at approximately 6:16 pm, JDF staff physically transferred T.M. from Unit A to Unit B of the Health and Wellness Pod.

90. At the time that JDF staff transferred T.M. to the Unit B of the Health and Wellness Pod, staff and supervision knew that it was dangerous to transfer T.M.

to this Unit B because twin brothers were housed in the Unit B and there was a policy not to house relatives/co-defendants on the same unit because of differences and influence they may have. (MSP Investigative Report, June 13, 2023, Supplemental Date, page 3 of 3, attached as Exhibit 3).

91. Prior to T.M. being transferred to Unit B, a staff member told his supervisor that it was dangerous to transfer him to Unit B. (MSP Investigative Report, March 29, 2023, Supplemental Date, page 4 of 10, attached as Exhibit 3).

92. On March 14 and 15th, 2023, there were 5 staff Persons and 2 Supervisors assigned to the Health and Wellness Pod, as follows:

- a. Staff Person 1 worked the 3 p.m. to 11 p.m. shift;
- b. Staff Person 2 worked the 3 p.m to 11 p.m shift ;
- c. Staff Person 3, worked the 3 p.m. to 11 p.m shift ;
- d. Staff Person 4, worked the 11 p.m. to 7 a.m. shift ;
- e. Staff Person 5 worked the 11p.m. to 7 a.m. shift;
- f. Supervisor 1 worked the 3 p.m. to 11 p.m. shift;
- g. Supervisor 2 worked the 11 p.m. to 7 a.m. shift.

93. As reported in a Special Investigative Report (SIR) dated January 3, 2024, No. 2023C0000325, completed by Defendant MDHHS ( attached as Exhibit 2), Wayne County Defendants failed to conduct a criminal background history and hired staff persons and supervisors who were responsible for supervising,

monitoring and protecting T.M. who had a history of child abuse or neglect and/or lacked the ability to perform duties of the position assigned and/or the experience to perform the duties of the position assigned.

94. On March 14<sup>th</sup> and 15<sup>th</sup>, 2023, there were five other male residents in Unit B identified herein as Youth A (T.M.), Youth B, C, D, E, and F.

95. At least one of the male residents was 18 years old or older.

96. Upon information in belief, at least one of the residents in Unit B had a history of sexual misconduct and/or had been charged of crimes involving sexual misconduct.

97. During the night of March 14, 2023, and morning of March 15, 2023, while in Unit B, T.M. was viciously attacked and beaten and anally raped by Youths B,C,D,E and F.

98. Prior to T.M being physically and sexually assaulted, JDF supervision directed staff to allow residents to stay out of their rooms all the times. (MSP Investigative Report, March 29<sup>th</sup>, 2023, Supplemental Date, page 8 of 10, Exhibit 3).

99. Prior to T. M. being physically and sexually assaulted, JDF Defendants knew that youth were staying in each other's rooms all the time, including boys in Unit B. (MSP Investigative Report, March 29<sup>th</sup>, 2023, Supplemental Date, page 4 of 10, Exhibit 3)

100. Prior to T.M. being physically and sexually assaulted, a JDF staff member told his supervisor that due to residents being unsecured and out of each other's rooms he was worried there was potential for sexual inappropriate behavior and assaults. (MSP Investigative Report, March 29<sup>th</sup>, 2023, Supplemental Date, page 4 of 10, Exhibit 3)

101. As reported in a Special Investigative Report (SIR) dated January 3, 2024, No. 2023C0000325, completed by Defendant MDHHS (attached as Exhibit 2), JDF video surveillance shows the following events that transpired in Unit B of the Health and Wellness Pod on March 14<sup>th</sup> and 15<sup>th</sup>, 2023, between 06:16 pm to 01:29 am:

- a. 06:16 pm - Youth A (T.M.) is escorted onto unit-B and staff leave.
- b. 08:00 pm - Staff did not enter the unit to lock-down youth in their respective cells.
- c. 08:41 pm – Supervisor 1 exits unit-B with a nurse.
- d. 09:18 pm – Youth A (T.M.), Youth B, Youth C, Youth D, Youth E and Youth F are inside room 10 -up (upstairs room 10).
- e. 09:20 pm – Staff Person 2 enters unit-B with a nurse and exits at 09:23 pm.
- f. 09:21 pm – All youth exit room 10-up and walk downstairs.  
Youth A appears to be wiping tears from his eyes and face.

- g. 09:38 pm – **Youth surround Youth A(T.M.) who has his hands up. Youth D and Youth E are observed punching Youth A as he is seated at a table. Staff members can see this assault as it happens but do not enter the unit.**
- h. 09:51 pm – Youth A(T.M.) enters room 7-up along with all other youth who continually walk in and out of the room. Staff do not enter the unit.
- i. 10:05 pm – All youth, except Youth A(T.M.), exit room 7-up. Staff Person 2 only stands at the door to speak with youth and does not fully enter the unit with a nurse. All youth, except for Youth A, are observed entering and exiting room 7-up.
- j. 10:08 pm – All youth, except for Youth A(T.M.), are downstairs.
- k. 10:40 pm – Youth A(T.M.) exits room 7-up and walks downstairs.
- l. 10:48 pm – Staff Person 2 opens the unit door and gives Youth E towels. Staff Person 2 leaves and comes back and opens the unit door but does not fully enter the unit before exiting.
- m. 11:05 pm – Youth A(T.M.) is observed walking on the lower level of the unit with a towel on his head.
- n. 11:14:25 pm - Staff Person 2 leaves the control room and hands a tee shirt to an unknown youth on unit B.

- o. 11:14:26 pm - Youth A(T.M.) is observed trying to run out of the unit past Staff Person 2. Staff Person 2 shoves Youth A(T.M.) back into the unit and closes the door.
- p. 11:32 pm – Youth A(T.M.) is still observed walking on the lower level of the unit with a towel on his head.
- q. 12:13 pm – Staff Person 5 looks into unit B but does not enter.
- r. 12:24 pm – Staff Person 6 slides paperwork under Unit B door but does not enter.
- s. 12:33 pm – Staff Person 5 looks into unit B door but does not enter. It is noted that a pillar blocks video surveillance of the room 10-down door.
- t. 01:16 am – **Youth A (T.M.) stands up on a table in the common area and appears naked. 22 seconds later Staff Person 4 is observed at the unit B door.**
- u. 01:17 am – Youth E and Youth F begin assaulting Youth A(T.M.) and go out of camera view. Staff Person 4 and Staff Person 5 walk toward Unit B door from outside the unit.
- v. 01:23 am – Supervisor 2 enters the control room.
- w. 01:26 am – **Youth A (T.M.) is assaulted at tables.**

- x. 01:27 am – **Supervisor 1 arrives and enters unit B as Youth E continues to assault Youth A(T.M.).** Staff Person 4 and Staff Person 5 enter unit B, and escort Youth A (T.M.) out of unit B.

102. During the timeframe set forth above, Youth A (T.M.) was repeatedly physically assaulted and gang raped by Youths B,C,D,E, and F.

103. At all times relevant hereto, Staff Persons 1-5 and Supervisors 1 and 2 either observed T.M. being physically and sexually assaulted or could have seen the assaults, but for deliberate indifference, and/or they knew or should have known that the physical and sexual assaults were occurring or were substantially likely to occur.

104. At no time during T.M.'s physical and sexual assaults did JDF Staff Persons 1- 5 or Supervisors 1 and 2 intervene to stop the assaults.

105. JDF staff and supervision failed to take action to prevent T.M.'s physical and sexual assaults because staff and supervision had been directed by JDF management and administration to:

- a. Allow the residents to stay out of their rooms all the time;
- b. Stay in Unit B's Control Room and not come out onto the Unit to perform 15-minute whereabouts checks of the residents;
- c. Not intervene when residents get into physical altercations;
- d. Not intervene when residents get into sexual alterations;
- e. Not keep the residents in their line of vision but instead stay in the

Control Room which does not provide a full range of vision for Unit B rooms and the common areas; and

f. Not secure vacant rooms.

106. As a result of this physical and sexual assaults, T.M. sustained severe traumatic physical and psychological injuries, including an injury to his eye, wrist, ribs, and gash to his head.

107. Following the physical and sexual assaults, T.M. was transported to Detroit Children's Hospital.

108. Wayne County Defendants failed to notify T.M.'s mother that he had been taken to the hospital due to sexual and physical assaults until hours after he was admitted into the hospital.

109. JDF Defendants failed to tell T.M.'s mother that he had been a victim of a sexual assault until the evening of March 15th.

110. At no time while T.M. was hospitalized was T.M.'s mother permitted to be present with her son to provide him with comfort, support, and consent and take part in important treatment and other decisions.

111. T.M.'s mother was not permitted to see T.M. until he was released from the hospital on March 15th, returned to the JDF/ Dickerson facility and released from JDF by a judge on March 16th.

112. On March 21, 2023, after T.M. was sexually and physically assaulted, MDHHS Defendants issued a Corrective Action Plan (CAP) that identified licensing violations and set forth a 15-part Plan for Compliance Achievements (March 21, 2023, CAP attached hereto as Exhibit 4).

113. The actions laid out in the March 21, 2023, CAP could and should have been taken by the MDHHS Defendants months before T.M was subjected to inhumane conditions of confinement, including being sexually and physically assaulted.

114. The 15-part Plan for Compliance Achievements included:

- a. Directing the JDC/Dickerson to begin utilizing day programming, such as Team Wellness day programming;
- b. Directing the JDC/ Dickerson to provide the MDHHS with unlimited and ongoing access to the entirety of all youth case files, including all assessments, reports, evaluations, progress notes, etc;
- c. Directing the JDC/Dickerson to provide the MDHHS with unlimited and ongoing access to all areas of the facility which house youth on a 24/7 basis. MDHHS staff shall be allowed to possess and use phones and computers while on-site;
- d. Directing the Chief Administrator to provide documentation by noon each Monday indicating which days they were present on-site at the facility the preceding week (Saturday-Sunday). This documentation will include a “punch list” of required daily checks completed (to include mattresses/blankets/clean and well-fitting clothes, meals provided, clean rooms, designated showers completed, rec time completed etc. for each youth);
- e. Directing the JDC/Dickerson to develop a training plan for all staff to include trauma informed training and restraint training and provided to MDHHS;
- f. Requiring the Chief Administrator to attest that the agency is in full compliance with licensing rule R 400.4158(1)(b)(i)(that food cannot be withheld);

- g. Requiring the JDC/Dickerson to provide a minimum shower 3xweek for all youth. All youth will be provided with appropriate hygiene items as required by rule 400.4148 including a toothbrush and toothpaste daily;
- h. Requiring that the JDC/Dickerson permit recreation time to all youth. Facility will assess any opportunities for outside recreation for small groups (perhaps 3-5);
- i. Ensuring youth have recipient rights access and training staff on the process to allow youth access;
- j. Establishing a youth advisory council with a small number of youth as members of the council;
- k. Requiring that if there are soiled towels, linens, clothing, etc. the JDC will provide clean ones when needed, at minimum once per week. Operations manager and supervisors will ensure this is completed as part of the punch list;
- l. Requiring that JDC/Dickerson staff do checks as prescribed in the rules. If a youth floods their cell or there is a water leak, staff clean and sanitize room and document in the log book, and requiring that this item be completed weekly;
- m. Requiring that youth who refuse to eat or are viewed to be malnourished receive a dietary consult and follow all recommendations and document. Consultations must be completed with 48-hours of noticing signs of malnutrition;
- n. Requiring that in compliance with rule 400.4150 any incident resulting in serious injury of a resident or illness requiring inpatient hospitalization, shall be reported to the parent/ legal guardian, responsible referring agency, and the licensing authority and Chief Administrator as soon as possible, but not more than 24 hours after the incident; and
- o. Requiring that if the sheriff's dept. engages with any youth, the facility will notify DCWL, per the rule requirement, "as soon as possible but not more than 24 hours after the incident". Any suspected abuse or neglect will be reported to centralized intake immediately.

115. If Defendants had taken the actions laid out in the March 21, 2023 CAP, the inhumane conditions of confinement that amounted to cruel and unusual punishment and a sexually hostile detention environment for T.M. would not have

occurred and would have prevented T.M. from being sexually and physically assaulted.

116. Defendants had the power and the financial means to implement the above corrective actions long before T.M.'s detention and sexual and physical assaults.

117. Defendants had actual and constructive notice that the conditions of the JDF were such that if these and other actions were not taken, it was substantially certain that a youth in the facility would sustain cruel and unusual conditions of detention, a sexually hostile prison environment would be created, and serious injury, including severe physical and sexual assaults would occur.

118. As a direct and proximate result of Defendants' actions, T.M. has suffered severe and permanent traumatic physical and psychological damages, including physical injuries to his entire body, including his eye, head, body, ribs, buttocks, and rectum; , and cognitive damage resulting in exacerbation of various diagnosis related to behavioral issues and ADHD; a permanent loss of trust in authority figures and in those who are responsible for protecting his safety and welfare, and; loss in earning capacity.

**V.**  
**DEFENDANTS' UNCONSTITUTIONAL CONDUCT**

119. Plaintiffs incorporate by reference the foregoing paragraphs of this Complaint as though fully set forth herein.

120. Wayne County Policymaker Defendants (Defendants EVANS, TURFEE, FERNANEZ) violated T.M.'s rights under Fourteenth and Eighth Amendments by implementing policies that were deliberately indifferent to the health and welfare of T.M. where there was a significant risk of sexual and other violence and which would foreseeably lead to Plaintiff being physically and sexually assaulted. They further created and ratified customs and practices that resulted in the violation of T.M.'s constitutional rights. These policies, customs and practices included but are not limited to:

- a. Confining youths to their rooms for extended periods of time, depriving them of basic care, including daily showers, recreation time and vital medication;
- b. Reducing the staff resident ratio to 20 to 1 in violation of PREA;
- c. Placing younger residents, including Plaintiff, in confinement with older residents;
- d. Confining youth residents with other residents who have a history of sexual misconduct;

- e. Allowing youth residents to be unsecured and out of their rooms;
- f. Not requiring JDF staff to keep the youth residents within the line of sight;
- g. Not requiring JDF staff to conduct 15 minute round checks;
- h. Not requiring JDF staff to secure vacant rooms;
- i. Not requiring JDF staff to intervene when residents get into physical altercations;
- j. Directing supervision to remain in the Unit Control Room during the shift and not come out onto the floor;

121. The Policymaker Defendants are individually liable for the unconstitutional conditions at the JDF and are responsible for establishing the unconstitutional policies that caused the harm to T.M.

122. The Wayne County JDF administrators and managers ( Defendants ROLAND, BARBE, STEWART, and DOE 1 ) violated T.M.'s Eighth and Fourteenth Constitutional rights by creating inhumane conditions at the JDF by:

- a. Their failure to properly oversee the JDF to ensure that T.M. and other youth were being properly cared for and supervised;
- b. Their failure to enforce rule and regulations that would have prevented inhumane conditions at the JDF and prevented physical and sexual assaults;

- c. Their ratification and acquiesce to customs and practices, including allowing youth residents to be out of their rooms without supervision, that subjected T.M. to inhumane conditions at the JDF, including physical and sexual assaults
- d. Placing younger residents, including Plaintiff, in confinement with older residents;
- e. Confining youth residents with other residents who have a history of sexual misconduct.
- f. Not requiring JDF staff to keep the youth residents within the line of sight;
- g. Not requiring JDF staff to conduct 15 -minute round checks;
- h. Not requiring JDF staff to secure vacant rooms;
- i. Not requiring JDF staff to intervene when residents get into physical altercations;
- j. Directing supervision to remain in the Unit Control Room during the shift and not come out onto the floor.

123. MDHSS Policymaker Defendants ( Defendants HERTEL, STERLING, YAGER, and BROTHERRSON), by their actions and failure to act and their unconstitutional policies have violated T.M.'s rights under the Eighth and Fourteenth Amendments by, among other things:

- a. Failing to secure residential treatment facilities so that adjudicated youth can obtain the necessary care to complete their sentences and not remain for extended periods of time in the JDF;
- b. Granting the JDF variances allowing the JDF to operate with fewer staff and allowing the JDF to lock up the youth in their rooms facility-wide when there were not enough workers;
- c. Continuing to license the JDF after it repeatedly violated rules and regulations that created inhumane conditions for Plaintiff and others and subjected Plaintiff to physical and sexual violence;
- d. Failing to monitor and oversee the JDF to ensure that it was providing proper care, education, health, and protection to Plaintiff and other JDF youth.
- e. Their actions in licensing the JDF when it repeatedly failed to abide by the basic rules and regulations necessary to provide a safe detention environment for Plaintiff and others;

124. Defendants BARR and MALLECK as a MDHHS Consultants by their actions and failure to act violated T.M.'s rights under the Eighth and Fourteenth Amendments by, among other things:

- a. Their deliberate indifference in conducting onsite inspections in identifying obvious violations of rules and regulations that would

foreseeably lead to inhumane conditions for T.M. and other youth and T.M. being subject to physical and sexual violence;

- b. Their deliberate indifference in conducting thorough investigations into violations of rules and regulations that would foreseeably lead to inhumane conditions for T.M. and other youth and T.M. being subject to physical and sexual violence;
- c. Their failure to enforce rules and laws such as, among others, those under the Child Care Organization Act (1973 PA 116).

125. Wayne County JDF staff members and supervisors (Defendants STAFF MEMBER 1- 5 and Supervisors 1 and 2 and DOES 1 and 2), violated T.M.'s rights under Eighth and Fourteenth Amendments by, among other things:

- a. Receiving T.M.'s report of being physically threatened by intentionally and recklessly placing him in Unit B with a group that included residents who were related as brothers, at least one resident with a record of criminal sexual conduct, and at least one resident over the age of 18, which the Defendants knew or should have known was dangerous to T.M., who at age 12 was particularly vulnerable to physical and sexual abuse in these circumstances;

- b. After placing T.M. in Unit B, staying in Unit B's Control Room and not coming out onto the Unit to perform 15-minute whereabouts checks of the residents;
- c. Not intervening when T.M. was physically assaulted by other youth residents;
- d. Not intervening when youth residents sexually assaulted T.M.;
- e. Failing to keep the residents in their line of vision but instead staying in the Control Room which did not provide a full range of vision for Unit B rooms and the common areas;
- f. Not securing vacant rooms;
- g. Allowing Youth B-F to roam B Unit without proper supervision;  
and
- h. Shoving T.M. back into Unit B and closing the door to Unit B when T.M. tried to get away.

126. Wayne County and MDHSS policymaker Defendants and MDHSS consultants had sufficient knowledge, including through the statutes and regulations established in PREA and through its own internal policies and correctional knowledge, to know that youthful residents, in particular T.M., was at substantial risk of harm, and failed to adequately protect him.

127. Wayne County administrative, management, staff and supervisor Defendants had actual knowledge that T.M. was at high risk, and failed to adequately protect him.

128. Defendants' unconstitutional policies and practices and customs and practices and their actions and inactions encouraged physical and sexual assaults, harassment, degrading treatment and privacy violations of the youthful residents, including T.M. by other youthful residents.

129. Defendants unconstitutional policies and practices and customs and practices and actions and inactions deprived T.M. of his constitutional right to bodily integrity and right to privacy without due process of law in violation of the Eighth and Fourteenth Amendments of the United States Constitution and 42 U.S.C. § 1983.

130. The deprivation of constitutional rights and the injuries and harm to T.M. alleged in this Complaint are the direct result of official policy, custom and practices of Wayne County and MDHHS Policymakers and administrative and management Defendants.

**VI.**  
**LEGAL CLAIMS**

**COUNT I**  
**Violation of the Fourteenth Amendment (42 U.S.C. § 1983)**  
*(Plaintiff versus All Defendants)*

131. Plaintiffs incorporate by reference each and every allegation contained in the preceding paragraphs as if set forth fully herein.

132. This case arises out of periods of detention in which T.M. was housed as a pretrial detainee and as a post-adjudication detainee.

133. Under the Fourteenth Amendment, juvenile detention officials are required to provide for the reasonable health and safety of youth in their custody as pretrial detainees.

134. During T.M.'s detention as a pretrial detainee, Defendants violated Plaintiff's due process rights by subjecting him to inhumane conditions of detainment and failing to adequately safeguard his health and safety resulting in T.M. being subjected to deplorable and inhumane detention conditions and physically and sexually assaulted.

135. As set forth above, Defendants' actions were deliberate, not accidental, and were reckless in the face of an unjustifiably high risk of harm that was either known to Defendants, or so obvious that it should have been known.

136. As set forth above, each of the Defendant officers acted intentionally in a manner that put T.M. at substantial risk of harm, without taking reasonable steps to abate that risk, and by failing to do so caused T.M.'s injuries.

137. The conditions of confinement created and maintained by Defendants put T.M. at substantial risk of serious harm.

138. Reasonable officers in Defendants' position in the circumstances described in this Complaint would have appreciated the high degree of risk involved and the obvious consequences of their intentional conduct of placing T.M. into Unit B under the circumstances presented, and their intentional conduct of ignoring the beating and abuse of T.M. in Unit B, yet Defendants did not take reasonable available measures to abate that risk.

139. Defendants caused T.M.'s harms and injuries by not taking reasonable measures to monitor the activities within unit B and to intervene when there were indications that T.M. was being subjected to physical and sexual abuse in Unit B.

140. The conditions of detainment that Defendants subjected Plaintiff to were unconstitutional and amounted to cruel and unusual punishment, and an express intent to punish on the part of Defendants and /or the conditions of detainment were not rationally related to a legitimate governmental objective and/or were excessive in relation to that purpose.

141. Defendants violated Plaintiff's constitutional rights.

142. The constitutional rights that Defendants violated are and were clearly established.

143. Accordingly, Defendants, as supervisors, direct participants, and policy makers for Wayne County and the MDHHS, have violated Plaintiff's rights under the Fourteenth Amendment.

WHEREFORE, Plaintiff, as Next of Friend of T.M., a minor, respectfully requests this Honorable Court enter Judgment in her favor and against Defendant in an amount in excess of \$1,000,000.00 exclusive of costs, interest, attorney fees, and punitive and/or exemplary damages.

**COUNT II**  
**Violation of the Eight Amendment (42 U.S.C. § 1983)**  
*(Plaintiff v. All Defendants)*

144. Plaintiffs incorporate by reference each and every allegation contained in the preceding paragraphs as if set forth fully herein.

145. The Eighth Amendment to the United States Constitution, as incorporated in and enforced against Defendants through the Fourteenth Amendment as well as through 42 U.S.C. § 1983, provides post-adjudication detainees the right to be free from cruel and unusual punishment.

146. Under the Eighth Amendment, “prison officials have a duty...to protect prisoners from violence at the hands of other prisoners.” *Farmer*, 511 U.S. at 833.

147. This constitutional right was clearly established such that all of the Defendants in this action were on notice that their actions were unconstitutional at the time of the events giving rise to this case. *Id.*

148. In this case, Defendants violated T.M.'s right to be free from cruel and unusual punishment when, as alleged above, they held him under conditions posing a substantial risk of harm.

149. When Defendants received T.M.'s report that he was being physically threatened and responded by placing him into Unit B with residents whom they knew were related as brothers, whom they knew included at least one resident over the age of 18, and whom they knew included at least one person with a history of criminal sexual conduct, they were aware of facts from which the inference could be drawn that a substantial risk of harm existed and they actually drew the inference that a substantial risk of harm existed.

150. Defendants consciously disregarded those known risks when they placed T.M. in Unit B under the circumstances of this case, failed to lock down the residents inside of Unit B, allowed T.M. to remain inside Unit B when they knew or should have known he was being beaten and sexually assaulted, and when they shoved T.M. back in to Unit B and closed the door when he tried to leave.

151. In addition, in creating, maintaining, and failing to remediate the deplorable conditions alleged in this Complaint, and has determined through the

investigations of those conditions by Wayne County, the State of Michigan, and or MDHHS, Defendants were aware of facts from which the inference could be drawn that a substantial risk of harm to residents existed, they actually drew the inference that a substantial risk of harm existed, and they consciously disregarded those known risks.

152. Accordingly, Defendants, as supervisors, direct participants, and policy makers for Wayne County and the MDHHS, have violated Plaintiff's rights under the Eighth Amendment.

WHEREFORE, Plaintiff, as Next of Friend of T.M., a minor, respectfully requests this Honorable Court enter Judgment in her favor and against Defendant in an amount in excess of \$1,000,000.00 exclusive of costs, interest, attorney fees, and punitive and/or exemplary damages.

### **COUNT III**

#### **Failure to Train, Inadequate Policies and/or Procedures, Customs and Practices and Failure to Supervise – Deliberate Indifference**

*(Plaintiff v. all Defendants, except Staff Members 1-5)*

153. Plaintiff hereby re-alleges each and every allegation contained in paragraphs 1 through of this Complaint as if fully stated herein.

154. Pursuant to 42 USC § 1983, as well as the Eighth and Fourteenth Amendments to the United States Constitution, Defendants owed Plaintiff's Next of Friend, T.M., a minor certain duties to properly supervise, monitor and train its

detention administrators, managers, supervisors and staff so as to monitor and supervise the detainees so that they would prevent physical and sexual assaults committed on them by other detainees.

155. Defendants have maintained a custom and policy of improper training and supervision of its employees. Defendants are not protected by governmental immunity when following a policy that deprives individuals of their constitutional rights. *Monell v N.Y. City Dep't of Soc. Servs.*, 436 658, 690-91, 692 (1978).

156. Defendants were aware of previous incidents where youthful detainees who were detained at the JDF were physically and sexually assaulted by other detainees.

157. Defendants were aware of the custom and practice of JDF staff members failing to keep youthful detainees within their line of sight, not secured vacant rooms, not intervening when youthful detainees got into physical and sexual altercations, not conducting 15 minute visual checks on the detainees, similar to the actions of Defendants Supervisors 1-3, and Staff Members 1-5.

158. Defendants owed T.M. the following duties and obligations:

- a. To use due care and caution;
- b. To adequately and properly create and promulgate guidelines and policies that comply with the requirements of the Eighth and Fourteenth

Amendments regarding the detention of youthful detainees and the supervision of detainees.

c. To adequately and properly train and supervise JDF detention employees under their supervision on the proper method of supervising youthful detainees and providing for their safety and medical needs and on effectively controlling detainees who have or are suspected to have psychological or psychiatric problems;

d. To avoid hiring or selecting individuals who it knows or should know are incapable of performing their responsibilities or who are likely to misuse or abuse the power conferred on them as employees of the JDF.

159. Defendants breached these duties via its policies, procedures, regulations, customs and/or lack of training and thus exhibited a conscious disregard for the known dangers to youthful detainees, and T.M. specifically, in the following ways, including but not limited to:

a. Defendants' failure to sufficiently staff the JDF with a safe and proper ratio of staff to detainees;

b. Defendants' failure to sufficiently staff the JDF with competent medical personnel and mental health professionals;

c. Defendants' failure to monitor their detention staff and medical personnel to ensure that they adequately monitor and supervise detainees who were vulnerable because of their age and serious medical needs;

d. Defendants' failure to have proper policies and procedures, and training to deal with youthful detainees to ensure that JDF personnel conduct timely and adequate rounds and record their observations of the youthful detainees every 15 minutes as required by their own policies and/or procedures;

e. Defendants' failure to have proper policies and procedures in place to deal with JDF overcrowding;

f. Defendants' failure to have proper policies and procedures, and training to deal with youthful detainees who have threatened physical and sexual violence and to ensure that JDF staff personnel can immediately and appropriately respond and take action when a detainee is in distress and has been threatened with physical and/or sexual violence.

g. Defendants' failure to fully investigate and discipline its JDF personnel and/or medical/mental health personnel who do not abide by its policies and procedures relative to ensuring the safety of the youthful detainees and providing medical care for serious conditions; and,

h. All other breaches learned through the course of discovery.

160. Defendants trained their officials and/or employees and agents in such a reckless and deliberately indifferent manner, that it was inevitable that a youthful detainee would be physically and sexually assaulted by other youthful detainees.

161. Notwithstanding JDF personnel's observation that T.M. was being physically attacked by other detainees, Defendants repeated and acquiesced in the continued practice of not intervening to stop the physical violence placing youthful detainees, such as T.M., in imminent peril of serious physical and psychological injury.

162. The failure of the Defendants to provide training and supervision regarding the prevention of physical and sexual assaults amounts to deliberate indifference to the safety and lives of the detainees of the JDF and particularly T.M.

163. Defendants knew or in the exercise of reasonable care should have known that individual JDF personnel had engaged in misconduct and other violations of the constitutional rights of JDF detainees, more specifically of T.M.

164. Despite knowledge of its aforesaid pattern and practice, the Defendants failed to properly investigate the improper practices and to supervise and train the JDF personnel.

165. Defendants developed a "hands off" policy or custom with regard to the omissions of JDF personnel which encouraged JDF personnel to believe they could

violate the constitutional rights of T.M. with the explicit or tacit approval of the Defendants herein.

166. As a direct and proximate result of the aforementioned conduct and omissions of Defendants, T.M. has suffered the injuries and damages set forth above.

WHEREFORE, Plaintiff, and Next of Friend of T.M., a minor, respectfully requests that this Honorable Court enter judgment in her favor and against Defendants, including punitive damages under 42 U.S.C. § 1983, in excess of \$1,000,000.00 together with interest, costs and attorney's fees.

Respectfully submitted,

Pitt McGehee Palmer Bonanni & Rivers PC

By: s/ Cary S. McGehee  
Cary S. McGehee (P42318)  
Attorney for Plaintiff  
117 W. 4<sup>th</sup> Street, Ste. 200  
Royal Oak, MI 48067  
(248) 398-9800  
[cmcgehee@pittlawpc.com](mailto:cmcgehee@pittlawpc.com)

Dated: July 11, 2024

UNITED STATES DISTRICT COURT  
FOR THE EASTERN DISTRICT OF MICHIGAN  
SOUTHERN DIVISION

TOCARRA MCMULLIN, NEXT OF  
FRIEND TO T. M., a minor,

Plaintiff,

v.

WAYNE COUNTY, d/b/a Wayne County  
Juvenile Detention Center, a political  
subdivision of the State of Michigan;  
WARREN EVANS, in his individual and  
official capacity as Wayne County  
Executive; ASSAD TURFE, Deputy  
Wayne County Executive, in his individual  
capacity; MELISSA FERNANDEZ, in her  
individual capacity as Division Director of  
Wayne County Juvenile and Youth  
Services and Chief Administrator of  
Wayne County Juvenile Detention Center;  
MARK ROLAND, in his individual  
capacity as Deputy Director of  
Administration for the Wayne County  
Juvenile Detention Facility; BRANDON  
BARBER, in his individual capacity as  
Facility Director of the Wayne County  
Juvenile Detention Facility; DOE 1, in her  
capacity as Operations Director of the JDF;  
KIRPHEOUS STEWART, in his  
individual capacity as the Wayne County  
Juvenile Detention Center Deputy Director  
of Operations; JDF STAFF MEMBER 1, in  
his individual capacity; JDF STAFF  
MEMBER 2, in his individual capacity;  
JDF STAFF MEMBER 3, in his individual  
capacity; JDF STAFF MEMBER 4, in his

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individual capacity; JDF STAFF MEMBER 5, in his individual capacity; JDF SUPERVISOR 1, in his individual capacity; JDF SUPERVISOR 2, in his individual capacity; DOE 2 (JDF Juvenile Detention Specialist) in his or her individual capacity; DOE 3 (JDF Team Leader/Supervisor); ELIZABETH HERTEL, in her individual capacity as the Director of the Michigan Department of Health and Human Services; DEMETRUIS STARLING, in his individual capacity as Senior Deputy Director, Department of Health and Human Services; STEVE YAGER, in his individual capacity as the Executive Director of the Division of Child Welfare Licensing of the Michigan Department of Health and Human Services; ASHLEIGH BROTHERSON, in her individual capacity as the Division Director of Child Welfare Licensing for the Michigan Department of Health and Human Services; VIVIAN MALLECK, in her individual capacity as a Licensing Consultant for the Michigan Department of Health and Human Services; CHRISTOPHER BARR, in his individual capacity as a Licensing Consultant for the Michigan Department of Health and Human Services. Jointly and severally,

Defendants.

**JURY DEMAND**

Plaintiff demands a trial by jury of all issues within the causes of action.

Respectfully submitted,

Pitt McGehee Palmer Bonanni & Rivers PC

By: s/ Cary S. McGehee  
Cary S. McGehee (P42318)  
Attorney for Plaintiff  
117 W. 4<sup>th</sup> Street, Ste. 200  
Royal Oak, MI 48067  
(248) 398-9800  
[cmcgehee@pittlawpc.com](mailto:cmcgehee@pittlawpc.com)

Dated: July 11, 2024

UNITED STATES DISTRICT COURT  
FOR THE EASTERN DISTRICT OF MICHIGAN  
SOUTHERN DIVISION

TOCARRA MCMULLIN, NEXT OF  
FRIEND TO T. M., a minor,

Plaintiff,

v.

WAYNE COUNTY, d/b/a Wayne County  
Juvenile Detention Center, a political  
subdivision of the State of Michigan;  
WARREN EVANS, in his individual and  
official capacity as Wayne County Executive;  
ASSAD TURFE, Deputy Wayne County  
Executive, in his individual capacity;  
MELISSA FERNANDEZ, in her individual  
capacity as Division Director of Wayne  
County Juvenile and Youth Services and  
Chief Administrator of Wayne County  
Juvenile Detention Center; MARK  
ROLAND, in his individual capacity as  
Deputy Director of Administration for the  
Wayne County Juvenile Detention Facility;  
BRANDON BARBER, in his individual  
capacity as Facility Director of the Wayne  
County Juvenile Detention Facility; DOE 1,  
in her capacity as Operations Director of the  
JDF; KIRPHEOUS STEWART, in his  
individual capacity as the Wayne County  
Juvenile Detention Center Deputy Director of  
Operations; JDF STAFF MEMBER 1, in his  
individual capacity; JDF STAFF MEMBER  
2, in his individual capacity; JDF STAFF  
MEMBER 3, in his individual capacity; JDF  
STAFF MEMBER 4, in his individual  
capacity; JDF STAFF MEMBER 5, in his

Case no.  
Hon.  
Mag.

individual capacity; JDF SUPERVISOR 1, in his individual capacity; JDF SUPERVISOR 2, in his individual capacity; DOE 2 (JDF Juvenile Detention Specialist) in his or her individual capacity; DOE 3 (JDF Team Leader/Supervisor), in his/her individual capacity; ELIZABETH HERTEL, in her individual capacity as the Director of the Michigan Department of Health and Human Services; DEMETRUIS STARLING, in his individual capacity as Senior Deputy Director of the Department of Health and Human Services; STEVE YAGER, in his individual capacity as the Executive Director of the Division of Child Welfare Licensing of the Michigan Department of Health and Human Services; ASHLEIGH BROTHERTON, in her individual capacity as the Division Director of Child Welfare Licensing for the Michigan Department of Health and Human Services; VIVIAN MALLECK, in her individual capacity as a Licensing Consultant for the Michigan Department of Health and Human Services; CHRISTOPHER BARR, in his individual capacity as a Licensing Consultant for the Michigan Department of Health and Human Services.

Jointly and severally,

Defendants.

**INDEX OF EXHIBITS TO COMPLAINT AND JURY DEMAND**

| <b>Exhibit</b> | <b>Description</b>                        |
|----------------|---|
| 1              | September 29, 2023 SIR, No. 2023C0000340  |
| 2              | January 3, 2024 SIR, No. 2023C0000325     |
| 3              | March 29th, 2023 MSP Investigative Report |
| 4              | March 21, 2023 Corrective Action Plan     |

# **Exhibit 1**



STATE OF MICHIGAN  
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
LANSING

GRETCHEN WHITMER  
GOVERNOR

ELIZABETH HERTEL  
DIRECTOR

September 29, 2023

Melissa Fernandez  
Wayne County Juvenile Detention Center  
3501 Hamtramck Dr.  
Hamtramck, MI, 48211

Re: License #: CE820414010  
SI#: 2023C0000340

Dear Melissa Fernandez:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each rule will be achieved.
- For any repeat violations, why the prior corrective action plan did not result in compliance.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the action steps will be completed or implemented.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

A six-month provisional license is recommended. You must contest or agree to the issuance of a provisional license in writing, on the CWL-4617 within 15 days, with submission of the corrective action plan. If you do not submit the CWL-4617, it will be treated as contested. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available, and you need to speak to someone immediately, please contact the area manager at (616) 204-6992.

Sincerely,

A handwritten signature in cursive script that reads "Venus M. Decker". The signature is written in black ink and is positioned above the typed name.

Venus M. Decker  
Child Welfare Licensing Consultant

enclosure

**MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES  
DIVISION OF CHILD WELFARE LICENSING  
SPECIAL INVESTIGATION REPORT**

**I. IDENTIFYING INFORMATION**

**License #:** CE820414010

**Licensee Group Organization:** County of Wayne

**Licensee Designee:** Melissa Fernandez

**Chief Administrator:** Melissa Fernandez

**Agency Name:** Wayne County Juvenile Detention Center

**Agency Address:** 3501 Hamtramck Dr.  
Hamtramck, MI 48211

**License Status:** Original

**License Expiration Date:** 05/14/2023

**Capacity:** 180

**II. METHODOLOGY**

| <b>Contact Date</b> | <b>Contact Method</b> | <b>Contact Purpose</b>                                    |
|---------------------|-----------------------|---|
| 3/21/2023 9:22 AM   | Phone                 | Initiation  |
| 3/22/23             | Email                 | Requested Documentation                                   |
| 3/23/2023 9:23 AM   | Face-to-Face          | Interviews and observations                               |
| 3/24/2023 9:25 AM   | Email                 | Requested documents and confirmation of safety plans      |
| 3/30/23             | Face to Face          | Interviews and observations                               |
| 4/07/23             | Email                 | Requested documents                                       |
| 4/14/23             | Email                 | Requested documents                                       |
| 4/20/23             | Face to face          | Interviews  |
| 4/20/23             | Face to Face          | Pre-liminary exit   |
| 4/20/23             | Email                 | Email directing all coordination to go through Director 2 |

### III. INVESTIGATION

|  |  |
|--|--|
| <b>Rule Code &amp; Section Description</b> | <b>CCI Rule 400.4407 Facility and premises maintenance (1) A facility and premises shall be maintained in a clean, comfortable, and safe condition. The facility shall be located on land that is properly drained.</b>  |
| <b>Violation Type</b>                      | Potential Rule or Statute Violation  |
| <b>Allegation</b>                          | The facility has poor living conditions and is flooded with sewage and garbage.  |
| <b>Investigation</b>                       | <p>On 3/21/23, I spoke to Administrator 1 concerning the allegations. Administrator 1 reported that the youth are clogging their bedroom toilets and causing an overflow of water. Administrator 1 reported they are being cleaned up as the issue arises. Administrator 1 was unable to provide incident reports or work orders showing the dates of the backups or the dates the toilets were fixed.</p> <p>On 3/22/23, I spoke to Complainant 1. No new information was provided.</p> <p>All interviews were conducted face to face at the facility with DHHS Worker 1 and DHHS Worker 2.</p> <p>On 3/23/23, I observed four PODS; Pod A, Pod C, Pod G, and Pod H. Pod A is named the <i>Health and Wellness Pod</i>. On 3/23/23, four youth had clogged their bedroom toilets, causing an overflow of toilet water. At my arrival, there were maintenance men in Pod A and they were working on fixing the situation. The youth were not in Pod A while they were working. I went back into Pod A on 3/30/23 and the toilets were not an issue at that time.</p> <p>I observed Pod C on 3/23/23 to be unclean. Pod C had smeared and dried feces on the walls and bodily fluids splattered on the walls. The middle bedroom had dried feces in the air vent. Trash was on the floor.</p> <p>Sheriff 1, reported on 3/23/23 the previous youth in this particular room, the room with the feces in the vent, used to smear feces on the walls and throw feces and bodily fluid out of the door and the small window opening in the door.</p> <p>Youth A, who is now placed in this bedroom, reported he had been moved into this room on January 17, 2023. At this time, the previous youth's feces were still in the vent.</p> |

Administrator 1 verified this date on 4/20/23.

I spoke to Administrator 1 3/23/23 concerning these conditions and Administrator 1 reported the areas would be cleaned. On 3/24/23, I received an email from Administrator 1 stating the “room/wall that was referenced in an earlier email has been cleaned and disinfected.”

On 3/30/23, I observed Pod C. The walls continued to have the same dried and smeared feces on the wall as well as other bodily fluids. Youth A reported that he cleaned the other youth’s feces that was in his room’s air vents. Youth A reported staff gave him gloves and a spray to clean the vent.

I spoke to Administrator 1 3/30/23 concerning the lack of follow up on cleaning the walls. It was also discussed how Youth A had to clean another youth’s feces. It was discussed that staff or maintenance should be cleaning these areas due to the nature of the issue.

Youth B on 3/30/23 reported there was a backup in the unit toilets in Pod G and they didn’t fix them right away. He was unable to provide a time frame when they were fixed.

Youth C on 3/30/23 reported Pod G had a backup of toilets and the water overflowed in the rooms. Youth C reported staff obtained a vacuum the following day and cleaned it up.

Youth D reported the toilets overflowed a “couple weeks” ago. Youth D reported that staff mopped it up.

I observed Pod G. Pod G was clean to look at. Inside multiple rooms had multiple styrofoam food trays not placed in the trash yet, from more than one breakfast/lunch/or dinner time.

**A room search was requested by DCWL on 3/21/23, 3/23/23, and 3/24/23 due to allegations that a youth was going to be** A room search was completed on 3/27/23. Administrator 1 reported the following via email after the room search was completed on 3/27/23:

“During the inspection, we located multiple rooms that need to be serviced for missing wall plates. The loose wall plates were removed...During the searches, we also discovered that several doors had hardened milk cartons stuffed inside the door

|                   |  |
|-------------------|--|
|                   | <p>mechanism, which allows them to exit easily. Also inside the rooms was an excess amount of milk cartons, torn fabric material, and trash from meals that had not been discarded. These items were removed.”</p> <p>I interviewed Staff 1 on 3/23/23. Staff 1, direct care staff on Pod G, reported they had toilets overflow within the last two weeks and Staff 1 reported the staff mopped it up and called in a work order. Staff 1 reported they moved the youth it had affected into other rooms. Staff 1 reported that staff are to take the food trays out the youth’s room after they are finished eating, but all staff do not complete this task.</p> <p>I observed Pod C on 4/20/23 and the same walls have not been cleaned yet. This information was once again provided to Administrator 1 and Director 1.</p>  |
| <b>Analysis</b>   | <p>Through observation the facility is not maintained in a clean, comfortable, and safe condition.</p> <ul style="list-style-type: none"> <li>• Pod C had youth feces on the air vents in a bedroom that was being occupied by Youth A. Youth A has been in that room for over three months with no one cleaning or disinfecting the room.</li> <li>• The walls outside of his room also had dried feces and bodily fluids on it. Even after reporting this information to Administrator 1 on 3/23/30, it was not cleaned or disinfected in a safe manner. My last observation was on 4/20/23 and it was still an issue.</li> <li>• Pod G had bedrooms with multiple styrofoam food trays in the bedrooms. Staff 1 reported staff are to remove these after meals but do not always complete this. A room search on 3/27/23, confirmed that trash was not being removed from the rooms.</li> </ul> |
| <b>Conclusion</b> | <p><b>Repeat Violation Established</b></p> <p><b>SI 2023C0000167</b></p>   |

|  |   |
|--|---|
| <b>Rule Code &amp; Section Description</b> | <p><b>CCI Rule 400.4148 Personal hygiene</b><br/> <b>(1) An institution shall assure that each resident maintains or receives personal care, hygiene, and grooming appropriate to the resident’s age, sex, race, cultural background, and health needs.</b></p> |
|--|---|

| <b>Violation Type</b> | Potential Rule or Statute Violation  |
|-----------------------|--|
| <b>Allegation</b>     | Youth are not receiving hygiene products and are not able to brush their teeth daily or shower.  |
| <b>Investigation</b>  | <p>On 3/22/23, allegations were discussed with Administrator 1.</p> <p>All interviews were conducted face to face at the facility with DHHS Worker 1 and DHHS Worker 2.</p> <p><b><u>On 3/23/23 the following interviews were conducted:</u></b></p> <p>Youth E reported he does not have a toothbrush or toothpaste or soap. Youth E reported he has lotion and deodorant. Youth E reported the last time he took a shower was last Friday (March 17).</p> <p>Youth A reported he does not have a toothbrush, toothpaste or deodorant. Youth A reported he came out of his room two days ago and took a shower (March 21).</p> <p>Youth F reported he does have toothpaste but does not have a toothbrush. Youth F reported he has a “cup” of soap and does not have deodorant.</p> <p>Youth B reported he does not have a toothbrush but does have toothpaste and soap. Youth B reported he took a shower four-five days ago.</p> <p>Youth G reported he does not have a toothbrush, toothpaste, or soap. Youth G reported he has showered within the week.</p> <p>Youth C reported he has a toothbrush and toothpaste. Youth C reported he showered today (3/23/23) and the last time before that was a week and a half ago. Youth C reported you only get soap when you come out of your room. Youth C reported he has face cleaner in his room.</p> <p>Youth D reported he has toothpaste and a toothbrush but when you run out, you have to wait for them to order more and you go without. Youth D reported he has deodorant. Youth D reported he last showered on Monday, March 20, “when the state came out”. Youth D reported before that, it was two weeks ago. Youth D reported that they sometimes don’t have toilet paper or only just a few sheets.</p> |

Youth SS was interviewed by DHHS Worker 2 at Lincoln Center on 3/23/23. Youth SS reported that he did not have a hygiene kit. Youth SS reported staff would tell him there was none to give him.

**Interviews conducted on 3/30/23:**

Youth H reported he does not have toothpaste or a toothbrush. Youth H reported they give them a travel size toothpaste and when it runs out they have to wait to get another one. Youth H reported that staff tell them they have no toothpaste to give them. Youth H reported he receives a shower once or twice a week sometimes, but it is not consistent.

Youth I reported he does not have toothpaste or toothbrush, soap, or deodorant. Youth I reported that he took a shower three days ago (March 20). Youth I reported that the staff will not give him any hygiene products.

Staff 1 reported that if the youth run out of toothpaste or don't have a toothbrush, they do not get anything until a new shipment comes in. Staff 1 was asked to provide the youth who currently don't have toothpaste with toothpaste and Staff 1 reported there is nothing to give them. Staff 1 reported there is nothing in the supply closet to give. Staff 1 reported the youth only get a few sheets of toilet paper when they need to use the restroom because they will use the excess to stuff the door locks.

Staff 2 reported that some youths do not have toothpaste or toothbrushes because the facility does not have any to give them at this time.

Staff 3 reported they do not have toothpaste or toothbrushes to give the youth. Staff 3 reported they do not have supplies to give the youth. Staff 3 reported the facility is not ordering enough.

DHHS Worker 2 and I went around to each room in Pod H. 27 of the 36 youth were unable to show us their toothpaste. Staff reported they did not have any supplies to provide to the youth. In Pod C, five of the youth did not have toothpaste.

I spoke to Administrator 1 on 3/30/23 and reported that youth do not have proper hygiene supplies. It was stated that the youth will need to receive these items. Administrator 1 reported she was unaware that the youth did not have hygiene products. Administrator 1 reported she had just ordered some and didn't know why the youth did not have hygiene.

Administrator 1 emailed me on 3/31/23 and reported that all “youth have been issued toothpaste, soap, lotion, deodorant, and toothbrushes. A roster will indicate youth initials for receipt.”

I requested the roster on 4/14/23 and 4/20/23 and the agency did not provide it.

I interviewed via telephone Staff 4 on 4/17/23. Staff 4 reported the youth were not getting hygiene packets before but have received them now.

I interviewed via telephone Staff 5 on 4/17/23. Staff 5 reported the youth are not receiving showers daily. Staff 5 reported they do not always have hygiene supplies to give the youth when they need it.

I reviewed the *Daily Activity Schedules* for Pod H and Health and Wellness Pods. The *Daily Activity Schedule* report if meals are eaten, showers taken, and recreation provided.

#### **Pod H**

| <b>Date</b> | <b># of Youth</b> | <b>Showered</b> | <b>Other</b>  |
|-------------|-------------------|-----------------|---|
| 3/3/23      | 60                | 19              | NA  |
| 3/4/23      | 60                | 5               | NA  |
| 3/5/23      | 60                | 9               |   |
| 3/6/23      | 59                | 6               | “Laundry shortage prevents hygiene for some residents” (5 socks) (6 shorts/underpants, (8 large towels), (2 rags), (18 face towels) |
| 3/11/23     | 44                | 18 (1 declined) |   |
| 3/13/23     | 45                | 10              |   |
| 3/16/23     | 36                | 18              |   |
| 3/17/23     | 46                | 11              |   |

#### **Health and Wellness Pod:**

| <b>Date</b> | <b># Youth</b> | <b>Showered</b> |
|-------------|----------------|-----------------|
| 3/17/23     | 47             | 10 (2 refused)  |
| 3/18/23     | 59             | 3               |
| 3/19/23     | 50             | 1               |
|             |                |                 |

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|-------------------|--|
| <b>Analysis</b>   | Multiple youth interviewed reported they did not have basic hygiene supplies. DHHS Worker 2 and I went around to all the rooms and 27 youth did not have toothpaste. Staff 1, Staff 2, and Staff 3 all confirmed that youth go without the basic hygiene products, and they do not have any to provide the youth with when they run out. Multiple youth reported they have not had the opportunity to maintain personal care by having the opportunity to shower on a regular basis. |
| <b>Conclusion</b> | <b>Repeat Violation Established</b><br><br><b>SI 2023C0000207</b><br><b>SI 2023C0000169</b>  |

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| <b>Rule Code &amp; Section Description</b> | <b>CCI Rule 400.4136 Recreational activities, equipment, and supplies; swimming restriction</b><br><b>(2) Residents shall be provided a variety of indoor and outdoor recreational activities designed to meet the residents' needs.</b>   |
| <b>Violation Type</b>                      | Potential Rule or Statute Violation  |
| <b>Allegation</b>                          | Youth are not receiving daily recreation.  |
| <b>Investigation</b>                       | All interviews were completed face to face at the facility with DHHS Worker 2.<br><br><b><u>All youth were asked to state the last time they were involved in recreational activity outside of their bedroom. The following are their responses:</u></b><br><br><b><u>Youth interviewed on 3/23/23:</u></b><br>Youth E: 3/17/23.<br>Youth A: 3/21/23<br>Youth F: week and a half ago (this is also when he stated he took a shower)<br>Youth B: reported he was moved to the unit a week ago and has not been involved in recreation since that move<br>Youth G: within the last week<br>Youth C: week and a half ago<br>Youth D: two weeks ago<br><br><b><u>Youth interviewed on 3/30/23:</u></b><br>Youth I: 3/28/23 |

Staff 1 reported that there are not enough staff to keep the youth safe during fights or when youth come out of their room and refuse to go back into their room. Once youth refuse to go back into their room, this holds up everyone else from having recreation activities.

Administrator 1 reported that staff are to keep a log of when youth are allowed out of their room for various activities. Administrator 1 reported she was unsure if the staff were completing this. This document was asked for on 3/23/30, 3/30/23, and 4/14/23. I received this document on 4/20/23.

**The Daily Activity Schedule reported:**

I reviewed the *Daily Activity Schedules* for Pod H and Health and Wellness Pods. The *Daily Activity Schedule* reports if meals are eaten, showers taken, and recreation provided.

**Pod H**

| <u>Date</u> | <u># of Youth</u> | <u>Recreation</u> |
|-------------|-------------------|-------------------|
| 3/3/23      | 60                | 18                |
| 3/4/23      | 60                | 14                |
| 3/5/23      | 60                | 7                 |
| 3/6/23      | 59                | 0                 |
| 3/11/23     | 44                | 7                 |
| 3/13/23     | 45                | 21                |
| 3/16/23     | 36                | 0                 |
| 3/17/23     | 46                | 24                |

**Health and Wellness Pod:**

| <u>Date</u> | <u># Youth</u> | <u>Recreation</u> |
|-------------|----------------|-------------------|
| 3/17/23     | 47             | 0                 |
| 3/18/23     | 59             | 0                 |
| 3/19/23     | 50             | 10                |

**I reviewed Attachment 11.5 of the *Resident Confinements Sleeping hours and Non-sleeping hours Temporary Disaster Plan* which included:**

“In accordance with WCJDF policy #11.5, whenever a Supervisor or Manager determines that a temporary disaster must be ordered

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|                   | <p>to ensure the safety and security of the JDF Facility, a written plan must be adopted by the Supervisor or Manager.</p> <p>The following are guidelines to be used to devise emergency procedures necessary to maintain the continuity of operations in order to assure the safety of residents during a temporary disaster.</p> <ol style="list-style-type: none"> <li>1. Any plan must ensure that residents receive daily recreation. Recreation activities shall be coordinated with the Recreation Leader who shall be available to assist the JDS staff.”</li> </ol> <p>“The JDS Supervisor or Manager in creating a Temporary Disaster Plan must:</p> <p>Ensure that there is a continuity of service for residents in the areas of recreation and other youth activities.”</p> <p>Wayne County Juvenile Detention is on a variance effective 2/24/23-5/29/23. Variance states, groups of five to ten youth will be rotated out of their rooms for up to one-hour intervals at least one time per day, with a staff ratio of 1:20.</p> |
| <b>Analysis</b>   | <p>All youth interviewed and Staff 1 reported that recreational activities are not occurring often. The range of time out of their rooms to engage in a recreational activity was 2 days to 2 weeks ago. Staff 1 confirmed that if youth refused to go into their room when they were let out, other youth were unable to be involved in recreational activities. According to the <b><i>Resident Confinements Sleeping hours and Non-sleeping hours Temporary Disaster Plan</i></b>, the JDS supervisor is to ensure that daily recreation is continued as well as other activities. The Daily Activity Schedule confirmed youth are not coming out of their room as noted in the Disaster plan and the variance dated 2/24/23-5/29/23.</p>   |
| <b>Conclusion</b> | <p><b>Repeat Violation Established</b></p> <p><b>SI 2023C0000169</b></p>   |

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| <b>Rule Code &amp; Section Description</b> | <b>CCI Rule 400.4142 Health services; policies and procedures</b><br><b>(1) An institution shall establish and follow written health service policies and procedures addressing all of the following:</b><br><b>(a) Routine and emergency medical, and dental, and behavioral health care.</b>   |
| <b>Violation Type</b>                      | Potential Rule or Statute Violation  |
| <b>Allegation</b>                          | <p>#1 Allegation: Youth J's medical needs are not being met. He has lice and a growth on his neck that requires surgery.</p> <p>#2 Allegation: The Health and Wellness Pod youth have mental health needs that are not being met.</p> <p>#3 Allegation: Youth TT did not receive his medications for three weeks due to staff shortage.</p>  |
| <b>Investigation</b>                       | <p><b>#1 Allegation: Youth J's medical needs are not being met. He has lice and a growth on his neck that requires surgery.</b></p> <p>I spoke to Administrator 1 on 3/22/23. Administrator 1 reported she was not aware of Youth J having lice.</p> <p>I spoke to Complainant 1 on 4/10/23 and Complainant 1 was unsure if Youth J actually had lice.</p> <p>Youth J was placed at the facility on 2/11/23.</p> <p>I interviewed Doctor 1 on 3/23/23. Doctor 1 reported that Youth J does have lice. Doctor 1 reported she was asked on 3/21/23 to check on Youth J to see whether had lice. Doctor 1 reported they did their Initial Health Assessment with Youth J on 3/21/23. Doctor 1 reported they treated his hair yesterday and bagged up belongings. In three days, they will check him again.</p> <p>I interviewed Youth J face to face at the facility on 4/20/23. Youth J reported that three weeks after he was placed at the facility his head began to itch. Youth J reported he told Supervisor 1, but no one did anything about it. Youth J had a follow up from the nurse on 3/29/23 but has not seen anyone since today (4/20/23). Youth J reported someone just told him before I came into the unit that a nurse would see him tonight.</p> <p>I was on site at the facility and emailed Doctor 1 at 11:25am. Around 12:45pm, I spoke to Youth J. Doctor 1 emailed on 4/20/23</p> |

that Youth A “still has lice and that we need to get his hair cut but he refused.” I received a follow up email on 4/21/23 from Doctor 1 reporting that Youth J no longer has lice. “We will follow-up in a week to check on the resident’s status. If he continues to insist that the lice are present than the only option will be a haircut. The risk of retreatment out weights the benefits in the situation.”

**I reviewed the Medical Progress Notes for Youth J.**

3/21/23. “Upon physical examination resident was found to have lice (head), the 1<sup>st</sup> treatment and comb out was done today...resident instructed on hair care and staff on G Pod notified. Resident is due for another shampoo/comb out on 3/28/23, date documented on daily report and staff notified of disinfecting protocol...will continue to monitor for any changes in condition.”

3/29/23: Resident received 2<sup>nd</sup> lice treatment. There was no notes on whether there was lice or not.

**#3 Allegation: The Health and Wellness Pod youth have mental health needs that are not being met.**

On 3/30/23, I reviewed the Health and Wellness Pod’s medical administration logs. All youth prescribed medications were receiving their medications or it was noted that they refused the medications.

**Additional Allegations: Policy does not comply with licensing rules.**

Doctor 1 reported that they did not pass out medications on 3/22/23 in the evening for H Pod because youth were refusing to go into their rooms. Doctor 1 reported the staff had placed a note on the unit door stating not to come into the unit. Doctor 1 reported she then makes an assessment of what medications must be given and those that can miss a dose. Doctor 1 reported she then reissued the medications in the morning. Doctor 1 reported the youth did not receive the missed medication just the next dosage the following day.

***I reviewed the Resident Confinements Sleeping hours and Non-sleeping hours Temporary Disaster Plan which include:***

A. Procedures

“A Temporary Disaster may only be ordered by a JDS Supervisor or Manager. The Supervisor ordering the

temporary disaster plan must indicate in the Pod logbook the specific reason for the disaster and provide information as to the anticipated length of time the disaster plan will be necessary. Additionally, the JDS Supervisor or Manager shall determine the conditions that must be present in order to resume a normal daily operational schedule”.

**Disaster Plan Implementation:**

Plan of action for the facility implored to prevent, mitigate, prepare for, respond to and recover from emergencies.

1. Supervisor will notify the nurse that a disaster plan has been implemented.
2. If the time frame of the plan effects the scheduled medication pass the nurse will notify the physician on call.
3. The nurse will identify the residents who are scheduled to receive medication during the effected medication pass.
4. The physician and the nurse will review the medications scheduled to be given and identify any medications that are essential and would cause harm if missed.
5. The health services staff along with the supervisor will develop a plan to pass these essential medications safely and securely.
6. The remaining medications will be ordered to be held by the physician until the disaster plan has resolved. This will be documented on the MAR for each resident effected.
7. Once the disaster plan has been completed and medications can be safely and securely passed the physician will reorder the medications

The Disaster plan approved by DCWL and the Approved Variance dated 2/24/23 did not approve routine medical to be missed.

I reviewed the Use of Pharmaceuticals Policy. The Pharmaceutical Policy is not a part of the DCWL approved Disaster Plan.

**#3 Allegation: Youth TT did not receive his medications for three weeks due to staff shortage.**

Youth TT was placed at the facility on 2/13/23 and was discharged on 3/20/23 according to the Youth TT’s face sheet.

Parent 1 stated Youth TT did not receive his mental health medication until he spoke with Case Manger 1. He stated after three weeks he contacted Case Manager 1, and she made sure Youth TT got his medication.

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|                        | <p>Youth TT reported he did not receive his medications for three weeks. Youth TT reported he was placed in the facility for 30 days.</p> <p>I interviewed Doctor 1 at the facility face to face. Doctor 1 reported that Youth TT's medical consent was signed on 2/21/23 and Youth TT's medication should have been started then. Doctor 1 reported Youth TT came in to the facility with his medicine, Clonidine. Doctor 1 was only able to find the Medication Administration Review (MARS) form from March 1-March 20. Doctor 1 was unable to supply the MARS from February 21-March 1.</p>   |
| <p><b>Analysis</b></p> | <ul style="list-style-type: none"> <li>• Youth J was placed in the facility on 2/11/23. Youth J did not receive his initial health screening until 3/21/23. Youth J was found to have lice on 3/21/23 and was given the first round of shampoo/comb out. Youth J was to receive his second round of medical treatment (shampoo/comb out) on 3/28/23 but did not receive it until 3/29/29. Youth J reported that no one ever combed his hair. Youth J reported he was given the shampoo and washed his hair in the shower. Youth J was not seen again by a nurse until 4/20/23, when this consultant requested an update on his medical needs. Initially it was stated Youth J still had lice and his hair would need to be cut, but then a subsequent email reported he did not have lice, but if he continues to state he did, they would cut his hair. The agency failed to monitor Youth J's medical treatment as outlined in their notes. They did not complete a second treatment on 3/28/23 and did not monitor his condition until this consultant asked about his condition.</li> <li>• The Health and Wellness Pod are receiving their medications as prescribed.</li> <li>• The Disaster Plan and Variance approved by DCWL does not allow for youth to miss psychotropic medications or any other routine medications. The agency has created a policy <b><u>Use of Pharmaceuticals</u></b>, which allows for medications to be missed during an implementation of the disaster plan. This policy is not under the disaster plan approved by DCWL. This is an additional policy created outside of the approved disaster plan.</li> <li>• Youth TT did reported he did not receive his medications for weeks. The agency was unable to provide the MARS</li> </ul> |

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|                   | document for 2/21/23-2/28/21. There are seven days where medication is not documented as being given to Youth TT, although they had the order and consent to provide his medication. |
| <b>Conclusion</b> | <b>Violation Established</b>   |

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| <b>Rule Code &amp; Section Description</b> | <b>R 400.4154 Shelter care and detention institutions; service plans (1) Within 30 calendar days after admission and every 15 calendar days thereafter, an institution shall complete a written service plan. The service plan shall include all of the following.<br/>(d) How service needs will be met.</b>  |
| <b>Violation Type</b>                      | Additional Findings of Non-Compliance  |
| <b>Allegation</b>                          | Youth K is malnourished and refuses to eat but the agency has not done anything to intervene.  |
| <b>Investigation</b>                       | <p>I requested Youth K's service plans on 3/23/23, 3/24/23, 3/30/23, and 4/14/23. I received them on 4/20/23.</p> <p><b><u>I reviewed Youth K's service plans. The plans before 10/9/23 did not address any concerns.</u></b></p> <p>10/9/22: Resident has not been eating and sleeping a lot. Writer notified appropriate staff and supervisor to inform them of positive behavior changes and depression.</p> <p>10/24/22: There are no concerns noted.</p> <p>11/9/22: No concerns noted.</p> <p>11/24/22: Resident is not expressive as in past sessions. Writer asked JDS staff to keep an extra watch on resident for depressive behavior. Writer also informed Therapist 1 of concerns.</p> <p>12/9/22: No concerns.</p> <p>12/24/22: No concerns</p> <p>1/23/23: No concerns</p> |

2/6/23: Resident is nonverbal with writer when she visits pod, refusing to answer questions...Resident has been this way for months now and all supportive staff are aware of concern and are asked to monitor any sudden changes in behavior. Resident has form on the door now to monitor his daily intake.

2/22/23: Resident was unresponsive to the writer

3/9/23: The writer spoke through the door to Youth K. There were no updates.

**I reviewed Youth K's file.** There were two incident reports noted in his file, but they did not address Youth K refusing or not eating his food.

I spoke to Complainant 2 on 3/21/23. There was no new information.

I spoke to Administrator 1 on 3/23/23. Administrator 1 reported that Youth K does not talk to anyone, refuses to come out of his room, and does refuse to eat. Administrator 1 reported he has lost 50lbs since being at the facility. Administrator 1 reported that two months ago they sent him to the hospital. Administrator 1 reported that the medical personnel do come and check on Youth K. Administrator 1 reported that Youth K has a food log that they keep track of since Youth K went to the hospital.

I interviewed Doctor 1. Doctor 1 reported that the medical personnel do not assess Youth K daily, but the workers on the unit check Youth K. Doctor 1 reported medical staff do see Youth K when they are attempting to give him his medicine. Doctor 1 reported he refuses his medications and refuses to be weighed by staff. There was no plan noted other than continuing to offer food, medication, and attempting to weigh him.

I reviewed Youth K's Initial Health Assessment. Youth K entered the program on 7/13/22. The Initial Health Assessment as completed on 7/22/23. Youth K is 5'5" and 170lbs. The Initial History Exam notes that Youth K is in the "BMI category of obesity."

**I reviewed SIR # 2023C0000137 previously addressing similar complaint pertaining to Youth K.** It was noted that the Medical Supervisor stated, "...bed covers were pulled back on 12/29/22 to verify his wellbeing and youth's noticeable weight loss was

reported to the doctor. Medical supervisor stated youth was sent off site for an evaluation on 12/29/22.”

**I reviewed the hospital documentation with an admission date of 12/13/22 and a discharge date of 1/2/23.**

Diagnosis:...abnormal weight loss...

**Follow up Appointments/Instructions:**

Follow up with your doctor within Wayne County Juvenile Detention Center. The time frame was outlined as 2-5 days.

I reviewed the medical notes for Youth K. Youth K was seen by doctor 1 on 1/5/23.

**I reviewed Youth K's Psychiatrist Medication Review documents:**

11/30/22: ...attitude and behavior are clinically concerning as he appears to be more hopeless. Youth K spends most of his time locked in his cell and attention to his personal hygiene and dietary consumption is in decline...

12/29/22: ...related to his depressed mood anhedonia and poor to not existent appetite and weight loss. He requires a higher level of care.

1/9/23: Dietary consultation recommended...

1/13/23: Continues to maintain adequate hydration via his consumption of extra milk and water...dietary consultation remains a recommendation...extra bedtime snacks and sandwich.

**I reviewed Therapist 1's Clinical Notes:**

11/23/22: Therapist 1 reports concerns about Youth K due to not eating or talking and has lost a “significant amount of weight.”

11/30/22: Therapist 1 reports concerns with his eating and reports requesting Psychiatrist 1 to meet with him. Youth K refused. Therapist 1 contacted Youth K's mother and obtained two phone numbers of family to help talk to Youth K and received medical consents from mother.

12/13/22: Therapist 1 reported Youth K was up and talking to her.

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|  | <p>12/22/23: Therapist 1 reported Youth K told her he was eating and sleeping.</p> <p>12/29/23: Therapist 1 reported she recommended hospitalization for Youth K due to losing 25lbs or more, generally non-responsive, refusing medications, showers and peer interaction.</p> <p>12/30/23: Therapist 1 reported she was contacted by a supervisor on duty stating they were going to send Youth K to the hospital for losing 30 lbs., not showering in 4-5 months, very thin.</p> <p>On 4/20/23, I interviewed Administrator 1 face to face at the facility. Administrator 1 reported she was unaware of any interventions put into place concerning Youth K's weight loss. Administrator 1 reported she was unsure if he was receiving doubles in food or extra snacks. Administrator 1 reported she thought he was getting "ensure" drinks. Administrator 1 reported she contacted medical department days before he went to the hospital to check on him.</p> <p><b><u>I reviewed the Food Chart described by Administrator 1.</u></b> The food chart started on 1/19/23. I reviewed from 1/19/23-3/12/23. The following dates did not have food documented either for the partial day or for the full day:</p> <p>1/31/23-2/5/23 were not filled out completely.<br/> 2/24/23 was not filled out completely.<br/> 2/25/23-2/26/23 were not completed.<br/> 3/6/23-3/8/23 did not have the snack area filled out.<br/> 3/9/23 only had breakfast filled out.<br/> 3/10/23-3/11/23 were not completed.<br/> 3/12/23 did not have the snack filled out.<br/> 3/13/23 did not have dinner or snack filled out.<br/> 3/14/23 did not have the snack filled out<br/> 3/15/23 did not have dinner or the snack filled out.<br/> 3/16/23 did not have lunch or snack filled out.<br/> 3/17/23 only had dinner filled out.<br/> 3/18/23-3/19/23 were not complete.</p> <p>**Note the week of 1/23/23-1/30/23 was not documented. There was an additional food chart that was provided but did not have dates on it. If this was that particular week, then 1/23/23-1/25/23 was not completed and 1/26/23-1/28/23 was not complete.</p> |
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|                   | I attempted to interview Youth K on 1/30/23. Youth K refused to talk to me and covered himself with his blanket. Youth K was observed to be small in stature.   |
| <b>Analysis</b>   | <p>The service plans did not consistently address the ongoing concern of Youth K's medical and emotional state. The service plans did not consistently evaluate the service needs or comment on how Youth K's needs were to be met. Administrator 1 was unsure of any interventions put into place before the hospital stay on 12/30/22. Doctor 1 reported they would offer him his food, medication and attempted to weigh him, but he would refuse. There were no interventions noted or described to his consultant before the hospital stay. Multipled documents outlined a concern for Youth K's weight and emotional state, but nothing was put into place to service those needs.</p> <p>After his hospital visit, a food chart was started. The food chart was not filled out consistently. The food chart did not note any double portions of food or extra snacks as noted in the Psychiatrist reports.</p> |
| <b>Conclusion</b> | <b>Violation Established</b>  |

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| <b>Rule Code &amp; Section Description</b> | <b>CCI Rule 400.4126 Sufficiency of staff</b><br><b>(1) The licensee shall have a sufficient number of administrative, supervisory, social service, direct care, and other staff on duty to perform the prescribed functions required by these administrative rules and in the agency's program statement and to provide for the continual needs, protection, and supervision of youth.</b>   |
| <b>Violation Type</b>                      | Potential Rule or Statute Violation   |
| <b>Allegation</b>                          | <p>Allegations: On three separate occasions staff did not intervene in physical assaults because they did not have enough staff to intervene:</p> <p>#1 Allegation: Staff did not intervene when Youth H was in a fight.<br/>#2 Allegation: Youth J is being threatened by peers. The peers have stated to him they are going to stab him and afraid that staff will not intervene.<br/>#3 Allegation: Youth SS reported he was jumped by multiple peers and staff did not intervene.</p> |

|               |   |
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| Investigation | <p><b>#1 Allegation: Staff did not intervene when Youth H was in a fight.</b></p> <p>I spoke to Complainant 2 on 4/11/23. Complainant 2 did not provide any new information.</p> <p>I interviewed Youth H on 3/23/23. Youth H reported that he was in a fight previously and staff did break it up. Youth H was unable to provide any other information.</p> <p>I requested any incident reports that Youth H may have been in a fight and the agency did not have any incident reports.</p> <p>I interviewed Doctor 1 on 3/23/23 and she reported they do not have any medical documents pertaining to a fight Youth H may have been in.</p> <p><b>#2 Allegation: Youth J is being threatened and afraid that staff will not intervene. The peers have stated to him they are going to stab him and afraid that staff will not intervene.</b></p> <p>I spoke to Administrator 1 on 3/21/23 concerning allegations via telephone. Administrator 1 reported that the last time they completed a room search was about a month ago. Administrator 1 reported she will complete another room search. DHHS Worker 1 reported this was also part of the safety plan to include Youth J was safe. On 3/23/23, I spoke to Administrator 1 face-to-face at the facility and Administrator 1 reported that she had not set up the room search. Administrator 1 reported that she doesn't have enough staff to complete room searches. I emailed Administrator 1 on 3/24/23 and asked when the room search was going to occur. Administrator 1 reported that the search would happen on 3/27/23, 3/29/23, 3/31/23 for the three separate pods.</p> <p>I spoke to Director 1 on 3/23/23. Director 1 reported that Youth J has not been hurt in any incident at this time.</p> <p><b>Administrator 1 emailed the following after the room search was completed on 3/27/23:</b></p> <p>"While searching cell number 27U, belonging to Youth QQ, a metal wall plate was found lodged underneath his sink. When we searched cell number 4U, belonging to Youth RR, we found a sharpened wall plate and an ink pen on his during a pat down."</p> |
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**#3 Allegation: Youth SS reported he was jumped by multiple peers and staff did not intervene.**

Youth SS was interviewed by DHHS Worker 2 on 3/23/23 at his new location, Lincoln Center. Youth SS did not mention an incident where staff did not intervene. Youth SS only discussed a restraint completed by the sheriff's department.

**Additional Findings:**

Doctor 1 reported they are missing a total of six registered nurses and one doctor. During the investigation, one more doctor quit, but Doctor 1 reported there were interviews set up to replace some of these positions. Doctor 1 reported that the youth in the G Pod have to come to the medical offices in the building to be seen. This causes an issue as well as not having enough staff to fulfill the duties needed. A total of 22 initial health assessments were not completed during this investigation. There were 11 initial health assessments that were reviewed that were late. This consultant did not review every youth's initial health assessment only these ones stated.

On 3/23/23, I spoke to Administrator 1 concerning the room search not being set up. Administrator 1 reported they do not have staff to complete this task and should write a variance to this rule as well. The room search did get completed by the sheriff's department on 3/27/23.

I spoke to Administrator 1 on 3/30/23 and reported that youth do not have proper hygiene supplies. It was stated that the youth will need to receive these items. Administrator 1 reported she was unaware that the youth did not have hygiene products. Administrator 1 reported she had just ordered some and didn't know why the youth did not have hygiene. Administrator 1 reported she does not have someone overseeing the lack of products and was in the process of hiring someone.

On 4/20/23, I interviewed Administrator 1 with DHHS Worker 1 and DHHS Supervisor 1. Administrator 1 reported they have a lack of staff and even the Disaster Plan staffing is not enough. Administrator 1 reported they also have too many kids on the pods. Administrator 1 reported specifically that Pods G and H do not have enough staff on it. Administrator 1 reported they are on a constant disaster plan. Administrator 1 reported that Inventory Specialist 1 was unable to keep up with the demands of inventory and this created shortage. Administrator 1 reported that staff on the floor are supposed to document in JAIS when youth need

supplies, but this may not have been done. Administrator 1 reported this responsibility has been passed on to someone who is able to take more time to complete. Administrator 1 reported they need additional staff, supervisors, and administration. Administrator 1 reported she is short supervisors. Administrator 1 reported three supervisors are on medical. She stated that she has temporarily assigned 2 workers to be supervisors.

Staff 1 reported that there are not enough staff to keep the kids safe during fights or when youth come out of their room and refuse to go back into their room. Once youth refuse to go back into their room, this holds up everyone else from having recreation activities.

I reviewed the Daily Activity Log on 4/20/23. On 3/6/23, 59 youth did not receive school due to staff shortage. Youth also did not receive school on 3/8/23 and 3/9/23 due to staff shortage.

Youth K had lice and was given shampoo on 3/29/23 and there was no follow up until 4/20/23, when I asked for the outcome of his medical needs.

**Based on the interviews throughout the entirety of the investigation youth are not being provided certain aspects of the program due to staff shortage. The area of services lacking are:**

- Showers consistently in a timely manner to ensure proper hygiene.
- Basic hygiene: toothbrushes and toothpaste.
- Clean clothes.
- Recreation time.
- Appropriate medical assessments upon entry and continual services
- Food in a timely manner.

**I reviewed the current variance approved by Director 2, dated 2/24/23.**

The variance allows for a 1:20 staff to resident ratio during normal awake and sleeping hours in coordination with the current Temporary Disaster Plan.

The variance states, "JDF will document reasons for daily confinements, as well as documenting each youth on its Daily Activities report for the times each youth participates in activity, any refusals of activity, showers, and meals. Groups of five to ten

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|                   | youth will be rotated out of their rooms for up to one-hour intervals at least one time per day, with a staff ratio of 1:20.”   |
| <b>Analysis</b>   | <ul style="list-style-type: none"> <li>• Youth are not receiving their initial health assessments which provide the agency with a plethora of information concerning their medical and mental health needs. There are not enough staff to provide this necessary and important assessment. Youth K did not receive the necessary follow up treatment or monitoring after his second shampoo/comb treatment for lice.</li> <li>• Youth are being withheld food due to the lack of staff available to deliver food and manage environment. Staff are afraid to open youth’s doors in case the youth will push pass them to come out of their room.</li> <li>• Youth are not receiving recreation on a daily basis due to the lack of staff available to manage the environment. Some youth are reporting they have gone over 7 days.</li> <li>• Youth are not receiving their showers in a time frame to maintain proper hygiene.</li> <li>• The Daily Activity Schedules show a consistency in lack of recreation and showers. Youth and staff interviewed all report these areas are nor being completed.</li> <li>• The Daily Activity Schedule shows that school has been missed due to staff shortage.</li> <li>• Youth are not provided the basic hygiene products. Administrator 1 reported she is attempting to hire someone to be the lead to but no one had taken the initiative to provide this service in the meantime.</li> </ul> <p>The agency does not have a sufficient number of administrative, medical, supervisory, or direct care staff to provide for the basic physical needs of each youth as well as safety needs of the youth, resources, clean and secure environment and access to health personnel upon entry and throughout their stay.</p> |
| <b>Conclusion</b> | <b>Violation Established</b>  |

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| <b>Rule Code &amp; Section Description</b> | <b>CCI Rule 400.4125 Personal possessions; money; clothing; storage space</b><br><b>(1) A licensee shall have a written policy that designates all of the following:</b><br><b>(c) The method for ensuring that each resident has sufficient clean, properly fitting, seasonal clothing.</b>  |
| <b>Violation Type</b>                      | Potential Rule or Statute Violation   |
| <b>Allegation</b>                          | Youth do not have clean clothes to wear. Youth are wearing the same clothes for multiple days in a row.   |
| <b>Investigation</b>                       | <p>I spoke to Complainant 1 and Complainant 2. No new information was provided.</p> <p>All interviews were conducted face-to-face at the facility.</p> <p><b>On 3/23/23 the following interviews were conducted:</b></p> <p>Youth A and Youth E reported they had not received clean clothes in two days. Youth A and Youth E described the clothes as boxers, t-shirt and shorts. Additionally, Youth A reported he washes his boxers in the room sink so they are clean.</p> <p>Youth F reported he received a “bundle” of new clothes a week and half ago. Youth F reported a bundle includes boxers, t-shirt, and shorts.</p> <p>Youth B reported he did not remember when he received clean clothes last. Youth B reported he was placed in this unit a week ago and has not been out of his room yet.</p> <p>Youth G reported he last received clean clothes on 3/17/23. He received one pair of boxers and a t-shirt.</p> <p>Youth D reported he gets clothes once a week. Youth D reported he received one pair of boxers and one pair of shorts. Youth D reported he has not received socks in his bundles. Youth D reported every two weeks he receives a t-shirt and towel.</p> <p>Youth H reported he received a clean pair of boxers a week ago but has not had a new shirt and shorts for a while. Youth H reported he washes his boxers in the room sink. Youth H reported that he doesn’t always have a washcloth or towel. He reported he doesn’t have these items currently. Youth H reported that staff tell him there aren’t any clean clothes to give him.</p> |

Youth I reported he received one pair of boxers last week. Youth I reported he hasn't received a t-shirt and shorts for over two weeks. Youth I reported he hasn't had a clean pair of socks for over three weeks. Youth I reported it is inconsistent if they receive clothes or not. Youth I reported he needs new flip-flops. I observed them to be broken.

Youth SS was interviewed by DHHS Worker 2 at Lincoln Center on 3/23/23. Youth SS reported that they did not provide clean clothes. Youth SS reported he would clean his clothes in the room sink and put them back on.

Youth TT was interviewed at his house by MDHHS Worker 2. Youth TT reported that he did not have clean clothes while at the facility.

I did observe clothing bundles on the table in the interview room.

Staff 1 reported that some youth have multiple items of clothing in their room and some youths do not have any clean clothes. Staff 1 reported that staff are supposed to collect the clothes so that laundry can be done. Staff 1 reported that staff are afraid to get the clothes from the youth so there is only so many clothing items getting cleaned, so not all the youth get clean clothes because they are not doing all of the laundry. Staff 1 reported this is the first time she has seen the bundles in larger amounts on the table.

Staff 2 reported they do not have clean clothes to give the youth. Staff 2 reported they never have enough to give out to the youth. Staff 2 reported it may take up a week to get clothes in the unit.

Staff 3 reported it is possible that the youth are not receiving clothes every day because they do not have enough clothes. Staff 3 reported they may receive 25 bundles of clothes, but they have 36 youth so some will go without clean clothes. Staff 3 reported they will rotate who gets clean clothes. Staff 3 reported he does not have socks to hand out to the youth.

I interviewed Staff 4 and 5 via telephone on 4/17/23. Both stated the youth do not always receive clothes.

Staff 4 reported they will receive "bundles" of clothes but it will not be enough for all the youth.

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|                   | <p>Staff 5 reported that they are lacking socks, boxers, and outer shorts. Staff 5 reported he has told supervisors and they report to him that there are no clothes to get.</p> <p>Administrator 1 reported they have a new person now doing the clothing inventory and each pod will have their own supply closet.</p>   |
| <b>Analysis</b>   | <p>Youth are not receiving clean clothes to wear. This includes boxers, t-shirts, shorts, and socks. Youth report they are wearing the same boxers for a week and Youth A, Youth H, and Youth SS reported they wash their boxers in the sink to clean them. Youth I is in need of new flip flops to wear as well. Staff 1, Staff 2, and Staff 3 reported there is not enough clean clothes to provide the youth.</p> |
| <b>Conclusion</b> | <p><b>Repeat Violation Established</b></p> <p><b>SI 2023C0000207</b></p>   |

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| <b>Rule Code &amp; Section Description</b> | <p><b>CCI Rule 400.4158 Intervention standards and prohibitions</b><br/> <b>(1) A child caring institution shall establish and follow written policies and procedures that prohibit the following forms of intervention: These include, but are not limited to, the following:</b><br/> <b>(b) Denial of any essential program service as punishment.</b><br/> <b>(i) Food or creating alternative menus.</b></p>  |
| <b>Violation Type</b>                      | Potential Rule or Statute Violation  |
| <b>Allegation</b>                          | Staff are withholding food from youth when other youth act out or are in trouble.  |
| <b>Investigation</b>                       | <p>I spoke to Complainant 2 on 4/11/23 Complainant 2 did not provide any new information.</p> <p>Youth A and Youth B on 3/23/23 reported they receive three meals a day. Youth A and Youth B are on A Pod.</p> <p>Youth C reported 3/23/23 he receives three meals a day. Youth C is on G Pod.</p> <p>Youth D reported 3/23/23 he receives three meals a day but not always at the same time. Youth D is on Pod G. Youth D reported that if other youth are not listening then he may not get his food for</p> |

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|                        | <p>hours later. Youth D reported this has happened when there are youth out of their room and they refuse to go back into their room. Youth D reported they have to wait for those youth to return to their room before they get food.</p> <p>Staff 1 reported on 3/23/23 that when youth refuse to go back into their rooms, it causes everything to stop. Staff 1 reported that youth always get their food, it just might be late. Staff 1 was on Pod G.</p> <p>Youth H reported on 3/30/23 that they get three meals a day. Youth H is on H Pod. Youth H reported there are times that they do not get their food when they are supposed to. Youth H reported that lunch is at 11:00am, but they might not get their food until 2:00pm. Youth H reported this is because youth refuse to go into their rooms. Youth H reported there has been a couple times they did not receive breakfast because the youth that are refusing to go back into their rooms ate their food and staff never replaced it.</p> <p>Youth I reported on 3/30/23 that they receive three meals a day. Youth I is on H Pod. Youth I reported there have been a couple breakfasts they have not received because other youth would not go back into their room.</p> <p>Staff 2 on 3/30/23 reported that there are times that the youth have received their food after the mealtime. Staff 2 is on H Pod. Staff 2 reported there are delays due to other youth's behavior. Staff 2 is not aware of times youth do not receive their food at all.</p> <p>Staff 3 reported on 3/30/23 that there have been times that the youth have not received breakfast due to other youth's behavior. Staff 3 was on H Pod.</p> <p>I reviewed the Daily Log Activity for H pod. On 3/5/23, there were ten youth who did not receive lunch. There were no notes to describe why this happened.</p> |
| <p><b>Analysis</b></p> | <p>Youth and staff reported that at times youth who are in their room during mealtimes are not receiving meals at the appropriate mealtime due to other youth's behaviors. Youth H and Youth I and Staff 3 all reported youth have missed breakfast due to other youth's behaviors. The behaviors outlined by staff and youth are that the youth refuse to go into their room. The youth in their rooms are being punished, by having their food withheld for hours or not receiving the food, due to other youth not returning to their</p>  |

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|                   | <p>room. Based on Daily Activity Schedule 10 youth did not receive food on 3/5/23.</p> <p>It is understandable if youth's food is delayed for a short time due to an unsafe situation or escalated situation, but it appears that youth are being denied food due to youth refusing to go back into their rooms; therefore, other youth are being denied essential basic needs.</p> |
| <b>Conclusion</b> | <b>Violation Established</b>  |

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| <b>Rule Code &amp; Section Description</b> | <b>CCI Rule 400.4122 Resident and parent visitation<br/>(1) An institution shall provide for visits between each resident and the resident's parents, unless parental rights have been terminated or the resident's record contains documentation that visitation is detrimental to the resident.</b> |
| <b>Violation Type</b>                      | Additional Findings of Non-Compliance   |
| <b>Allegation</b>                          | Youth are not permitted to have phone calls or visits with parents.   |
| <b>Investigation</b>                       | <p>I spoke to Complainant 1. Complainant 1 did not provide any new information.</p> <p>I interviewed Youth A, Youth F, Youth B, Youth G, Youth C, Youth J and Youth D all reported they receive weekly phone calls and could have visitors.</p>   |
| <b>Analysis</b>                            | There is no evidence to validate the allegations.   |
| <b>Conclusion</b>                          | <b>Violation Not Established</b>  |

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| <b>Rule Code &amp; Section Description</b> | <b>CCI Rule 400.4144 Admission health screening; physical examinations<br/>(1) An initial health screening shall be completed for each resident within 24 hours of admission to a facility.</b> |
| <b>Violation Type</b>                      | Additional Findings of Non-Compliance   |
| <b>Allegation</b>                          | Youth are not receiving their initial health assessments.   |

| <b>Investigation</b> | <p>It was discovered during reviewing the medical records of Youth J that his initial health assessment was not completed in a timely manner. Youth J had entered the facility on 2/11/23 and received his initial health assessment due to the current investigation. Youth J received his initial health assessment on 3/21/23.</p> <p>Youth K's medical records were reviewed pertaining to allegations of lack of medical interventions. It was discovered that Youth K was placed in the facility on 7/13/22 and the initial health assessment was completed on 7/22/23.</p> <p>Doctor 1 reported that there are youth who have not yet received their medical assessments and youth are receiving them late due to lack of staffing. Doctor 1 reported they are making it a priority to see those youth who have come in with medication first. Doctor 1 reported they are understaffed. Doctor 1 reported they are missing a total of six registered nurses and one doctor. During the course of the investigation, one more doctor quit, but Doctor 1 reported there were interviews set up to replace some of these positions. Doctor 1 reported that the youth in the G Pod have to come to the medical offices in the building to be seen. This causes an issue as well as not having enough staff to fulfill the duties needed.</p> <p>Due to the above findings, I requested the names of the youth who had not received their initial health assessment as of this date as well as the Health and Wellness Pod initial health assessments. Doctor 1 provided the below information:</p> <p><b><u>Youth who have not received their initial health assessments:</u></b></p> <table border="1" data-bbox="480 1289 1312 1892"> <thead> <tr> <th data-bbox="480 1289 846 1329"><b>YOUTH</b></th> <th data-bbox="846 1289 1312 1329"><b>DATE OF ENTRY</b></th> </tr> </thead> <tbody> <tr> <td data-bbox="480 1329 846 1365">Youth U</td> <td data-bbox="846 1329 1312 1365">3/1/23</td> </tr> <tr> <td data-bbox="480 1365 846 1400">Youth V</td> <td data-bbox="846 1365 1312 1400">11/2/22</td> </tr> <tr> <td data-bbox="480 1400 846 1436">Youth W</td> <td data-bbox="846 1400 1312 1436">3/16/23</td> </tr> <tr> <td data-bbox="480 1436 846 1472">Youth X</td> <td data-bbox="846 1436 1312 1472">3/18/23</td> </tr> <tr> <td data-bbox="480 1472 846 1507">Youth Y</td> <td data-bbox="846 1472 1312 1507">3/15/23</td> </tr> <tr> <td data-bbox="480 1507 846 1543">Youth Z</td> <td data-bbox="846 1507 1312 1543">2/6/23</td> </tr> <tr> <td data-bbox="480 1543 846 1579">Youth AA</td> <td data-bbox="846 1543 1312 1579">3/14/23</td> </tr> <tr> <td data-bbox="480 1579 846 1614">Youth BB</td> <td data-bbox="846 1579 1312 1614">3/13/23</td> </tr> <tr> <td data-bbox="480 1614 846 1650">Youth CC</td> <td data-bbox="846 1614 1312 1650">3/4/23</td> </tr> <tr> <td data-bbox="480 1650 846 1686">Youth DD</td> <td data-bbox="846 1650 1312 1686">2/25/23</td> </tr> <tr> <td data-bbox="480 1686 846 1722">Youth EE</td> <td data-bbox="846 1686 1312 1722">3/26/23</td> </tr> <tr> <td data-bbox="480 1722 846 1757">Youth FF</td> <td data-bbox="846 1722 1312 1757">3/28/23</td> </tr> <tr> <td data-bbox="480 1757 846 1793">Youth GG</td> <td data-bbox="846 1757 1312 1793">3/24/23</td> </tr> <tr> <td data-bbox="480 1793 846 1829">Youth HH</td> <td data-bbox="846 1793 1312 1829">3/29/23</td> </tr> <tr> <td data-bbox="480 1829 846 1864">Youth II</td> <td data-bbox="846 1829 1312 1864">3/29/23</td> </tr> </tbody> </table> | <b>YOUTH</b> | <b>DATE OF ENTRY</b> | Youth U | 3/1/23 | Youth V | 11/2/22 | Youth W | 3/16/23 | Youth X | 3/18/23 | Youth Y | 3/15/23 | Youth Z | 2/6/23 | Youth AA | 3/14/23 | Youth BB | 3/13/23 | Youth CC | 3/4/23 | Youth DD | 2/25/23 | Youth EE | 3/26/23 | Youth FF | 3/28/23 | Youth GG | 3/24/23 | Youth HH | 3/29/23 | Youth II | 3/29/23 |
|----------------------|---|--------------|----------------------|---------|--------|---------|---------|---------|---------|---------|---------|---------|---------|---------|--------|----------|---------|----------|---------|----------|--------|----------|---------|----------|---------|----------|---------|----------|---------|----------|---------|----------|---------|
| <b>YOUTH</b>         | <b>DATE OF ENTRY</b>  |              |                      |         |        |         |         |         |         |         |         |         |         |         |        |          |         |          |         |          |        |          |         |          |         |          |         |          |         |          |         |          |         |
| Youth U              | 3/1/23  |              |                      |         |        |         |         |         |         |         |         |         |         |         |        |          |         |          |         |          |        |          |         |          |         |          |         |          |         |          |         |          |         |
| Youth V              | 11/2/22   |              |                      |         |        |         |         |         |         |         |         |         |         |         |        |          |         |          |         |          |        |          |         |          |         |          |         |          |         |          |         |          |         |
| Youth W              | 3/16/23   |              |                      |         |        |         |         |         |         |         |         |         |         |         |        |          |         |          |         |          |        |          |         |          |         |          |         |          |         |          |         |          |         |
| Youth X              | 3/18/23   |              |                      |         |        |         |         |         |         |         |         |         |         |         |        |          |         |          |         |          |        |          |         |          |         |          |         |          |         |          |         |          |         |
| Youth Y              | 3/15/23   |              |                      |         |        |         |         |         |         |         |         |         |         |         |        |          |         |          |         |          |        |          |         |          |         |          |         |          |         |          |         |          |         |
| Youth Z              | 2/6/23  |              |                      |         |        |         |         |         |         |         |         |         |         |         |        |          |         |          |         |          |        |          |         |          |         |          |         |          |         |          |         |          |         |
| Youth AA             | 3/14/23   |              |                      |         |        |         |         |         |         |         |         |         |         |         |        |          |         |          |         |          |        |          |         |          |         |          |         |          |         |          |         |          |         |
| Youth BB             | 3/13/23   |              |                      |         |        |         |         |         |         |         |         |         |         |         |        |          |         |          |         |          |        |          |         |          |         |          |         |          |         |          |         |          |         |
| Youth CC             | 3/4/23  |              |                      |         |        |         |         |         |         |         |         |         |         |         |        |          |         |          |         |          |        |          |         |          |         |          |         |          |         |          |         |          |         |
| Youth DD             | 2/25/23   |              |                      |         |        |         |         |         |         |         |         |         |         |         |        |          |         |          |         |          |        |          |         |          |         |          |         |          |         |          |         |          |         |
| Youth EE             | 3/26/23   |              |                      |         |        |         |         |         |         |         |         |         |         |         |        |          |         |          |         |          |        |          |         |          |         |          |         |          |         |          |         |          |         |
| Youth FF             | 3/28/23   |              |                      |         |        |         |         |         |         |         |         |         |         |         |        |          |         |          |         |          |        |          |         |          |         |          |         |          |         |          |         |          |         |
| Youth GG             | 3/24/23   |              |                      |         |        |         |         |         |         |         |         |         |         |         |        |          |         |          |         |          |        |          |         |          |         |          |         |          |         |          |         |          |         |
| Youth HH             | 3/29/23   |              |                      |         |        |         |         |         |         |         |         |         |         |         |        |          |         |          |         |          |        |          |         |          |         |          |         |          |         |          |         |          |         |
| Youth II             | 3/29/23   |              |                      |         |        |         |         |         |         |         |         |         |         |         |        |          |         |          |         |          |        |          |         |          |         |          |         |          |         |          |         |          |         |

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|                   | Youth JJ  | 3/29/23              |                           |
|                   | Youth KK  | 3/29/23              |                           |
|                   | Youth LL  | 3/23/23              |                           |
|                   | Youth MM  | 3/24/23              |                           |
|                   | Youth NN  | 3/27/23              |                           |
|                   | Youth OO  | 3/23/23              |                           |
|                   | Youth PP  | 3/21/23              |                           |
|                   | <b><u>Youth on Health and Wellness Pod with late initial health assessments:</u></b>  |                      |                           |
|                   | <b>YOUTH</b>  | <b>DATE OF ENTRY</b> | <b>DATE OF ASSESSMENT</b> |
|                   | Youth L   | 8/11/22              | 8/22/23                   |
| Youth M           | 12/2/21   | 12/6/21              |                           |
| Youth N           | 8/18/22   | 8/22/22              |                           |
| Youth O           | 7/14/22   | 7/26/22              |                           |
| Youth P           | 9/10/22   | 3/22/23              |                           |
| Youth Q           | 8/31/22   | 9/16/22              |                           |
| Youth R           | 8/8/22  | 2/16/23              |                           |
| Youth S           | 1/20/22   | 3/28/23              |                           |
| Youth T           | 10/3/22   | 3/5/23               |                           |
| <b>Analysis</b>   | There are 11 youth that I reviewed who had a completed initial health assessment, but they were not done within 24 hours of admission. There are currently 22 youth who have not been seen for their initial health assessment. The dates of completion rane from one day late to five months late. |                      |                           |
| <b>Conclusion</b> | <b>Violation Established</b>  |                      |                           |

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| <b>Rule Code &amp; Section Description</b> | <p><b>CCI Rule 400.4109 Program statement</b></p> <p><b>(1) An institution shall have and follow a current written program statement which specifically addresses all of the following:</b></p> <p><b>(c) Policies and procedures pertaining to admission, care, safety, and supervision, methods for addressing residents' needs, implementation of treatment plans, and discharge of residents.</b></p> |
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| <b>Violation Type</b> | Additional Findings of Non-Compliance   |
| <b>Allegation</b>     | <p>#1 Allegation: Staff are not following the procedure of ensuring youth bedroom doors are locked.</p> <p>#2 Staff are not following the daily logging outlined in the Temporary Disaster Plan.</p>  |
| <b>Investigation</b>  | <p><b>#1 Allegation: Staff are not following the procedure of ensuring youth bedroom doors are locked.</b></p> <p>On 3/23/23, Director 1 reported that staff have been trained to look at the locks before closing the door to a youth's room to ensure that the youth have not placed something in the locks. Director 1 reported that now the youth are ripping blankets and shimmying them up the door to unlock the door.</p> <p>On 4/20/23, Administrator 1 reported the locks to the youth's doors are to be checked by the staff when the doors are opened and closed. Administrator 1 reported Director 1 trained them on how to do this. Administrator 1 reported she doesn't not have any written policies or procedures on this.</p> <p><b>A room check was completed on 3/27/23, requested by DCWL and MDDHS Worker 2. On 3/28/23, Administrator 1 reported the following via email:</b></p> <p>"During the inspection, we located multiple rooms that need to be serviced for missing wall plates. The loose wall plates were removed...During the searches, we also discovered that several doors had hardened milk cartons stuffed inside the door mechanism, which allows them to exit easily. Also inside the rooms was an excess amount of milk cartons, torn fabric material, and trash from meals that had not been discarded. These items were removed."</p> <p>Sheriff 1 reported on 3/30/23 that the milk cartons were visible when you look into the lock.</p> <p>Staff 1 reported on 3/23/30 youth will place tissue in their locks if staff are not paying attention.</p> <p>Staff 6 reported on 4/20/23 that staff are supposed to look into the locks and the floor bolts to make sure that the youth are not placing anything in the locks. Staff 6 reported that staff do not always do this.</p> |

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|                   | <p>On 4/14/23 and 4/20/23, Administrator 1 was asked to provide the Director Reports outlined in the Disaster Plan. Administrator 1 did not provide the reports.</p> <p>On 4/30/23, Administrator 1 reported that supervisors are not completing logs although this is outlined in the Disaster Plan.</p>  |
| <b>Analysis</b>   | <p>The agency has a procedure for looking into the locks to ensure that youth are not placing items in the locks. This process ensures the safety of youth and staff. Based on interviews and the latest room search, this is not being done consistently, although Administrator 1 and Director 1 both report they are to be done. Because this is a process to help supervise youth, the agency is to have this written down as a procedure or within their policies.</p> <p>The agency is not completing Director Reports or supervision logs as outlined in their Disaster Plan.</p> |
| <b>Conclusion</b> | <p><b>Repeat Violation Established</b></p> <p><b>SI 2023C0000207</b></p>   |

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| <b>Rule Code &amp; Section Description</b> | <b>CCI Rule 400.4138 Bedding and linen<br/>(2) Each resident shall be provided with clean sheets and a pillowcase at least weekly and more often if soiled.</b>  |
| <b>Violation Type</b>                      | Additional Findings of Non-Compliance  |
| <b>Allegation</b>                          | There are no sheets on the beds in the youth's room.   |
| <b>Investigation</b>                       | <p>I walked through the facility on 3/23/23 and 3/30/23 and went into Pod A, C, G, and H. None of the beds had sheets for the mattress.</p> <p>On 4/30/23, I interviewed Administrator 1. Administrator 1 reported she did not know why the youth did not have sheets on their beds.</p> |
| <b>Analysis</b>                            | None of the youth are provided sheets to sleep on.   |
| <b>Conclusion</b>                          | <b>Violation Established</b>   |

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| <b>Rule Code &amp; Section Description</b> | <b>CCI Rule 400.4116 Chief administrator; responsibilities</b><br>(1) An agency shall assign the chief administrator responsibility for the onsite day-to-day operation of the institution and for ensuring compliance with these rules.   |
| <b>Violation Type</b>                      | Additional Findings of Non-Compliance  |
| <b>Allegation</b>                          | The agency is not in compliance with rules or with the CAP's that have been put into place.  |
| <b>Investigation</b>                       | <p>On 3/23/23, I spoke to Administrator 1 concerning Pod C. There were dried feces and bodily fluids on the walls and the air vent in the room. On 3/30/23 and 4/20/23 I observed Pod C and the same walls have not been cleaned yet. This information was once again provided to Administrator 1 and Director 1.</p> <p>I spoke to Administrator 1 on 3/30/23 and reported that youth do not have proper hygiene supplies. It was stated that the youth will need to receive these items. Administrator 1 reported she was unaware that the youth did not have hygiene products. Administrator 1 reported she had just ordered some and didn't know why the youth did not have hygiene.</p> <p>Administrator 1 emailed me on 3/31/23 and reported that all "youth have been issued toothpaste, soap, lotion, deodorant, and toothbrushes. A roster will indicate youth initials for receipt."</p> <p>Administrator 1 reported that staff are to keep a log of when youth are allowed out of their room for various activities. Administrator 1 reported she was unsure if the staff were completing this.</p> <p>On 4/20/23, I interviewed Administrator 1 face to face at the facility. Administrator 1 reported she was unaware of any interventions put into place concerning Youth K's weight loss. Administrator 1 reported she was unsure if he was receiving doubles in food or extra snacks. Administrator 1 reported she though he was getting "ensure" drinks. Administrator 1 reported she contacted medical department days before he went to the hospital to check on him.</p> <p>Administrator 1 reported she was unaware that youth did not have clothes, were not receiving their Initial health assessments, were not getting food on time or missed food at all. Administrator 1 reported that she is not receiving the Director Reports, although she has been recently asking to be given these. Administrator 1 reported that she does not believe she is the personal responsible</p> |

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|                        | <p>or the chief administrator for the day-to-day operations of the facility, although she did acknowledge that she signs the corrective action plans and that her name is on the license. Administrator 1 reported that she walks through the pods daily. Administrator 1 reported that the youth and staff have never told her through her walk throughs that they needed showers, food, clothing or hygiene. Administrator 1 reported she has asked the youth about these things and none of them reported they needed these things. Administrative 1 reported that the corrective action plans are not consistently being done. Administrative 1 reported that she does not have to follow the old caps because Director 2, Director 3, and Director 4, and Director 5 told her she did not have to.</p> <p>Administrator 1 reported that Consultant 2 reported to her that she was unable to use the floor bolts by the door. Administrator 1 reported that Consultant 2 did not provide her a rule and later had a meeting with Director 2, Director 3, Director 4, and Director 5 and they did not tell her she had to remove the locks. Administrator 1 reported they didn't tell her she could use them but didn't tell her she couldn't either. Administrator 1 reported that she needed that in writing. I verbally reported to her that she could not use them and reported she would have an email from DCWL as well stating that.</p> <p>The facilities corrective action plans were reviewed and found to be in non-compliance.</p> |
| <p><b>Analysis</b></p> | <p>The agency is in violation of multiple rules. Administrator 1 reported she was unaware of the multiple issues that her facility was having, although she reported that she walks through the facility daily. Administrator 1 reported she was not receiving Director Reports. Administrator 1 reported she is working on completing corrective action plans (CAP), but they are not consistently being completed.</p> <p>Numerous CAPS are in noncompliance.</p> <p>Administrator 1 is on the license as the chief administrator. Administrator 1 repeated that she is not the Chief Administrator and that she has other job duties to perform and that this facility is a small percentage of that job. Administrator 1 reported that does have her name on the license, signs off on all CAPS, completes variance requests, and is writing the policies.</p>  |

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|                          | <p>It is the chief administrator’s responsibility for the onsite day-to-day operation of the institution and for ensuring compliance with these rules. The lack of knowledge of the everyday basic needs and lack of knowledge of the non-compliances throughout the facility reveal the lack of involvement she has with Operations Managers, Supervisors, and medical professionals. Administrator 1 has not been inserting herself into her role completely and by her own admission, she has not felt responsible to perform the role or take responsibility for the role. Administrator 1 has selectively chosen the areas that she is involved in, CAPS, variances, policies, and procedures, and even meeting with a youth in December 2022, but has not fully accepted the responsibility of the functioning or lack thereof in the facility. CAPS are a part of the chief administrator’s role and Administrator 1 reported that she has been looking into those and knows that they are not consistently completed.</p> |
| <p><b>Conclusion</b></p> | <p>Violation Established</p>  |

**IV. RECOMMENDATION**

Based on investigative findings the facility is not in compliance with all applicable licensing statutes and rules. Upon receipt of an acceptable corrective action plan, it is recommended that the license be modified to a First Provisional license/Revocation of license.



May 22, 2023

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Venus M. Decker  
Licensing Consultant

Date

Approved By:



August 29, 2023

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Claudia Triestram  
Program Manager

Date

# **Exhibit 2**



STATE OF MICHIGAN  
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
LANSING

GRETCHEN WHITMER  
GOVERNOR

ELIZABETH HERTEL  
DIRECTOR

January 3, 2024

Mark McGhee  
Wayne County Juvenile Detention Center  
3501 Hamtramck Dr.,  
Hamtramck, MI, 48211

Re: License #: CE820414010  
SIR#: 2023C0000325

Dear Mark McGhee:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each rule will be achieved.
- For any repeat violations, why the prior corrective action plan did not result in compliance.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the action steps will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available, and you need to speak to someone immediately, please contact the area manager at (517) 899-6024.

Sincerely,



Chris Barr, Licensing Consultant

enclosure

**MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES  
DIVISION OF CHILD WELFARE LICENSING  
SPECIAL INVESTIGATION REPORT**

**\*\*\*This report contains sexually implicit information\*\*\***

**I. IDENTIFYING INFORMATION**

**License #:** CE820414010

**Licensee Group Organization:** County of Wayne

**Licensee Designee:** Melissa Ann Fernandez

**Chief Administrator:** Mark McGhee

**Agency Name:** Wayne County Juvenile Detention Center

**Agency Address:** 3501 Hamtramck Dr.  
Hamtramck, MI 48211

**License Status:** Original

**License Expiration Date:** 05/14/2023

**Capacity:** 180

**II. METHODOLOGY**

| <b>Contact Date</b> | <b>Contact Method</b> | <b>Contact Purpose</b> |
|---------------------|-----------------------|------------------------|
| 03/15/2023          | On-site               | Unannounced Visit      |
| 03/15/2023          | Phone                 | Interview              |
| 03/20/2023          | Face to Face          | Interview              |
| 03/21/2023          | Face to Face          | Video review           |
| 07/18/2023          | Face to Face          | Interview              |
| 07/27/2023          | Face to Face          | Interview              |
| 09/19/2023          | Telephone             | Pre-dispo. Conference  |
| 10/11/2023          | Face to Face          | Informational          |

### III. INVESTIGATION

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| <b>Rule Code &amp; Section Description</b> | <b>CCI Rule 400.4126. Sufficiency of Staff</b><br>The licensee shall have a sufficient number of administrative, supervisory, social service, direct care, and other staff on duty to perform the prescribed functions required by these administrative rules and in the agency's program statement and to provide for the continual needs, protection, and supervision of residents.   |
| <b>Violation Type</b>                      | Potential Rule or Statute Violation   |
| <b>Allegation</b>                          | On 03/15/23, youth received a physical and sexual assault exam. Youth was assaulted by 4 other youth at facility while staff were in their office. The assault occurred 03/14/23 and there are concerns staff did not observe for an hour.  |
| <b>Investigation</b>                       | <p>Consultant 1 reviewed intake dated 03/15/2023. It states Youth A, Youth B, Youth C, Youth D, Youth E, and Youth F were placed at the facility and Youth A was brought to the hospital on 03/15/2023 for a sexual assault and physical exam. It was alleged that Youth A was jumped and raped by Youth B, Youth C, Youth E and Youth F. Staff were reported to be in the office and did not see what happened. Youth A did not say anything to staff at first because the youth threatened him. Staff noticed Youth A to have a swollen eye and brought him to the hospital. All five youth jumped and anally penetrated him on 03/14/2023 between 10:00pm and 11:00pm. Youth A has a swollen right eye. A rape kit will be completed. There are concerns that staff did not witness the assault for an hour.</p> <p><b>Interviews:</b><br/>         Consultant 1 and DHHS Worker interviewed <u>State Police 1</u> at Children's Hospital on 03/15/2023. He reported Youth A stated he was inside room 7 just outside of the cameras view when approximately four to five other youth entered and physically assaulted him. Youth A then reported entering his room, Room 10, wearing shorts and underwear when he was held down by four youth and another Youth penetrated him. Youth A told State Police 1 Youth B and Youth E ejaculated on him. Youth A then reported stepping outside his room into the common area and being instructed to stand on top of a table to be in view of the cameras before being physically assaulted again. Youth A reported the doors at the facility not locking. State Police 1 noted Youth A is not to be interviewed further due to the police investigation.</p> <p>Consultant 1 interviewed hospital <u>Nurse 1</u> with DHHS Worker on 03/15/2023. She reported Youth A having bruised ribs and</p> |

extremities and he reported pain/discomfort to his buttocks. She noted Youth A requiring follow up for his eye and prophylaxis.

Consultant 1 interviewed hospital Nurse 2 with DHHS Worker on 03/15/2023. She reported taking Youth A's statement regarding his alleged sexual assault. She reported Youth A did not allow her to examine his buttocks or genital region though did allow her to swab his upper body. Results of the swab were not available at time of the writing of this report.

Consultant 1 interviewed Chief Administrator, via telephone, on 03/15/2023 and in person on 03/21/2023. She reported the youth from the Health and Wellness unit returned from visits at approximately 07:00PM on 03/14/2023. The youth did not go back inside their rooms and noted a breakout did not occur. She reported that at 8:00PM youth should be in their rooms with the doors locked. If youth refuse to enter their room, then those doors and any unassigned room doors should be closed and locked. She reported staff remained inside the control room which does not have direct visual contact of all the rooms on the unit. She reported the following staff worked the 3:00-11:00PM shift on 03/14/2023: Staff Person 1, Staff Person 2, Staff Person 3, and Supervisor 1. The following staff worked the 11:00pm-7:00AM shift: Staff Person 4, Staff Person 5, and Supervisor 2.

Consultant 1 observed Youth A's Kid-Talk interview on 03/20/2023 with DHHS Worker, State Police 1, State Police 2, and Kid-Talk Interviewer. Youth A stated he was beat and raped at the facility on pod B of the Health and Wellness unit on 03/14/2023 by Youth B, Youth C, Youth D, Youth E, and Youth F. He reported he and other youth being returned to the unit after visits at approximately 05:00pm. He reported Youth B first spoke with him on the side of the office control room at which point he was punched in the face. Youth A noted that Staff Person 4 and Staff Person 5 were inside the office though later in the interview stated staff were checking on the other pods. Youth A reported Youth D and Youth F then punched him in the face while on the first floor.

Youth A went on to report Youth B instructed him to walk upstairs and enter room 7 where he was rushed and beaten by Youth B, Youth C, Youth D, Youth E, and Youth F noting that someone "stomped" on his head with a foot. After being beat, Youth A reported all the youth went downstairs and he was made to clean room 7. Youth A stated Staff Person 4 and Staff Person 5 were inside the control room office when he was beaten inside second floor room 7.

Youth A then reported all doors on the pod are broken and staff lock all the locks. He said staff know about the problems with the locks and youth being able to get out. Youth A further stated that Staff Person 4 and Staff Person 5 are scared and only enter the pod when the youth are inside their rooms with the doors locked.

Youth A refused to discuss what had occurred in downstairs room 10 and his allegations of being raped by other youth. Youth A stated his mother told him to talk and that he wanted to see a lawyer. He noted the incident had already been reported in the newspaper and that he did not feel safe inside the interview room with the cameras documenting his interview.

Mother met with Kid-Talk interviewer, DHHS Worker, State Police 1, State Police 2, and Consultant 1 following Youth A's 03/20/2023 interview. She noted Youth A being scared and nervous about the interview and that he could come back at another time.

I interviewed Youth E onsite on 07/27/2023 with DHHS Worker. He reported he has pending charges of rape and denies raping Youth A and stated no other youth raped Youth A. Youth E reported Youth A was talking about his sister and that he threatened to "blow his (expletive) out". He reported all the youth refused to step-down. Staff remained in the control room and did not enter the unit due to someone on the unit having COVID. Youth E reported fighting with Youth A three times noting these fights occurred in the upstairs room 7, downstairs room 12, and the downstairs open area. Youth E does not know why Youth A came out of the room wearing only shorts.

I interviewed Staff Person 1 onsite on 07/18/2023 with DHHS Worker and Union Representative 1. She reported being employed by the facility for 14 months and being assigned to the control room desk on 03/14/2023. She reported the youth of units A and B were out of their rooms and she and Staff Person 2 refused to take the pod, meaning accepting the unit to supervise, because the youth were not supposed to be out of their rooms during shift change. She reported accepting the units, meaning accepting responsibility, of the units sometime around 3:30 or 4:00PM and that they proceeded with programing to include cleaning, but stated the B unit youth never entered their rooms. Staff Person 1 reported she would go inside the pod if needed though she also stated she needed to stay in the control room. She reported Staff Person 3 arrived late for the beginning of the shift and began taking the youth to visitation noting that Staff Person 3 left the pod and came back to relieve her at

10:18PM. Staff Person 1 reported observing nothing out of the ordinary during her shift noting that Staff Person 2 and Staff Person 3 entered units A, B, and C when needed. She recalled later in the evening that the youth in units A and C were in their rooms and the youth in unit B were outside of their rooms playing cards and horseplaying. Staff Person 1 reported she did not observe Youth A attempt to leave the unit, nor did she see him get hit or wipe away tears. Staff Person 1 did observe youth go upstairs and enter a room then come back out. Staff Person 1 stated she reported this to Supervisor 1 and entered it in the logbook. Staff Person 1 reported 15-minute checks of youth occur by entering the pod to view the youth or observe them through the pod door. Staff Person 1 reported if youth are in their rooms then staff are to enter the pod and check on the youth in their rooms.

I interviewed Staff Person 2 onsite with Union Representative 2 on 07/18/2023 with DHHS Worker. He reported being employed by the facility for 33 years and worked the 3:00-11:00PM shift on 03/14/2023. He stated he was assigned to the Health and Wellness unit with Staff Person 1 and Staff Person 3. He reported initially refusing to “take the pod” because it was just him and Staff Person 1. All the youth were out of their rooms and had been out for four days. He reported one staff is to remain in the control room and that he contacted Supervisor 3 because of the youth being out of their rooms. He reported Supervisor 3 instructed him to monitor the units from the control room. Staff Person 2 did not know how often he was actually in the control room. Staff Person 2 reported going into units A, B, and C and sometimes he would have visual contact of the youth as he moved between the units. He reported staff being able to do variable interval checks to see inside some of the rooms from the control room, noting one room cannot be seen into, though he stated the cameras can see into the room. Staff Person 2 reported 15-minute checks occur when the youth are in their rooms and when they are out staff can see the youth through the control room window.

Staff 2 stated he was assigned to the H&W pod, which has three units (A, B, C). Staff Person 2 reported 18 youth were on the three units. Youth A was transferred from unit A to unit B. He reported Staff Person 3 entered the unit at approximately 04:15PM and that dinner, showers, medication administration, and visits were performed. Staff Person 3 left the unit at approximately 06:45PM and later returned at approximately 10:30PM. Staff Person 2 reported Youth A and Youth E were horseplaying near the door to the unit and he opened the door and instructed the two youth to go back inside their rooms. Staff Person 2 reported Youth E exclaimed

“Run out of the pod” so Youth A attempted to run out of the unit through the door. Staff Person 2 reported he stood in the doorway preventing Youth A’s egress from the unit. Staff Person 2 denied putting his hands on Youth A or pushing him. Staff Person 2 went on to state that Youth A did not appear to be in any distress during that time. Staff Person 2 reported he does not recall observing more than one youth in one bedroom at the same time. He also reported that if two or more youth are observed in the same room, at the same time, that he would go onto the unit and tell them to get out. Staff Person 2 reported he did not see Youth A get hit, was not informed of any fights, and did not see Youth A crying. Staff 2 was assigned to the H&W pod, which has three units (A, B, C).

I interviewed Staff Person 3 onsite on 07/18/2023 with DHHS Worker. She reported being employed by the facility since 11/2021 and worked the 7:00AM-3:00PM shift and being mandated to work the 3:00-11:00PM shift on 03/14/2023. She reported entering the Health and Wellness unit with Staff Person 1 and Staff Person 2 at approximately 4:45PM and began assisting with youth visitations. She then reported exiting the unit after 7:00PM to assist with staff breaks on other units. She returned to the Health and Wellness unit at 10:30PM before leaving the facility at 11:00PM. Staff Person 3 reported when there is enough staff that staff enter the units and when there is not enough staff it is appropriate to supervise the youth through the windows of the control room. Staff Person 3 reported when she came back to the unit at 10:30PM that Staff Person 1 exited the floor, and Staff Person 2 conducted the rounds but she did not recall if he did it for all the units. Staff Person 3 reported 15-minute bed checks occur when the youth are in their rooms, and noted staff are supposed to be in each of the units when the youth are out of their rooms. Staff Person 3 reported it is acceptable practice for staff to supervise the youth through the control room window. She also reported if youth go inside a room or are out of the line of sight then staff should go on the unit to make a visual check. Staff Person 3 did not recall speaking with any youth at 10:40PM.

I interviewed Staff Person 4 onsite on 07/18/2023 with DHHS Worker. He reported being employed by the facility for three years and worked the 11:00PM-7:00AM shift starting on 03/14/2023. He recalled speaking with Staff Person 1 and informed him that the B-unit had a COVID+ youth and no behavioral problems were noted. Staff Person 4 reported the A and C units were locked in their rooms and the B unit was sitting at the table playing cards. He recalled at one time that Youth A was verbally threatening Staff Person 2 and Youth B told Youth A to take a swing at Staff Person

2. Staff Person 4 reported bed checks were conducted on A and C units because they were all locked in their rooms, whereas the B unit were not all in their rooms, though states Youth C and Youth D were in their rooms with their doors closed. Staff Person 4 reported Supervisor 1 and Supervisor 2 were informed of the B unit being out of their rooms. He went on to report that he was able to maintain line of sight supervision with all the youth in the common area though did not enter the unit because they were making verbal threats. He acknowledged that no one made 15-minute visual checks on Youth C and Youth D as they were inside their rooms. Staff Person 4 stated he was told by the supervisors not to go in the B unit after midnight because the youth were out of their rooms and due to the positive cases of COVID. Staff Person 4 reported all the youth were in line of sight, except for Youth C and Youth D, and running up and down the stairs. He said he did not see any youth go inside a room with each other. He reported Staff Person 5 did 15-minute bed checks on the youth in the A and C units though did not go into the B unit.

Staff Person 4 reported hearing a commotion at approximately 1:15AM and saw Youth A standing at the control room door. He instructed Staff Person 5 to check it out as he proceeded to check on the A and C units. He reported Youth A was only wearing shorts, though stated he was only wearing shorts throughout the shift. Staff Person 4 then reported Youth E started to hit Youth A two to three times and the supervisors were called. Staff Person 4 reported Supervisor 2 instructed him and Staff Person 5 not to enter the B unit but to monitor the youth through the windows because of the threats to harm them if they entered. He reported he and Staff Person 5 exited the control room and stood just outside the B unit door waiting for the supervisors to assist. He reported Supervisor 1 arrived and he and Staff Person 5 entered the B unit. Staff Person 4 transported Youth A out of the B unit and placed him in the C unit noting that he heard Youth A exclaim, "You guys raped me".

I interviewed Staff Person 5 onsite on 07/18/2023 with DHHS Worker. He reported being employed by the facility since 01/2023 and working in the Health and Wellness unit starting on 03/14/2023 from 11:00PM-7:00AM. He reported the shift update report indicated that the units were "ok", and Supervisor 2 began doing her rounds. Staff Person 5 reported prior to 03/2023 supervisors, including Supervisor 2, instructed staff not to enter the B unit because the youth were not stepping down and were testing positive for COVID. He also reported that Staff Person 4 couldn't enter the B unit on 03/14/2023 because the youth were threatening to harm him if he entered. Staff Person 5 reported that if youth

began fighting they are not to enter the unit and to wait for back-up to arrive. He also reported, hearing from Supervisor 2 and other administrators at the facility, that visual contact of youth from inside the control room is appropriate when the youth are in the open common area. He reported visual contact cannot be maintained if youth enter the rooms unless the room is positioned in front of the control room windows. Staff Person 5 reported observing Youth B, Youth E, and Youth F enter room 9 or 10 and that he did not know where Youth A was but was informed Youth A was inside his own room. Staff Person 5 then reported observing Youth B, Youth E, and Youth F run into Youth A's room and exit within two minutes. Youth A then exited his room with his shorts at his ankles. Staff Person 5 further reported Youth E began to repeatedly hit Youth A in the common area and Staff Person 4 initially said that they should go inside the unit, then said they shouldn't enter, and placed another call to Supervisor 1 and Supervisor 2 for their assistance.

I interviewed Supervisor 1 onsite on 07/18/2023 with DHHS Worker and Union Representative 3. He reported being employed by the facility for five years and as a supervisor for one of those years. He reported working 03/14/2023 for the 3:00-11:00PM shift and the 11:00PM-7:00AM shift as well. He recalled assigning Staff Person 1, Staff Person 2, and Staff Person 3 to the Health and Wellness unit at 3PM and for them to get the youth out of their rooms for recreation and shower time, noting that the B unit was already out of their rooms. He reported staff are required to go onto each of the units to perform their duties and noted that the B unit youth were to start their visitations at 4:00PM. Supervisor 1 reported entering the A unit with Staff Person 1 during dinner time and Supervisor 1 also entered the B unit around 9:00PM with the nurse. Supervisor 1 did not note any issues other than the youth refusing to enter their rooms. He also reported transferring Youth A from the A unit to the B unit because Youth A was having problems on the A unit. He stated Youth A was refusing to go in the C unit. Supervisor 1 stated he stayed on the Health and Wellness unit until shortly after 9:00PM when the nurse was done and he started his rounds on the rest of the facility.

Supervisor 1 reported 15-minute bed checks of youth start around dinner time and are continuous after that stating he observed checks as occurring prior to him leaving the unit at 9:00PM. Supervisor 1 reported two staff go onto each unit to do checks and one staff person stays in the control room. He reported staff are required to go onto each unit and visually check on all youth regardless if they are inside their rooms or not. Supervisor 1 noted Staff Person 4 couldn't go inside B unit due to the youth making

threats of physical violence. Supervisor 1 reported staff did not contact him once he left the unit at 9:00PM through the end of the 3:00-11:00PM shift. He then reported being contacted to arrive at the Health and Wellness unit at approximately 01:15AM due to Youth A being assaulted by Youth E. He reported Staff Person 4 and Staff Person 5 were positioned inside the control room when he arrived, and noted staff are to immediately intervene when a youth is being assaulted. He reported Staff Person 5 entered the B unit with him and the youth were still making threats toward Staff Person 4. He reported when Youth A was removed from the B unit and placed on the C unit that he heard Youth A state, "They sexually assaulted me".

I interviewed Supervisor 2 onsite on 07/18/2023 with DHHS Worker and Union Representative 1. She reported being employed by the facility for four years and has been a supervisor for one of those years. She reported working 03/14/2023 for the 11:00PM-7:00AM shift. She reported doing rounds on other units when supervisory assistance was called on the Health and Wellness unit at 1:20AM. She reported observing Staff Person 4 and Staff Person 5 in the control room and being informed that Youth A was just jumped, noting that the fight was over at that time. Supervisor 2 reported she observed Youth A being hit by Youth E and staff entered the unit to removed Youth A. Supervisor 2 reported staff are required to go on each unit to do 15-minute checks of all youth, regardless if they are in their rooms or not, and that staff are not supposed to just look through the control room windows. Supervisor 2 reported Youth A yelled through the window, "Everyone molested me except Youth C".

**Video Review:**

Consultant 1 reviewed video surveillance of unit B dated 03/14/2023 on the Health and Wellness Unit with DHHS Worker, Chief Administrator, Director, and Deputy on 03/21/2023. Facility administration reported Youth A being initially placed on the A unit and being transferred to the B unit due to threats by another youth. Youth A left the A unit to have a visit, returned to the gymnasium, and was then placed on the B unit after problems occurring on the A unit. Bedtime is 8:00PM and facility administration states that if a resident refuses to enter their bedroom that the room door should be closed and locked, as well as any other unassigned room. Camera view of the first floor shows a common area with tables, stairs, and downstairs room 10 is positioned behind a pillar. Facility administration supplied a timeline of events to accompany the viewing of the video surveillance of the pod common area. Noted below is an abridged version of what the facility presented and what

was viewed by this consultant.

This summary of video surveillance is between 06:16 pm and 01:29 pm starting on 03/14/2023:

- 06:16 pm - Youth A is escorted onto unit-B and staff leave.
- 08:00 pm - Staff did not enter the unit to lock-down youth in their respective cells.
- 08:41 pm – Supervisor 1 exits unit-B with a nurse.
- 09:18 pm – Youth A, Youth B, Youth C, Youth D, Youth E and Youth F are inside room 10-up (upstairs room 10).
- 09:20 pm – Staff Person 2 enters unit-B with a nurse and exits at 09:23 pm.
- 09:21 pm – All youth exit room 10-up and walk downstairs. Youth A appears to be wiping tears from his eyes and face.
- 09:38 pm – Youth surround Youth A who has his hands up. Youth D and Youth E are observed punching Youth A as he's seated at a table. Staff do not enter the unit.
- 09:51 pm – Youth A enters room 7-up along with all other youth who continually walk in and out of the room. Staff do not enter the unit.
- 10:05 pm – All youth, except Youth A, exit room 7-up. Staff Person 2 only stands at the door to speak with youth and does not fully enter the unit with a nurse. All youth, except for Youth A, are observed entering and exiting room 7-up.
- 10:08 pm – All youth, except for Youth A, are downstairs.
- 10:40 pm – Youth A exits room 7-up and walks downstairs.
- 10:48 pm – Staff Person 2 opens the unit door and gives Youth E towels. Staff Person 2 leaves and comes back and opens the unit door but does not fully enter the unit before exiting.
- 11:05 pm – Youth A is observed walking on the lower level of the unit with a towel on his head.
- 11:32 pm – Youth A is still observed walking on the lower level of the unit with a towel on his head.
- 12:13 pm – Staff Person 5 looks into unit B but does not enter.
- 12:24 pm – Staff Person 6 slides paperwork under Unit B door but does not enter.
- 12:33 pm – Staff Person 5 looks into unit B door but does not enter.
- It is noted that a pillar blocks video surveillance of the room 10-down door.
- 01:16 am – Youth A stands up on a table in the common

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|  | <p>area and appears naked. 22 seconds later Staff Person 4 is observed at the unit B door.</p> <ul style="list-style-type: none"> <li>• 01:17 am – Youth E and Youth F begin assaulting Youth A and go out of camera view. Staff Person 4 and Staff Person 5 walk toward Unit B door from outside the unit.</li> <li>• 01:23 am – Supervisor 2 enters the control room.</li> <li>• 01:26 am – Youth A is assaulted at tables.</li> <li>• 01:27 am – Supervisor 1 arrives and enters unit B as Youth E continues to assault Youth A. Staff Person 4 and Staff Person 5 enter unit B, and escort Youth A out of unit B.</li> </ul> <p><b>Documents Reviewed:</b><br/> Facility Juvenile Detention Specialist, general role and responsibilities policy was reviewed. It states, “It is the responsibility of Juvenile Detention Specialist staff (JDS) to provide and be responsible for the welfare, supervision, custodial care, safety, security, and development of youth detained in the Wayne County Juvenile Detention Facility (WCJDF).”</p> <p>Youth Movement and Supervision policy was reviewed. It states, “To ensure resident and public safety, residents will never be left unattended in any area inside or outside the Wayne County Juvenile Detention Facility (WCJDF). It is the WCJDF policy to maintain “line-of-sight” supervision by Juvenile Detention Specialists and all other facility staff...Line of Sight Supervision: Coordinating all activities of the residents under staff supervision so that visible contact is maintained, and the actions of the residents are known at all times.”</p> <p>Staff Person 1, Staff Person 2, Staff Person 4, Staff Person 5, and Supervisor 2’s personnel records were reviewed. Staff Person 1 was hired on 05/02/2022, oriented on 05/02/2022, and is up to date on her training. Staff Person 2 was hired on 04/02/1990, initial orientation records could not be found, and is up to date on his training. Staff Person 4 was hired on 01/21/2020, oriented on 01/23/2020, and is up to date on his training. Staff Person 5 was hired on 01/03/2023, oriented on 01/09/2023, and is up to date on his training. Supervisor 2 was hired on 01/28/2019 and oriented on 01/28/2019, and is up to date on her training.</p> <p>Facility incident report dated 03/15/2023 was reviewed. It states that approximately 01:15am Staff Person 4 and Staff Person 5 observed Youth A being assaulted by Youth B, Youth E, and Youth F. Staff Person 4 and Staff Person 5 radioed for assistance needed on the Health and Wellness unit. Supervisor 2 questioned Youth A about the assault, and he denied being assaulted. Youth B, Youth</p> |
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|                          | <p>E, and Youth F began to punch and kick Youth A. Supervisor 1 and Staff Person 5 entered the B side pod of the Health and Wellness unit, Youth A stated he had been physically and sexually assaulted around 10:30pm by Youth B, Youth D, Youth E, Youth F.</p> <p>A <u>pre-dispositional case conference</u> occurred on 09/19/2023. Another department through the State of Michigan determined Staff Person 1, Staff Person 2, Staff Person 4, and Staff Person 5 would be confirmed for improper supervision. A face-to face informational conference occurred with DHHS Worker on 10/11/2023. She indicated Supervisor 2 would also be confirmed for improper supervision.</p>   |
| <p><b>Analysis</b></p>   | <p>Staff did not provide for the continual needs, protection, and supervision of youth. Video surveillance shows that the 3:00-11:00PM and 11:00PM-7:00AM shift staff did not maintain line-of-sight supervision of youth per policy. Staff remained in the control room and did not enter the unit when youth got out of their line-of-sight by walking into bedrooms, as a group, or when staff's line-of-sight was obstructed by a column or the rooms being on the second floor and out of view.</p> <p>Staff did not enter the unit to close and lock doors of unoccupied rooms and rooms of youth refusing to enter noted as protocol by Chief Administrator.</p> <p>The 11:00PM-7:00AM shift did not immediately enter the unit when staff observed Youth A getting assaulted by other residents and waited for supervisor assistance.</p> |
| <p><b>Conclusion</b></p> | <p><b>Repeat Violation Established</b></p> <p>2023C0000550 initiated on 06/20/2023; CAP approved 10/19/23<br/>                 2023C0000516 initiated on 06/05/2023; CAP approved 10/20/23<br/>                 2023C0000392 initiated on 04/13/2023; CAP approved 10/31/23<br/>                 2022C0219053 initiated on 08/22/2022; CAP approved 1/18/23</p>   |

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| <p><b>Rule Code &amp; Section Description</b></p> | <p><b>R 400.4127 Staff to resident ratio.</b><br/>                 (4) When residents are asleep or otherwise outside of the direct supervision of staff, staff shall perform variable interval, eye-on checks of residents. The time between the variable interval checks shall not exceed fifteen minutes.</p> |
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| <b>Violation Type</b>      | Potential Rule or Statute Violation  |
| <b>Additional Findings</b> | Staff did not perform variable interval, eye-on checks of residents, not to exceed fifteen minutes.  |
| <b>Investigation</b>       | <p>During a phone call with <u>Chief Administrator</u> on 03/15/2023 and in person on 03/21/2023 she stated on the night of 03/14/2023 the staff remained inside the control room which does not have direct visual contact of all the rooms on the unit.</p> <p>During <u>Staff Person 1's</u> interview on 07/18/2023 it was reported 15-minute checks of youth occur by entering the pod to view the youth or observe them through the pod door. Staff Person 1 reported if youth are in their rooms that staff are to enter the pod and check the youth in their room. Staff Person 1 did observe youth go upstairs and enter a room then come out noting that she reported it to Supervisor 1 and entered it in the logbook.</p> <p><u>Staff Person 2</u> reported in his interview on 07/18/2023 that he went into units A, B, and C and that he would make visual contact of the youth as he moved between the units though not all the time. He reported staff being able to do variable interval checks to see inside some of the rooms from the control room, noting one room cannot be seen into, though he stated the cameras can see into the rooms. Staff Person 2 reported 15-minute checks occur when the youth are in their rooms and that when they are out the staff can see the youth through the control room window.</p> <p>During her interview on 07/18/2023 <u>Staff Person 3</u> reported when there are enough staff that staff enter the units and when there is not enough staff it is appropriate to supervise the youth through the windows of the control room. Staff Person 3 reported 15-minute bed checks occur when the youth are in their rooms and noted that staff are supposed to be in each of the units when the youth are out of their rooms. Staff Person 3 reported it is acceptable practice for staff to supervise the youth through the control room window. She also reported if youth go inside a room, or are out of the line of sight, that staff should go in the unit to make a visual check.</p> <p><u>Staff Person 4</u> reported in his interview on 07/18/2023 that on the night of 03/14/2023 bed checks were conducted on A and C units because the youth were all locked in their rooms, whereas the B unit youth were not all in their rooms. He stated Youth C and Youth D were in their rooms with their doors closed. He went on to report that he was able to maintain line of sight supervision with all the youth in the common area though did not enter the unit because</p> |

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|                        | <p>they were making verbal threats. He did acknowledge that no one made 15-minute visual checks on Youth C and Youth D as they were inside their rooms. Staff Person 4 stated he was told by the supervisors not to go in the B unit after midnight because the youth were out of their rooms and some had tested positive for COVID. Staff Person 4 reported all the youth were in line of sight, except for Youth C and Youth D. He reported Staff Person 5 did 15-minute bed checks on the youth in the A and C units though did not go into the B unit.</p> <p>During his interview on 07/18/2023 <u>Staff Person 5</u> reported visual contact of youth from inside the control room is appropriate when the youth are in the open common area, though he reported visual contact cannot be maintained if youth enter the rooms unless the room is positioned in front of the control room windows. Staff Person 5 reported on the night of 03/14/2023 observing Youth B, Youth E, and Youth F enter room 9 or 10 and that he did not know where Youth A was but was informed Youth A was inside his own room.</p> <p><u>Document Review:</u><br/>Pod Staffing / Pod Management policy was reviewed. It states, "When residents are in their rooms, they shall be checked and documented every fifteen (15) minutes to ensure safety and security. Residents placed on constant watch, check, and document every five (5) minutes.</p> <p><u>Video Review:</u><br/>Video review does not show staff enter the B unit to make a visual check of all residents every 15 minutes. Staff Person 4 noted that Youth C and D were in their rooms and staff did not enter the B unit to observe them which video surveillance supports. Furthermore, video surveillance shows staff did not enter the B unit to check on youth when more than one youth entered a room and were out of sight of staff.</p> |
| <p><b>Analysis</b></p> | <p>Video surveillance shows that staff did not complete variable interval checks, not exceeding fifteen minutes, as required for all youth. Staff report checking on youth through the control room window which cannot view into all rooms on the unit.</p> <p><u>Technical Assistance:</u><br/>The agency policy does not reflect the rule requirement of variable interval checks not to exceed 15 minutes. Part of the corrective action plan will need to be updating this policy.</p>  |

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| <b>Conclusion</b> | <b>Repeat Violation Established</b><br>2023C0000392 initiated on 04/13/2023; CAP Pending.<br>2022C0325005 initiated on 11/23/2021; CAP approved 4/21/22 |
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| <b>Rule Code &amp; Section Description</b> | <b>R 400.4112 Criminal history check, subject to requirements; staff qualifications.</b><br>(2) A person who has unsupervised contact with children shall not have been convicted of either of the following:<br>(a) Child abuse or neglect.<br>(4) A person with ongoing duties shall have both of the following:<br>(a) Ability to perform duties of the position assigned.<br>(b) Experience to perform the duties of the position assigned.   |
| <b>Violation Type</b>                      | Potential Rule or Statute Violation   |
| <b>Investigation</b>                       | <p>This investigation was completed in conjunction with another department through the State of Michigan. That investigation did have findings resulting in confirmed cases of improper supervision.</p> <p>During the above investigation <u>Staff Person 1</u> reported the youth of units A and B were out of their rooms and she and Staff Person 2 refused to take the pod because the youth were not supposed to be out of their rooms during shift change. She further indicated she observed youth go upstairs and enter a room then come back out noting she reported it to Supervisor 1 and entered it in the logbook. Staff Person 1 reported 15-minute checks of youth occur by entering the pod to view the youth or observe them through the pod door. Staff Person 1 reported if youth are in their rooms, then staff are to enter the pod and check on the youth in their room.</p> <p><u>Staff Person 2</u> reported initially refusing to “take the pod” because it was just him and Staff Person 1 and that all the youth were out of their rooms. Staff Person 2 reported going into units A, B, and C and that he would sometimes have visual contact of the youth as he moved between the units. He reported staff being able to do variable interval checks to see inside some of the rooms. Staff Person 2 reported 15-minute checks occur when the youth are in their rooms and when they are out staff can see the youth through the control room window. Staff Person 2 did not recall observing more than one youth in a bedroom at the same time.</p> <p><u>Staff Person 4</u> reported on the night of 03/14/2023 bed checks did not occur on B unit because the youth were not all in their rooms.</p> |

He did however state Youth C and Youth D were in their rooms with their doors closed. He said he was able to maintain line of sight supervision with all the youth in the common but no one made 15-minute visual checks on Youth C and Youth D. He said he did not see any youth go inside a room with other youth. Staff Person 4 reported he did not enter the unit when Youth E started to hit Youth A two to three times and the supervisors were called. Staff Person 4 reported Supervisor 2 instructed him and Staff Person 5 not to enter B unit and to monitor the youth through the windows. He reported he and Staff Person 5 exited the control room and stood just outside the B unit door waiting for the supervisors to assist.

Staff Person 5 reported prior to 03/14/2023 supervisors, including Supervisor 2, instructed staff not to enter the B unit because the youth were not stepping down and were testing positive for COVID. Staff Person 5 reported that if youth began fighting that they are not to enter the unit and to wait for back-up to arrive. He also reported that visual contact of youth from inside the control room is appropriate when youth are in the open common area. He reported visual contact cannot be maintained if youth enter their rooms unless the room is positioned in front of the control room windows. Staff Person 5 reported observing Youth B, Youth E, and Youth F enter room 9 or 10 and he did not know where Youth A was but was informed that Youth A was inside his own room. Staff Person 5 reported observing Youth B, Youth E, and Youth F run into Youth A's room and exit within two minutes then Youth A exited his room with his shorts at his ankles. Staff Person 5 reported Youth E began to repeatedly hit Youth A in the common area but he did not enter the unit and instead placed another call to Supervisor 1 and Supervisor 2 for their assistance.

Supervisor 1 reported he observed bed checks occurring prior to his leaving the unit on 03/14/2023 at 9:00PM. Supervisor 1 reported staff are required to go onto each unit and visually check on all youth regardless of if they are inside their rooms or not. Supervisor 1 noted that Staff Person 4 couldn't go inside of the B unit due to the youth making threats of physical violence. He reported Staff Person 4 and Staff Person 5 were positioned inside the control room when he arrived, and noted staff are to immediately intervene when a youth is being assaulted.

Supervisor 2 reported observing Staff Person 4 and Staff Person 5 in the control room and being informed that Youth A was just jumped. Supervisor 2 reported she observed Youth A being hit by Youth E and then staff entered the unit and removed Youth A. Supervisor 2 reported staff are required to go on each unit to do 15-

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|                   | minute checks of all youth, regardless if they are in their rooms or not, and staff are not supposed to just look through the control room windows.  |
| <b>Analysis</b>   | <p>Another department through the State of Michigan determined Staff Person 1, Staff Person 2, Staff Person 4, Staff Person 5, and Supervisor 2 have been confirmed for improper supervision.</p> <p>The staff responsible for the youth on the night of the incident with Youth A did not have the ability or experience to perform their duties as evidenced by their conflicting statements regarding staff entering the B unit and their reports that it is appropriate to observe youth through the control room window, yet supervisory staff reported line-of-sight checks needed to be made of all youth regardless of them refusing to enter their rooms.</p> |
| <b>Conclusion</b> | <p><b>Repeat Violation Established</b></p> <p>2023C0000550 initiated on 06/20/2023; CAP approved 10/19/23<br/> 2023C0000516 initiated on 06/05/2023; CAP approved 10/20/23<br/> 2023C0000454 initiated on 05/11/2023; CAP approved 10/24/23<br/> 2022C0103026 initiated on 09/14/2022; CAP approved 3/6/22</p>   |

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| <b>Rule Code &amp; Section Description</b> | <p><b>R 400.4158 Intervention standards and prohibitions.</b></p> <p>(1) A child caring institution shall establish and follow written policies and procedures that prohibit the following forms of interventions:</p> <p>(a) Any type of physical punishment including, but not limited to:</p> <p>(ii) Hitting or striking, throwing, kicking, pulling, or pushing a youth on any part of their body.</p>   |
| <b>Violation Type</b>                      | Additional Findings of Non-Compliance   |
| <b>Investigation</b>                       | <p>Consultant 1 reviewed video surveillance of unit B dated 03/14/2023 on the Health and Wellness Unit with DHHS Worker, Chief Administrator, Director, and Deputy on 03/21/2023.</p> <p>11:14:25 pm - Staff Person 2 leaves the control room and hands a tee shirt to an unknown youth on unit B.</p> <p>11:14:26 pm - Youth A is observed trying to run out of the unit past Staff Person 2. Staff Person 2 shoves Youth A back into the unit and closes the door.</p> <p>I interviewed <u>Staff Person 2</u> onsite with Union Representative 2 on 07/18/2023, with DHHS Worker. He reported being employed by</p> |

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|                   | <p>the facility for 33 years and worked the 3:00PM-11PM shift on 03/14/2023. That night he was assigned to the Health and Wellness unit with Staff Person 1 and Staff Person 3. Staff Person 2 reported Youth A and Youth E were horseplaying near the door to the unit and he opened the door to instruct them to go back inside their rooms. He reported Youth E exclaimed, "Run out of the pod" and Youth A did attempt to run out of the unit through the door. Staff Person 2 reported he stood in the doorway preventing Youth A's egress from the unit and denied putting his hands on Youth A or pushing him. Staff Person 2 went on to state that Youth A did not appear to be in any distress during that time.</p> |
| <b>Analysis</b>   | Staff Person 2 is observed on video shoving Youth A.  |
| <b>Conclusion</b> | <p><b>Repeat Violation Established</b><br/>                 2023C0000672SI initiated on 08/04/2023; CAP approved 10/20/23<br/>                 2023C0000267 initiated on 02/23/2023; CAP approved 9/25/23<br/>                 2023C0103026 initiated on 09/14/2022; CAP approved 3/6/22<br/>                 2022C0217058 initiated on 08/22/2022; CAP approved 11/21/22</p>   |

**IV. RECOMMENDATION**

Based on investigative findings the facility is not in compliance with all applicable licensing statutes and rules. Due to the violations a corrective action plan is required.



12/03/2023

Chris Barr  
Licensing Consultant

Date

Approved By:



12/7/2023

Rorie Dodge-Pifer  
Area Manager

Date

# **Exhibit 3**

**MICHIGAN DEPARTMENT OF STATE POLICE**

ORIGINAL INCIDENT REPORT

|   |                            |                                       |                           |
|---|----------------------------|---------------------------------------|---------------------------|
| <b>ORIGINAL DATE:</b><br>Wed, Mar 15, 2023                                |                            | <b>INCIDENT NO:</b><br>SIS-0000062-23 |                           |
| <b>TIME RECEIVED:</b><br>1145   |                            | <b>FILE CLASS:</b><br>11003           |                           |
| <b>WORK UNIT:</b><br>MSP SIS (2ND DISTRICT SPECIAL INVESTIGATIVE SECTION) |                            | <b>COUNTY:</b><br>WAYNE               |                           |
| <b>COMPLAINANT:</b><br>[REDACTED]   |                            | <b>TELEPHONE NO:</b>                  |                           |
| <b>ADDRESS: STREET AND NO:</b><br>[REDACTED]                              | <b>CITY:</b><br>[REDACTED] | <b>STATE:</b><br>MI                   | <b>ZIP CODE:</b><br>48211 |
| <b>INCIDENT STATUS:</b><br>OPEN   |                            |                                       |                           |

**CRIMINAL SEXUAL CONDUCT**

**INFORMATION:**

D/Lt. Rich Sanchez, Assistant Section Commander of Michigan State Police 2<sup>nd</sup> District Special Investigation Section, requested I go to [REDACTED] regarding a sexual assault that occurred at the [REDACTED]. D/Lt. Sanchez advised the victim, [REDACTED], was currently at [REDACTED]. The incident was reported to [REDACTED] by [REDACTED] who is the director of the [REDACTED].

**VENUE:**

WAYNE COUNTY

[REDACTED]  
[REDACTED], MI

**DATE & TIME:**

ON OR AFTER: TUE, MAR 14, 2023, AT 2200 AND BEFORE: TUE, MAR 14, 2023, AT 2300

**COMPLAINANT:**

**BUSINESS NAME:** [REDACTED]  
**ADDRESS:**  
[REDACTED]  
[REDACTED] MI 48211

**CODE: POLICE AGENCY**  
**DOT #**  
**ICC #**  
**MPSC #**  
**MISC #**

**INTERVIEW COMPLAINANT:**

I spoke with [REDACTED], who is the director of the [REDACTED], on March 16, 2023, regarding this incident. [REDACTED] advised he received a call while at home at approximately 2am (March 15, 2023) of a sexual assault that occurred at the [REDACTED]. [REDACTED] advised he attempted to contact D/Lt.

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| <b>PAGE:</b><br>1 of 7 | <b>INVESTIGATED BY:</b><br>DIGGS, DENNIS, 300, D/SERGEANT | <b>INVESTIGATED BY:</b> | <b>REVIEWED BY:</b> |
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**MICHIGAN DEPARTMENT OF STATE POLICE**

ORIGINAL INCIDENT REPORT

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| ORIGINAL DATE:<br>Wed, Mar 15, 2023 | INCIDENT NO:<br>SIS-0000062-23 |
| TIME RECEIVED:<br>1145              | FILE CLASS:<br>11003           |

Sanchez but was unsuccessful. He then made other notifications with the prosecutor's office and to his staff. [REDACTED] indicated he was able to speak with D/Lt. Sanchez about the incident. He also notified [REDACTED] who secured the scene where the incident occurred.

**VICTIM:**

NAM: [REDACTED]  
 BIR: [REDACTED] RAC: [REDACTED] ETH: [REDACTED]  
 NBR: [REDACTED] DIR: [REDACTED] SEX: [REDACTED] DL: /  
 STR: [REDACTED] DOB: [REDACTED] SSN: [REDACTED]  
 SFX: [REDACTED] HGT: ' " SI: /  
 CTY: [REDACTED] ST: MI WGT: [REDACTED] FBI: [REDACTED]  
 TXH: [REDACTED] ZIP: [REDACTED] HAI: [REDACTED] MNU: [REDACTED]  
 TXW: [REDACTED] EYE: [REDACTED] PR: [REDACTED]  
 CT: [REDACTED]  
 SMT: [REDACTED]

**INTERVIEW VICTIM:**

[REDACTED] was currently in an exam room at [REDACTED]. Also present with [REDACTED] were to officers, Ofc. Greenwade and Ofc. Mitchell, from the [REDACTED]. I asked the officers if I could speak with [REDACTED] privately. They agreed and stepped out of the exam room. I visually observed [REDACTED] had a swollen right eye. I identified myself to [REDACTED] and asked if [REDACTED] was willing to talk with me regarding the incident. [REDACTED] agreed to tell me what occurred. I then informed [REDACTED] that I would be audio recording the interview, to which [REDACTED] acknowledged.

After getting [REDACTED]'s personal information, I asked [REDACTED] to tell me where the incident occurred and explain what happened. [REDACTED] said the incident occurred in [REDACTED]. [REDACTED] began saying that [REDACTED] was on the lower level when [REDACTED], who was on the [REDACTED], was speaking on [REDACTED]. I asked [REDACTED] to explain what [REDACTED] meant. [REDACTED] said [REDACTED] is beefing with [REDACTED] and [REDACTED] ([REDACTED]). When I asked what the beef was about, [REDACTED] said [REDACTED] killed [REDACTED] ([REDACTED]) back in Oct 2018 (believed it occurred on Oct 18, 2018) near Avon and 7 Mile in Detroit. So, [REDACTED] said [REDACTED] wanted [REDACTED] to stop speaking about [REDACTED] and [REDACTED].

[REDACTED] said [REDACTED] then told [REDACTED] to come to the [REDACTED]. [REDACTED] said [REDACTED] went to the [REDACTED] and saw [REDACTED] inside of [REDACTED] by the door while [REDACTED], [REDACTED], [REDACTED], and [REDACTED] were all in the back of [REDACTED]. [REDACTED] said [REDACTED] closed the door as [REDACTED] entered [REDACTED]. [REDACTED] said [REDACTED] then runs up to [REDACTED] and began hitting and punching [REDACTED] with his fist. [REDACTED] said [REDACTED] fell to the floor and that is when [REDACTED] was kicked and stomped in the head and back by the suspects ([REDACTED], [REDACTED], [REDACTED], [REDACTED], and [REDACTED]).

[REDACTED] said the physical assault lasted approximately ten minutes and [REDACTED] went to [REDACTED] by [REDACTED] self. [REDACTED] said [REDACTED] was lying on [REDACTED] bed for approximately five minutes when all the suspects came to [REDACTED] cell. I specifically asked [REDACTED] which of the suspects [REDACTED] was referring to. [REDACTED] said all of them came inside [REDACTED] cell. [REDACTED] went on to say the six of them, including [REDACTED] self, were the only [REDACTED]. [REDACTED] said [REDACTED] was

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| PAGE:<br>2 of 7 | INVESTIGATED BY:<br>DIGGS, DENNIS, 300, D/SERGEANT | INVESTIGATED BY: | REVIEWED BY: |
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**MICHIGAN DEPARTMENT OF STATE POLICE**

ORIGINAL INCIDENT REPORT

|                                     |                                |
|-------------------------------------|--------------------------------|
| ORIGINAL DATE:<br>Wed, Mar 15, 2023 | INCIDENT NO:<br>SIS-0000062-23 |
| TIME RECEIVED:<br>1145              | FILE CLASS:<br>11003           |

laying on bed face down when four of the suspects pinned down at each limb. I asked if was able to tell me who grabbed which limb. said was pinned down by , , , and . right arm was pinned by , left arm was pinned by , left leg pinned by , and right leg pinned by . said was only wearing a pair of shorts and underwear when was laying on bed.

While was pinned on bed, said was wearing. said the said, "You my bitch!" and said fully . I asked if was saying anything at the time. said was . I also asked if believed if . said .

said was by all the suspects. After was done, moved to left arm and pinned it while then said for approximately 10 minutes; however, . When was done, went to right leg and got behind an for about 7-8 minutes. said After was done, went to right arm while got behind and for approximately 10 minutes. said when was done, went to right arm and moved to left arm. then got behind for approximately 8-9 minutes. said

said th . At the time of the interview, said the occurred in . did not articulate if it was on the upper level or lower level. I later learned that was being housed in on the lower level. After the said was told to go outside of the cell and stand on the table while for a few seconds. said went out, stood on the table for a few seconds, stepped off and began to put on when all the suspects began to physically assault again. said was punched and kicked by all the suspects before the staff came in and broke it up.

**MEDICAL FACILITY/INJURIES:**

was taken by the (Ofc. Greenwade and Ofc. Mitchell) to for treatment. was treated by Dr. Nirupama Kannikeswaran, MD. suffered swelling and contusions to the following areas:

- Left back scalp
- Right orbital
- Right nasal bridge
- Medial right orbital
- Anterior nose
- Left cheek
- Left jaw

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| PAGE:<br>3 of 7 | INVESTIGATED BY:<br>DIGGS, DENNIS, 300, D/SERGEANT | INVESTIGATED BY: | REVIEWED BY: |
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**MICHIGAN DEPARTMENT OF STATE POLICE**

ORIGINAL INCIDENT REPORT

|                                     |                                |
|-------------------------------------|--------------------------------|
| ORIGINAL DATE:<br>Wed, Mar 15, 2023 | INCIDENT NO:<br>SIS-0000062-23 |
| TIME RECEIVED:<br>1145              | FILE CLASS:<br>11003           |

**OTHER STATE AGENCIES:**

Heather Mercado [REDACTED] from the Michigan Department of Health and Human Services [REDACTED] and Christopher Barr, [REDACTED] from the Department of Human Services [REDACTED] were both present at [REDACTED]

**WAYNE COUNTY SHERIFF'S DEPARTMENT CONTACT:**

Sgt. Radken Smith [REDACTED]

**REQUEST EVIDENCE TECHNICIAN:**

An evidence technician was requested to take photographs of the scene and collect any evidence from the scene. Sgt. Dan Martin, MSP Metro South, responded to the [REDACTED] to assist with the collection of evidence and photography.

[REDACTED]

I contacted [REDACTED] to notify them of this incident. I spoke with Tamika Willis, Intake Coordinator – Detroit, who informed me that I would have to submit a request to their system via hyperlink. Ms. Willis sent me the instructions on how to submit the request as well as the link via email. [REDACTED] ticket was submitted on 3-16-23 by D/Sgt. Diggs

**SUSPECT:**

NAM: [REDACTED]

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| BIR: | RAC: | ETH:  |
| NBR: | SEX: | DL: / |
| STR: | DOB: | SSN:  |
| SFX: | HGT: | SI: / |
| CTY: | WGT: | FBI:  |
| TXH: | HAI: | MNU:  |
| TXW: | EYE: | PR:   |
| SMT: |      |       |

NAM: [REDACTED]

|      |      |       |
|------|------|-------|
| BIR: | RAC: | ETH:  |
| NBR: | SEX: | DL: / |
| STR: | DOB: | SSN:  |
| SFX: | HGT: | SI: / |
| CTY: | WGT: | FBI:  |
| TXH: | HAI: | MNU:  |
| TXW: | EYE: | PR:   |
| SMT: |      |       |

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| PAGE:<br>4 of 7 | INVESTIGATED BY:<br>DIGGS, DENNIS, 300, D/SERGEANT | INVESTIGATED BY: | REVIEWED BY: |
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**MICHIGAN DEPARTMENT OF STATE POLICE**

ORIGINAL INCIDENT REPORT

|                                     |                                |
|-------------------------------------|--------------------------------|
| ORIGINAL DATE:<br>Wed, Mar 15, 2023 | INCIDENT NO:<br>SIS-0000062-23 |
| TIME RECEIVED:<br>1145              | FILE CLASS:<br>11003           |

NAM: [REDACTED]

BIR: [REDACTED] RAC: [REDACTED] ETH: [REDACTED]  
 NBR: [REDACTED] DIR: [REDACTED] SEX: [REDACTED] DL: /  
 STR: [REDACTED] DOB: [REDACTED] SSN: [REDACTED]  
 SFX: [REDACTED] HGT: [REDACTED] SI: /  
 CTY: [REDACTED] ST: [REDACTED] WGT: [REDACTED] FBI: [REDACTED]  
 TXH: [REDACTED] ZIP: [REDACTED] HAI: [REDACTED] MNU: [REDACTED]  
 TXW: [REDACTED] EYE: [REDACTED] PR: [REDACTED]  
 SMT: [REDACTED]

NAM: [REDACTED]

BIR: [REDACTED] RAC: [REDACTED] ETH: [REDACTED]  
 NBR: [REDACTED] DIR: [REDACTED] SEX: [REDACTED] DL: /  
 STR: [REDACTED] DOB: [REDACTED] SSN: [REDACTED]  
 SFX: [REDACTED] HGT: [REDACTED] SI: /  
 CTY: [REDACTED] ST: [REDACTED] WGT: [REDACTED] FBI: [REDACTED]  
 TXH: [REDACTED] ZIP: [REDACTED] HAI: [REDACTED] MNU: [REDACTED]  
 TXW: [REDACTED] EYE: [REDACTED] PR: [REDACTED]  
 SMT: [REDACTED]

NAM: [REDACTED]

BIR: [REDACTED] RAC: [REDACTED] ETH: [REDACTED]  
 NBR: [REDACTED] DIR: [REDACTED] SEX: [REDACTED] DL: /  
 STR: [REDACTED] DOB: [REDACTED] SSN: [REDACTED]  
 SFX: [REDACTED] HGT: [REDACTED] SI: /  
 CTY: [REDACTED] ST: [REDACTED] WGT: [REDACTED] FBI: [REDACTED]  
 TXH: [REDACTED] ZIP: [REDACTED] HAI: [REDACTED] MNU: [REDACTED]  
 TXW: [REDACTED] EYE: [REDACTED] PR: [REDACTED]  
 SMT: [REDACTED]

**SEX MOTIVATED CRIME REPORT (DD-79):**

To be submitted

**WEAPON:**

[REDACTED]

|                 |  |                  |              |
|-----------------|--|------------------|--------------|
| PAGE:<br>5 of 7 | INVESTIGATED BY:<br>DIGGS, DENNIS, 300, D/SERGEANT | INVESTIGATED BY: | REVIEWED BY: |
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**MICHIGAN DEPARTMENT OF STATE POLICE**

ORIGINAL INCIDENT REPORT

|                                     |                                |
|-------------------------------------|--------------------------------|
| ORIGINAL DATE:<br>Wed, Mar 15, 2023 | INCIDENT NO:<br>SIS-0000062-23 |
| TIME RECEIVED:<br>1145              | FILE CLASS:<br>11003           |

**SEIZED:**

SEIZED BY: D/SGT. DIGGS

Prop 0002 -Type: CLOTHES/FUR Qty: 1 Article Type: Clothing (Description Req) Brand: Model: Serial #: Misc #: OAN: Value: \$0.00 Recovered Value: \$0.00

Descrp: ONE PAIR OF BLACK SHORT W/ELASTIC WAISTBAND.

Obtained From: [REDACTED]

Date/Time Recovered: 03/15/2023

SEIZED BY: D/SGT. DIGGS

Prop 0003 -Type: RECORDING AUDIO/VISUAL Qty: 1 Article Type: Disc, Compact Audio Brand: Model: Serial #: Misc #: OAN: Value: \$0.00 Recovered Value: \$0.00

Descrp: COMPACT DISC CONTAINING AUDIO RECORDED INTERVIEW (PT 1 AND PT 2) WITH VICTIM

Obtained From: [REDACTED]

Date/Time Recovered: 03/15/2023

SEIZED BY: D/SGT. DIGGS

Prop 0004 -Type: EVIDENCE Value: \$0.00

Descrp: ONE SANE EVIDENCE COLLECTION KIT FROM VICTIM [REDACTED]

Obtained From: [REDACTED]

Date/Time Recovered: 03/15/2023

SEIZED BY: D/SGT. DIGGS

Prop 0005 -Type: COMPUTER HARDWARE/SOFTWARE Qty: 1 Article Type: Magnetic Disk (hard, floppy) Brand: Model: Serial #: Misc #: OAN: Value: \$0.00 Recovered Value: \$0.00

Descrp: ONE BLACK/SILVER 16GB USB FLASH DRIVE CONTAINING SURVEILLANCE VIDEO FOOTAGE FROM [REDACTED].

Obtained From: [REDACTED]  
82 - [REDACTED]  
82 - [REDACTED]

Date/Time Recovered: 03/16/2023

|                 |  |                  |              |
|-----------------|--|------------------|--------------|
| PAGE:<br>6 of 7 | INVESTIGATED BY:<br>DIGGS, DENNIS, 300, D/SERGEANT | INVESTIGATED BY: | REVIEWED BY: |
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**MICHIGAN DEPARTMENT OF STATE POLICE**

ORIGINAL INCIDENT REPORT

|  |                                       |
|--|---------------------------------------|
| <b>ORIGINAL DATE:</b><br>Wed, Mar 15, 2023 | <b>INCIDENT NO:</b><br>SIS-0000062-23 |
| <b>TIME RECEIVED:</b><br>1145              | <b>FILE CLASS:</b><br>11003           |

SEIZED BY: D/SGT. DIGGS

Prop 0006 -Type: CLOTHES/FUR Qty: 1 Article Type: Clothing (Description Req) Brand: Model: Serial #: Misc #: OAN: Value: \$0.00 Recovered Value: \$0.00

Descrp: ONE BLACK T-SHIRT WORN BY AND RECOVERED FROM VICTIM.

Obtained From: [REDACTED]

82 - [REDACTED]

82 - [REDACTED]

[REDACTED]

Date/Time Recovered: 03/16/2023

**EXTERNAL DOCUMENT:**

The following documents were obtained by the [REDACTED] via email by Sgt. Radken Smith, WCSD:

- Sheet with suspects information and name of staff present
- Timeline of incident
- Copies of Victim and suspect's intake records

**CRIME VICTIM'S RIGHTS:**

UD-30 provided to [REDACTED]

**STATUS:**

Open, pending further investigation and additional reports from the [REDACTED] (WCSD and [REDACTED]).

|                        |   |                         |                     |
|------------------------|---|-------------------------|---------------------|
| <b>PAGE:</b><br>7 of 7 | <b>INVESTIGATED BY:</b><br>DIGGS, DENNIS, 300, D/SERGEANT | <b>INVESTIGATED BY:</b> | <b>REVIEWED BY:</b> |
|------------------------|---|-------------------------|---------------------|

**MICHIGAN DEPARTMENT OF STATE POLICE**

**SUPPLEMENTAL INCIDENT REPORT 0001**

**ORIGINAL DATE:**  
Wed, Mar 15, 2023

**SUPPLEMENTARY DATE:**  
Wed, Mar 15, 2023

**INCIDENT NO:**  
SIS-0000062-23

**FILE CLASS:**  
11003

**INCIDENT STATUS:**  
OPEN

**CRIMINAL SEXUAL CONDUCT**

**NO JOURNALS**

**INFORMATION:**

I was requested by D/Sgt. Diggs to meet [REDACTED] at the listed venue to assist [REDACTED] with collecting evidence at the scene reference to this complaint.

**SCENE:**

The reported assault occurred in a [REDACTED]

**INSPECT SCENE:**

D/Sgt. Diggs and I inspected the scene.

**PHOTOGRAPHS:**

I took photographs of the scene using a departmental digital camera. The photographs were uploaded to the Crime Scene Repository.

**EVIDENCE COLLECTED:**

The victim reported that the assault occurred on [REDACTED] There was a blue blanket over some cushioning pads that were on the steel bed. The blanket was collected and packaged as evidence.

**SEIZED:**

SEIZED BY: MARTIN

Prop 0001 -Type: OTHER Qty: 1 Article Type: Article Other (Description Req) Brand: Model: Serial #:

Misc #: OAN: Value: \$0.00 Recovered Value: \$0.00

Descrp: BLUE BLANKET

Obtained From: [REDACTED]

82 - [REDACTED]

[REDACTED]

Date/Time Recovered: 03/15/2023 1530

|                        |   |   |                     |
|------------------------|---|---|---------------------|
| <b>PAGE:</b><br>1 of 2 | <b>INVESTIGATED BY:</b><br>DIGGS, DENNIS, 300, D/SERGEANT | <b>INVESTIGATED BY:</b><br>MARTIN, DAN, 409, SERGEANT | <b>REVIEWED BY:</b> |
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**MICHIGAN DEPARTMENT OF  
STATE POLICE**

**SUPPLEMENTAL INCIDENT REPORT  
0001**

**STATUS:**

OPEN

|   |                                       |
|---|---------------------------------------|
| <b>ORIGINAL DATE:</b><br>Wed, Mar 15, 2023      | <b>INCIDENT NO:</b><br>SIS-0000062-23 |
| <b>SUPPLEMENTARY DATE:</b><br>Wed, Mar 15, 2023 | <b>FILE CLASS:</b><br>11003           |

|                        |   |   |                     |
|------------------------|---|---|---------------------|
| <b>PAGE:</b><br>2 of 2 | <b>INVESTIGATED BY:</b><br>DIGGS, DENNIS, 300, D/SERGEANT | <b>INVESTIGATED BY:</b><br>MARTIN, DAN, 409, SERGEANT | <b>REVIEWED BY:</b> |
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|---|---|---------------------------------------|
| <b>MICHIGAN DEPARTMENT OF STATE POLICE</b><br><br>SUPPLEMENTAL INCIDENT REPORT<br><b>0002</b> | <b>ORIGINAL DATE:</b><br>Wed, Mar 15, 2023      | <b>INCIDENT NO:</b><br>SIS-0000062-23 |
|   | <b>SUPPLEMENTARY DATE:</b><br>Fri, Mar 17, 2023 | <b>FILE CLASS:</b><br>11003           |

**INCIDENT STATUS:**  
OPEN

## CRIMINAL SEXUAL CONDUCT

### INFORMATION:

D/Lt. Sanchez requested the clothes that were worn by the suspects be seized and entered into evidence. I made contact with Sgt. Radken Smith, Wayne County Sheriff's Department, to request the clothing from each suspect involved in the incident. [REDACTED] checked with his staff and believed the suspects had not showered or changed out of their clothing. Arrangements were made to have the nursing staff collect the clothing from each suspect. I went to [REDACTED] and waited for the clothing to be collected. I collected five large paper bags containing clothing/bedding articles from the staff.

### INVENTORY BAGS:

Each large paper bag was inventoried to account for the items inside each bag for entry into eAICS property. There were bags marked the suspects [REDACTED]. There were two bags marked with the name [REDACTED]. There were no bags marked with [REDACTED]'s name.

### SEIZED:

SEIZED BY: D/SGT. DIGGS

Prop 0007 -Type: CLOTHES/FUR Qty: 1 Article Type: Clothing (Description Req) Brand: Model: Serial #: Misc #: OAN: Value: \$0.00 Recovered Value: \$0.00  
 Descrp: ONE LARGE PAPER BAG MARKED [REDACTED] CONTAINING: (1) BLUE BLANKET, (1) WHITE TOWEL, AND (1) PAIR OF BLACK SHORTS.

Obtained From: [REDACTED]  
 82 - [REDACTED]  
 82 - [REDACTED]

Date/Time Recovered: 03/17/2023

SEIZED BY: D/SGT. DIGGS

Prop 0008 -Type: CLOTHES/FUR Qty: 1 Article Type: Clothing (Description Req) Brand: Model: Serial #: Misc #: OAN: Value: \$0.00 Recovered Value: \$0.00  
 Descrp: ONE LARGE PAPER BAG MARKED [REDACTED] CONTAINING: (2) BLUE BLANKETS, (2) WHITE TOWELS, (1) BLACK T-SHIRT, AND (2) BLACK SWEATSHIRTS.

Obtained From: [REDACTED]  
 82 - [REDACTED]  
 82 - [REDACTED]

Date/Time Recovered: 03/17/2023

SEIZED BY: D/SGT. DIGGS

Prop 0009 -Type: CLOTHES/FUR Qty: 1 Article Type: Clothing (Description Req) Brand: Model: Serial #:

|                        |   |   |                     |
|------------------------|---|---|---------------------|
| <b>PAGE:</b><br>1 of 2 | <b>INVESTIGATED BY:</b><br>DIGGS, DENNIS, 300, D/SERGEANT | <b>INVESTIGATED BY:</b><br>DIGGS, DENNIS, 300, D/SERGEANT | <b>REVIEWED BY:</b> |
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**MICHIGAN DEPARTMENT OF STATE POLICE**

**SUPPLEMENTAL INCIDENT REPORT 0002**

|   |                                       |
|---|---------------------------------------|
| <b>ORIGINAL DATE:</b><br>Wed, Mar 15, 2023      | <b>INCIDENT NO:</b><br>SIS-0000062-23 |
| <b>SUPPLEMENTARY DATE:</b><br>Fri, Mar 17, 2023 | <b>FILE CLASS:</b><br>11003           |

Misc #: OAN: Value: \$0.00 Recovered Value: \$0.00

Descrp: ONE LARGE PAPER BAG MARKED ██████████ CONTAINING: (2) PAIR OF BLACK SHORTS, (1) PAIR OF GREY UNDERWEAR, (1) BLACK T-SHIRT, (1) WHITE TOWEL, AND (1) BLUE BLANKET.

Obtained From: ██████████

82 - ██████████  
82 - ██████████

Date/Time Recovered: 03/17/2023

SEIZED BY: D/SGT. DIGGS

Prop 0010 -Type: CLOTHES/FUR Qty: 1 Article Type: Clothing (Description Req) Brand: Model: Serial #:

Misc #: OAN: Value: \$0.00 Recovered Value: \$0.00

Descrp: ONE LARGE PAPER BAG MARKED ██████████ CONTAINING: (2) PAIR OF BLACK SHORTS, (2) BLACK T-SHIRTS, (1) WHITE TOWEL, AND (1) BLUE BLANKET.

Obtained From: ██████████

82 - ██████████  
82 - ██████████

Date/Time Recovered: 03/17/2023

SEIZED BY: D/SGT. DIGGS

Prop 0011 -Type: CLOTHES/FUR Qty: 1 Article Type: Clothing (Description Req) Brand: Model: Serial #:

Misc #: OAN: Value: \$0.00 Recovered Value: \$0.00

Descrp: ONE LARGE PAPER BAG ██████████ CONTAINING: (2) PAIR OF BLACK SHORTS, (1) PAIR OF WHITE BOXER UNDERWEAR, (1) BLACK T-SHIRT, AND (1) BLUE BLANKET.

Obtained From: ██████████

82 - ██████████  
82 - ██████████

Date/Time Recovered: 03/17/2023

**STATUS:**

OPEN.

|                        |   |   |                     |
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| <b>PAGE:</b><br>2 of 2 | <b>INVESTIGATED BY:</b><br>DIGGS, DENNIS, 300, D/SERGEANT | <b>INVESTIGATED BY:</b><br>DIGGS, DENNIS, 300, D/SERGEANT | <b>REVIEWED BY:</b> |
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**MICHIGAN DEPARTMENT OF STATE POLICE**

**SUPPLEMENTAL INCIDENT REPORT 0003**

|   |                                       |
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| <b>ORIGINAL DATE:</b><br>Wed, Mar 15, 2023      | <b>INCIDENT NO:</b><br>SIS-0000062-23 |
| <b>SUPPLEMENTARY DATE:</b><br>Mon, Mar 20, 2023 | <b>FILE CLASS:</b><br>11003           |

**INCIDENT STATUS:**  
OPEN

**CRIMINAL SEXUAL CONDUCT**

**INFORMATION:**

A [REDACTED] forensic interview was scheduled for [REDACTED] on March 20, 2023, at 12pm at the [REDACTED] located at [REDACTED] D/Sgt. LaMay and I were there when [REDACTED] D/Sgt. LaMay and I briefly spoke with [REDACTED] prior to introduce ourselves and to see if [REDACTED] had any questions of us prior to the interview. After speaking and answering any questions, [REDACTED] had a brief interview with [REDACTED] interviewer Ms. R. Miller. D/Sgt LaMay left the center prior to the interview. Present in the observation room was myself, Heather Mercado, and Christopher Barr.

**INTERVIEW:**

[REDACTED] had a very brief interview with Ms. R. Miller. [REDACTED] began the interview telling things about [REDACTED] to Ms. Miller. [REDACTED] then began discussing the beginning of the incident (first physical assault) to Ms. Miller. After answering a few questions about the physical assault, [REDACTED] said [REDACTED] did not want to talk about it anymore and wanted to talk with [REDACTED] attorney. [REDACTED] said several times [REDACTED] wished not to discuss the matter any further. Therefore, no further questions were asked by Ms. R. Miller and the interview ended.

**INTERVIEW WITH [REDACTED]**

We briefly spoke with [REDACTED] at the end of [REDACTED]'s interview. We informed [REDACTED] that [REDACTED] did not want to talk any further about the incident during the interview and mentioned several times [REDACTED] wanted to talk with [REDACTED] attorney. [REDACTED] staff expressed to [REDACTED] that [REDACTED] can always come back when [REDACTED]'s ready. [REDACTED] provided me with the name and telephone number of [REDACTED] attorney as Carrie McGee [REDACTED]

**SEIZED:**

SEIZED BY: D/SGT. DIGGS  
 Prop 0012 -Type: RECORDING AUDIO/VISUAL Qty: 1 Article Type: DVD (digital video disc) Brand: Model:  
 Serial #: Misc #: OAN: Value: \$0.00 Recovered Value: \$0.00  
 Descrp: ONE DVD (DIGITAL VIDEO DISC) FROM [REDACTED]  
 CONTAINING VIDEO INTERVIEW WITH [REDACTED]  
 Obtained From: [REDACTED]

Date/Time Recovered: 03/20/2023

|                        |   |   |                     |
|------------------------|---|---|---------------------|
| <b>PAGE:</b><br>1 of 2 | <b>INVESTIGATED BY:</b><br>DIGGS, DENNIS, 300, D/SERGEANT | <b>INVESTIGATED BY:</b><br>DIGGS, DENNIS, 300, D/SERGEANT | <b>REVIEWED BY:</b> |
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**MICHIGAN DEPARTMENT OF  
STATE POLICE**

**SUPPLEMENTAL INCIDENT REPORT  
0003**

|   |                                       |
|---|---------------------------------------|
| <b>ORIGINAL DATE:</b><br>Wed, Mar 15, 2023      | <b>INCIDENT NO:</b><br>SIS-0000062-23 |
| <b>SUPPLEMENTARY DATE:</b><br>Mon, Mar 20, 2023 | <b>FILE CLASS:</b><br>11003           |

**EXTERNAL DOCUMENT:**

2<sup>nd</sup> Updated Video timeline of incident provided by Sgt. Radken Smith, WCSO.

**STATUS:**

OPEN

|                        |   |   |                     |
|------------------------|---|---|---------------------|
| <b>PAGE:</b><br>2 of 2 | <b>INVESTIGATED BY:</b><br>DIGGS, DENNIS, 300, D/SERGEANT | <b>INVESTIGATED BY:</b><br>DIGGS, DENNIS, 300, D/SERGEANT | <b>REVIEWED BY:</b> |
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| <b>MICHIGAN DEPARTMENT OF STATE POLICE</b><br><br>SUPPLEMENTAL INCIDENT REPORT<br><b>0004</b> | ORIGINAL DATE:<br>Wed, Mar 15, 2023      | INCIDENT NO:<br>SIS-0000062-23 |
|   | SUPPLEMENTARY DATE:<br>Wed, Mar 22, 2023 | FILE CLASS:<br>11003           |

INCIDENT STATUS:  
OPEN

**CRIMINAL SEXUAL CONDUCT**

**JOURNAL:**

| DATE       | JOURNALED BY                        | ACTION  |
|------------|-------------------------------------|---|
| 03-21-2023 | ENTERED BY: HONEY, ROBERT, CIVILIAN | ITEM # 04 WAS DROPPED OFF AT THE DETROIT LAB THIS DATE. LAB NUMBER MD23-842 |

**INFORMATION:**

Sgt. Radken Smit, Wayne County Sheriff's Office, contacted me to advise [REDACTED] was able to obtain surveillance video footage from [REDACTED] that has the date and time stamps included with the video. [REDACTED] said [REDACTED] would place the footage on a USB flash drive and have it ready for me to pick up. On 3-22-23, I went to the [REDACTED] and picked up an envelope containing a USB flash drive and an updated timeline of the video incident from [REDACTED]. The USB flash drive was entered into eAICS property and the updated timeline of the video incident will be placed in the master file.

**SEIZED:**

SEIZED BY: D/SGT. DIGGS  
 Prop 0013 -Type: COMPUTER HARDWARE/SOFTWARE Qty: 1 Article Type: Disk, Hard, Floppy, Magnetic, etc. Brand: Model: Serial #: Misc #: OAN: Value: \$0.00 Recovered Value: \$0.00  
 Descrp: ONE BLACK VERBATIM USB FLASH DRIVE CONTAINING UPDATED SURVEILLANCE VIDEO FOOTAGE FROM [REDACTED].  
 Obtained From: [REDACTED]  
 82 - [REDACTED]

Date/Time Recovered: 03/22/2023

**ATTEMPTS TO CONTACT VICTIM'S ATTORNEY:**

Two attempts have been made to contact Carrie McGee (sp) via phone at [REDACTED] who I learned from [REDACTED] is the attorney representing [REDACTED]. The first attempt was made on Tuesday March 21, 2023, at approximately 10:39am. A message was left for Ms. McGee to contact me. The second attempt was made on this date (March 23, 2023) at approximately 11:20am. Another message was left for Ms. McGee to contact me.

|                 |  |  |              |
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| PAGE:<br>1 of 2 | INVESTIGATED BY:<br>DIGGS, DENNIS, 300, D/SERGEANT | INVESTIGATED BY:<br>DIGGS, DENNIS, 300, D/SERGEANT | REVIEWED BY: |
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**MICHIGAN DEPARTMENT OF  
STATE POLICE**

**SUPPLEMENTAL INCIDENT REPORT  
0004**

|   |                                       |
|---|---------------------------------------|
| <b>ORIGINAL DATE:</b><br>Wed, Mar 15, 2023      | <b>INCIDENT NO:</b><br>SIS-0000062-23 |
| <b>SUPPLEMENTARY DATE:</b><br>Wed, Mar 22, 2023 | <b>FILE CLASS:</b><br>11003           |

**EXTERNAL DOCUMENT:**

3<sup>rd</sup> Updated timeline of video incident placed in master file.

**STATUS:**

OPEN

|                        |   |   |                     |
|------------------------|---|---|---------------------|
| <b>PAGE:</b><br>2 of 2 | <b>INVESTIGATED BY:</b><br>DIGGS, DENNIS, 300, D/SERGEANT | <b>INVESTIGATED BY:</b><br>DIGGS, DENNIS, 300, D/SERGEANT | <b>REVIEWED BY:</b> |
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| <b>MICHIGAN DEPARTMENT OF STATE POLICE</b><br><br>SUPPLEMENTAL INCIDENT REPORT<br><b>0005</b> | ORIGINAL DATE:<br>Wed, Mar 15, 2023      | INCIDENT NO:<br>SIS-0000062-23 |
|   | SUPPLEMENTARY DATE:<br>Thu, Mar 23, 2023 | FILE CLASS:<br>11003           |

INCIDENT STATUS:  
OPEN

**CRIMINAL SEXUAL CONDUCT**

**INFORMATION:**

I was requested by D/Lt. Sanchez to assist in an investigation regarding an alleged physical and sexual assault which occurred at the [REDACTED].

I have contacted the employees involved as well as the [REDACTED] of the alleged offenders; I have done so in attempt to request interviews of those individuals.

Below are accounts of interviews or attempts to set an interview up. Further interviews will be conducted.

The interviews are summaries and not verbatim accounts. The interviews will be stored in the Digital Evidence Retention drive within the Special Investigation Section; please refer to the interviews for specific details.

**DIGITAL EVIDENCE RETENTION:**

DIGITAL EVIDENCE RETENTION: The digital evidence reports will be retained on the MSP Special Investigation Section, Second District Data Retention Storage Drive and held in MSP property under SIS-3-23.

**EMPLOYEE:**

NAM: [REDACTED]  
 BIR: [REDACTED] RAC: [REDACTED] ETH: [REDACTED]  
 NBR: [REDACTED] DIR: [REDACTED] SEX: [REDACTED] DL: [REDACTED]  
 STR: [REDACTED] DOB: [REDACTED] SSN: [REDACTED]  
 SFX: [REDACTED] APT/LOT: [REDACTED] HGT: [REDACTED] SI: /  
 CTY: [REDACTED] ST: [REDACTED] WGT: [REDACTED] FBI:  
 TXH: [REDACTED] ZIP: [REDACTED] HAI: [REDACTED] MNU:  
 TXW: [REDACTED] EYE: [REDACTED] PR:  
 MB: [REDACTED]  
 SMT: [REDACTED]

**INTERVIEW [REDACTED]**

[REDACTED] was interviewed at the Metro North post; the interview was audio recorded. The following is a summary of that interview.

- [REDACTED] acknowledged [REDACTED] was being interviewed voluntarily
- [REDACTED] stated the has been employed at the [REDACTED] for approximately 4 yrs and holds the title of supervisor
- On an average [REDACTED] supervises 14-18 people on a shift

|                 |  |   |              |
|-----------------|--|---|--------------|
| PAGE:<br>1 of 8 | INVESTIGATED BY:<br>DIGGS, DENNIS, 300, D/SERGEANT | INVESTIGATED BY:<br>LAMAY, LARISSA, 124, D/SERGEANT | REVIEWED BY: |
|-----------------|--|---|--------------|

**MICHIGAN DEPARTMENT OF STATE POLICE**

SUPPLEMENTAL INCIDENT REPORT  
0005

|  |                                |
|--|--------------------------------|
| ORIGINAL DATE:<br>Wed, Mar 15, 2023      | INCIDENT NO:<br>SIS-0000062-23 |
| SUPPLEMENTARY DATE:<br>Thu, Mar 23, 2023 | FILE CLASS:<br>11003           |

- [REDACTED] states there are four pods [REDACTED] supervises either alone or with another supervisor
- [REDACTED] states [REDACTED] has been involved with working with [REDACTED] approximately 30 years
- The Wayne County is his actual employer
- Typical shift starts with [REDACTED] receiving a shift report and then giving assignments to his subordinates.
- [REDACTED] stated dinner is around 4p and then "rec time" occurs and various in length according to the pod and the number of residents.
- [REDACTED] states the four pods are identified as [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED] addresses issues in all the pods as they occur.
- [REDACTED] all residents are supposed to be in [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED] confirmed [REDACTED] was working on March 13, 2023
- [REDACTED] stated victim [REDACTED] was initially on [REDACTED] [REDACTED] explained there are [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED] contacted [REDACTED] and initially tried to move [REDACTED]
- [REDACTED] who was throwing feces.
- [REDACTED] again contacted [REDACTED] and received permission to move [REDACTED] which [REDACTED] did.
- [REDACTED] stated [REDACTED] remained on [REDACTED] for approximately 2 hours and everything seemed to be ok.
- [REDACTED] continued with his duties throughout the shift until 2 residents on [REDACTED] were refusing to go into their [REDACTED] [REDACTED] was addressing those issues and completing his paperwork.
- [REDACTED] stated around 10pm 2 residents on [REDACTED] and refused to go back in which resulted in [REDACTED] staying after his shift to monitor the situation and complete paperwork.
- [REDACTED] stated at approximately 1:10-1:15am (3/15/23) [REDACTED] (staff) informed [REDACTED] there was issue on [REDACTED] which escalated to a code 1 (fighting). White (staff) stated code 1 on the radio.
- When [REDACTED] responded to the [REDACTED] and observes [REDACTED] on top of [REDACTED] physically assaulting [REDACTED]
- [REDACTED] stated [REDACTED] assisted [REDACTED] in separating [REDACTED] and [REDACTED]
- [REDACTED] stated [REDACTED] took [REDACTED] to the [REDACTED] [REDACTED] stated "they assaulted me too"
- [REDACTED] stated there are 6 residents on [REDACTED]
- [REDACTED]
- [REDACTED] stated [REDACTED] was moved off the [REDACTED] because [REDACTED] had COVID.
- [REDACTED] stated after [REDACTED] stated [REDACTED] was assaulted [REDACTED] immediately called his manager [REDACTED]

|                 |  |   |              |
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| <b>MICHIGAN DEPARTMENT OF STATE POLICE</b><br>SUPPLEMENTAL INCIDENT REPORT<br>0005 | ORIGINAL DATE:<br>Wed, Mar 15, 2023      | INCIDENT NO:<br>SIS-0000062-23 |
|  | SUPPLEMENTARY DATE:<br>Thu, Mar 23, 2023 | FILE CLASS:<br>11003           |

- [REDACTED] clarified [REDACTED] originally stated [REDACTED]
- [REDACTED] stated the on staff doctor, Dr. Scott, was contacted and placed an order for [REDACTED] be taken to a hospital for an examination [REDACTED]
- [REDACTED] stated [REDACTED] was transported to the hospital within 15-20 minutes by [REDACTED] and [REDACTED] stated they are both [REDACTED]
- [REDACTED] stated [REDACTED] completed the required reports, including a written statement prior to leaving. [REDACTED] also stated [REDACTED] completed written reports.
- [REDACTED] thought it was strange written reports were required as they are normally done electronically.
- [REDACTED] said [REDACTED] did not specifically state who [REDACTED] at that time.
- [REDACTED] stated [REDACTED] at the direction of [REDACTED] and that was completed at approximately 2:30am.
- [REDACTED] stated [REDACTED] is not confident the staff actually completes rounds every 15 minutes, even though the logs may indicate the 15 minute checks are completed.
- [REDACTED] stated 100% of the staff is scared of the residents; several staff members have been assaulted in the past.
- [REDACTED]
- [REDACTED]

**EMPLOYEE:**

NAM: [REDACTED]  
 BIR: [REDACTED] RAC: [REDACTED] ETH: [REDACTED]  
 NBR: [REDACTED] DIR: [REDACTED] SEX: [REDACTED] DL: [REDACTED]  
 STR: [REDACTED] DOB: [REDACTED] SSN: [REDACTED]  
 SFX: [REDACTED] HGT: [REDACTED] SI: /  
 CTY: [REDACTED] ST: [REDACTED] WGT: [REDACTED] FBI: [REDACTED]  
 TXH: [REDACTED] ZIP: [REDACTED] HAI: [REDACTED] MNU: [REDACTED]  
 TXW: [REDACTED] EYE: [REDACTED] PR: [REDACTED]  
 MB: [REDACTED]  
 SMT: [REDACTED]

**INTERVIEW:**

[REDACTED] scheduled to be interviewed April 11, 2023.

**EMPLOYEE:**

NAM: [REDACTED]  
 BIR: [REDACTED] RAC: [REDACTED] ETH: [REDACTED]  
 NBR: [REDACTED] DIR: [REDACTED] SEX: [REDACTED] DL: [REDACTED]  
 STR: [REDACTED] DOB: [REDACTED] SSN: [REDACTED]  
 SFX: [REDACTED] HGT: [REDACTED] SI: /

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**MICHIGAN DEPARTMENT OF STATE POLICE**

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CTY: [REDACTED] ST: [REDACTED] WGT: [REDACTED] FBI:  
 TXH: [REDACTED] ZIP: [REDACTED] HAI: [REDACTED] MNU:  
 TXW: [REDACTED] EYE: [REDACTED] PR:  
 MB: [REDACTED]  
 SMT:

**INTERVIEW [REDACTED]**

[REDACTED] is scheduled to be interviewed April 12, 2023.

**EMPLOYEE:**

NAM: [REDACTED]  
 BIR: [REDACTED] RAC: [REDACTED] ETH: [REDACTED]  
 NBR: [REDACTED] DIR: [REDACTED] SEX: [REDACTED] DL: [REDACTED]  
 STR: [REDACTED] DOB: [REDACTED] SSN: [REDACTED]  
 SFX: [REDACTED] HGT: [REDACTED] SI: /  
 CTY: [REDACTED] ST: [REDACTED] WGT: [REDACTED] FBI:  
 TXH: [REDACTED] ZIP: [REDACTED] HAI: [REDACTED] MNU:  
 TXW: [REDACTED] EYE: [REDACTED] PR:  
 MB: [REDACTED]  
 SMT:

**INTERVIEW [REDACTED]**

[REDACTED] is scheduled to be interviewed April 13, 2023.

**EMPLOYEE:**

NAM: [REDACTED]  
 BIR: [REDACTED] RAC: [REDACTED] ETH: [REDACTED]  
 NBR: [REDACTED] DIR: [REDACTED] SEX: [REDACTED] DL: [REDACTED]  
 STR: [REDACTED] DOB: [REDACTED] SSN: [REDACTED]  
 SFX: [REDACTED] APT/LOT: [REDACTED] HGT: [REDACTED] SI: /  
 CTY: [REDACTED] ST: [REDACTED] WGT: [REDACTED] FBI:  
 TXH: [REDACTED] ZIP: [REDACTED] HAI: [REDACTED] MNU:  
 TXW: [REDACTED] EYE: [REDACTED] PR:  
 MB: [REDACTED]  
 SMT:

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**MICHIGAN DEPARTMENT OF STATE POLICE**

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**INTERVIEW [REDACTED]**

[REDACTED] is scheduled to be interviewed April 12, 2023.

**EMPLOYEE:**

NAM: [REDACTED]  
 BIR: [REDACTED] RAC: [REDACTED] ETH: [REDACTED]  
 NBR: [REDACTED] DIR: [REDACTED] SEX: [REDACTED] DL: [REDACTED]  
 STR: [REDACTED] DOB: [REDACTED] HGT: [REDACTED] SSN: [REDACTED]  
 SFX: [REDACTED] APT/LOT: [REDACTED] WGT: [REDACTED] SI: /  
 CTY: [REDACTED] ST: [REDACTED] HAI: [REDACTED] FBI: [REDACTED]  
 TXH: [REDACTED] ZIP: [REDACTED] EYE: [REDACTED] MNU: [REDACTED]  
 TXW: [REDACTED] PR: [REDACTED]  
 MB: [REDACTED]  
 SMT: [REDACTED]

**INTERVIEW [REDACTED]**

[REDACTED] is scheduled to be interviewed April 11, 2023.

**EMPLOYEE:**

NAM: [REDACTED]  
 BIR: [REDACTED] RAC: [REDACTED] ETH: [REDACTED]  
 NBR: [REDACTED] DIR: [REDACTED] SEX: [REDACTED] DL: [REDACTED]  
 STR: [REDACTED] DOB: [REDACTED] HGT: [REDACTED] SSN: [REDACTED]  
 SFX: [REDACTED] ST: [REDACTED] WGT: [REDACTED] SI: /  
 CTY: [REDACTED] ZIP: [REDACTED] HAI: [REDACTED] FBI: [REDACTED]  
 TXH: [REDACTED] EYE: [REDACTED] MNU: [REDACTED]  
 TXW: [REDACTED] PR: [REDACTED]  
 MB: [REDACTED]  
 MB: [REDACTED]  
 SMT: [REDACTED]

**INTERVIEW [REDACTED]**

[REDACTED] is scheduled to be interviewed April 12, 2023.

NAM: [REDACTED]  
 BIR: [REDACTED] RAC: [REDACTED] ETH: [REDACTED]

|                        |   |  |                     |
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**MICHIGAN DEPARTMENT OF STATE POLICE**

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**0005**

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NBR: [REDACTED] DIR: [REDACTED] SEX: [REDACTED] DL: [REDACTED]  
 STR: [REDACTED] DOB: [REDACTED] SSN: [REDACTED]  
 SFX: [REDACTED] HGT: [REDACTED] SI: /  
 CTY: [REDACTED] ST: [REDACTED] WGT: [REDACTED] FBI:  
 TXH: [REDACTED] ZIP: [REDACTED] HAI: [REDACTED] MNU:  
 TXW: [REDACTED] EYE: [REDACTED] PR:  
 MB: [REDACTED]  
 SMT: [REDACTED]

**CONTACT [REDACTED]**

Initial message left 3/21/23.  
 Return call from [REDACTED] 3/21/23 initially granting permission however she wants to contact an attorney prior to setting date/time for interviews.  
 Second message left 3/29/2023.

[REDACTED]

NAM: [REDACTED]  
 BIR: [REDACTED] RAC: [REDACTED] ETH: [REDACTED]  
 NBR: [REDACTED] DIR: [REDACTED] SEX: [REDACTED] DL: [REDACTED]  
 STR: [REDACTED] DOB: [REDACTED] SSN: [REDACTED]  
 SFX: [REDACTED] HGT: [REDACTED] SI: /  
 CTY: [REDACTED] ST: [REDACTED] WGT: [REDACTED] FBI:  
 TXH: [REDACTED] ZIP: [REDACTED] HAI: [REDACTED] MNU:  
 TXW: [REDACTED] EYE: [REDACTED] PR:  
 MB: [REDACTED]  
 SMT: [REDACTED]

**CONTACT WITH [REDACTED]**

[REDACTED] informed me she would be contacting and attorney and will let me know.

[REDACTED]

NAM: [REDACTED]  
 BIR: [REDACTED] RAC: [REDACTED] ETH: [REDACTED]  
 NBR: [REDACTED] DIR: [REDACTED] SEX: [REDACTED] DL: [REDACTED]  
 STR: [REDACTED] DOB: [REDACTED] SSN: [REDACTED]  
 SFX: [REDACTED] HGT: [REDACTED] SI: /  
 CTY: [REDACTED] ST: [REDACTED] WGT: [REDACTED] FBI:  
 TXH: [REDACTED] ZIP: [REDACTED] HAI: [REDACTED] MNU:  
 TXW: [REDACTED] EYE: [REDACTED] PR:  
 MB: [REDACTED]

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**MICHIGAN DEPARTMENT OF STATE POLICE**

**SUPPLEMENTAL INCIDENT REPORT 0005**

SMT:

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**CONTACT WITH** [REDACTED]

Message left 3/21/2023  
Message left 3/29/2023

[REDACTED]

NAM: [REDACTED]  
 BIR: [REDACTED] RAC: [REDACTED] ETH: [REDACTED]  
 NBR: [REDACTED] DIR: [REDACTED] SEX: [REDACTED] DL: [REDACTED]  
 STR: [REDACTED] CTY: [REDACTED] ST: [REDACTED] DOB: [REDACTED] SSN: [REDACTED]  
 SFX: [REDACTED] TXH: [REDACTED] ZIP: [REDACTED] HGT: [REDACTED] SI: /  
 CTY: [REDACTED] TXW: [REDACTED] WGT: [REDACTED] HAI: [REDACTED] FBI: [REDACTED]  
 TXH: [REDACTED] ZIP: [REDACTED] EYE: [REDACTED] MNU: [REDACTED]  
 TXW: [REDACTED] PR: [REDACTED]  
 MB: [REDACTED]  
 SMT:

**CONTACT WITH** [REDACTED]

Message left 3/21/2023  
Message left 3/29/2023

[REDACTED]

NAM: [REDACTED]  
 BIR: [REDACTED] RAC: [REDACTED] ETH: /  
 NBR: [REDACTED] DIR: [REDACTED] SEX: [REDACTED] DL: /  
 STR: [REDACTED] CTY: [REDACTED] ST: [REDACTED] DOB: [REDACTED] SSN: /  
 SFX: [REDACTED] TXH: [REDACTED] ZIP: [REDACTED] HGT: [REDACTED] SI: /  
 CTY: [REDACTED] TXW: [REDACTED] WGT: [REDACTED] HAI: [REDACTED] FBI: [REDACTED]  
 TXH: [REDACTED] ZIP: [REDACTED] EYE: [REDACTED] MNU: [REDACTED]  
 TXW: [REDACTED] PR: [REDACTED]  
 MB: [REDACTED]  
 SMT:

**CONTACT WITH** [REDACTED]:

Initial message left 3/21/2023.  
Return call 3/21/2023 stating she wants to contact attorney.  
Second call 3/29/2023, stating she will have attorney contact me.

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**MICHIGAN DEPARTMENT OF STATE POLICE**

SUPPLEMENTAL INCIDENT REPORT  
**0005**

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**EXTERNAL DOCUMENTS:**

Copy of [REDACTED] written statement; provided by Wayne County Sheriffs Department (Sgt. Smith)  
Copy of [REDACTED] written statement; provided by Wayne County Sheriffs Department (Sgt. Smith)  
Copy of [REDACTED] written statement; provided by Wayne County Sheriffs Department (Sgt. Smith)

**STATUS:**

Open, pending further investigation

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**MICHIGAN DEPARTMENT OF STATE POLICE**

**SUPPLEMENTAL INCIDENT REPORT 0006**

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| <b>SUPPLEMENTARY DATE:</b><br>Wed, Mar 29, 2023 | <b>FILE CLASS:</b><br>11003           |

**INCIDENT STATUS:**  
OPEN

**CRIMINAL SEXUAL CONDUCT**

**INFORMATION:**

The following individuals were interviewed regarding this complaint; the interviews were captured on audio recordings and secured on the Digital Evidence Retention storage drive. The interviews are summarized below respective to the individuals; this is not a verbatim account, please refer to the audio copy for specific details.

During the interviews additional names were developed and requests for interviews with those individuals have been made.

**DIGITAL EVIDENCE RETENTION:**

DIGITAL EVIDENCE RETENTION: The digital evidence reports will be retained on the MSP Special Investigation Section, Second District Data Retention Storage Drive and held in MSP property under SIS-3-23.

**WITNESS**

NAM: [REDACTED]  
 BIR: [REDACTED] RAC: [REDACTED] ETH: [REDACTED]  
 NBR: [REDACTED] DIR: [REDACTED] SEX: [REDACTED] DL: [REDACTED]  
 STR: [REDACTED] DOB: [REDACTED] SSN: [REDACTED]  
 SFX: [REDACTED] HGT: [REDACTED] SI: /  
 CTY: [REDACTED] ST: [REDACTED] WGT: [REDACTED] FBI:  
 TXH: [REDACTED] ZIP: [REDACTED] HAI: [REDACTED] MNU:  
 TXW: [REDACTED] EYE: [REDACTED] PR:  
 MB: [REDACTED]  
 SMT:

**INTERVIEW [REDACTED]**

I spoke with [REDACTED] at the Metro North Post; she was accompanied by union representatives [REDACTED] and [REDACTED]

- [REDACTED] was informed I was conducting a criminal investigation and she was here freely and on a voluntary basis.
- She stated she is aware of the incident I am investigating
- She has been employed with the [REDACTED] for 4 years and holds the title of TA (temporary supervisor)
- States her responsibilities include monitoring the employees to make sure they are completing their job duties as well as monitoring the residents.
- [REDACTED] states she is assigned to the midnight shift 11p-7a.

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**MICHIGAN DEPARTMENT OF STATE POLICE**

**SUPPLEMENTAL INCIDENT REPORT  
0006**

|   |                                       |
|---|---------------------------------------|
| <b>ORIGINAL DATE:</b><br>Wed, Mar 15, 2023      | <b>INCIDENT NO:</b><br>SIS-0000062-23 |
| <b>SUPPLEMENTARY DATE:</b><br>Wed, Mar 29, 2023 | <b>FILE CLASS:</b><br>11003           |

- [REDACTED] stated a normal shift involves receiving shift report from the outgoing shift supervisor, making rounds to check on residents.
- [REDACTED] stated she is in charge of [REDACTED]
- [REDACTED] stated the number of employees she supervisors varies due to staff shortages and number of residents.
- [REDACTED] said she went to the supervisors office the night of the incident and [REDACTED] was in the office doing paperwork. She stated she received a verbal report from [REDACTED].
- [REDACTED] told her the [REDACTED] were not in their rooms and would not 'go down'. ('go down' means the residents are in their rooms/bed)
- [REDACTED] stated she saw [REDACTED] because the residents were still out. [REDACTED] works afternoons)
- She stated she talked to each resident to try to get them to go to their rooms. She said the [REDACTED] were complaining about how they were being treated and that they had not been allowed phone calls, showers, etc.
- She said she was on [REDACTED] for at least an hour.
- She went to [REDACTED] while there she stated she used the restroom
- While in the restroom [REDACTED] called on the prep radio a supervisor assistance was needed on [REDACTED] did not advise why a supervisor was needed.
- [REDACTED] stated she responded she was indisposed at the moment and would respond shortly.
- She said a few minutes later [REDACTED] called on the radio again for a supervisor.
- [REDACTED] stated she used the telephone to call [REDACTED] in the supervisors office and did not get an answer so she called on the radio but did not get a response on the radio either.
- She stated she called the [REDACTED] upervisors office and [REDACTED] answered, she asked if [REDACTED] was there and [REDACTED]
- [REDACTED] asked [REDACTED] to ask [REDACTED]
- [REDACTED] stated when she got to [REDACTED] she went into control room and [REDACTED] was typing on the computer, [REDACTED] was sitting in a chair in the office.
- [REDACTED] stated [REDACTED] told her [REDACTED] asked who and [REDACTED] stated [REDACTED].
- [REDACTED] said she looked out in the [REDACTED]
- [REDACTED] told [REDACTED]
- [REDACTED] stated she tapped on the window and motioned [REDACTED] to come over and [REDACTED] flipped her off.
- [REDACTED] said [REDACTED]'s face appeared to be swollen.
- [REDACTED] stated she asked [REDACTED] and [REDACTED] if they did anything to [REDACTED] and they both denied it.
- [REDACTED] stated she asked [REDACTED] if [REDACTED] jumped on [REDACTED] and [REDACTED] stated [REDACTED] did because [REDACTED] had been out in the [REDACTED]
- [REDACTED] stated that [REDACTED] walked away and back towards [REDACTED] and began punching [REDACTED] again.
- [REDACTED] said she told [REDACTED] to go get [REDACTED] off [REDACTED]. At the same time [REDACTED] and [REDACTED] come into [REDACTED] and tried to get [REDACTED] off [REDACTED].
- [REDACTED] stated she saw [REDACTED] pick up a plastic chair and throw it at [REDACTED].
- [REDACTED] stated [REDACTED] was trying to get in the [REDACTED] and [REDACTED] and [REDACTED] were trying to pull the door open to get out.
- [REDACTED] had separated [REDACTED] and [REDACTED] and then got [REDACTED] off the [REDACTED]
- [REDACTED] observed [REDACTED] to have swelling to [REDACTED] face and eyes.
- [REDACTED] talked to [REDACTED] through the glass - [REDACTED] told her [REDACTED], and [REDACTED] jumped [REDACTED].

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**MICHIGAN DEPARTMENT OF STATE POLICE**

**SUPPLEMENTAL INCIDENT REPORT 0006**

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- [REDACTED] stated she was told by [REDACTED] the first assault occurred when [REDACTED] called on the radio the first time.
- [REDACTED] stated she called [REDACTED] medical supervisor for further instructions.
- Before calling [REDACTED] said [REDACTED] told her at the time [REDACTED]
- [REDACTED] stated [REDACTED] told her to send [REDACTED] to hospital and to [REDACTED]
- [REDACTED] stated she called [REDACTED] who is [REDACTED] manager; she left her a voicemail.
- [REDACTED] called [REDACTED]
- [REDACTED] told [REDACTED] to bring [REDACTED] to admitting so [REDACTED] could go to hospital
- [REDACTED] transported [REDACTED] to hospital.
- [REDACTED] stated [REDACTED] was in admitting at that time and had been on [REDACTED] during the afternoon shift. [REDACTED] stated [REDACTED] became very upset, stating 'it wasn't her fault' and then ran out of admitting and into the gym.
- [REDACTED] stated [REDACTED] had been talking on the phone to [REDACTED]
- [REDACTED] stated [REDACTED] and [REDACTED] were having a conversation in the gym.
- [REDACTED] said [REDACTED] stated [REDACTED] was blaming her [REDACTED]
- [REDACTED] told [REDACTED] the assault had occurred on the 3p-11p shift.
- [REDACTED] said she asked [REDACTED] why [REDACTED] didn't check on [REDACTED] and [REDACTED] responded because the residents had COVID.
- [REDACTED] stated [REDACTED] made statements the assaults occurred when [REDACTED] was on break.
- [REDACTED] stated [REDACTED]'s face was already swollen when she got on the pod (after [REDACTED] called for a supervisor) and before she [REDACTED] witnessed [REDACTED] strike [REDACTED].
- [REDACTED] stated [REDACTED] called her back and said she would meet them at the hospital.
- [REDACTED] came back to the [REDACTED] and told [REDACTED] to write down what happened.
- [REDACTED] said [REDACTED] made threats [REDACTED] would jump the staff if [REDACTED] name was documented in the log books.
- [REDACTED] said she has complained about the policies and handling of the residents since February 2023.

**WITNESS**

NAM: [REDACTED]  
 BIR: [REDACTED] RAC: [REDACTED] ETH: [REDACTED]  
 NBR: [REDACTED] DIR: [REDACTED] SEX: [REDACTED] DL: [REDACTED]  
 STR: [REDACTED] DOB: [REDACTED] SSN: [REDACTED]  
 SFX: [REDACTED] HGT: [REDACTED] SI: /  
 CTY: [REDACTED] ST: [REDACTED] WGT: [REDACTED] FBI: [REDACTED]  
 TXH: [REDACTED] ZIP: [REDACTED] HAI: [REDACTED] MNU: [REDACTED]  
 TXW: [REDACTED] EYE: [REDACTED] PR: [REDACTED]  
 MB: [REDACTED]  
 SMT: [REDACTED]

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| <b>PAGE:</b><br>3 of 10 | <b>INVESTIGATED BY:</b><br>DIGGS, DENNIS, 300, D/SERGEANT | <b>INVESTIGATED BY:</b><br>LAMAY, LARISSA, 124, D/SERGEANT | <b>REVIEWED BY:</b> |
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**MICHIGAN DEPARTMENT OF STATE POLICE**

**SUPPLEMENTAL INCIDENT REPORT 0006**

|   |                                       |
|---|---------------------------------------|
| <b>ORIGINAL DATE:</b><br>Wed, Mar 15, 2023      | <b>INCIDENT NO:</b><br>SIS-0000062-23 |
| <b>SUPPLEMENTARY DATE:</b><br>Wed, Mar 29, 2023 | <b>FILE CLASS:</b><br>11003           |

**INTERVIEW [REDACTED]**

I spoke with [REDACTED] at the Metro North post; he was accompanied by [REDACTED] who is his union representative..

- [REDACTED] was informed I was conducting a criminal investigation into the incident at the JDF.
- [REDACTED] asked if he was being accused of anything and I told him at this time I was interviewing him as a witness, he was free to go at any time and this was a voluntary interview.
- [REDACTED] said he has been [REDACTED]
- [REDACTED] stated he works the 3p-11p shift.
- [REDACTED] said a during normal shift the residents should be in their rooms around 3p during shift change, he states it is called 'reflection' time.
- Dinner is served around 4p, visitation sessions at 5p.
- 7p is shower time
- [REDACTED] stated the residents should be in their rooms around 8p however they have been out of their rooms around 8p lately.
- On the date of the incident [REDACTED] said he came on H&W around 3:05p. [REDACTED] ([REDACTED] were working the 3p-11p. [REDACTED] was on H&W with him.
- [REDACTED] stated he noticed the residents were intermixed between pods and when he asked outgoing staff ([REDACTED]) what was going on he ([REDACTED]) stated the boys would not go down (meaning they would not go in their rooms for reflection)
- [REDACTED] stated he told [REDACTED] he would not accept the pod in this form; [REDACTED] he had called for assistance but had not received any help.
- [REDACTED] stated he called day shift supervisor [REDACTED] and expressed his concerns about the residents being unsecured and in & out of each other's room.
- [REDACTED] stated he told [REDACTED] he was worried there was potential for sexual inappropriate behavior and assaults and he did not want to take responsibility for the pod without assistance.
- [REDACTED] said [REDACTED] told him [REDACTED]
- [REDACTED] stated [REDACTED] told him to call [REDACTED] and ask for assistance. She then left the pod with [REDACTED] and reassigned her to another pod. [REDACTED] said [REDACTED] never called him back.
- [REDACTED] said [REDACTED] would send [REDACTED] up to assist; which she did at approximately 4-430p.
- [REDACTED] said [REDACTED] came back to assist with the food cart.
- [REDACTED] stated visitors came at approximately 5p. [REDACTED] was on A pod at this time and had a visitor.
- [REDACTED] said [REDACTED] was refusing to back into [REDACTED]
- [REDACTED] stated [REDACTED] said [REDACTED] was afraid of another resident on A side; [REDACTED] called [REDACTED] who told him to transfer [REDACTED] to the C side.
- [REDACTED] stated [REDACTED] did not want to go C side and wanted to go the B side instead. [REDACTED] stated [REDACTED] couldn't do that without permission so he took [REDACTED] to the gym where [REDACTED] was watching a resident who was having an attorney visit.
- [REDACTED] stated he spoke to [REDACTED] about [REDACTED] refusing to go the C side and [REDACTED] desire to go the B side. [REDACTED] told [REDACTED] to transfer [REDACTED] to the B side; [REDACTED] expressed his concern that wasn't a good idea. [REDACTED] told him just to transfer [REDACTED] to B side.
- [REDACTED] said he started showers on A side at approximately 7p. followed by C side.
- He said he was going back and forth between the three sides, conducting showers on A & C sides and giving B side their towels, bundles, soap etc until almost 10pm.
- [REDACTED] stated he was the only one doing rounds during this time

|                         |   |  |                     |
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| <b>PAGE:</b><br>4 of 10 | <b>INVESTIGATED BY:</b><br>DIGGS, DENNIS, 300, D/SERGEANT | <b>INVESTIGATED BY:</b><br>LAMAY, LARISSA, 124, D/SERGEANT | <b>REVIEWED BY:</b> |
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**MICHIGAN DEPARTMENT OF STATE POLICE**

**SUPPLEMENTAL INCIDENT REPORT 0006**

|   |                                       |
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| <b>ORIGINAL DATE:</b><br>Wed, Mar 15, 2023      | <b>INCIDENT NO:</b><br>SIS-0000062-23 |
| <b>SUPPLEMENTARY DATE:</b><br>Wed, Mar 29, 2023 | <b>FILE CLASS:</b><br>11003           |

- [REDACTED] stated he left shortly after 11pm
- [REDACTED] stated he received a phone call the next day not to come to work as he was suspended due to the incident the day before.
- [REDACTED] stated he did not witness or hear of any assaults occurring during his shift.
- [REDACTED] stated none of the residents reported any assaults and no staff in the control room called to report any incidents
- [REDACTED] stated he heard about the assault the next day as he began receiving phone calls from staff as he is the [REDACTED].
- [REDACTED] stated he never saw a group of residents come out of a specific room.
- [REDACTED] stated to his knowledge he did not hear of any assaults occurring on his shift.
- [REDACTED] stated [REDACTED] called him at approximately 1am.
- [REDACTED] stated he informed [REDACTED] complete a UI (unusual incident) on the system.
- [REDACTED] that [REDACTED] instructed him [REDACTED] not to complete a UI on the system and to send it to her. [REDACTED] told [REDACTED] he wasn't comfortable with that and would send [REDACTED] a copy also.
- [REDACTED] stated [REDACTED] sent him two copies of his statement – one that said [REDACTED]

**WITNESS**

NAM: [REDACTED]  
 BIR: [REDACTED] RAC: [REDACTED] ETH: [REDACTED]  
 NBR: [REDACTED] DIR: [REDACTED] SEX: [REDACTED] DL: [REDACTED]  
 STR: [REDACTED] DOB: [REDACTED] SSN: [REDACTED]  
 SFX: [REDACTED] APT/LOT: [REDACTED] HGT: [REDACTED] SI: /  
 CTY: [REDACTED] ST: [REDACTED] WGT: [REDACTED] FBI:  
 TXH: [REDACTED] ZIP: [REDACTED] HAI: [REDACTED] MNU:  
 TXW: [REDACTED] EYE: [REDACTED] PR:  
 MB: [REDACTED]  
 SMT:

**INTERVIEW [REDACTED]**

- I spoke [REDACTED] at the Metro North post; she was accompanied by [REDACTED] who is her union representative.
- [REDACTED] was informed she was not under arrest and could leave anytime. She was informed of the criminal investigation.
  - [REDACTED] stated she has been employed at the [REDACTED].
  - [REDACTED] stated she normally works the 3p-11p shift.
  - [REDACTED] stated a normal shift involves feeding the residents, rec time, clothing, phone calls, visitation and showers.
  - [REDACTED] stated the day of the incident was a normal shift.
  - [REDACTED] stated the residents are normally in their rooms when she comes on shift.

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| <b>PAGE:</b><br>5 of 10 | <b>INVESTIGATED BY:</b><br>DIGGS, DENNIS, 300, D/SERGEANT | <b>INVESTIGATED BY:</b><br>LAMAY, LARISSA, 124, D/SERGEANT | <b>REVIEWED BY:</b> |
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**MICHIGAN DEPARTMENT OF STATE POLICE**

**SUPPLEMENTAL INCIDENT REPORT 0006**

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| <b>ORIGINAL DATE:</b><br>Wed, Mar 15, 2023      | <b>INCIDENT NO:</b><br>SIS-0000062-23 |
| <b>SUPPLEMENTARY DATE:</b><br>Wed, Mar 29, 2023 | <b>FILE CLASS:</b><br>11003           |

- ██████ stated on the day of the incident she was in the control room.
- ██████ stated she keeps the log books, answers phone calls and assists staff
- ██████ stated the residents 'horseplay' on a consistent basis
- ██████ said she did not witness or hear of any assaults happening on her 3p-11p shift.
- ██████ stated after her 3p-11p on H&W she went to admitting for the midnight shift 11p-7a.
- ██████ stated she normally works a double shift 6 or 7 days a week.
- ██████ stated she heard about the assault when staff brought ██████ down to be taken to the hospital
- ██████ said ██████ did not make any statements in her presence.
- ██████ stated ██████ came in at approximately 5am and asked what happened.
- ██████ said ██████ was fine on afternoon shift

**WITNESS**

NAM: ██████  
 BIR: ██████ RAC: ██████ ETH: ██████  
 NBR: ██████ DIR: ██████ SEX: ██████ DL: ██████  
 STR: ██████ DOB: ██████ SSN: ██████  
 SFX: ██████ APT/LOT: ██████ HGT: ██████ SI: /  
 CTY: ██████ ST: ██████ WGT: ██████ FBI: ██████  
 TXH: ██████ ZIP: ██████ HAI: ██████ MNU: ██████  
 TXW: ██████ EYE: ██████ PR: ██████  
 MB: ██████  
 SMT: ██████

**INTERVIEW ██████**

I spoke with ██████ at the Metro North post; he was accompanied by ██████ who is his union representative.

- ██████ was informed he was free to leave at anytime, he was not under arrest and this is a voluntary interview.
- ██████ stated he has been employed at the ██████
- ██████ says his title is Juvenile Detention Specialist
- ██████ says his responsibilities include safety and security of the residents, make rounds, complete log books and documentation.
- ██████ says he makes rounds 15-45 minutes
- ██████ states he has concerns about safety and security of the staff. Says he has previously been assaulted by residents.
- ██████ states he was working 11p-7a shift the day of the incident; it was supposed to be his day off however ██████ called him in because they were short.
- ██████ says he was assigned to the H&W pod on this day
- Stated when he arrived he went through security, punched in, saw ██████ laying on couch (states on her break) and went to control room.
- Stated he went to relieve ██████ in the control room, and saw ██████ get up
- ██████ states he observed residents out in pod and not in their rooms

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| <b>MICHIGAN DEPARTMENT OF STATE POLICE</b><br><br>SUPPLEMENTAL INCIDENT REPORT<br><b>0006</b> | ORIGINAL DATE:<br>Wed, Mar 15, 2023      | INCIDENT NO:<br>SIS-0000062-23 |
|   | SUPPLEMENTARY DATE:<br>Wed, Mar 29, 2023 | FILE CLASS:<br>11003           |

- [redacted] and [redacted] exchanged information in control room
- [redacted] states [redacted] told him [redacted] wanted to fight with [redacted]
- [redacted] said [redacted] came to control room and [redacted] and [redacted] left. [redacted] giving report to [redacted]
- [redacted] said [redacted] left control room and went to A and C sides to check on them; all were secure
- [redacted] stated B side was the only side not in their rooms.
- [redacted] said [redacted] [redacted] [redacted] and [redacted]
- [redacted] stated he had been instructed not to go into B side because there was only 2 staff on the pod and the [redacted] were not in [redacted] rooms.
- [redacted] also said he could not go out into pod because he was the control room person
- [redacted] said the [redacted] were playing cards out in pod until approximately 1am.
- [redacted] said at approximately 1am he went to check A and C side residents.
- [redacted] stated at approximately 1:13am he heard a commotion on B side and asked [redacted] to check on what was going on.
- [redacted] said he observed [redacted] standing at the door to B side and the [redacted] were surrounding [redacted] on the right, [redacted] on stairs on left, and [redacted] in front of [redacted]
- [redacted] heard [redacted] state 'don't swing on me, I can't fight'.
- [redacted] then observed [redacted] hit [redacted] he also observed [redacted] hit [redacted]
- [redacted] radioed a code 1 on the prep radio
- Both [redacted] and [redacted] left control room to go to B side.
- [redacted] said [redacted] told him 'don't go out they are going to swing on you'.
- [redacted] observed [redacted] was on the floor.
- [redacted] responded and he [redacted] and [redacted] went out on the B side to separate [redacted]
- [redacted] put [redacted] behind him and [redacted] opened the door and brought [redacted] in
- [redacted] stated he put [redacted] on C side
- [redacted] stated [redacted] said the [redacted] on afternoon shift
- [redacted] stated [redacted] did not have a shirt on but did have shorts on
- [redacted] instructed [redacted] to not do a UI, said to just to a written statement
- [redacted] told [redacted] to remove the [redacted] part out. [redacted] sent both to [redacted] ([redacted] did send one copy and [redacted] sent the original to me)
- [redacted] stated [redacted] responded and asked what happened.
- [redacted] stated [redacted] questioned why [redacted] was on the B side and [redacted] responded it was a directive from him ([redacted])
- [redacted] instructed [redacted] not to do a UI; said to do a statement and they may have to do some editing
- [redacted] stated [redacted] took log book at approximately 4:35a and brought it back at approximately 6:15a.
- [redacted] said [redacted] called him at approximately 5:30p to tell him he was suspended.
- [redacted] appeared to be upset two people were on break at the same time
- [redacted] stated [redacted] completed a UI and he would email me a copy which he did.
- [redacted] confirmed he observed a notation in the log book at approximately 6:44p indicating [redacted] had given the directive for [redacted] to be transferred to B side.

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**MICHIGAN DEPARTMENT OF STATE POLICE**

SUPPLEMENTAL INCIDENT REPORT  
**0006**

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| ORIGINAL DATE:<br>Wed, Mar 15, 2023      | INCIDENT NO:<br>SIS-0000062-23 |
| SUPPLEMENTARY DATE:<br>Wed, Mar 29, 2023 | FILE CLASS:<br>11003           |

**WITNESS**

NAM: [REDACTED]  
 BIR: [REDACTED] RAC: [REDACTED] ETH: [REDACTED]  
 NBR: [REDACTED] DIR: [REDACTED] SEX: [REDACTED] DL: [REDACTED]  
 STR: [REDACTED] DOB: [REDACTED] SSN: [REDACTED]  
 SFX: [REDACTED] HGT: [REDACTED] SI: /  
 CTY: [REDACTED] ST: [REDACTED] WGT: [REDACTED] FBI: [REDACTED]  
 TXH: [REDACTED] ZIP: [REDACTED] HAI: [REDACTED] MNU: [REDACTED]  
 TXW: [REDACTED] EYE: [REDACTED] PR: [REDACTED]  
 MB: [REDACTED]  
 MB: [REDACTED]  
 SMT: [REDACTED]

**INTERVIEW [REDACTED]**

I spoke to [REDACTED] at Metro North post; he did not bring a union representative as he is a contract employee. He works for [REDACTED] and has been employed with the company since January 2023.

- [REDACTED] was informed he was not under arrest, he was free to go anytime and this interview was voluntary
- His current title is Team Leader/Supervisor.
- He currently has four people he supervises; normally he works 11p-7a but typically he works a double.
- [REDACTED] stated he go upstairs at approximately 11:05p and received report from [REDACTED]
- [REDACTED] stated he was a little late getting upstairs because he was complaining about working with [REDACTED] because [REDACTED] cannot go out onto pod due to residents wanting to assault him
- [REDACTED] stated he did not [REDACTED] as well as a [REDACTED]. He assumed [REDACTED] was in [REDACTED] room sleeping
- [REDACTED] stated he saw [REDACTED]
- [REDACTED] stated he went back into control room.
- [REDACTED] stated he talked to [REDACTED] he then went to A and C sides to do rounds – at approximately 11:30p
- [REDACTED] stated he was instructed to monitor B side through the glass because [REDACTED] could not go onto B side and [REDACTED]
- At approximately 12:15 – 12:20a [REDACTED] went back to control room and [REDACTED] did rounds on A and C sides.
- At approximately 1-1:10a [REDACTED] observed [REDACTED] come out of room 9 or 10 on the lower level.
- Approximately 10 secs [REDACTED] then observes [REDACTED] come out of room 10 on the lower level.
- [REDACTED] stated [REDACTED] had [REDACTED]
- [REDACTED] yelled at [REDACTED] to call a code because [REDACTED] immediately punched [REDACTED]
- [REDACTED] stated he heard [REDACTED] state 'I thought you guys were gonna hit on me anymore'

|                  |  |   |              |
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| PAGE:<br>8 of 10 | INVESTIGATED BY:<br>DIGGS, DENNIS, 300, D/SERGEANT | INVESTIGATED BY:<br>LAMAY, LARISSA, 124, D/SERGEANT | REVIEWED BY: |
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**MICHIGAN DEPARTMENT OF STATE POLICE**

**SUPPLEMENTAL INCIDENT REPORT 0006**

|   |                                       |
|---|---------------------------------------|
| <b>ORIGINAL DATE:</b><br>Wed, Mar 15, 2023      | <b>INCIDENT NO:</b><br>SIS-0000062-23 |
| <b>SUPPLEMENTARY DATE:</b><br>Wed, Mar 29, 2023 | <b>FILE CLASS:</b><br>11003           |

- [REDACTED] called code 1 and requested a supervisor
- Both [REDACTED] and [REDACTED] exited the control room but did not go out onto the pod for safety reasons
- [REDACTED] observed [REDACTED] continued to beat on [REDACTED]
- [REDACTED] stated [REDACTED] went directly to control room and tried asking [REDACTED] questions through the glass
- [REDACTED] yelled from control room that [REDACTED] was hitting [REDACTED] again
- [REDACTED] state [REDACTED] responded
- [REDACTED] stated [REDACTED] told him ([REDACTED] and [REDACTED])
- [REDACTED] stated [REDACTED] told him [REDACTED]
- [REDACTED] stated he pulled [REDACTED] aside on the C side and [REDACTED] said [REDACTED] (also told [REDACTED] this on the way to admitting)
- [REDACTED] said [REDACTED] told him the [REDACTED]
- [REDACTED] stated the boys on B side have a tool to pop their locks in there room
- [REDACTED] stated the staff was given a directive by [REDACTED] to allow the boys to stay out of their rooms all the time.
- [REDACTED] stated all of the command know the boys are staying in each other's rooms all the time. This included at the boys on B side as well as [REDACTED].
- [REDACTED] escorts [REDACTED] to admitting
- [REDACTED] stated he did not see [REDACTED] on top of the table.
- [REDACTED] stated [REDACTED] told [REDACTED] about the [REDACTED] (while [REDACTED] was in admitting)
- [REDACTED] stated he went back up to complete a UI and written statement; he submitted both to [REDACTED]
- [REDACTED] stated [REDACTED] came in and asked what happened. Said [REDACTED] wanted to see their statements before they turned them in however [REDACTED] just gave his to [REDACTED]

**WITNESS / OTHER:**

NAM: [REDACTED]  
 BIR: [REDACTED] RAC: [REDACTED] ETH: [REDACTED]  
 NBR: [REDACTED] DIR: [REDACTED] SEX: [REDACTED] DL: [REDACTED]  
 STR: [REDACTED] DOB: [REDACTED] SSN: [REDACTED]  
 SFX: [REDACTED] HGT: [REDACTED] SI: /  
 CTY: [REDACTED] ST: [REDACTED] WGT: [REDACTED] FBI: [REDACTED]  
 TXH: [REDACTED] ZIP: [REDACTED] HAI: [REDACTED] MNU: [REDACTED]  
 TXW: [REDACTED] EYE: [REDACTED] PR: [REDACTED]  
 MB: [REDACTED]  
 SMT: [REDACTED]

**INTERVIEW [REDACTED]:**

[REDACTED] cancelled her appointment for an interview and subsequently declined to be interviewed, stating she already provided a written statement and would not be making another. This information was provided through her union president [REDACTED].

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| <b>PAGE:</b><br>9 of 10 | <b>INVESTIGATED BY:</b><br>DIGGS, DENNIS, 300, D/SERGEANT | <b>INVESTIGATED BY:</b><br>LAMAY, LARISSA, 124, D/SERGEANT | <b>REVIEWED BY:</b> |
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**MICHIGAN DEPARTMENT OF STATE POLICE**

SUPPLEMENTAL INCIDENT REPORT  
**0006**

|  |                                |
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| ORIGINAL DATE:<br>Wed, Mar 15, 2023      | INCIDENT NO:<br>SIS-0000062-23 |
| SUPPLEMENTARY DATE:<br>Wed, Mar 29, 2023 | FILE CLASS:<br>11003           |

**SUSPECT:**

NAM: [REDACTED]  
 BIR: [REDACTED] RAC: [REDACTED] ETH: [REDACTED]  
 NBR: [REDACTED] DIR: [REDACTED] SEX: [REDACTED] DL: /  
 STR: [REDACTED] DOB: [REDACTED] SSN: [REDACTED]  
 SFX: [REDACTED] HGT: [REDACTED] SI: /  
 CTY: [REDACTED] ST: [REDACTED] WGT: [REDACTED] FBI: [REDACTED]  
 TXH: [REDACTED] ZIP: [REDACTED] HAI: [REDACTED] MNU: [REDACTED]  
 TXW: [REDACTED] EYE: [REDACTED] PR: [REDACTED]  
 SMT: [REDACTED]

**PARENT OF [REDACTED]**

NAM: [REDACTED]  
 BIR: [REDACTED] RAC: [REDACTED] ETH: [REDACTED]  
 NBR: [REDACTED] DIR: [REDACTED] SEX: [REDACTED] DL: [REDACTED]  
 STR: [REDACTED] DOB: [REDACTED] SSN: [REDACTED]  
 SFX: [REDACTED] HGT: [REDACTED] SI: /  
 CTY: [REDACTED] ST: [REDACTED] WGT: [REDACTED] FBI: [REDACTED]  
 TXH: [REDACTED] ZIP: [REDACTED] HAI: [REDACTED] MNU: [REDACTED]  
 TXW: [REDACTED] EYE: [REDACTED] PR: [REDACTED]  
 MB: [REDACTED]  
 SMT: [REDACTED]

**INTERVIEW [REDACTED]**

[REDACTED] informed me she was declining an interview of her [REDACTED].

**ADDITIONAL INFORMATION:**

No other parents or guardians have responded back to the request for an interview of the juveniles. Several attempts have been made to the attorney of the victim with no response received.

**EXTERNAL DOCUMENTS:**

Copy of both of [REDACTED] statement (via email)  
 Copy of Discrimination-Harassment-Retaliation Complaint form [REDACTED] filed related to the incident on 3/14/2023  
 Copy of Wayne County Incident Report 2777-23

**STATUS:**

Open, pending additional interviews.

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| PAGE:<br>10 of 10 | INVESTIGATED BY:<br>DIGGS, DENNIS, 300, D/SERGEANT | INVESTIGATED BY:<br>LAMAY, LARISSA, 124, D/SERGEANT | REVIEWED BY: |
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| <b>MICHIGAN DEPARTMENT OF STATE POLICE</b><br><br>SUPPLEMENTAL INCIDENT REPORT<br><b>0007</b> | ORIGINAL DATE:<br>Wed, Mar 15, 2023      | INCIDENT NO:<br>SIS-0000062-23 |
|   | SUPPLEMENTARY DATE:<br>Sun, Apr 30, 2023 | FILE CLASS:<br>11003           |

INCIDENT STATUS:  
OPEN

**CRIMINAL SEXUAL CONDUCT**

**INFORMATION:**

The following individuals were identified as having responded to the JDF on the night of the alleged incident. Attempts to interview these individuals have been made.

**WITNESS**

NAM: [REDACTED]  
 BIR: [REDACTED] RAC: [REDACTED] ETH: [REDACTED]  
 NBR: [REDACTED] DIR: [REDACTED] SEX: [REDACTED] DL: [REDACTED]  
 STR: [REDACTED] DOB: [REDACTED] SSN: [REDACTED]  
 SFX: [REDACTED] HGT: [REDACTED] SI: /  
 CTY: [REDACTED] ST: [REDACTED] WGT: [REDACTED] FBI: [REDACTED]  
 TXH: [REDACTED] ZIP: [REDACTED] HAI: [REDACTED] MNU: [REDACTED]  
 TXW: [REDACTED] EYE: [REDACTED] PR: [REDACTED]  
 MB: [REDACTED]  
 SMT: [REDACTED]

**INTERVIEW [REDACTED]**

Call made to [REDACTED] voicemail not set up. Text message sent. Awaiting response.

**WITNESS**

NAM: [REDACTED]  
 BIR: [REDACTED] RAC: [REDACTED] ETH: [REDACTED]  
 NBR: [REDACTED] DIR: [REDACTED] SEX: [REDACTED] DL: [REDACTED]  
 STR: [REDACTED] DOB: [REDACTED] SSN: [REDACTED]  
 SFX: [REDACTED] HGT: [REDACTED] SI: /  
 CTY: [REDACTED] ST: [REDACTED] WGT: [REDACTED] FBI: [REDACTED]  
 TXH: [REDACTED] ZIP: [REDACTED] HAI: [REDACTED] MNU: [REDACTED]  
 TXW: [REDACTED] EYE: [REDACTED] PR: [REDACTED]  
 MB: [REDACTED]  
 SMT: [REDACTED]

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|-----------------|--|---|--------------|
| PAGE:<br>1 of 2 | INVESTIGATED BY:<br>DIGGS, DENNIS, 300, D/SERGEANT | INVESTIGATED BY:<br>LAMAY, LARISSA, 124, D/SERGEANT | REVIEWED BY: |
|-----------------|--|---|--------------|

**MICHIGAN DEPARTMENT OF STATE POLICE**

**SUPPLEMENTAL INCIDENT REPORT 0007**

|   |                                       |
|---|---------------------------------------|
| <b>ORIGINAL DATE:</b><br>Wed, Mar 15, 2023      | <b>INCIDENT NO:</b><br>SIS-0000062-23 |
| <b>SUPPLEMENTARY DATE:</b><br>Sun, Apr 30, 2023 | <b>FILE CLASS:</b><br>11003           |

**INTERVIEW [REDACTED]:**

Call made to [REDACTED] voicemail not set up. Text message sent. Awaiting response

**WITNESS**

NAM: [REDACTED]  
 BIR: [REDACTED] RAC: [REDACTED] ETH: [REDACTED]  
 NBR: [REDACTED] DIR: [REDACTED] SEX: [REDACTED] DL: [REDACTED]  
 STR: [REDACTED] DOB: [REDACTED] SSN: [REDACTED]  
 SFX: [REDACTED] HGT: [REDACTED] SI: /  
 CTY: [REDACTED] ST: [REDACTED] WGT: [REDACTED] FBI:  
 TXH: [REDACTED] ZIP: [REDACTED] HAI: [REDACTED] MNU:  
 TXW: [REDACTED] EYE: [REDACTED] PR:  
 MB: [REDACTED]  
 SMT:

**INTERVIEW [REDACTED]**

Call made to [REDACTED] voicemail left. Awaiting response.

**FURTHER INFORMATION:**

A request was made to Wayne County for further information; Lt. Rinehart will send information.

**STATUS:**

Open, pending further

|                        |   |  |                     |
|------------------------|---|--|---------------------|
| <b>PAGE:</b><br>2 of 2 | <b>INVESTIGATED BY:</b><br>DIGGS, DENNIS, 300, D/SERGEANT | <b>INVESTIGATED BY:</b><br>LAMAY, LARISSA, 124, D/SERGEANT | <b>REVIEWED BY:</b> |
|------------------------|---|--|---------------------|

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|---|--|--------------------------------|
| <b>MICHIGAN DEPARTMENT OF STATE POLICE</b><br><br>SUPPLEMENTAL INCIDENT REPORT<br><b>0008</b> | ORIGINAL DATE:<br>Wed, Mar 15, 2023      | INCIDENT NO:<br>SIS-0000062-23 |
|   | SUPPLEMENTARY DATE:<br>Tue, Jun 13, 2023 | FILE CLASS:<br>11003           |

|                          |
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| INCIDENT STATUS:<br>OPEN |
|--------------------------|

**CRIMINAL SEXUAL CONDUCT**

**JOURNAL:**

| DATE       | JOURNALED BY                                 | ACTION  |
|------------|--|---|
| 05-05-2023 | ENTERED BY: PRICE, EDWARD, 171, D/LIEUTENANT | ORIG - SUPP 7 REVIEWED; PENDS FURTHER INTERVIEWS AND PROS REVIEW. |
| 05-08-2023 | ENTERED BY: PRICE, EDWARD, 171, D/LIEUTENANT | DB REVIEW COMPLETED   |
| 05-08-2023 | ENTERED BY: LAMAY, LARISSA, 124, D/SERGEANT  | MESSAGE LEFT WITH ATTORNEY CARY MCGEHEE (VICTIM/FAMILY ATTORNEY)  |
| 06-07-2023 | ENTERED BY: PRICE, EDWARD, 171, D/LIEUTENANT | PENDS FURTHER INVESTIGATION                                       |
| 06-07-2023 | ENTERED BY: PRICE, EDWARD, 171, D/LIEUTENANT | PENDS FURTHER INVESTIGATION                                       |

**INFORMATION:**

The attorney representing the victim's family, Cary McGehee advised me she would be recontacting the family to discuss scheduling another forensic interview of the victim. As of this date McGehee has not returned my calls to confirm if the forensic interview will be completed.

██████████ was interviewed at the Metro North post; the interview was audio recorded and a copy stored on the 2<sup>nd</sup> District Digital Evidence drive.

Message left with ██████████ with request for interview. Contact information received for ██████████ – whose last name has recently changed to ██████████ scheduled for interview on June 15, 2023.

██████████ scheduled for interview at Metro North post on June 15, 2023.

Copies of log book received from Lt. Rinehart, these are included as external documents.

|                 |  |   |              |
|-----------------|--|---|--------------|
| PAGE:<br>1 of 3 | INVESTIGATED BY:<br>DIGGS, DENNIS, 300, D/SERGEANT | INVESTIGATED BY:<br>LAMAY, LARISSA, 124, D/SERGEANT | REVIEWED BY: |
|-----------------|--|---|--------------|

PRINTED: 2/26/2024 12:20

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**MICHIGAN DEPARTMENT OF STATE POLICE**

**SUPPLEMENTAL INCIDENT REPORT 0008**

|   |                                       |
|---|---------------------------------------|
| <b>ORIGINAL DATE:</b><br>Wed, Mar 15, 2023      | <b>INCIDENT NO:</b><br>SIS-0000062-23 |
| <b>SUPPLEMENTARY DATE:</b><br>Tue, Jun 13, 2023 | <b>FILE CLASS:</b><br>11003           |

**DIGITAL EVIDENCE RETENTION:**

DIGITAL EVIDENCE RETENTION: The digital evidence reports will be retained on the MSP Special Investigation Section, Second District Data Retention Storage Drive and held in MSP property under SIS-3-23

**WITNESS:**

NAM: [REDACTED]  
 BIR: [REDACTED] RAC: [REDACTED] ETH: [REDACTED]  
 NBR: [REDACTED] DIR: [REDACTED] SEX: [REDACTED] DL: [REDACTED]  
 STR: [REDACTED] DOB: [REDACTED] SSN: [REDACTED]  
 SFX: [REDACTED] HGT: [REDACTED] SI: /  
 CTY: [REDACTED] ST: [REDACTED] WGT: [REDACTED] FBI: [REDACTED]  
 TXH: [REDACTED] ZIP: [REDACTED] HAI: [REDACTED] MNU: [REDACTED]  
 TXW: [REDACTED] EYE: [REDACTED] PR: [REDACTED]  
 MB: [REDACTED]  
 SMT: [REDACTED]

**INTERVIEW WITNESS**

[REDACTED] agreed to come to the Metro North post for an interview; he came voluntarily and stated he understood he could leave at any time. The following is a summary of the interview and not a verbatim account; please refer to the audio for specific details.

- Employed at [REDACTED] current title is Deputy Director of Operations
- [REDACTED] prior to this position
- Daily responsibilities include: liaison between CPS and BCCAL (bureau of child care and licensing) and oversees daily operations
- Also the interim Deputy Director of Administration since the incident
- Oversees programs, staffing, normal hours are 9a-5p
- States he was working day of incident, showing staff how to run programs and manage residents
- States he got off around 5p the day of the incident
- Received a call around 2a-3a the next morning from [REDACTED] about the assault of victim
- Stated he spoke with Operations Manager [REDACTED] and Director/Commander [REDACTED]
- Responded back to facility
- Stated he went to his office to drop his belongings off and went to B unit
- Observed [REDACTED] and B. [REDACTED] lying on mattress on floor under stairs
- Stated he told [REDACTED] to go to his room and [REDACTED] told he was not going to his room
- Spoke about sheets jammed in doors to keep them open
- Stated he left unit and went back to his office, contacted front desk to see if [REDACTED] was there yet
- Stated [REDACTED] came to his office with [REDACTED] and [REDACTED]

|                        |   |  |                     |
|------------------------|---|--|---------------------|
| <b>PAGE:</b><br>2 of 3 | <b>INVESTIGATED BY:</b><br>DIGGS, DENNIS, 300, D/SERGEANT | <b>INVESTIGATED BY:</b><br>LAMAY, LARISSA, 124, D/SERGEANT | <b>REVIEWED BY:</b> |
|------------------------|---|--|---------------------|

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| <b>MICHIGAN DEPARTMENT OF STATE POLICE</b><br>SUPPLEMENTAL INCIDENT REPORT<br>0008 | ORIGINAL DATE:<br>Wed, Mar 15, 2023      | INCIDENT NO:<br>SIS-0000062-23 |
|  | SUPPLEMENTARY DATE:<br>Tue, Jun 13, 2023 | FILE CLASS:<br>11003           |

- [REDACTED] and [REDACTED] told [REDACTED] the victim told them [REDACTED] was sexually assaulted in one of the rooms on the second level
- Stated they waited in his office for [REDACTED] to call them with further instructions
- Stated [REDACTED] called him downstairs to command center at approximately 4-5am to complete unusual incident report completed
- States everyone on site during the incident should complete a report
- States he doesn't know what time the incident actually happened
- States he did not meet with any staff members regarding this incident
- States he spoke with victim when [REDACTED] returned from hospital
- States victim was still talking about fighting other residents; victim stayed in admitting for constant observation
- [REDACTED] states he did not authorize victim to be moved to B unit
- States [REDACTED] allowed [REDACTED] and his twin brother [REDACTED] on the same unit at the same time
- States he instructed [REDACTED] to move [REDACTED] off of B unit as they don't allow relatives/co-defendants on the same unit
- States [REDACTED] moved victim to B unit on his own and without authorization
- States scene should be secured as soon as possible
- Stated he did not want victim housed on same unit as [REDACTED] brothers due to difference and influence they may have
- States residents did not say anything to him about incident

**WITNESS:**

NAM: [REDACTED]  
 BIR: [REDACTED] RAC: [REDACTED] ETH: [REDACTED]  
 NBR: [REDACTED] DIR: [REDACTED] SEX: [REDACTED] DL: /  
 STR: [REDACTED] DOB: [REDACTED] SSN: [REDACTED]  
 SFX: [REDACTED] HGT: ' " SI: /  
 CTY: [REDACTED] ST: [REDACTED] WGT: [REDACTED] FBI: [REDACTED]  
 TXH: [REDACTED] ZIP: [REDACTED] HAI: [REDACTED] MNU: [REDACTED]  
 TXW: [REDACTED] EYE: [REDACTED] PR: [REDACTED]  
 CT: [REDACTED]  
 SMT: [REDACTED]

**EXTERNAL DOCUMENTS:**

Copies of log books from JDF

**STATUS:**

Open, pending further

|                 |  |   |              |
|-----------------|--|---|--------------|
| PAGE:<br>3 of 3 | INVESTIGATED BY:<br>DIGGS, DENNIS, 300, D/SERGEANT | INVESTIGATED BY:<br>LAMAY, LARISSA, 124, D/SERGEANT | REVIEWED BY: |
|-----------------|--|---|--------------|

**MICHIGAN DEPARTMENT OF STATE POLICE**

**SUPPLEMENTAL INCIDENT REPORT 0009**

**ORIGINAL DATE:**  
Wed, Mar 15, 2023

**SUPPLEMENTARY DATE:**  
Fri, Jun 16, 2023

**INCIDENT NO:**  
SIS-0000062-23

**FILE CLASS:**  
11003

**INCIDENT STATUS:**  
OPEN

**CRIMINAL SEXUAL CONDUCT**

**JOURNAL:**

| DATE       | JOURNALED BY                                 | ACTION                                       |
|------------|--|--|
| 06-13-2023 | ENTERED BY: PRICE, EDWARD, 171, D/LIEUTENANT | SUPP 8 REVIEWED; PENDS FURTHER INVESTIGATION |

**INFORMATION:**

The following individuals were interviewed regarding the alleged assault.

**WITNESS**

NAM: [REDACTED]  
 BIR: [REDACTED] RAC: [REDACTED] ETH: [REDACTED]  
 NBR: [REDACTED] DIR: [REDACTED] SEX: [REDACTED] DL: [REDACTED]  
 STR: [REDACTED] DOB: [REDACTED] SSN: [REDACTED]  
 SFX: [REDACTED] HGT: [REDACTED] SI: [REDACTED]  
 CTY: [REDACTED] ST: [REDACTED] WGT: [REDACTED] FBI: [REDACTED]  
 TXH: [REDACTED] ZIP: [REDACTED] HAI: [REDACTED] MNU: [REDACTED]  
 TXW: [REDACTED] EYE: [REDACTED] PR: [REDACTED]  
 MB: [REDACTED]  
 SMT: [REDACTED]

**INTERVIEW [REDACTED]**

[REDACTED] was interviewed at the Metro North Post. [REDACTED] voluntarily came in for an interview and was advised she could end the conversation at any time and was not obligated to speak with me. The following is a summary of the interview and not a verbatim account. The interview was audio recorded; for specific details please refer to the recorded copy.

- [REDACTED] stated she has been employed at the [REDACTED] and holds the title of Operations Manager.
- She states she oversees the daily operations and works the 11a-7p shift.
- States she worked earlier in the day on the day of the incident
- States she became aware of the situation when she received a phone call from [REDACTED] stating the victim had been 'jumped'
- [REDACTED] stated she immediately called [REDACTED] to inform him however [REDACTED] had already been notified.

|                        |   |  |                     |
|------------------------|---|--|---------------------|
| <b>PAGE:</b><br>1 of 4 | <b>INVESTIGATED BY:</b><br>DIGGS, DENNIS, 300, D/SERGEANT | <b>INVESTIGATED BY:</b><br>LAMAY, LARISSA, 124, D/SERGEANT | <b>REVIEWED BY:</b> |
|------------------------|---|--|---------------------|

**MICHIGAN DEPARTMENT OF STATE POLICE**

**SUPPLEMENTAL INCIDENT REPORT 0009**

|   |                                       |
|---|---------------------------------------|
| <b>ORIGINAL DATE:</b><br>Wed, Mar 15, 2023      | <b>INCIDENT NO:</b><br>SIS-0000062-23 |
| <b>SUPPLEMENTARY DATE:</b><br>Fri, Jun 16, 2023 | <b>FILE CLASS:</b><br>11003           |

- [REDACTED] said she called the nurse who informed her there was also an allegation of a sexual assault.
- [REDACTED] said she and [REDACTED] rode to the hospital together
- [REDACTED] said she requested a private room for the victim given the nature of the allegations
- [REDACTED] stated the victim said they told [REDACTED] to go into a room and [REDACTED] was afraid if [REDACTED] didn't go into the room [REDACTED] would be physically assaulted
- [REDACTED] stated the victim said [REDACTED] was the aggressor and was giving the orders.
- [REDACTED] initially stated [REDACTED] and [REDACTED] were also involved. She could not initially remember the other individuals however later identified [REDACTED] and [REDACTED] as being involved.
- [REDACTED] stated the victim was initially on the A pod and was afraid an older resident on A would physically assault [REDACTED]
- [REDACTED] said she had a conference call with [REDACTED] and [REDACTED] and all decided to move the victim to C pod and was surprised to hear the victim was on B pod when the incident happened since [REDACTED] was supposed to be on C pod
- [REDACTED] stated the victim said [REDACTED]
- [REDACTED] stated the victim appeared sad and docile
- [REDACTED] said it was obvious the victim had been physically assaulted
- [REDACTED] said the victim said [REDACTED] had also been stomped on
- [REDACTED] said she requested the nurse complete a [REDACTED]
- [REDACTED] stated she and [REDACTED] then went back to the JDF
- [REDACTED] stated she collected the staff's written statements and gave them to [REDACTED]
- [REDACTED] stated she did not at any time instruct staff to change their statements or direct the staff as to what to say in their statements.
- [REDACTED] stated she heard the physical assaults began on the afternoon shift and continued into the midnight shift; although she did not see any of the assaults.
- [REDACTED] stated the victim did not hesitate when stating [REDACTED]
- [REDACTED] said the victim told her [REDACTED] was taken to rooms 7 & 10 but did not know if it was the upper or lower floor for sure.

**WITNESS**

NAM: [REDACTED]  
 BIR: [REDACTED] RAC: [REDACTED] ETH: [REDACTED]  
 NBR: [REDACTED] DIR: [REDACTED] SEX: [REDACTED] DL: /  
 STR: [REDACTED] DOB: [REDACTED] SSN: [REDACTED]  
 SFX: [REDACTED] HGT: ' " SI: /  
 CTY: [REDACTED] ST: [REDACTED] WGT: [REDACTED] FBI: [REDACTED]  
 TXH: [REDACTED] ZIP: [REDACTED] HAI: [REDACTED] MNU: [REDACTED]  
 TXW: [REDACTED] EYE: [REDACTED] PR: [REDACTED]  
 CT: [REDACTED]  
 SMT: [REDACTED]

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|------------------------|---|--|---------------------|
| <b>PAGE:</b><br>2 of 4 | <b>INVESTIGATED BY:</b><br>DIGGS, DENNIS, 300, D/SERGEANT | <b>INVESTIGATED BY:</b><br>LAMAY, LARISSA, 124, D/SERGEANT | <b>REVIEWED BY:</b> |
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**MICHIGAN DEPARTMENT OF STATE POLICE**

**SUPPLEMENTAL INCIDENT REPORT 0009**

|   |                                       |
|---|---------------------------------------|
| <b>ORIGINAL DATE:</b><br>Wed, Mar 15, 2023      | <b>INCIDENT NO:</b><br>SIS-0000062-23 |
| <b>SUPPLEMENTARY DATE:</b><br>Fri, Jun 16, 2023 | <b>FILE CLASS:</b><br>11003           |

**INTERVIEW [REDACTED]**

[REDACTED] was interviewed at the Metro North Post. [REDACTED] voluntarily came in for an interview and was advised she could end the conversation at any time and was not obligated to speak with me. The following is a summary of the interview and not a verbatim account. The interview was audio recorded; for specific details please refer to the recorded copy

- [REDACTED] stated she has been employed at the [REDACTED] and holds the title of Dept Manager of Operatons and at the time of the incident it was Dept Suervisor of medical and mental health
- [REDACTED] states she is not licensed as a nurse
- [REDACTED] states [REDACTED] received [REDACTED] and informed a resident had been physically and sexually assaulted
- [REDACTED] said she spoke to [REDACTED] and instructed him to make arrangements to get the victim transported to the hospital for evaluation.
- [REDACTED] states she rode to the hospital with [REDACTED]
- [REDACTED] stated she observed facial injuries on victim
- [REDACTED] stated [REDACTED] and [REDACTED] transported the victim
- [REDACTED] stated the victim said the first physical assault happened on the afternoon shift and the staff [REDACTED] had checked on [REDACTED] however [REDACTED] had a towel on [REDACTED] head and [REDACTED] kept [REDACTED] down so the staff couldn't see [REDACTED] injuries.
- [REDACTED] said the victim stated the first attack happened upstairs and [REDACTED] told [REDACTED] to come upstairs and the rest followed. She states she wrote the names of the rest of the individuals down and will attempt to locate the notes.
- [REDACTED] said the victim balled up on the floor and took the beating.
- [REDACTED] said the victim said something made the individuals stop and leave the room and that is when [REDACTED] put the towel on [REDACTED] head
- [REDACTED] stated the victim said the [REDACTED] occurred in downstairs in [REDACTED] room at the end under the stairwell. [REDACTED] said [REDACTED] was told to get on the desk on all fours and she asked [REDACTED] if they [REDACTED]. [REDACTED] said it was the same individuals who assaulted [REDACTED] prior.
- [REDACTED] stated she did not ask any further questions.
- [REDACTED] said she told [REDACTED] to tell the nurse everything that happened
- [REDACTED] stated she and [REDACTED] then went back to the JDF

**OTHER:**

NAM: [REDACTED]  
 BIR: [REDACTED] RAC: [REDACTED] ETH: [REDACTED]  
 NBR: [REDACTED] DIR: [REDACTED] SEX: [REDACTED] DL: /  
 STR: [REDACTED] DOB: [REDACTED] SSN: [REDACTED]  
 SFX: [REDACTED] HGT: ' " SI: /  
 CTY: [REDACTED] ST: [REDACTED] WGT: [REDACTED] FBI: [REDACTED]  
 TXH: [REDACTED] ZIP: [REDACTED] HAI: [REDACTED] MNU: [REDACTED]  
 TXW: [REDACTED] EYE: [REDACTED] PR: [REDACTED]  
 MB: [REDACTED]  
 SMT: [REDACTED]

|                        |   |  |                     |
|------------------------|---|--|---------------------|
| <b>PAGE:</b><br>3 of 4 | <b>INVESTIGATED BY:</b><br>DIGGS, DENNIS, 300, D/SERGEANT | <b>INVESTIGATED BY:</b><br>LAMAY, LARISSA, 124, D/SERGEANT | <b>REVIEWED BY:</b> |
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**MICHIGAN DEPARTMENT OF STATE POLICE**

**SUPPLEMENTAL INCIDENT REPORT 0009**

|   |                                       |
|---|---------------------------------------|
| <b>ORIGINAL DATE:</b><br>Wed, Mar 15, 2023      | <b>INCIDENT NO:</b><br>SIS-0000062-23 |
| <b>SUPPLEMENTARY DATE:</b><br>Fri, Jun 16, 2023 | <b>FILE CLASS:</b><br>11003           |

**INTERVIEW [REDACTED]**

I spoke with [REDACTED] and advised her she was not under any obligation to speak with me and could end the conversation at any time. I explained to her I wanted to speak with her regarding the incident which took place at the JDF in March and she agreed to speak with me.

- [REDACTED] advised she and staff member [REDACTED] transported the victim to the hospital from the JDF.
- [REDACTED] stated she drove the van and did not have any conversations with the victim during the ride to the hospital, said she could not hear if the victim made any statements to [REDACTED]
- [REDACTED] stated she observed facial injuries on the victim
- [REDACTED] stated she did not hear any statements made by the victim while at the hospital as she gave [REDACTED] privacy due to the nature of the incident.
- [REDACTED] stated the victim did not make any statements to her on the way back to the JDF from the hospital.

**MANUFACTURED/TRACE EVIDENCE**

OBTAINED BY: D/SGT LAMAY  
 Prop 0014 -Type: EVIDENCE Value: \$0.00  
 Descrp: ONE CD WITH AUDIO RECORDINGS OF INTERVIEWS WITH [REDACTED] AND [REDACTED]  
 Obtained From: 14350 W TEN MILE RD  
 83 - OAK PARK, MI 48237  
 63 - OAKLAND,  
 AUDIO RECORDING - METRO NORTH POST  
 Date/Time Recovered: 06/15/2023

**STATUS:**

Open

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| <b>PAGE:</b><br>4 of 4 | <b>INVESTIGATED BY:</b><br>DIGGS, DENNIS, 300, D/SERGEANT | <b>INVESTIGATED BY:</b><br>LAMAY, LARISSA, 124, D/SERGEANT | <b>REVIEWED BY:</b> |
|------------------------|---|--|---------------------|

**MICHIGAN DEPARTMENT OF STATE POLICE**

SUPPLEMENTAL INCIDENT REPORT  
**0010**

ORIGINAL DATE:  
Wed, Mar 15, 2023

SUPPLEMENTARY DATE:  
Tue, Oct 17, 2023

INCIDENT NO:  
SIS-0000062-23

FILE CLASS:  
11003

INCIDENT STATUS:  
OPEN

**CRIMINAL SEXUAL CONDUCT**

**JOURNAL:**

| DATE       | JOURNALED BY                                 | ACTION   |
|------------|--|--|
| 06-28-2023 | ENTERED BY: PRICE, EDWARD, 171, D/LIEUTENANT | SUPP 9 REVIEWED; PENDS WR FOR WCPO   |
| 06-28-2023 | ENTERED BY: PRICE, EDWARD, 171, D/LIEUTENANT | REASSIGNED TO LAMAY, LARISSA; OIC  |
| 07-17-2023 | ENTERED BY: PRICE, EDWARD, 171, D/LIEUTENANT | PENDS WR TO WCPO   |
| 07-17-2023 | ENTERED BY: PRICE, EDWARD, 171, D/LIEUTENANT | NOTE TO OIC; WHAT IS STATUS OF WR  |
| 08-11-2023 | ENTERED BY: LAMAY, LARISSA, 124, D/SERGEANT  | OIC CONTACTED BY VICTIM/FAMILY CIVIL ATTORNEY 8/10/2023, VICTIM NOW WILLING TO COMPLETE FORENSIC INTERVIEW. PENDS ██████████, DATE TBD |
| 09-18-2023 | ENTERED BY: LAMAY, LARISSA, 124, D/SERGEANT  | FORENSIC INTERVIEWED FOR SEPT 14, 2023 - CANCELLED BY VICTIMS ATTORNEYS. TICKET CREATED TO RESCHEDULE                                  |
| 09-28-2023 | ENTERED BY: LAMAY, LARISSA, 124, D/SERGEANT  | ██████████ SCHEDULED FOR OCT 16 @8:45AM  |
| 10-12-2023 | ENTERED BY: PRICE, EDWARD, 171, D/LIEUTENANT | PENDS FORENSIC INTERVIEW WITH VICTIM   |
| 10-12-2023 | ENTERED BY: PRICE, EDWARD, 171, D/LIEUTENANT | PENDS FORENSIC INTERVIEW AND CASE BEING REASSIGNED.  |
| 10-12-2023 | ENTERED BY: PRICE, EDWARD, 171, D/LIEUTENANT | REASSIGNED TO WALDEN, JONATHAN; NEW OIC  |

|                 |   |   |              |
|-----------------|---|---|--------------|
| PAGE:<br>1 of 3 | INVESTIGATED BY:<br>WALDEN, JONATHAN, 125, D/SERGEANT | INVESTIGATED BY:<br>LAMAY, LARISSA, 124, D/SERGEANT | REVIEWED BY: |
|-----------------|---|---|--------------|

PRINTED: 2/26/2024 12:20

000045

**MICHIGAN DEPARTMENT OF STATE POLICE**

SUPPLEMENTAL INCIDENT REPORT  
0010

|  |                                |
|--|--------------------------------|
| ORIGINAL DATE:<br>Wed, Mar 15, 2023      | INCIDENT NO:<br>SIS-0000062-23 |
| SUPPLEMENTARY DATE:<br>Tue, Oct 17, 2023 | FILE CLASS:<br>11003           |

**INFORMATION:**

A forensic interview was conducted 10/16/202 at [REDACTED]). The interview was conducted by Recalia Miller and is summarized below. The interview was captured on DVD and a copy included in this complaint. The below is a summary and not a verbatim account; please refer to the DVD for specific details.

**INTERVIEW [REDACTED]**

- Miller asks [REDACTED] about the incident that brought [REDACTED] here and [REDACTED] describes being at JDF when [REDACTED] was [REDACTED]
- [REDACTED] stated [REDACTED] had moved from pod A to pod B on the day of the incident
- [REDACTED] things the initial physical assault took place in room 7
- [REDACTED] names 5 individuals as the persons who assaulted [REDACTED]
- [REDACTED] stated [REDACTED] told [REDACTED] to go upstairs to room 7 on upper level, which [REDACTED] did
- [REDACTED] stated the five individuals started punching and kicking [REDACTED] causing [REDACTED] nose to bleed
- [REDACTED] stated the five individuals told [REDACTED] not to tell anyone and gave [REDACTED] a towel for [REDACTED] nose, [REDACTED] left the room after getting the towel
- [REDACTED] stated he went into [REDACTED] room #12 on the lower level and laid down on [REDACTED] bed, on [REDACTED] stomach
- [REDACTED] stated all five came into [REDACTED] room, [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED] stated the lights were off in [REDACTED] room but the door was open and the light was on in the common area
- [REDACTED] stated all five told [REDACTED] to stop moving
- [REDACTED]
- [REDACTED] stated [REDACTED] was able to get up and run out of [REDACTED] room – [REDACTED] had no clothes on
- [REDACTED] stated this is when staff saw [REDACTED] and came out.
- [REDACTED] stated the [REDACTED] m
- [REDACTED] stated [REDACTED] was taken to the hospital and examined
- [REDACTED] stated staff was not on the pod until after [REDACTED] and when [REDACTED] ran out of [REDACTED] room [REDACTED]
- [REDACTED] [REDACTED] does not feel safe at the [REDACTED] is also a resident there and gave [REDACTED] a letter stating he was going to beat [REDACTED] up again
- [REDACTED] stated [REDACTED] feels better getting this off [REDACTED] chest

**MANUFACTURED/TRACE EVIDENCE:**

OBTAINED BY: D/SGT LAMAY  
 Prop 0015 -Type: RECORDING AUDIO/VISUAL Qty: 1 Article Type: DVD (digital video disc) Brand: Model:  
 Serial #: Misc #: OAN: Value: \$0.00 Recovered Value: \$0.00  
 Descrp: ONE DVD CONTAINING FORENSIC INTERVIEW OF [REDACTED]  
 Obtained From: [REDACTED]

|                 |   |   |              |
|-----------------|---|---|--------------|
| PAGE:<br>2 of 3 | INVESTIGATED BY:<br>WALDEN, JONATHAN, 125, D/SERGEANT | INVESTIGATED BY:<br>LAMAY, LARISSA, 124, D/SERGEANT | REVIEWED BY: |
|-----------------|---|---|--------------|

**MICHIGAN DEPARTMENT OF STATE POLICE**

**SUPPLEMENTAL INCIDENT REPORT 0010**

|   |                                       |
|---|---------------------------------------|
| <b>ORIGINAL DATE:</b><br>Wed, Mar 15, 2023      | <b>INCIDENT NO:</b><br>SIS-0000062-23 |
| <b>SUPPLEMENTARY DATE:</b><br>Tue, Oct 17, 2023 | <b>FILE CLASS:</b><br>11003           |

99 - [REDACTED]

Date/Time Recovered: 10/16/2023

**ADDITIONAL INFORMATION:**

Video was obtained from JDF and a review was completed. The Wayne County Sheriffs Office has provided a detailed timeline according to the details of the video.

Medical records received from [REDACTED] also included

**EXTERNAL DOCUMENTS:**

Copy of the timeline provided by Wayne County Sheriffs Office

**MANUFACTURED/TRACE EVIDENCE**

OBTAINED BY: D/SGT LAMAY

Prop 0016 -Type: EVIDENCE Value: \$0.00

Descrp: ONE VERBATIM USB CONTAINING VIDEO SURVEILLANCE OBTAINED FROM [REDACTED] INCIDENT 3/14/2023

Obtained From: [REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]

Date/Time Recovered: 10/19/2023

**SEIZED**

SEIZED BY: D/SGT LAMAY

Prop 0017 -Type: RECORDING AUDIO/VISUAL Qty: 1 Article Type: Laser/Audio Compact Disc (CD) Brand: Model: Serial #: Misc #: OAN: Value: \$0.00 Recovered Value: \$0.00

Descrp: ONE CD/DVD CONTAINING MEDICAL RECORDS FOR [REDACTED] Obtained From: [REDACTED]

[REDACTED]  
[REDACTED]  
[REDACTED]

Date/Time Recovered: 10/19/2023

**STATUS:**

Open, pends WCPO review

|                        |  |  |                     |
|------------------------|--|--|---------------------|
| <b>PAGE:</b><br>3 of 3 | <b>INVESTIGATED BY:</b><br>WALDEN, JONATHAN, 125, D/SERGEANT | <b>INVESTIGATED BY:</b><br>LAMAY, LARISSA, 124, D/SERGEANT | <b>REVIEWED BY:</b> |
|------------------------|--|--|---------------------|

**MICHIGAN DEPARTMENT OF STATE POLICE**

**SUPPLEMENTAL INCIDENT REPORT 0011**

|   |                                       |
|---|---------------------------------------|
| <b>ORIGINAL DATE:</b><br>Wed, Mar 15, 2023      | <b>INCIDENT NO:</b><br>SIS-0000062-23 |
| <b>SUPPLEMENTARY DATE:</b><br>Tue, Jan 02, 2024 | <b>FILE CLASS:</b><br>11003           |

**INCIDENT STATUS:**  
OPEN

**CRIMINAL SEXUAL CONDUCT**

**JOURNAL:**

| DATE       | JOURNALED BY                                  | ACTION  |
|------------|---|---|
| 10-19-2023 | ENTERED BY: PRICE, EDWARD, 171, D/LIEUTENANT  | SUPP 10 REVIEWED; HAS INVESTIGATIVE REPORT BEEN UPLOADED IN KARPEL? |
| 11-14-2023 | ENTERED BY: PRICE, EDWARD, 171, D/LIEUTENANT  | PENDS REVIEW AND UPDATE FROM NEW OIC                                |
| 11-14-2023 | ENTERED BY: PRICE, EDWARD, 171, D/LIEUTENANT  | NOTE TO NEW OIC; HAS INVESTIGATIVE REPORT BEEN UPLOADED IN KARPEL?  |
| 11-30-2023 | ENTERED BY: WALDEN, JONATHAN, 125, D/SERGEANT | PENDS ENTRY INTO KARPEL. WILL DO ASAP                               |
| 12-19-2023 | ENTERED BY: PRICE, EDWARD, 171, D/LIEUTENANT  | PENDS IR  |
| 12-19-2023 | ENTERED BY: PRICE, EDWARD, 171, D/LIEUTENANT  | PENDS IR  |

**INFORMATION:**

One white VERBATIM DVD disk containing digital artifacts, reports and exams; pulled from the SIS Digital Evidence Repository, to be placed in property.

**SEIZED:**

SEIZED BY: GRZADZINSKI

Prop 0018 -Type: RECORDING AUDIO/VISUAL Qty: 1 Article Type: DVD (digital video disc) Brand: Model: Serial #: Misc #: OAN: Value: \$0.00 Recovered Value: \$0.00  
 Descrp: ONE VERBATIM BRAND DVD DISK CONTAINING DIGITAL ARTIFACTS, REPORTS AND EXAMS.  
 Obtained From: [REDACTED]

|                        |  |   |                     |
|------------------------|--|---|---------------------|
| <b>PAGE:</b><br>1 of 2 | <b>INVESTIGATED BY:</b><br>WALDEN, JONATHAN, 125, D/SERGEANT | <b>INVESTIGATED BY:</b><br>GRZADZINSKI, SARAH, CIVILIAN | <b>REVIEWED BY:</b> |
|------------------------|--|---|---------------------|

PRINTED: 2/26/2024 12:20

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**MICHIGAN DEPARTMENT OF STATE POLICE**

**SUPPLEMENTAL INCIDENT REPORT 0011**

|   |                                       |
|---|---------------------------------------|
| <b>ORIGINAL DATE:</b><br>Wed, Mar 15, 2023      | <b>INCIDENT NO:</b><br>SIS-0000062-23 |
| <b>SUPPLEMENTARY DATE:</b><br>Tue, Jan 02, 2024 | <b>FILE CLASS:</b><br>11003           |

82 - WAYNE,  
DIGITAL ARTIFACTS, EXAMS AND REPORTS PULLED FROM THE SIS DIGITAL EVIDENCE REPOSITORY.  
Date/Time Recovered: 01/02/2024

**STATUS:**

OPEN

|                        |  |   |                     |
|------------------------|--|---|---------------------|
| <b>PAGE:</b><br>2 of 2 | <b>INVESTIGATED BY:</b><br>WALDEN, JONATHAN, 125, D/SERGEANT | <b>INVESTIGATED BY:</b><br>GRZADZINSKI, SARAH, CIVILIAN | <b>REVIEWED BY:</b> |
|------------------------|--|---|---------------------|

PRINTED: 2/26/2024 12:20

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Metro Detroit Forensic Laboratory

Submission Report

| Case #   | Submission # | Page   |
|----------|--------------|--------|
| MD23-842 | 1            | 1 of 2 |



Primary Agency: Second District SIS 1301 Third St. Detroit, MI 48226

Agency Case Number(s): SIS-62-23

Submitted Date and Time: 3/21/2023 9:18:41 AM

Primary Examiner:

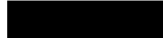
Investigating Officer Lamay, Larissa

Submitting Officer Honey, Robert

Names of Victims (Last, first, mid):



DOB



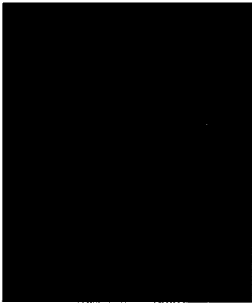
Race



Sex



Names of Suspects (Last, first, mid):



DOB



Race



Sex



Date and Type of Offense: March 15, 2023 - Sexual Assault CSC 1st

Court and Court Date:

Examinations Requested: Biology

Jurisdiction: 82 - Wayne County

Brief Statement of Fact:

Specify manner of return of evidence: Personal Delivery

This evidence is being submitted in connection with a criminal investigation and has not been examined by another laboratory.

Evidence Submitted: (Itemize and Describe)



Container 1 Sealed evidence collection kit (Agency Item# MI22-3741) containing:

By requesting services (Crime Scene Response or Forensic Testing) of FSD, you agree to the following:

All MSP Forensic Science Division laboratory reports will be issued in a simplified format.

Additional information will be made available to our customers upon request. This information may include the location of any testing if different from the listed laboratory, date of issue (release) for the report, the contact information of the customer, the specific dates of performance of any laboratory testing activities, a highly detailed description of the evidence item(s) and/or their condition, evidence disposition, identification of test methods used (where not provided by policy), dates of sampling (if applicable), reference to the sampling plan and sampling method used by the laboratory or other bodies where these are relevant to the validity or application of the results, additions/deviations/exclusions from methods, specific test and environmental conditions, and any other activity or report parameters that

000051

SIS-62-23




Michigan State Police

# Metro Detroit Forensic Laboratory

## Submission Report

| Case #   | Submission # | Page   |
|----------|--------------|--------|
| MD23-842 | 1            | 2 of 2 |

**Primary Agency:**

Second District SIS  
1301 Third St.  
Detroit, MI 48226

**Agency Case Number(s):**

SIS-62-23

**Submitted Date and Time:**

3/21/2023 9:18:41 AM

**Primary Examiner:**

may be of interest.

For additional information about simplified reporting, please visit the MSP Forensic Science Division Website at:

[https://www.michigan.gov/msp/0,4643,7-123-72297\\_60141---,00.html](https://www.michigan.gov/msp/0,4643,7-123-72297_60141---,00.html)

510-20-010

27 - TIME ONE UPDATE

Tuesday, March 14, 2023 – Wednesday, March 15, 2023

**Victim**

1.



**Charge: Domestic Violence/Tether Violation**

**Post Adjudicated: Insight**

**Offenders**

1.



**Charge: Domestic Violence**

**Pre-Adjudicated**

2.



**Charge: Break and Enter w/intent to Commit Felony/Larceny**

**Post-Adjudicated**

3.



**Charge: Felonious**

**Pre-Adjudicated**

4.



**Charge: Carjacking**

**Post Adjudicated: CCMO**

5.



**Charge: CSC I**

**Post Adjudicated: CCMO**

5) 5-62-23

Tuesday, March 14, 2023 – Wednesday, March 15, 2023

**Staff Involvement:**

1. [REDACTED] - Juvenile Detention Supervisor
2. [REDACTED] Juvenile Detention Supervisor
3. [REDACTED] - Juvenile Detention Specialist
4. [REDACTED] New Image Juvenile Detention Supervisor
5. [REDACTED] - Juvenile Detention Specialist
6. [REDACTED] Juvenile Detention Specialist
7. [REDACTED] - Juvenile Detention Specialist

06:10:16p Resident [REDACTED] is out from visiting booth after visitation.

06:32:11p Resident [REDACTED] is escorted off Health and Wellness Unit A with property by JDS [REDACTED]

06:34:08p Resident [REDACTED] is escorted to the gym with property by JDS [REDACTED]

06:43:35p Resident [REDACTED] is escorted to Health and Wellness Unit B with property.

09:39:35p Residents [REDACTED] observed horse playing outside of cell #10 of Unit A.

09:39:41p Residents [REDACTED] enter cell #10 while still horse playing wrestling with each other.

09:41:08p Resident [REDACTED] exits cell #10, closes the door, and locks [REDACTED] into the cell.

09:42:06p Resident [REDACTED] enters cell #11 and exits back in front of cell #10.

09:42:46p Resident [REDACTED] is observed calling up other youth from the lower level.

09:43:02p Resident [REDACTED] enters cell #9, [REDACTED] is observed walking up the stairs. [REDACTED] and [REDACTED] are at cell #10 where [REDACTED] is locked.

09:43:40p Resident [REDACTED] is observed walking upstairs also in front of cell #10 where [REDACTED] is locked.

09:44:06p Resident [REDACTED] is observed walking up the stairs. At same time Resident [REDACTED] slides something to [REDACTED] underneath the door of cell#10.

09:45:27p Resident [REDACTED] manages to open the door from the inside. Residents [REDACTED] enter cell#10 with [REDACTED] still inside.

09:45:49p Resident [REDACTED] is observed entering cell #10. Shortly after Resident [REDACTED] Resident [REDACTED] also enter.

09:46:33p Resident [REDACTED] leaves cell#10

09:47:08p [REDACTED] enters Unit B with Nurse for med pass and Resident [REDACTED] comes downstairs.

09:47:30p Resident [REDACTED] and Resident [REDACTED] exit cell #10

111-621-25

Tuesday, March 14, 2023 – Wednesday, March 15, 2023

09:48:30p All exit cell#10. [redacted] is seen wiping [redacted] eyes exiting the room. [redacted] goes to the lower level.

09:50:25p [redacted] and Nurse exit.

\*\*\*\*no abnormal activity documented. All youth \*\*\*\*

10:00:48p All youth now observed on the lower level. Resident [redacted] appears on camera.

10:01:05p Resident [redacted] appears to be wiping tears from [redacted] face.

10:05:00p All youth residents appear to surround [redacted] as [redacted] backs off view of the camera with [redacted] hands up.

10:07:31p - [redacted] leaves Health and Wellness

10:09:19p - [redacted] is observed walking back into view of cameras and taking a seat at the tables.

10:09:31p - [redacted] seen grabbing [redacted] while [redacted] seated at the tables.

10:11:05p - All youth residents surrounding [redacted] while [redacted] seated at the tables.

10:12:25p - [redacted] is observed punching [redacted] while [redacted] seated at the tables.

10:15:50p - [redacted] is observed punching [redacted] again while [redacted] seated at the tables.

10:16:04p - [redacted] observed punching [redacted] in the back of the head.

10:18:28p - [redacted] observed getting up from the table following [redacted] upstairs. All youth residents follow into cell#7 out of view of the camera.

10:21:57p - [redacted] seen leaving cell#7 going to lower level to look into the control room

10:22:30p - [redacted] returns upstairs

10:22:35p - [redacted] exits cell#7 to lower level to look into the control room

10:23:15p - [redacted] returns to cell#9

10:23:36p - [redacted] is observed low crawling back to cell#7

10:23:56p - [redacted] exits cell#7 to lower level to look into the control room.

10:24:44p - [redacted] exits cell#7 to lower level and [redacted] returns to cell#7.

10:25:05p - [redacted] investigates control room.

10:26:29p - [redacted] exits cell#7 and [redacted] returns. [redacted] is observed exiting cell#7

10:26:45p - All youth return to cell#7

10:27:47p - [redacted] exits cell#7 and returns to cell#9.

10:28:22p - [redacted] observed low crawling back to cell#7

10:29:33p - [redacted] exits control room and enters Unit A.

515-62-25

Tuesday, March 14, 2023 – Wednesday, March 15, 2023

10:29:50p - [REDACTED] exits cell#7 and enters cell#10 with a piece of paper in hand and immediately exits looking down to lower level.

10:30:15p - [REDACTED] returns to cell#7

10:31:04p - [REDACTED] exits Unit A and meets nurses at the entry slider.

10:32:12p - [REDACTED] and nurses go to the door of Unit B with paperwork in hand.

10:32:25p - Youth residents [REDACTED] are observed exiting cell#7 in response to [REDACTED] entering unit and talking down from the upper catwalk. [REDACTED] only stands at the door to communicate.

10:33:14p - [REDACTED] and nurses depart from Unit B and all youth residents [REDACTED] return to cell#7.

10:35:00p - [REDACTED] returns to Unit B and opens the door but does not enter. [REDACTED] and [REDACTED] exit cell#7. [REDACTED] retrieves something from [REDACTED] returns to the control room.

10:35:45p - Youth residents [REDACTED] seen in and out of cell#7.

10:39:28p - [REDACTED] enters Unit A. No change on Unit B. (No visual of [REDACTED])

10:41:12p - [REDACTED] observed looking through the door of Unit B.

10:41:59p - [REDACTED] returns to control room. Youth residents [REDACTED] are on the lower level sitting at the tables.

10:43:33p - [REDACTED] return to cell#7 where [REDACTED] is expected to be.

10:45:44p - [REDACTED] exit cell#7. [REDACTED] re-enters and [REDACTED] goes to lower level.

10:46:27p - [REDACTED] is observed standing at the railing on the upper catwalk and returning as [REDACTED] goes upstairs and enters cell#7.

10:47:28p - [REDACTED] returns to upper level and enters cell#10 briefly and enters cell#7.

10:48:09p - [REDACTED] exits cell#7 and returns to the lower level.

10:48:31p - [REDACTED] exits cell#7 and returns to the lower level.

10:49:52p - [REDACTED] enters into the control room.

10:50:28p - [REDACTED] exits the control room and the H&W pod.

10:54:22 - [REDACTED] and enter cell number 7

10:57:03 - [REDACTED] exists cell 7 and enters cell 10, returns to cell 7

10:59:16 - [REDACTED] enters cell 7

215-64-23

Tuesday, March 14, 2023 – Wednesday, March 15, 2023

11:00:47 - █████ enters cell 7 and █████ leaves the cell and immediately returns back

11:03:55 - Subjects are seen exiting and entering the room.

11:04:16 - █████ exits the control room and goes to the door at unit B and is talking through the door.

11:07:38 - █████ leaves the door and re-enters the control room

11:07:42 - █████ exits cell 7 with █████ They go down to the lower level out of camera view

11:08:40 - Youth are observed on the lower level

11:09:13 - █████ is back at unit door B talking through the door.

11:09:51 - █████ is observed talking to █████ through the door and leaves at 11:10:14 and returns to the control room.

11:14:40 - █████ exits the control room with towels to Unit B's door and talks through the door.

11:15:30 - █████ is observed giving towels to a █████

11:16:10 - █████ departs from the door returns to control

11:16:49 - █████ returns to unit B's door. Opens the door and slightly enters before leaving

11:22:25 - █████ leaves the control room and goes to the door of unit B and returns back to the control room.

11:59:57 - █████ walking on lower level with towel on █████ head

10:07:31p - █████ leaves Health and Wellness

10:09:19p - █████ is observed walking back into view of cameras and taking a seat at the tables.

10:09:31p - █████ seen grabbing █████ seated at the tables.

10:11:05p - All youth residents surrounding █████ seated at the tables.

10:12:25p - █████ is observed punching █████ while █████ seated at the tables.

10:15:50p - █████ is observed punching █████ again while █████ seated at the tables.

10:16:04p - █████ observed punching █████ in the back of the head.

10:18:28p - █████ observed getting up from the table following █████ upstairs. All youth residents follow into cell#7 out of view of the camera.

10:21:57p - █████ seen leaving cell#7 going to lower level to look into the control room

10:22:30p - █████ returns upstairs

SIS-62-23

Tuesday, March 14, 2023 – Wednesday, March 15, 2023

10:22:35p - [REDACTED] exits cell#7 to lower level to look into the control room

10:23:15p - [REDACTED] returns to cell#9

10:23:36p - [REDACTED] is observed low crawling back to cell#7

10:23:56p - [REDACTED] exits cell#7 to lower level to look into the control room.

10:24:44p - [REDACTED] exits cell#7 to lower level and Mcknight returns to cell#7.

10:25:05p - [REDACTED] looks into control room.

10:26:29p - [REDACTED] exits cell#7 and [REDACTED] returns. [REDACTED] is observed exiting cell#7

10:26:45p - All youth return to cell#7

10:27:47p - [REDACTED] exits cell#7 and returns to cell#9.

10:28:22p - [REDACTED] observed low crawling back to cell#7

10:29:33p - [REDACTED] exits control room and enters Unit A.

10:29:50p - [REDACTED] exits cell#7 and enters cell#10 with a piece of paper in hand and immediately exits looking down to lower level.

10:30:15p - [REDACTED] returns to cell#7

10:31:04p - [REDACTED] exits Unit A and meets nurses at the entry slider.

10:32:12p - [REDACTED] and nurses go to the door of Unit B with paperwork in hand.

10:32:25p - Youth residents [REDACTED] are observed exiting cell#7 in response to [REDACTED] entering unit and talking down from the upper catwalk. [REDACTED] only stands at the door to communicate.

10:33:14p - [REDACTED] and nurses depart from Unit B and all youth residents [REDACTED] return to cell#7.

10:35:00p - [REDACTED] returns to Unit B and opens the door but does not enter [REDACTED] and [REDACTED] exit cell#7. [REDACTED] retrieves something from [REDACTED] returns to the control room.

10:35:45p - Youth residents [REDACTED] seen in and out of cell#7.

10:39:28p - [REDACTED] enters Unit A. No change on Unit B. (No visual of [REDACTED])

10:41:12p - [REDACTED] observed looking through the door of Unit B.

10:41:59p - [REDACTED] returns to control room. Youth residents [REDACTED] are on the lower level sitting at the tables.

10:43:33p - [REDACTED] return to cell#7 where [REDACTED] is expected to be.

10:45:44p - [REDACTED] exit cell#7. [REDACTED] re-enters and [REDACTED] goes to lower level.

11-16-23

Tuesday, March 14, 2023 – Wednesday, March 15, 2023

10:46:27p - [REDACTED] is observed standing at the railing on the upper catwalk and returning as [REDACTED] goes upstairs and enters cell#7.

10:47:28p - [REDACTED] returns to upper level and enters cell#10 briefly and enters cell#7.

10:48:09p - [REDACTED] exits cell#7 and returns to the lower level.

10:48:31p - [REDACTED] exits cell#7 and returns to the lower level.

10:49:52p - [REDACTED] enters into the control room.

10:50:28p - [REDACTED] exits the control room and Health and Wellness floor.

11:40:44 - [REDACTED] leaves the control room and the unit

11:41:25 - [REDACTED] leaves the control room and hands a tee shirt to an unknown resident on Unit B.

11:41:26 - [REDACTED] is observed shoving a youth down and closes the door.

11:41:33 - [REDACTED] exits the control room and goes to Unit B door. [REDACTED] returns to the control room.

11:43:33 - [REDACTED]-New Image entered pod and made contact at the door of unit B.

11:44:53 - [REDACTED] exits the control room and goes to Unit B door and enters the control room returns to the pod door 2 minutes later talking through the door.

11:47:56 - Residents are horseplaying [REDACTED] on the upper level. [REDACTED] exits control and enters the A unit.

11:48:47 - [REDACTED] goes up to use the restroom. [REDACTED] exits pod A and returns to the control room. Enters cell 10.

11:51:27 - [REDACTED] leaves the Unit

12:03:06 - [REDACTED] goes to pod B and talks through the door. Leaves at 12:08:52 and goes to the control room retrieves keys and enters Pod A.

12:22:04 - [REDACTED] retrieve a mattress from cell 10 and throw to lower level.

12:31:36 - [REDACTED] observed bringing bedding from cell 7 to lower level

12:38:27 - [REDACTED] is observed throwing bedding to the lower level

12:40:23 - [REDACTED] leaves unit A and looks into B and goes onto pod C.

12:51:04 - [REDACTED] run upstairs and [REDACTED] is seen leaving control room with paperwork in hand at door of Unit B. [REDACTED] passes paperwork under the door.

1:00:00 - [REDACTED] went to the pod B door.

515-62-23

Tuesday, March 14, 2023 – Wednesday, March 15, 2023

- 1:44:18 - ██████████ at the door of Unit B.
- 1:47:04 - ██████████ observed being seated at the tables.
- 1:47:14 - ██████████ observed being assaulted by ██████████ All end up out of the view of the camera.
- 1:47:42 - ██████████ exit the control room and slowly walk to Unit B Door.
- 1:49:13 - ██████████ seen pleading with ██████████ with ██████████ hands up.
- 1:50:35 - ██████████ seated at the tables
- 1:50:45 - ██████████ enters the entire unit and control room.
- 1:53:44 - ██████████ assaulted at the tables
- 1:54:12 - All youth surround ██████████ clearly in distress.
- 1:54:24 - ██████████ arrives and enters Unit B.
- 1:55:00 - ██████████ continues to assault ██████████ is on the unit. ██████████ and ██████████ watch from the outside.
- 1:55:10 - While ██████████ is still getting assaulted, ██████████ enter Unit B. ██████████ is still being assaulted.
- 1:56:37 - ██████████ is able to get off of Unit B and is secured on Unit C by ██████████
- 2:00:42 - ██████████ exits control room and goes up to Unit C's door and re-enters the control room.
- 2:01:45 - All JDF Staff exit Unit B and enter the control room.
- 2:04:36 - ██████████ exit the control room and re-enter Unit B talking from the door.
- 2:06:09 - ██████████ seen passing out face masks to the youth on Unit B.
- 2:09:06 - ██████████ and ██████████ leave from Unit B back to the control room.
- 2:13:27 - ██████████ enters Unit C where ██████████

215-822-223

3RD TIMELINE UPDATE

| CCTV Time   | Actual Time | Details   |
|-------------|-------------|---|
| 6:10:16 PM  | 5:43:16 PM  | Resident [REDACTED] is out from visiting booth after visitation.  |
| 6:32:11 PM  | 6:05:11 PM  | Resident [REDACTED] is escorted off Health and Wellness Unit A with property by [REDACTED]  |
| 6:34:08 PM  | 6:07:08 PM  | Resident [REDACTED] is escorted to the gym with property by [REDACTED]  |
| 6:43:35 PM  | 6:16:35 PM  | Resident [REDACTED] is escorted to Health and Wellness Unit B with property.  |
| 8:27:00 PM  | 8:00:00 PM  | JDF staff did not lock down the residents in respective cells.  |
| 9:08:00 PM  | 8:41:00 PM  | Supervisor [REDACTED] exits B side with medication nurse.   |
| 9:08:33 PM  | 8:41:33 PM  | Supervisor [REDACTED] enters A side with medication nurse.  |
| 9:15:51 PM  | 8:48:51 PM  | Supervisor [REDACTED] exits A side with medication nurse.   |
| 9:39:35 PM  | 9:12:35 PM  | Resident [REDACTED] observed horse playing outside of cell #10 of Unit A  |
| 9:39:41 PM  | 9:12:41 PM  | Residents [REDACTED] enter cell #10 while still horse playing wrestling with each other.  |
| 9:41:08 PM  | 9:14:08 PM  | Resident [REDACTED] exits cell #10, closes the door, and locks [REDACTED] into the cell.  |
| 9:42:06 PM  | 9:15:06 PM  | Resident [REDACTED] enters cell #11 and exits back in front of cell #10.  |
| 9:42:46 PM  | 9:15:46 PM  | [REDACTED] is observed calling up other [REDACTED] from the lower level.  |
| 9:43:02 PM  | 9:16:02 PM  | Resident [REDACTED] enters cell #9 [REDACTED] is observed walking up the stairs [REDACTED] are at cell #10 where [REDACTED] is locked.                  |
| 9:43:40 PM  | 9:16:40 PM  | Resident [REDACTED] is observed walking upstairs also in front of cell #10 where [REDACTED] is locked.  |
| 9:44:06 PM  | 9:17:06 PM  | Resident [REDACTED] is observed walking up the stairs. At same time Resident [REDACTED] slides something to [REDACTED] underneath the door of cell #10. |
| 9:45:27 PM  | 9:18:27 PM  | Resident [REDACTED] manages to open the door from the inside. Residents [REDACTED] enter cell #10 with [REDACTED] still inside.                         |
| 9:45:49 PM  | 9:18:49 PM  | Resident [REDACTED] is observed entering cell #10. Shortly after Resident [REDACTED] and Resident [REDACTED] also enter.                                |
| 9:46:43 PM  | 9:19:43 PM  | Resident [REDACTED] leaves cell #10   |
| 9:47:08 PM  | 9:20:08 PM  | [REDACTED] enters Unit B with Nurse for med pass and Resident [REDACTED] comes downstairs.  |
| 9:47:30 PM  | 9:20:30 PM  | Resident [REDACTED] exit cell #10   |
| 9:48:30 PM  | 9:21:30 PM  | All exit cell #10 [REDACTED] is seen wiping [REDACTED] eyes exiting the room. [REDACTED] goes to the lower level.                                       |
| 9:50:25 PM  | 9:23:25 PM  | [REDACTED] and Nurse exit.  |
|             |             | #VALUE! *****no abnormal activity documented [REDACTED] *****   |
| 10:00:48 PM | 9:33:48 PM  | All youth now observed on the lower level. Resident [REDACTED] appears on camera.   |
| 10:01:05 PM | 9:34:05 PM  | Resident [REDACTED] appears to be wiping tears from [REDACTED] face.  |
| 10:05:00 PM | 9:38:00 PM  | All youth residents appear to surround [REDACTED] backs off view of the camera with [REDACTED] hands up.  |
| 10:12:25 PM | 9:45:25 PM  | [REDACTED] is observed punching [REDACTED] while [REDACTED] seated at the tables.   |
| 10:15:50 PM | 9:48:50 PM  | [REDACTED] is observed punching [REDACTED] again while [REDACTED] seated at the tables.   |
| 10:16:04 PM | 9:49:04 PM  | [REDACTED] observed punching [REDACTED] in the back of the head.  |
| 10:18:28 PM | 9:51:28 PM  | [REDACTED] observed getting up from the table following [REDACTED] upstairs [REDACTED] residents follow into cell #7 out of view of the camera.         |
| 10:21:57 PM | 9:54:57 PM  | [REDACTED] seen leaving cell #7 going to lower level to look into the control room  |
| 10:22:30 PM | 9:55:30 PM  | [REDACTED] returns upstairs   |
| 10:22:35 PM | 9:55:35 PM  | [REDACTED] exits cell #7 to lower level to look into the control room   |
| 10:23:15 PM | 9:56:15 PM  | [REDACTED] returns to cell #9   |
| 10:23:36 PM | 9:56:36 PM  | [REDACTED] is observed low crawling back to cell #7   |
| 10:23:56 PM | 9:56:56 PM  | [REDACTED] exits cell #7 to lower level to look into the control room.  |
| 10:24:44 PM | 9:57:44 PM  | [REDACTED] exits cell #7 to lower level and [REDACTED] returns to cell #7.  |
| 10:25:05 PM | 9:58:05 PM  | [REDACTED] investigates control room.   |
| 10:26:29 PM | 9:59:29 PM  | [REDACTED] exits cell #7 and [REDACTED] returns [REDACTED] is observed exiting cell #7  |
| 10:26:45 PM | 9:59:45 PM  | [REDACTED] return to cell #7  |

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|             |             |  |
|-------------|-------------|--|
| 10:27:27 PM | 10:00:27 PM | exits cell#7 and returns to cell#9.  |
| 10:28:22 PM | 10:01:22 PM | observed low crawling back to cell#7   |
| 10:29:33 PM | 10:02:33 PM | exits control room and enters Unit A.  |
| 10:29:50 PM | 10:02:50 PM | exits cell#7 and enters cell#10 with a piece of paper in hand and immediately exits looking down to lower level. |
| 10:30:15 PM | 10:03:15 PM | returns to cell#7  |
| 10:31:04 PM | 10:04:04 PM | exits Unit A and meets nurses at the entry slider.   |
| 10:32:12 PM | 10:05:12 PM | and nurses go to the door of Unit B with paperwork in hand.  |
| 10:32:25 PM | 10:05:25 PM | resident are observed exiting cell#7 in response to entering the unit and talking down from the upper catwalk.   |
| 10:33:14 PM | 10:06:14 PM | only stands at the door to communicate.  |
| 10:35:00 PM | 10:08:00 PM | and nurses depart from Unit B and residents return to cell#7   |
| 10:35:45 PM | 10:08:45 PM | returns to Unit B and opens the door but does not enter. exit cell#7. retrieves something from                   |
| 10:39:28 PM | 10:12:28 PM | returns to the control room.   |
| 10:41:12 PM | 10:14:12 PM | residents seen in and out of cell#7  |
| 10:41:59 PM | 10:14:59 PM | enters Unit A. No change on Unit B. (No visual of  |
| 10:43:33 PM | 10:16:33 PM | observed looking through the door of Unit B  |
| 10:45:44 PM | 10:18:44 PM | returns to control room. residents are on the lower level sitting at the tables.                                 |
| 10:46:27 PM | 10:19:27 PM | and return to cell#7 where is expected to be.  |
| 10:47:28 PM | 10:20:28 PM | and exit cell#7. re-enters and goes to lower level.  |
| 10:48:09 PM | 10:21:09 PM | is observed standing at the railing on the upper catwalk and returning as goes upstairs and enters cell#7.       |
| 10:48:31 PM | 10:21:31 PM | returns to upper level and enters cell#10 briefly and enters cell#7.   |
| 10:49:52 PM | 10:22:52 PM | Exits cell#7 and returns to lower level  |
| 10:50:28 PM | 10:23:28 PM | exits cell#7 and returns to the lower level.   |
| 10:54:22 PM | 10:27:22 PM | enters into the control room.  |
| 10:57:03 PM | 10:30:03 PM | exits the control room and the H&W pod.  |
| 10:59:16 PM | 10:32:16 PM | and enter cell number#7  |
| 11:00:47 PM | 10:33:47 PM | exits cell#7 and enters cell#10, returns to cell#7   |
| 11:03:55 PM | 10:36:55 PM | enters cell#7  |
| 11:04:16 PM | 10:37:16 PM | enters cell 7 and leaves the cell and immediately returns back   |
| 11:07:38 PM | 10:40:38 PM | Subjects are seen exiting and entering the room.   |
| 11:07:42 PM | 10:40:42 PM | exits the control room and goes to the door at unit B and is talking through the door.                           |
| 11:08:40 PM | 10:41:40 PM | leaves the door and re-enters the control room   |
| 11:09:13 PM | 10:42:13 PM | exits cell 7 with They go down to the lower level out of camera view   |
| 11:09:51 PM | 10:42:51 PM | are observed on the lower level  |
| 11:14:40 PM | 10:47:40 PM | is back at unit door B talking through the door.   |
| 11:15:30 PM | 10:48:30 PM | is observed talking to through the door and leaves at 11:10:14 and returns to the control room                   |
| 11:16:10 PM | 10:49:10 PM | exits the control room with towels to Unit B's door and talks through the door.                                  |
| 11:16:49 PM | 10:49:49 PM | is observed giving towels to a   |
| 11:22:25 PM | 10:55:25 PM | departs from the door returns to control   |
| 11:32:16 PM | 11:05:16 PM | returns to unit B's door. Opens the door and slightly enters before leaving                                      |
| 11:38:41 PM | 11:11:41 PM | leaves the control room and goes to the door of unit B and returns back to the control room                      |
|             |             | observed walking on lower level with towel on head   |
|             |             | arrives on floor   |

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515-62-23

3RD TIMELINE UPDATE

|             |             |  |
|-------------|-------------|--|
| 11:40:44 PM | 11:13:44 PM | leaves the control room  |
| 11:41:25 PM | 11:14:25 PM | leaves the control room and hands a tee shirt to an unknown resident on Unit B:  |
| 11:41:26 PM | 11:14:26 PM | is observed trying to run out of the unit past shoves back into the unit and closes the door. leaves the floor                               |
| 11:41:33 PM | 11:14:33 PM | exits the control room and goes to Unit B door. returns to the control room.   |
| 11:42:59 PM | 11:15:59 PM | arrives for on duty  |
| 11:43:33 PM | 11:16:33 PM | entered pod and made contact at the door of unit B.  |
| 11:44:53 PM | 11:17:53 PM | exits the control room and goes to Unit B door and enters the control room returns to the pod door 2 minutes later talking through the door. |
| 11:47:56 PM | 11:20:56 PM | Residents are horseplaying on the upper level. exits control and enters the A unit.  |
| 11:48:47 PM | 11:21:47 PM | goes up to use the restroom. exists pod A and returns to the control room. Enters cell 10.   |
| 11:51:27 PM | 11:24:27 PM | leaves the floor for off duty  |
| 11:59:57 PM | 11:32:57 PM | walking on lower level with towel on head  |
| 12:03:06 AM | 11:36:06 PM | goes to pod B and talks through the door. Leaves at 12:08:52 and goes to the control room retrieves keys and enters Pod A                    |
| 12:22:04 AM | 11:55:04 PM | retrieve a mattress from cell 10 and throw to lower level.   |
| 12:31:36 AM | 12:04:36 AM | observed bringing bedding from cell 7 to lower level   |
| 12:38:27 AM | 12:11:27 AM | is observed throwing bedding to the lower level  |
| 12:40:23 AM | 12:13:23 AM | leaves unit A and looks into B and goes onto pod C.  |
| 12:51:04 AM | 12:24:04 AM | run upstairs and is seen leaving control room with paperwork in hand at door of Unit B. passes paperwork under the door.                     |
| 1:00:00 AM  | 12:33:00 AM | went to the pod B door.  |
| 1:43:56 AM  | 1:16:56 AM  | stands up on table appears to be naked   |
| 1:44:18 AM  | 1:17:18 AM  | observed at the door of Unit B   |
| 1:44:49 AM  | 1:17:49 AM  | begins to assault  |
| 1:47:04 AM  | 1:20:04 AM  | observed being seated at the tables.   |
| 1:47:14 AM  | 1:20:14 AM  | observed being assaulted by followed by All end up out of the view of the camera.  |
| 1:47:42 AM  | 1:20:42 AM  | exit the control room and slowly walk to Unit B Door.  |
| 1:49:13 AM  | 1:22:13 AM  | seen pleading with with hands up.  |
| 1:50:35 AM  | 1:23:35 AM  | seated at the tables   |
| 1:50:45 AM  | 1:23:45 AM  | enters the entire unit and control room.   |
| 1:53:44 AM  | 1:26:44 AM  | assaulted at the tables  |
| 1:54:12 AM  | 1:27:12 AM  | surround clearly in distress.  |
| 1:54:24 AM  | 1:27:24 AM  | assaults arrives and enters Unit B.  |
| 1:55:00 AM  | 1:28:00 AM  | continues to assault while is on the unit watch from the outside.  |
| 1:55:10 AM  | 1:28:10 AM  | still getting assaulted enter Unit B. is still being assaulted.  |
| 1:56:37 AM  | 1:29:37 AM  | is able to get off of Unit B and is secured on Unit C by   |
| 2:00:42 AM  | 1:33:42 AM  | exits control room and goes up to Unit C's door and re-enters the control room.  |
| 2:01:45 AM  | 1:34:45 AM  | All JDF Staff exit Unit B and enter the control room   |
| 2:04:36 AM  | 1:37:36 AM  | and exit the control room and re-enter Unit B talking from the door.   |
| 2:06:09 AM  | 1:39:09 AM  | seen passing out face masks to the on Unit B.  |
| 2:09:06 AM  | 1:42:06 AM  | and leave from Unit B back to the control room.  |
| 2:13:27 AM  | 1:46:27 AM  | enters Unit C where  |

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51562-33

3RD TIMELINE UPDATE

|            |                                   |
|------------|-----------------------------------|
| 2:37:00 AM | 2:10:00 AM   End Footage Capture. |
|------------|-----------------------------------|

000064

1. [Redacted]

**Charge: Domestic Violence/Tether Violation**  
**Post Adjudicated: Insight**

2. [Redacted]

**Charge: Domestic Violence**  
**Pre-Adjudicated**

3. [Redacted]

**Charge: Break and Enter w/Intent to Commit Felony/Larceny**  
**Post-Adjudicated**

4. [Redacted]

**Charge: Felonious**  
**Pre-Adjudicated**

5. [Redacted]

**Charge: Carjacking**  
**Post Adjudicated: CCMO**

6. [Redacted]

**Charge: CSC I**  
**Post Adjudicated: CCMO**

**Staff Involvement:**

- 1. [Redacted] - Juvenile Detention Supervisor
- 2. [Redacted] Juvenile Detention Supervisor
- 3. [Redacted] New Image Juvenile Detention Supervisor
- 4. [Redacted] -Juvenile Detention Specialist
- 5. [Redacted] Juvenile Detention Specialist
- 6. [Redacted] Juvenile Detention Specialist

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06:10:16p Resident [REDACTED] is out from visiting booth after visitation.

06:32:11p Resident [REDACTED] is escorted off Health and Wellness Unit A with property by [REDACTED]

06:34:08p Resident [REDACTED] is escorted to the gym with property by [REDACTED]

06:43:35p Resident [REDACTED] is escorted to Health and Wellness Unit B with property.

09:39:35p Residents [REDACTED] observed horse playing outside of cell #10 of Unit A.

09:39:41p Residents [REDACTED] enter cell #10 while still horse playing wrestling with each other.

09:41:08p Resident [REDACTED] exits cell #10, closes the door, and locks [REDACTED] into the cell.

09:42:06p Resident [REDACTED] enters cell #11 and exits back in front of cell #10.

09:42:46p Resident [REDACTED] is observed calling up other [REDACTED] from the lower level.

09:43:02p Resident [REDACTED] enters cell #9, [REDACTED] is observed walking up the stairs. [REDACTED] and [REDACTED] are at cell #10 where [REDACTED] is locked.

09:43:40p Resident [REDACTED] is observed walking upstairs also in front of cell #10 where [REDACTED] is locked.

09:44:06p Resident [REDACTED] is observed walking up the stairs. At same time Resident [REDACTED] slides something to [REDACTED] underneath the door of cell#10.

09:45:27p Resident [REDACTED] manages to open the door from the inside. Residents [REDACTED] enter cell#10 with [REDACTED] still inside.

09:45:49p Resident [REDACTED] is observed entering cell #10. Shortly after Resident [REDACTED] Resident [REDACTED] also enter.

09:46:33p Resident [REDACTED] leaves cell#10

09:47:08p [REDACTED] enters Unit B with Nurse for med pass and Resident [REDACTED] comes downstairs.

09:47:30p Resident [REDACTED] exit cell #10

09:48:30p All exit cell#10 [REDACTED] is seen wiping [REDACTED] eyes exiting the room. [REDACTED] goes to the lower level.

09:50:25p [REDACTED] and Nurse exit.

\*\*\*\*no abnormal activity documented. [REDACTED]\*\*\*\*

10:00:48p [REDACTED] now observed on the lower level. Resident [REDACTED] appears on camera.

10:01:05p Resident [REDACTED] appears to be wiping tears from [REDACTED] face.

10:05:00p [REDACTED] residents appear to surround [REDACTED] as [REDACTED] backs off view of the camera with [REDACTED] hands up.

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SIS 62.23

10:07:31p - ██████ leaves Health and Wellness

10:09:19p - ██████ is observed walking back into view of cameras and taking a seat at the tables.

10:09:31p - ██████ seen grabbing ██████ while ██████ seated at the tables.

10:11:05p - ██████ residents surrounding ██████ while ██████ seated at the tables.

10:12:25p - ██████ is observed punching ██████ while ██████ seated at the tables.

10:15:50p - ██████ is observed punching ██████ gain while ██████ seated at the tables.

10:16:04p - ██████ observed punching ██████ in the back of the head.

10:18:28p - ██████ observed getting up from the table following ██████ upstairs. ██████ residents follow into cell#7 out of view of the camera.

10:21:57p - ██████ seen leaving cell#7 going to lower level to look into the control room

10:22:30p - ██████ returns upstairs

10:22:35p - ██████ exits cell#7 to lower level to look into the control room

10:23:15p - ██████ returns to cell#9

10:23:36p - ██████ is observed low crawling back to cell#7

10:23:56p - ██████ exits cell#7 to lower level to look into the control room.

10:24:44p - ██████ exits cell#7 to lower level and ██████ returns to cell#7.

10:25:05p - ██████ investigates control room.

10:26:29p - ██████ exits cell#7 and ██████ returns. ██████ is observed exiting cell#7

10:26:45p - ██████ return to cell#7

10:27:47p - ██████ exits cell#7 and returns to cell#9.

10:28:22p - ██████ observed low crawling back to cell#7

10:29:33p - ██████ exits control room and enters Unit A.

10:29:50p - ██████ exits cell#7 and enters cell#10 with a piece of paper in hand and immediately exits looking down to lower level.

10:30:15p - ██████ returns to cell#7

10:31:04p - ██████ exits Unit A and meets nurses at the entry slider.

10:32:12p - ██████ and nurses go to the door of Unit B with paperwork in hand.

10:32:25p - ██████ are observed exiting cell#7 in response to ██████ entering unit and talking down from the upper catwalk. ██████ only stands at the door to communicate.

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23

SIS-6A-23

10:33:14p - ██████████ and nurses depart from Unit B and all ██████████ return to cell#7.

10:35:00p - ██████████ returns to Unit B and opens the door but does not enter. ██████████ exit cell#7. ██████████ retrieves something from ██████████ returns to the control room.

10:35:45p - ██████████ seen in and out of cell#7.

10:39:28p - ██████████ enters Unit A. No change on Unit B. (No visual of ██████████)

10:41:12p - ██████████ observed looking through the door of Unit B.

10:41:59p - ██████████ returns to control room. ██████████ are on the lower level sitting at the tables.

10:43:33p - ██████████ return to cell#7 where ██████████ is expected to be.

10:45:44p - ██████████ exit cell#7. ██████████ re-enters and ██████████ goes to lower level.

10:46:27p - ██████████ is observed standing at the railing on the upper catwalk and returning as ██████████ goes upstairs and enters cell#7.

10:47:28p - ██████████ returns to upper level and enters cell#10 briefly and enters cell#7.

10:48:09p - ██████████ exits cell#7 and returns to the lower level.

10:48:31p - ██████████ exits cell#7 and returns to the lower level.

10:49:52p - ██████████ enters into the control room.

10:50:28p - ██████████ exits the control room and the H&W pod.

10:54:22 - ██████████ and enter cell number 7

10:57:03 - ██████████ exists cell 7 and enters cell 10, returns to cell 7

10:59:16 - ██████████ enters cell 7

11:00:47 - ██████████ enters cell 7 and ██████████ leaves the cell and immediately returns back

11:03:55 - Subjects are seen exiting and entering the room.

11:04:16 - ██████████ exists the control room and goes to the door at unit B and is talking through the door.

11:07:38 - ██████████ leaves the door and re-enters the control room

11:07:42 - ██████████ exits cell-7 with TJ. They go down to the lower level out of camera view

11:08:40 - ██████████ are observed on the lower level

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11:09:13 - ██████████ is back at unit door B talking through the door.

11:09:51 - ██████ is observed talking to ██████████ through the door and leaves at 11:10:14 and returns to the control room.

11:14:40 - ██████████ exits the control room with towels to Unit B's door and talks through the door.

11:15:30 - ██████████ is observed giving towels to a ██████████

11:16:10 - ██████████ departs from the door returns to control

11:16:49 - ██████████ returns to unit B's door. Opens the door and slightly enters before leaving

11:22:25 - ██████████ leaves the control room and goes to the door of unit B and returns back to the control room.

11:59:57 - ██████ walking on lower level with towel on ██████ head

10:07:31p - ██████████ leaves Health and Wellness

10:09:19p - ██████ is observed walking back into view of cameras and taking a seat at the tables.

10:09:31p - ██████████ seen grabbing ██████ while ██████ seated at the tables.

10:11:05p - ██████████ residents surrounding ██████ while ██████ seated at the tables.

10:12:25p - ██████████ is observed punching ██████ while ██████ seated at the tables.

10:15:50p - ██████████ is observed punching ██████ again while ██████ seated at the tables.

10:16:04p - ██████████ observed punching ██████ in the back of the head.

10:18:28p - ██████ observed getting up from the table following ██████████ upstairs. ██████████ residents follow into cell#7 out of view of the camera.

10:21:57p - ██████████ seen leaving cell#7 going to lower level to look into the control room

10:22:30p - ██████████ returns upstairs

10:22:35p - ██████████ exits cell#7 to lower level to look into the control room

10:23:15p - ██████████ returns to cell#9

10:23:36p - ██████████ is observed low crawling back to cell#7

10:23:56p - ██████████ exits cell#7 to lower level to look into the control room.

10:24:44p - ██████████ exits cell#7 to lower level and ██████████ returns to cell#7.

10:25:05p - ██████████ looks into control room.

10:26:29p - ██████████ exits cell#7 and ██████████ returns. ██████████ is observed exiting cell#7

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10:26:45p - ██████ return to cell#7

10:27:47p - ██████ exits cell#7 and returns to cell#9.

10:28:22p - ██████ observed low crawling back to cell#7

10:29:33p - ██████ exits control room and enters Unit A.

10:29:50p - ██████ exits cell#7 and enters cell#10 with a piece of paper in hand and immediately exits looking down to lower level.

10:30:15p - ██████ returns to cell#7

10:31:04p - ██████ exits Unit A and meets nurses at the entry slider.

10:32:12p - ██████ and nurses go to the door of Unit B with paperwork in hand.

10:32:25p - ██████ are observed exiting cell#7 in response to ██████ entering unit and talking down from the upper catwalk. ██████ only stands at the door to communicate.

10:33:14p - ██████ and nurses depart from Unit B and all youth residents ██████ return to cell#7.

10:35:00p - ██████ returns to Unit B and opens the door but does not enter. ██████ and ██████ exit cell#7. ██████ retrieves something from ██████ returns to the control room.

10:35:45p - ██████ seen in and out of cell#7.

10:39:28p - ██████ enters Unit A. No change on Unit B. (No visual c ██████

10:41:12p - ██████ observed looking through the door of Unit B.

10:41:59p - ██████ returns to control room. ██████ are on the lower level sitting at the tables.

10:43:33p - ██████ return to cell#7 where ██████ is expected to be.

10:45:44p - ██████ exit cell#7. ██████ re-enters and ██████ goes to lower level.

10:46:27p - ██████ is observed standing at the railing on the upper catwalk and returning as ██████ goes upstairs and enters cell#7.

10:47:28p - ██████ returns to upper level and enters cell#10 briefly and enters cell#7.

10:48:09p - ██████ exits cell#7 and returns to the lower level.

10:48:31p - ██████ exits cell#7 and returns to the lower level.

10:49:52p - ██████ enters into the control room.

10:50:28p - ██████ ts the control room and Health and Wellness floor.

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11:40:44 - ██████ leaves the control room and the unit

11:41:25 - ██████ leaves the control room an hands a tee shirt to an unknown resident on Unit B.

11:41:26 - ██████ is observed shoving a ██████ down and closes the door.

11:41:33 - ██████ exits the control room and goes to Unit B door. ██████ returns to the control room.

11:43:33 - ██████ entered pod and made contact at the door of unit B.

11:44:53 - ██████ exits the control room and goes to Unit B door and enters the control room returns to the pod door 2 minutes later talking through the door.

11:47:56 - Residents are horseplaying ██████ on the upper level. ██████ exits control and enters the A unit.

11:48:47: - ██████ goes up to use the restroom. ██████ exists pod A and returns to the control room. Enters cell 10.

11:51:27: - ██████ leaves the Unit

12:03:06 - ██████ goes to pod B and talks through the door. Leaves at 12:08:52 and goes to the control room retrieves keys and enters Pod A.

12:22:04 - ██████ retrieve a mattress from cell 10 and throw to lower level.

12:31:36 - ██████ observed bringing bedding from cell 7 to lower level

12:38:27 - ██████ is observed throwing bedding to the lower level

12:40:23 - ██████ leaves unit A and looks into B and goes onto pod C.

12:51:04 - ██████ run upstairs and ██████ is seen leaving control room with paperwork in hand at door of Unit B. ██████ passes paperwork under the door.

1:00:00 - ██████ went to the pod B door.

1:44:18 - ██████ at the door of Unit B.

1:47:04 - ██████ observed being seated at the tables.

1:47:14 - ██████ observed being assaulted by ██████ followed by ██████ All end up out of the view of the camera.

1:47:42 - ██████ exit the control room and slowly walk to Unit B Door.

1:49:13 - ██████ seen pleading with Brown with ██████ hands up.

1:50:35 - ██████ seated at the tables

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- 1:50:45 - ██████████ enters the entire unit and control room.
- 1:53:44 - ██████ assaulted at the tables
- 1:54:12 - ██████ surround ██████ clearly in distress.
- 1:54:24 - ██████ assaults ██████ arrives and enters Unit B.
- 1:55:00 - ██████ continues to assault ██████ while ██████ is on the unit. ██████ and ██████ watch from the outside.
- 1:55:10 - While ██████ is still getting assaulted, ██████ enter Unit B. ██████ is still being assaulted.
- 1:56:37 - ██████ is able to get off of Unit B and is secured on Unit C by ██████
- 2:00:42 - ██████ exits control room and goes up to Unit C's door and re-enters the control room.
- 2:01:45 - All JDF Staff exit Unit B and enter the control room.
- 2:04:36 - ██████ exit the control room and re-enter Unit B talking from the door.
- 2:06:09 - ██████ seen passing out face masks to the ██████ on Unit B.
- 2:09:06 - ██████ leave from Unit B back to the control room.
- 2:13:27 - ██████ enters Unit C where ██████

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# Intake Record

## Wayne County



### CLIENT INFO

Date of Birth / Age :

Client Number# :

Court File# :

CMO :

Court ID# :

Neglect Wardship Termination Date# :

Dually Involved:

Primary Provider :

SSN :

Case Manager :

FIA Case# :

JAC Registration Date :

Legal Status :

Committing County :

Hohst Adl Offense :

Current Risk Level :

Current Sec Level :

CMT / Int Option :

Most Recent Probation Plan :

Initial Detention Level :

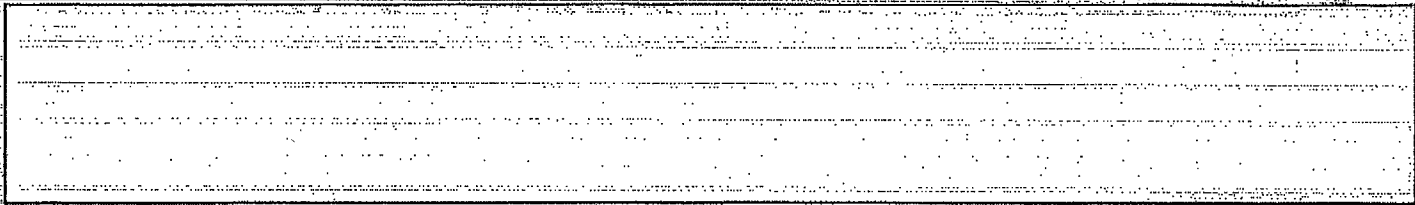
Funding Source :

Initial Risk Level :

Initial Security Level :

Recip ID (Medicaid #) :

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Probation Current Risk  
Level & Date

Current Security  
Level & Date

Creation  
Date:

Placed Current Risk  
Level & Date

Current Security  
Level & Date

Highest Adl. Offense

Name

Name

Mugshot not available

10/6/2022

Client Number

Click for Mug Shot Views:

AKAs

Domicile

Lives with:

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|                           |            |
|---------------------------|------------|
| Original Address:         | [REDACTED] |
| Relation Type             | [REDACTED] |
| Phone                     | [REDACTED] |
| Date of Birth             | [REDACTED] |
| Gender                    | [REDACTED] |
| Height/Wt.                | [REDACTED] |
| <b>Personal</b>           | [REDACTED] |
| Build - Complexion        | [REDACTED] |
| Hair/Eye Color            | [REDACTED] |
| SSN                       | [REDACTED] |
| Status                    | [REDACTED] |
| Client                    | [REDACTED] |
| Date Enrolled             | [REDACTED] |
| <b>Status and Numbers</b> | [REDACTED] |
| FAMCare #                 | [REDACTED] |
| FIA #                     | [REDACTED] |
| JAIS #                    | [REDACTED] |
| Recipient ID (Medicaid #) | [REDACTED] |
| Race                      | [REDACTED] |
| Ethnicity                 | [REDACTED] |
| Religion                  | [REDACTED] |
| <b>Demo-graphics</b>      | [REDACTED] |
| Language                  | [REDACTED] |
| Demographic Release       | [REDACTED] |
| TTY:                      | [REDACTED] |
| Interpreter: Select       | [REDACTED] |
| Special Needs             | [REDACTED] |
| Handicaps:                | [REDACTED] |

Click for Case Notes:

Legal Status: [REDACTED]

|                     |                   |            |
|---------------------|-------------------|------------|
| Last Known Address: | Street            | [REDACTED] |
|                     | City, State Zip:  | [REDACTED] |
|                     | County            | [REDACTED] |
| Phone Numbers:      | Primary           | [REDACTED] |
|                     | Alternate         | [REDACTED] |
|                     | Pager             | [REDACTED] |
| Tattoos:            | Description One   | [REDACTED] |
|                     | Description Two   | [REDACTED] |
|                     | Description Three | [REDACTED] |

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**CMO ENROLLMENT / DISENROLLMENT**

Click here to Enroll

| Enrollment Date (click to disenroll) | Disenrollment Date (blank if enrolled) | Action     | Request Status | CMO        |
|--------------------------------------|--|------------|----------------|------------|
| [REDACTED]                           | [REDACTED]                             | [REDACTED] | [REDACTED]     | [REDACTED] |

Click Here to Enter AFCARS Data

Click to access CMT Change/Add Function

**CMT AUTHORIZATIONS STATUS**

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SIS-62-23

| Edit | Status | Date Reviewed | CMO | Provider | CMT | Start Date | Stop Date |
|------|--------|---------------|-----|----------|-----|------------|-----------|
| Edit |        |               |     |          |     |            |           |
| Edit |        |               |     |          |     |            |           |
| Edit |        |               |     |          |     |            |           |
| Edit |        |               |     |          |     |            |           |
| Edit |        |               |     |          |     |            |           |
| Edit |        |               |     |          |     |            |           |
| Edit |        |               |     |          |     |            |           |

### PROVIDER PLACEMENTS

Records found: 7. Displaying records 1-7.

| Provider | Admission Date | Release Date | LOS |
|----------|----------------|--------------|-----|
|          |                |              | 215 |
|          |                |              | 10  |
|          |                |              | 5   |
|          |                |              | 21  |
|          |                |              | 78  |
|          |                |              | 22  |
|          |                |              | 29  |

### PARENT / GUARDIAN

| Name | Relation Type | Parent | Legal Guardian | Domicile | Parental Rights Terminated | Emergency Contact | Phone Number | Address | Contact Restrictions |
|------|---------------|--------|----------------|----------|----------------------------|-------------------|--------------|---------|----------------------|
|      |               |        |                |          |                            |                   |              |         |                      |

Marks/Scars/Tattoos n/a

#### Reference Information

CMO Case Mgr. [Redacted]  
 Committing County [Redacted]

DHHS Case ID Number  
 DHHS/CPN Case Worker  
 DHHS Personal ID (PID)

Referring County [Redacted]  
 JAC Assessment Specialist [Redacted]

Initial Detention Level [Redacted]  
 Initial Risk Level [Redacted]  
 Initial Security Level [Redacted]

| Committing / Admitting Offense | Offense Date | Offense | Disposition | Adj. Date |
|--------------------------------|--------------|---------|-------------|-----------|
|                                |              |         |             |           |

Click for entire Offense Note: selecting an offense from the full list will update the committing offense for this client. however, it will not History show up here until you reload this screen.

#### Abuse/Neglect History

Neglect History: Is there a history of Protective Services abuse/neglect involving this child? [Redacted]

Abuse Neglect Type: [Redacted]

Is the case currently open? [Redacted]

Court and County: [Redacted]

# of Court Documented Neglect/Abuse Complaints: [Redacted]

Out of Home: Has the child ever been placed out of the home by the Court due to Abuse/Neglect? [Redacted]

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How Long with dates?: From To

With whom? Identify type of placement made by Court direction:

Neglect Court Ward: Was the child made a ward of the court, due to Neglect/Abuse? [Redacted]

Dates of TCW Neglect(Temporary Court Ward)

Disposition:

Is this Juvenile the parent of a child: [Redacted]

Currently Pregnant? [Redacted]

Due Date if yes:

Other Information:

Any Gang Affiliation: [Redacted]  Unknown Gang Name:

U. S. Citizen: [Redacted]  Unknown

Native American/Indian Ancestry [Redacted] If yes, which tribe?

Multi-Racial [Redacted] If Yes, Select Two or More:  White  Black  A/A  API  Hispanic  Arabic/Chaldean

Title IV-E Eligible:  Yes  No  Unknown

Date Applied For

Date Approved

Social Security Eligible:  Yes  No  Unknown

Compliant Court Order:  Yes  No  NA

Birth Certificate:  Received  Applied For  N/A Reason Date:

On Suicide Watch (At Admission): [Redacted] Unknown

Number Of Preylous Out-of-Home Placements: [Redacted]

Truancy History (from placement): [Redacted] Unknown Number of Truancies:

On Truancy Status at Admission: [Redacted] Unknown

Living Status Prior to this Admssion: Parents Home/Own Home [Redacted]

Provider Number (Of prior living situation): Parent's Home

Does Family Have Private Medical Insurance? [Redacted] Unknown (If Yes, click here to enter information)

Date Medical Authorization (FIA-3762) Given:

Marital Status: N/A

School Information:

School Name and Address Last Grade Completed Click here to add new school info

Record Number: [Redacted]

County [Redacted]

District [Redacted]

School Name/Address:

School Info: [Redacted] 6

Credits:

Grad. Date:

Phone:

Fax:

IEPC Completed? Nolf Yes, Date

Education Designation Designation:

Education Type: [Redacted]

FAMILY INFORMATION

Zip Code of Parent's/Legal Guardian Home : [Redacted]

Family Type : [Redacted]

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Marital Status of Biological Parents : [REDACTED]

Female Juvenile Pregnant Currently : [REDACTED]

Victim's Rights Notification [REDACTED]

Staff Code :

### COURT INFORMATION

Records found: 4. Displaying records 1-4.

| Edit | JAC EntryDate | Court Hearing Date | JAC Reg.Date | Legal Status | Referral Type | Reason for Admission |
|------|---------------|--------------------|--------------|--------------|---------------|----------------------|
| Edit | [REDACTED]    |                    |              |              |               |                      |
| Edit | [REDACTED]    |                    |              |              |               |                      |
| Edit | [REDACTED]    |                    |              |              |               |                      |
| Edit | [REDACTED]    |                    |              |              |               |                      |

Comments / Other Information:

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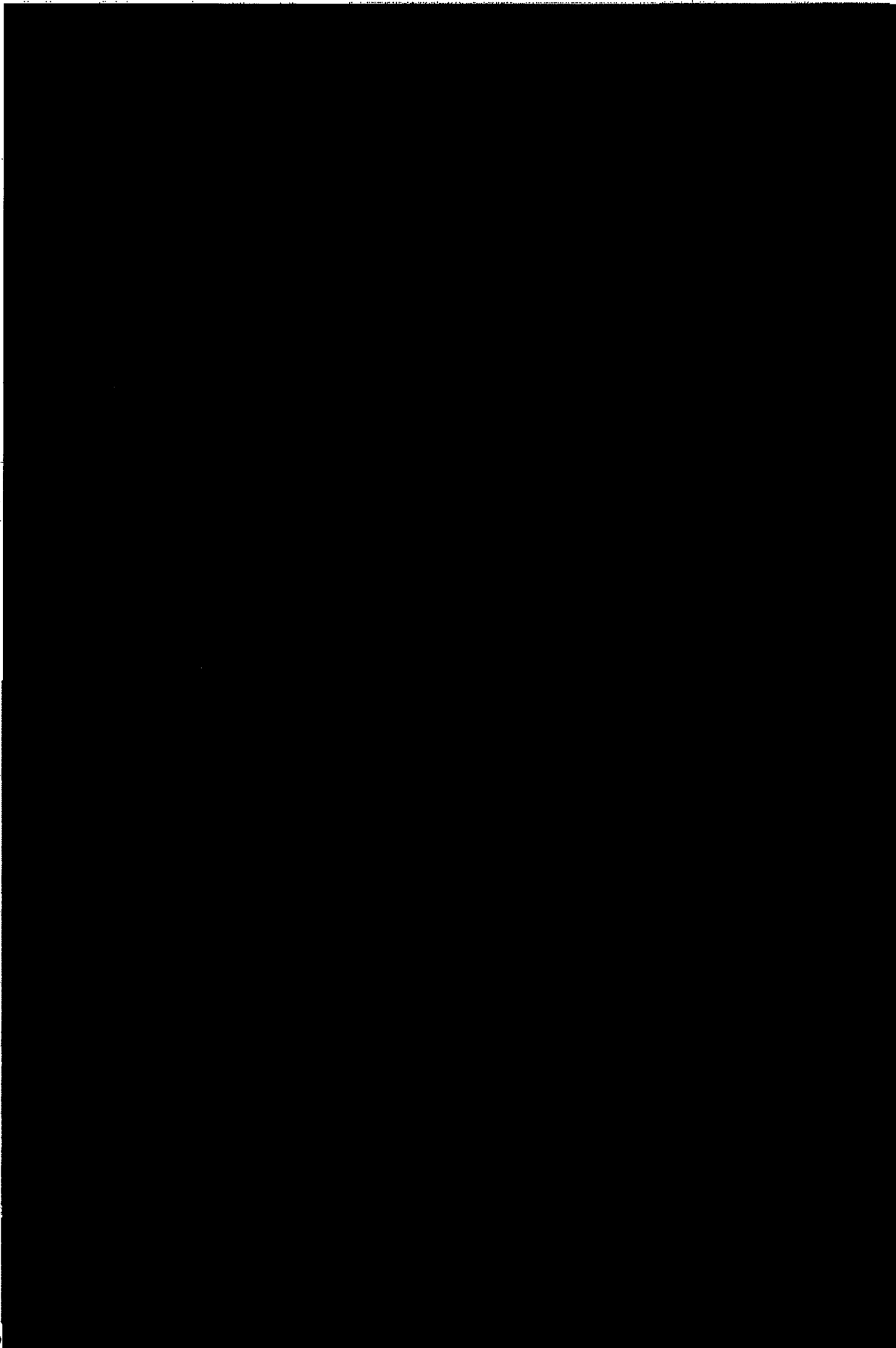
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# Intake Record

## Wayne County

[Redacted]

### CLIENT INFO

Date of Birth / Age: [Redacted]  
 County: [Redacted] CMO: [Redacted]  
 Enrollment: [Redacted]  
 Primary Provider: [Redacted]  
 Case Manager: [Redacted]  
 Legal Status: [Redacted]  
 Hghst Adj Offense: [Redacted]  
 CMT / Int Option: [Redacted]  
 Initial Detention Level: [Redacted]  
 Initial Risk Level: [Redacted]  
 Initial Security Level: [Redacted]  
 Recip ID (Medicaid #): [Redacted]

Client Number#: [Redacted]  
 Court File#: [Redacted]  
 Court ID#: [Redacted]  
 Neglect Wardship Termination Date#: [Redacted]  
 Dually Involved: [Redacted]  
 SSN: [Redacted]  
 FIA Case#: [Redacted]  
 JAC Registration Date: [Redacted]  
 Committing County: [Redacted]  
 Current Risk Level: [Redacted]  
 Current Sec Level: [Redacted]  
 Most Recent Probation Plan: [Redacted]  
 Funding Source: [Redacted]

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[Redacted]

Probation Current Risk Level & Date: [Redacted]  
 Current Security Level & Date: [Redacted]

Creation Date: [Redacted] Placed Current Risk Level & Date: [Redacted]  
 Current Security Level & Date: [Redacted] Highest Adj. Offense: [Redacted]

Name: [Redacted] Name: [Redacted] Mugshot not available  
 Client Number: [Redacted] AKAs: [Redacted] Click for Mug Shot Views:  
 Domicile: [Redacted] Lives with: [Redacted]

SIS-62-23

|                           |                           |                      |
|---------------------------|---------------------------|----------------------|
| Original Address:         |                           |                      |
| Relation Type             |                           |                      |
| Phone                     |                           |                      |
| Date of Birth             |                           |                      |
| Gender                    |                           |                      |
| Height/Wt.                |                           |                      |
| <b>Personal</b>           | Build -                   |                      |
|                           | Complexion                |                      |
|                           | Hair/Eye Color            |                      |
|                           | SSN                       |                      |
|                           | Status                    |                      |
|                           | Client                    |                      |
| <b>Status and Numbers</b> | Date Enrolled             |                      |
|                           | FAMCare #                 |                      |
|                           | FIA #                     |                      |
|                           | JAIS #                    |                      |
|                           | Recipient ID (Medicaid #) |                      |
|                           | Race                      | TTY:                 |
|                           | Ethnicity                 |                      |
| <b>Demo-graphics</b>      | Religion                  | Interpreter: Select  |
|                           | Language                  | <b>Special Needs</b> |

Demographic Release

Handicaps:

Click for Case Notes:

Legal Status:

Last Known Address: Street, City, State Zip, County, Primary

Phone Numbers: Alternate, Pager

Tattoos: Description One, Description Two, Description Three

**CMO ENROLLMENT / DISENROLLMENT**

Click here to Enroll

| Enrollment Date (click to disenroll) | Disenrollment Date (blank if enrolled) | Action | Request Status | CMO |
|--------------------------------------|--|--------|----------------|-----|
|                                      |  |        |                |     |
|                                      |  |        |                |     |
|                                      |  |        |                |     |
|                                      |  |        |                |     |

Click Here to Enter AFCARS Data

Click to access CMT Change/Add Function

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|                 |                       |                     |            |
|-----------------|-----------------------|---------------------|------------|
| <b>Provider</b> | <b>Admission Date</b> | <b>Release Date</b> | <b>LOS</b> |
| [REDACTED]      |                       |                     |            |

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### PARENT / GUARDIAN

| Name       | Relation Type | Parent | Legal Guardian | Domicile | Parental Rights Terminated | Emergency Contact | Phone Number | Address | Contact Restrictions |
|------------|---------------|--------|----------------|----------|----------------------------|-------------------|--------------|---------|----------------------|
| [REDACTED] |               |        |                |          |                            |                   |              |         |                      |

Marks/Scars/Tattoos [REDACTED]

|  |
|--|
|  |
|  |

|   |  |
|---|--|
| CMO Case Mgr. [REDACTED]<br>Committing County [REDACTED]<br>Referring County [REDACTED]<br>JAC Assessment Specialist [REDACTED] | DHHS Case ID Number [REDACTED]<br>DHHS/CPN Case Worker [REDACTED]<br>DHHS Personal ID (PID) [REDACTED]<br>Initial Detention Level [REDACTED]<br>Initial Risk Level [REDACTED]<br>Initial Security Level [REDACTED] |
|---|--|

| Committing / Admitting Offense | Offense Date | Offense | Disposition | Adj. Date |
|--------------------------------|--------------|---------|-------------|-----------|
| [REDACTED]                     |              |         |             |           |

Click for entire Offense Note: selecting an offense from the full list will update the committing offense for this client. however, it will not History show up here until you reload this screen.

|                               |
|-------------------------------|
| <b>Abuse/Neglect History:</b> |
|-------------------------------|

Neglect History: Is there a history of Protective Services abuse/neglect involving this child?

[REDACTED] Unknown

Abuse Neglect Type:

Is the case currently open?:  Yes  No

Court and County: [REDACTED]

# of Court Documented Neglect/Abuse Complaints:

Out of Home: Has the child ever been placed out of the home by the Court due to Abuse/Neglect?

Yes  No

How Long with dates?: From To

With whom? Identify type of placement made by Court direction:

Neglect Court Ward: Was the child made a ward of the court, due to Neglect/Abuse?  Yes  No

Dates of TCW Neglect(Temporary Court Ward)

Disposition:

Is this Juvenile the parent of a child: [REDACTED]

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Currently Pregnant? [Redacted] N/A

Due Date if yes:

Other Information:

Any Gang Affiliation: [Redacted] Unknown Gang Name:

U. S. Citizen: [Redacted] Unknown

Native American/Indian Ancestry  Yes  No If yes, which tribe?

Multi-Racial [Redacted] If Yes, Select Two or More:  White  Black  AIA  API  Hispanic  Arabic/Chaldean

Title IV-E Eligible:  Yes  No  Unknown

Date Applied For  
Date Approved

Social Security Eligible: [Redacted] Unknown

Compliant Court Order [Redacted] NA

Date Received [Redacted]

Birth Certificate:

On Suicide Watch (At Admission):  Yes  No  Unknown

Number Of Previous Out-of-Home Placements:

Truancy History (from placement): [Redacted] Unknown Number of Truancies:

On Truancy Status at Admission: [Redacted] Unknown

Living Status Prior to this Admission: Parents Home/Own Home [Redacted]

Provider Number (Of prior living situation): [Redacted]

Does Family Have Private Medical Insurance? [Redacted] Unknown (If Yes, click here to enter information)

Date Medical Authorization (FIA-3762) Given:

Marital Status: N/A

School Information:

School Info: School Name and Address

Last Grade Completed [Click here to add new school info](#)

Record Number: [Redacted]  
County: [Redacted]  
District: [Redacted]

School Name/Address:

[Redacted]

Record Number: [Redacted]  
County: [Redacted]  
District: [Redacted]

School Name/Address:

[Redacted]

Record Number: [Redacted]  
County: [Redacted]  
District: [Redacted]

School Name/Address:

[Redacted]

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[Redacted]

Record Number: [Redacted]  
County: [Redacted]  
District: [Redacted]

School Name/Address:

[Redacted]

Record Number: [Redacted]  
County: [Redacted]  
District: [Redacted]

School Name/Address:

[Redacted]

Record Number: [Redacted]  
County: [Redacted]  
District: [Redacted]

School Name/Address:

[Redacted]

Record Number: [Redacted]  
County: [Redacted]  
District: [Redacted]

School Name/Address:

[Redacted]

Record Number: [Redacted]  
County: [Redacted]  
District: [Redacted]

School Name/Address:

[Redacted]

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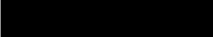


IEPC Completed? If Yes, Date

Education Designation

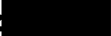
Designation: - Select (--)

Education Type



### FAMILY INFORMATION

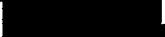
Zip Code of Parent's/Legal Guardian Home :



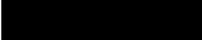
Family Type :



Marital Status of Biological Parents :

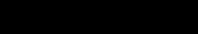


Female Juvenile Pregnant Currently :



Victim's Rights Notification :

Staff Code :



### COURT INFORMATION

Records found: 11. Displaying records 1-11.

| Edit | JAC EntryDate | Court Hearing Date | JAC Reg.Date | Legal Status | Referral Type | Reason for Admission |
|------|---------------|--------------------|--------------|--------------|---------------|----------------------|
| Edit |               |                    |              |              |               |                      |
| Edit |               |                    |              |              |               |                      |
| Edit |               |                    |              |              |               |                      |
| Edit |               |                    |              |              |               |                      |
| Edit |               |                    |              |              |               |                      |
| Edit |               |                    |              |              |               |                      |
| Edit |               |                    |              |              |               |                      |
| Edit |               |                    |              |              |               |                      |
| Edit |               |                    |              |              |               |                      |
| Edit |               |                    |              |              |               |                      |
| Edit |               |                    |              |              |               |                      |

Comments / Other Information:

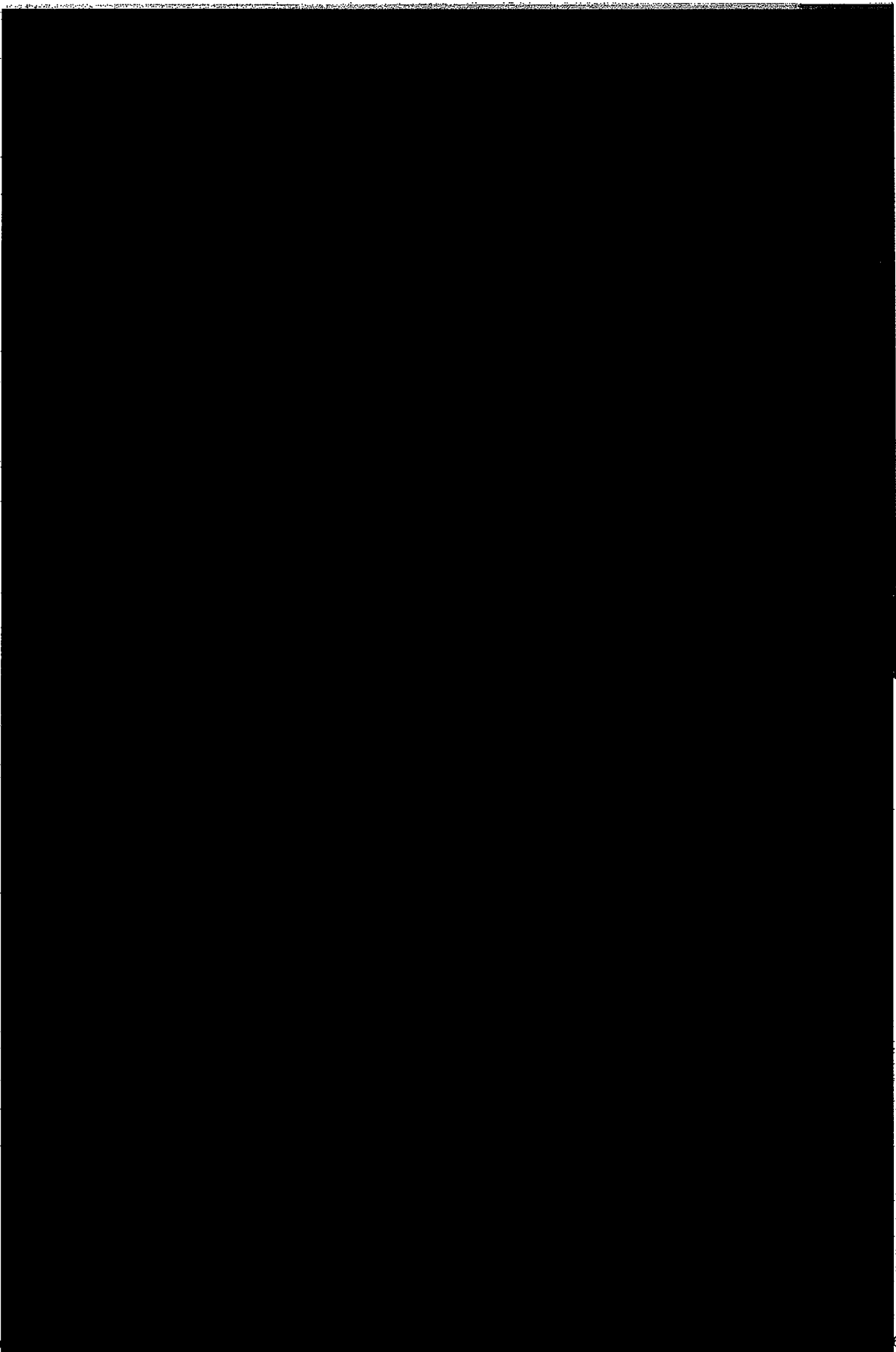


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# Intake Record

## Wayne County

[REDACTED]

### CLIENT INFO

Date of Birth / Age : [REDACTED]

Client Number# [REDACTED]

Court File# [REDACTED]

CMO : [REDACTED]

Court ID# [REDACTED]

Enrollment [REDACTED]

Neglect Wardship Termination Date# : [REDACTED]

Dually Involved: [REDACTED]

Primary Provider : [REDACTED]

SSN [REDACTED]

Case Manager : [REDACTED]

FIA Case# [REDACTED]

Legal Status : [REDACTED]

JAC Registration Date [REDACTED]

Committing County [REDACTED]

Hghst Adj Offense : [REDACTED]

Current Risk Level [REDACTED]

Current Sec Level [REDACTED]

CMT / Int Option : [REDACTED]

Most Recent Probation Plan : [REDACTED]

Initial Detention Level : [REDACTED]

Funding Source : [REDACTED]

Initial Risk Level : [REDACTED]

Initial Security Level : [REDACTED]

Recip ID (Medicaid #) : [REDACTED]

|            |            |            |            |
|------------|------------|------------|------------|
| [REDACTED] | [REDACTED] | [REDACTED] | [REDACTED] |
|------------|------------|------------|------------|

Probation Current Risk Level & Date

Current Security Level & Date

Creation Date:

Placed Current Risk Level & Date

Current Security Level & Date

Highest Adj. Offense

Name

Name

Mugshot not available

Client Number

AKAs

Click for Mug Shot Views

Domicile

Lives with:

SIS 62 23

SIS-62-23

000091

|                           |            |                      |
|---------------------------|------------|----------------------|
| Original Address:         | [REDACTED] |                      |
| Relation Type             | [REDACTED] |                      |
| Phone                     | [REDACTED] |                      |
| Date of Birth             | [REDACTED] |                      |
| Gender                    | [REDACTED] |                      |
| Height/Wt.                | [REDACTED] |                      |
| <b>Personal</b>           | [REDACTED] |                      |
| Build - Complexion        | [REDACTED] |                      |
| Hair/Eye Color            | [REDACTED] |                      |
| SSN                       | [REDACTED] |                      |
| Status                    | [REDACTED] |                      |
| Client                    | [REDACTED] |                      |
| Date Enrolled             | [REDACTED] |                      |
| <b>Status and Numbers</b> | [REDACTED] |                      |
| FAMCare #                 | [REDACTED] |                      |
| FIA #                     | [REDACTED] |                      |
| JAIS #                    | [REDACTED] |                      |
| Recipient ID (Medicaid #) | [REDACTED] |                      |
| Race                      | [REDACTED] | TTY:                 |
| Ethnicity                 | [REDACTED] |                      |
| <b>Demo-graphics</b>      | [REDACTED] | Interpreter: Select  |
| Religion                  | [REDACTED] | Special Needs        |
| Language                  | [REDACTED] |                      |
| Demographic Release       | [REDACTED] | Handicaps [REDACTED] |

Click for Case Notes:

Legal Status: [REDACTED]

Last Known Address: Street [REDACTED]  
 City, State Zip: [REDACTED]  
 County: [REDACTED]  
 Primary: [REDACTED]

Phone Numbers: Alternate [REDACTED]  
 Pager [REDACTED]

Tattoos: Description One [REDACTED]  
 Description Two [REDACTED]  
 Description Three [REDACTED]

**CMO ENROLLMENT / DISENROLLMENT**

Click here to Enroll

| Enrollment Date<br>(click to disenroll) | Disenrollment Date<br>(blank if enrolled) | Action     | Request Status | CMO        |
|---|---|------------|----------------|------------|
| [REDACTED]                              | [REDACTED]                                | [REDACTED] | [REDACTED]     | [REDACTED] |

Click Here to Enter AFCARS Data

Click to access CMT Change/Add Function

**CMT AUTHORIZATIONS STATUS**

000092

SIS 6/2/23 515-69-23

| Edit       | Status | Date Reviewed | CMO | Provider | CMT | Start Date | Stop Date |
|------------|--------|---------------|-----|----------|-----|------------|-----------|
| [REDACTED] |        |               |     |          |     |            |           |

### PROVIDER PLACEMENTS

Records found: 6. Displaying records 1-6.

| Provider   | Admission Date | Release Date | LOS |
|------------|----------------|--------------|-----|
| [REDACTED] |                |              |     |

### PARENT / GUARDIAN

| Name       | Relation Type | Parent     | Legal Guardian | Domicile   | Parental Rights Terminated | Emergency Contact | Phone Number | Address    | Contact Restrictions |
|------------|---------------|------------|----------------|------------|----------------------------|-------------------|--------------|------------|----------------------|
| [REDACTED] | [REDACTED]    | [REDACTED] | [REDACTED]     | [REDACTED] | [REDACTED]                 | [REDACTED]        | [REDACTED]   | [REDACTED] | [REDACTED]           |

#### Marks/Scars/Tattoos

|                       |
|-----------------------|
| Reference Information |
|-----------------------|

|                         |            |                         |            |
|-------------------------|------------|-------------------------|------------|
| CMO Case Mgr            | [REDACTED] | DHHS Case ID Number     | [REDACTED] |
| Committing County       | [REDACTED] | DHHS/CPN Case Worker    | [REDACTED] |
| Referring County        | [REDACTED] | DHHS Personal ID (PID)  | [REDACTED] |
| JAC Assessment Specials | [REDACTED] | Initial Detention Level | [REDACTED] |
|                         |            | Initial Risk Level      | [REDACTED] |
|                         |            | Initial Security Level  | [REDACTED] |

| Committing / Admitting Offense | Offense Date | Offense    | Disposition | Adj. Date  |
|--------------------------------|--------------|------------|-------------|------------|
| [REDACTED]                     | [REDACTED]   | [REDACTED] | [REDACTED]  | [REDACTED] |

Click for entire Offense Note: selecting an offense from the full list will update the committing offense for this client. however, it will not History show up here until you reload this screen.

|                       |
|-----------------------|
| Abuse/Neglect History |
|-----------------------|

Is there a history of Protective Services abuse/neglect involving this child?

Neglect History: [REDACTED] Unknown

Abuse Neglect Type: [REDACTED]

Is the case currently open?: [REDACTED] No

Court and County: [REDACTED]

# of Court Documented Neglect/Abuse Complaints: [REDACTED]

Out of Home: [REDACTED] Has the child ever been placed out of the home by the Court due to Abuse/Neglect?

62.23  
SIS. 62.23

How Long with dates?: From To

With whom? Identify type of placement made by Court direction:

Neglect Court Ward: Was the child made a ward of the court, due to Neglect/Abuse? [Redacted]

Dates of TCW Neglect(Temporary Court Ward) Disposition:

Is this Juvenile the parent of a child: [Redacted]

Currently Pregnant? [Redacted] N/A

Due Date If yes:

Other Information:

Any Gang Affiliation: [Redacted] Unknown Gang Name:

U. S. Citizen: [Redacted] Unknown

Native American/Indian Ancestry [Redacted] If yes, which tribe?

Multi-Racial [Redacted] \*If Yes, Select Two or More:  White  Black  AIA  API  Hispanic  Arabic/Chaldean

Title IV-E Eligible:  Yes  No  Unknown

Date Applied For Date Approved

Social Security Eligible: [Redacted] Unknown

Compliant Court Order [Redacted] NA

Date Received [Redacted]

Birth Certificate: [Redacted]

On Suicide Watch (At Admission): [Redacted]

Number Of Previous Out-of-Home Placements:

Truancy History (from placement): [Redacted] Unknown Number of Truancies:

On Truancy Status at Admission: [Redacted] Unknown

Living Status Prior to this Admission: Parents Home/Own Home [Redacted]

Provider Number (Of prior living situation): Parent's Home

Does Family Have Private Medical Insurance? [Redacted] unknown (If Yes, click here to enter information)

Date Medical Authorization (FIA-3762) Given:

Marital Status: N/A

School Information:

School Info: School Name and Address Last Grade Completed Click here to add new school info

Record Number [Redacted]  
County [Redacted]  
District [Redacted]

School Name/Address:

[Redacted]

Record Number [Redacted]  
County [Redacted]  
District [Redacted]

School Name/Address:

[Redacted]

58

62 23  
S15.62.23

Grad. Date:  
 Phone: [REDACTED]  
 Fax:

Record Number: [REDACTED]  
 County: [REDACTED]  
 District: [REDACTED]

School Name/Address:  
 [REDACTED]

Record Number: [REDACTED]  
 County: [REDACTED]  
 District: [REDACTED]

School Name/Address:  
 [REDACTED]

IEPC Completed? No/Yes, Date  
 Education Designation Designation: - Select (-)  
 Education Type: [REDACTED]

**FAMILY INFORMATION**

Zip Code of Parent's/Legal Guardian Home [REDACTED]  
 Family Type : [REDACTED]  
 Marital Status of Biological Parents [REDACTED]  
 Female Juvenile Pregnant Currently [REDACTED]  
 Victim's Rights Notification [REDACTED]  
 Staff Code [REDACTED]

**COURT INFORMATION**

Records found: 4. Displaying records 1-4.

| Edit | JAC EntryDate | Court Hearing Date | JAC Reg.Date | Legal Status | Referral Type | Reason for Admission |
|------|---------------|--------------------|--------------|--------------|---------------|----------------------|
| Edit | [REDACTED]    |                    |              |              |               |                      |
| Edit | [REDACTED]    |                    |              |              |               |                      |
| Edit | [REDACTED]    |                    |              |              |               |                      |
| Edit | [REDACTED]    |                    |              |              |               |                      |

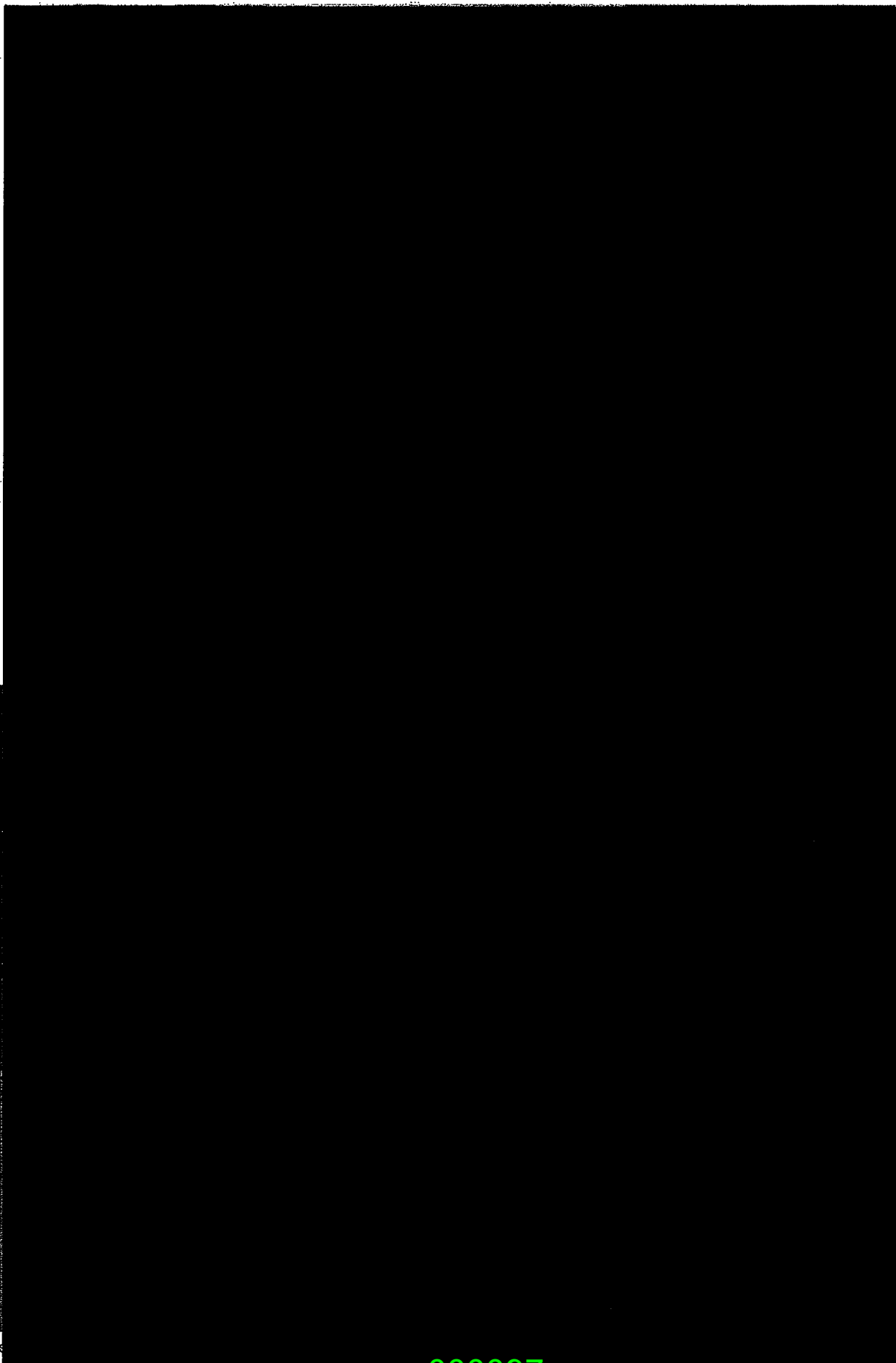
Comments / Other Informations:

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62 23  
SIS-62-23

52

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SIS-62-23



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62  
23  
SIS-62-23

915

62 23

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# Intake Record

## Wayne County

[Redacted]

### CLIENT INFO

Date of Birth / Age

Client Number#

Court File#

CMO

Court ID#

Neglect Wardship Termination Date# :

Primary Provider :

Dually Involved:

SSN :

Case Manager :

FIA Case# :

Legal Status :

JAC Registration Date :

Committing County :

Hghst Adj Offense :

Current Risk Level :

Current Sec Level :

CMT / Int Option :

Most Recent Probation Plan :

Initial Detention Level :

Funding Source

Initial Risk Level :

Initial Security Level :

Recip ID (Medicaid #) :

[Redacted]

Probation Current Risk Level & Date

Current Security Level & Date

Creation Date:

Placed Current Risk Level & Date

Current Security Level & Date

Highest Adj. Offense

Name

Name

Mugshot not available

Client Number

Click for Mug Shot Views:

AKAs

Lives with:

Domicile

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62 23  
S15-62-23

|                           |                           |                     |
|---------------------------|---------------------------|---------------------|
|                           | Original Address          |                     |
|                           | Relation Type             |                     |
|                           | Phone                     |                     |
|                           | Date of Birth             |                     |
|                           | Gender                    |                     |
| <b>Personal</b>           | Height/Wt                 |                     |
|                           | Build                     |                     |
|                           | Complexion                |                     |
|                           | Hair/Eye Color            |                     |
|                           | SSN                       |                     |
|                           | Status                    |                     |
|                           | Client                    |                     |
| <b>Status and Numbers</b> | Date Enrolled             |                     |
|                           | FAMCare #                 |                     |
|                           | FIA #                     |                     |
|                           | JAIS #                    |                     |
|                           | Recipient ID (Medicaid #) |                     |
|                           | Race                      | TTY:                |
|                           | Ethnicity                 |                     |
| <b>Demo-graphics</b>      | Religion                  | Interpreter: Select |
|                           | Language                  | Special Needs       |
|                           | Demographic Release       | Handicaps           |

Click for Case Notes:

Legal Status: [Redacted]

|                     |                   |            |
|---------------------|-------------------|------------|
| Last Known Address: | Street            | [Redacted] |
|                     | City, State Zip:  | [Redacted] |
|                     | County            | [Redacted] |
| Phone Numbers:      | Primary           | [Redacted] |
|                     | Alternate         | [Redacted] |
|                     | Pager             | [Redacted] |
| Tattoos:            | Description One   | [Redacted] |
|                     | Description Two   | [Redacted] |
|                     | Description Three | [Redacted] |

**CMO ENROLLMENT / DISENROLLMENT**

Click here to Enroll

| Enrollment Date (click to disenroll) | Disenrollment Date (blank if enrolled) | Action     | Request Status | CMO        |
|--------------------------------------|--|------------|----------------|------------|
| [Redacted]                           | [Redacted]                             | [Redacted] | [Redacted]     | [Redacted] |

Click Here to Enter AFCARS Data

Click to access CMT Change/Add Function

**CMT AUTHORIZATIONS STATUS**

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<< < 1 2 > >>

|                 |                       |                     |            |
|-----------------|-----------------------|---------------------|------------|
| <b>Provider</b> | <b>Admission Date</b> | <b>Release Date</b> | <b>LOS</b> |
| [REDACTED]      |                       |                     |            |

<< < 1 2 > >>

**PARENT / GUARDIAN**

| Name       | Relation Type | Parent | Legal Guardian | Domicile | Parental Rights Terminated | Emergency Contact | Phone Number | Address | Contact Restrictions |
|------------|---------------|--------|----------------|----------|----------------------------|-------------------|--------------|---------|----------------------|
| [REDACTED] |               |        |                |          |                            |                   |              |         |                      |

Marks/Scars/Tattoos [REDACTED]

|            |
|------------|
| [REDACTED] |
|------------|

|   |  |
|---|--|
| <b>Reference Information</b>  |  |
| CMO Case Mgr. [REDACTED]<br>Committing County [REDACTED]<br>Referring County [REDACTED]<br>JAC Assessment Specialist [REDACTED] | DHHS Case ID Number [REDACTED]<br>DHHS/CPN Case Worker [REDACTED]<br>DHHS Personal ID (PID) [REDACTED]<br>Initial Detention Level [REDACTED]<br>Initial Risk Level [REDACTED]<br>Initial Security Level [REDACTED] |

| Committing / Admitting Offense | Offense Date | Offense | Disposition | Adj. Date |
|--------------------------------|--------------|---------|-------------|-----------|
| [REDACTED]                     |              |         |             |           |

Click for entire Offense Note: selecting an offense from the full list will update the committing offense for this client. however, it will not History show up here until you reload this screen.

|                              |
|------------------------------|
| <b>Abuse/Neglect History</b> |
|------------------------------|

Neglect History: Is there a history of Protective Services abuse/neglect involving this child?  
 Neglect History: [REDACTED] Unknown

Abuse Neglect Type: [REDACTED]

Is the case currently open?: [REDACTED]

Court and County: [REDACTED]

# of Court Documented Neglect/Abuse Complaints: [REDACTED]

Out of Home: Has the child ever been placed out of the home by the Court due to Abuse/Neglect?  
 Out of Home: [REDACTED]

How Long with dates?: [REDACTED]

With whom? Identify type of placement made by Court direction: [REDACTED]

Neglect Court Ward: Was the child made a ward of the court, due to Neglect/Abuse?  
 Neglect Court Ward: [REDACTED]

Dates of TCW Neglect (Temporary Court Ward) Disposition: [REDACTED]

Is this Juvenile the parent of a child: [REDACTED]

Currently Pregnant: [REDACTED]

Due Date if yes: [REDACTED]

|                           |
|---------------------------|
| <b>Other Information:</b> |
|---------------------------|

Any Gang Affiliation: [REDACTED] Unknown Gang Name: [REDACTED]

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U. S. Citizen: [Redacted] Unknown

Native American/Indian Ancestry [Redacted] If yes, which tribe?

Multi-Racial [Redacted] \*If Yes, Select Two or More:  White  Black  AIIA  API  Hispanic  Arabic/Chaldean

Title IV-E Eligible:  Yes  No  Unknown

Date Applied For  
Date Approved

Social Security Eligible: [Redacted] Unknown

Compliant Court Order [Redacted] NA

Date Received [Redacted]

Birth Certificate: [Redacted]

On Suicide Watch (At Admission): [Redacted] Unknown

Number Of Previous Out-of-Home Placements: [Redacted]

Truancy History (from placement): [Redacted] Unknown Number of Truancies: [Redacted]

On Truancy Status at Admission: [Redacted] Unknown

Living Status Prior to this Admission: [Redacted]

Provider Number (Of prior living situation): [Redacted]

Does Family Have Private Medical Insurance? [Redacted] Unknown (If Yes, click here to enter information)

Date Medical Authorization (FIA-3762) Given: [Redacted]

Marital Status: [Redacted]

School Information:

School Info: School Name and Address

Last Grade Completed [Click here to add new school info](#)

Record Number: [Redacted]  
County: [Redacted]  
District: [Redacted]

School Name/Address:

[Redacted]

Record Number: [Redacted]  
County: [Redacted]  
District: [Redacted]

School Name/Address:

[Redacted]

Record Number: [Redacted]  
County: [Redacted]  
District: [Redacted]

School Name/Address:

[Redacted]

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Pho [redacted]  
Fax [redacted]

Record Number: [redacted]  
County: [redacted]  
District: [redacted]

School Name/Address:

[redacted]

Record Number: [redacted]  
County: [redacted]  
District: [redacted]

School Name/Address:

[redacted]

Record Number: [redacted]  
County: [redacted]  
District: [redacted]

School Name/Address:

[redacted]

Record Number: [redacted]  
County: [redacted]  
District: [redacted]

School Name/Address:

[redacted]

Record Number: [redacted]  
County: [redacted]  
District: [redacted]

School Name/Address:

[redacted]

Record Number: [redacted]  
County: [redacted]

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SSS-62-23

District: [REDACTED]

School Name/Address:

[REDACTED]

Record Number: [REDACTED]  
County: [REDACTED]  
District: [REDACTED]

School Name/Address:

[REDACTED]

Record Number: [REDACTED]  
County: [REDACTED]  
District: [REDACTED]

School Name/Address:

[REDACTED]

Record Number: [REDACTED]  
County: [REDACTED]  
District: [REDACTED]

School Name/Address:

[REDACTED]

IEPC Completed? [REDACTED]  
Education Designation [REDACTED] Designation [REDACTED]  
Education Type [REDACTED]

**FAMILY INFORMATION**

Zip Code of Parent's/Legal Guardian Home [REDACTED]  
Family Type : [REDACTED]  
Marital Status of Biological Parents [REDACTED]  
Female Juvenile Pregnant Currently [REDACTED]  
Victim's Rights Notification [REDACTED]  
Staff Code [REDACTED]

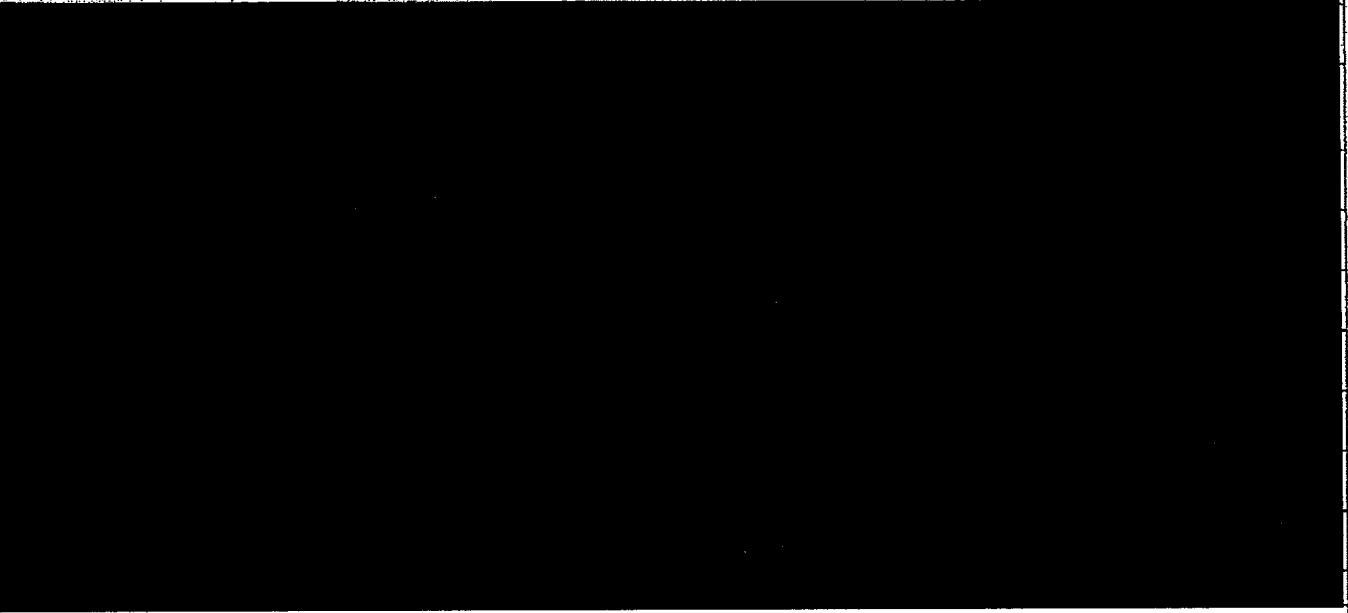
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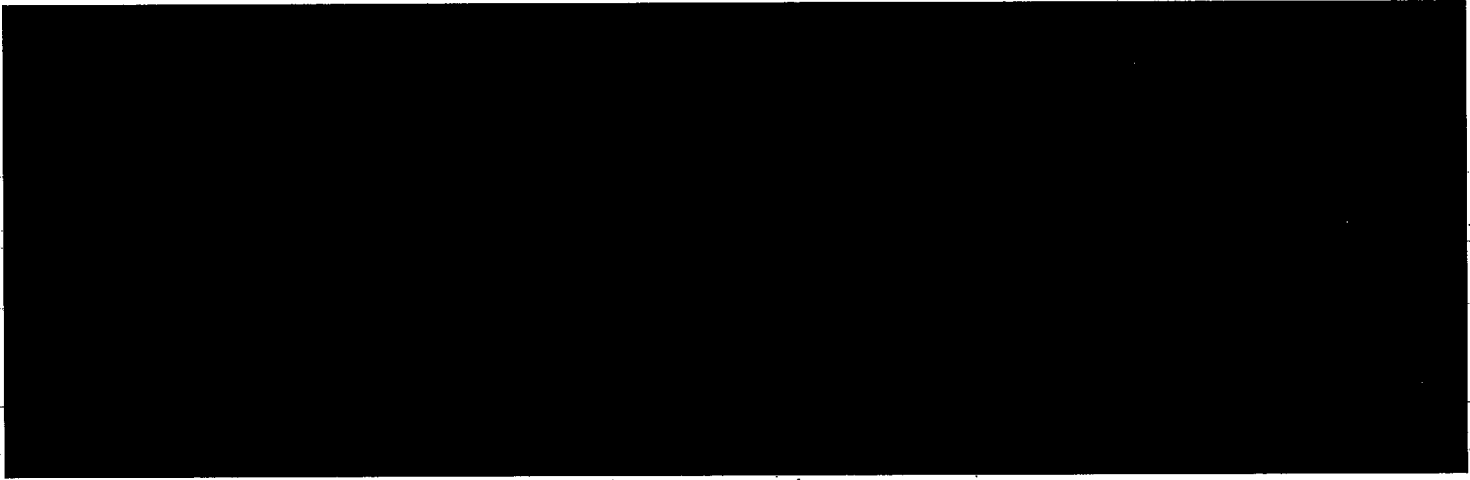
SS-62-23

### COURT INFORMATION

Records found: 10. Displaying records 1-10.

| Edit | JAC<br>EntryDate   | Court<br>Hearing<br>Date | JAC<br>Reg.Date | Legal Status | Referral Type | Reason for Admission |
|------|--|--------------------------|-----------------|--------------|---------------|----------------------|
| Edit |  |                          |                 |              |               |                      |
| Edit |  |                          |                 |              |               |                      |
| Edit |  |                          |                 |              |               |                      |
| Edit |  |                          |                 |              |               |                      |
| Edit |  |                          |                 |              |               |                      |
| Edit |  |                          |                 |              |               |                      |
| Edit |  |                          |                 |              |               |                      |
| Edit |  |                          |                 |              |               |                      |
| Edit |  |                          |                 |              |               |                      |
| Edit |  |                          |                 |              |               |                      |

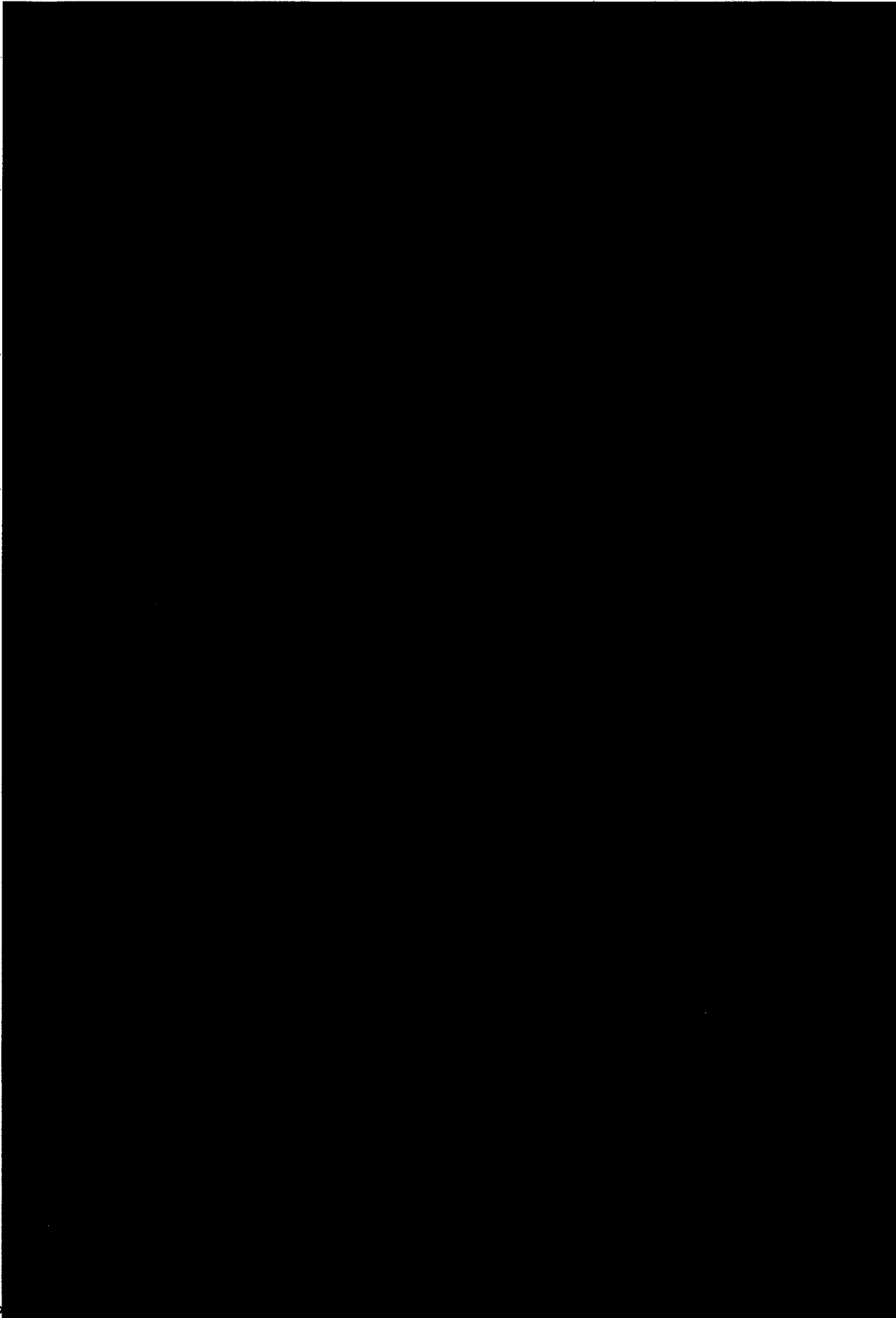
Comments / Other Information:



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# Intake Record

Wayne County

[Redacted]

## CLIENT INFO

Date of Birth / Age :

Client Number# :

Court File# :

CMO :

Court ID# :

Neglect Wardship Termination Date# :

Dually Involved:

Primary Provider :

SSN :

Case Manager :

FIA Case# :

Legal Status :

JAC Registration Date :

Committing County :

Hghst Adj Offense :

Current Risk Level :

Current Sec Level :

Most Recent Probation Plan :

Initial Detention Level :

Funding Source :

Initial Risk Level :

Initial Security Level :

Recip ID (Medicaid #) :

[Redacted]

Probation Current Risk Level & Date

Current Security Level & Date

Creation Date:

Placed Current Risk Level & Date

Current Security Level & Date

Highest Adj. Offense

62 23

Name

Name

Mugshot not available

Client Number

Click for Mug Shot Views:

AKAs

Domicile

Lives with

515-62-23

000109

Original Address  
 Relation Type  
 Phone  
 Date of Birth  
 Gender  
 Height/Weight  
 Build  
 Complexion  
 Hair/Eye Color  
 SSN  
 Status  
 Client  
 Date Enrolled  
 FAMCare #  
 FIA #  
 JAIS #  
 Recipient ID (Medicaid #)  
 Race  
 Ethnicity  
 Religion  
 Language  
 Demographic Release

**Personal**

**Status and Numbers**

**Demo-graphics**

TTY:  
 Interpreter: Select  
 Special Needs  
 Handicaps:

Click for Case Notes:

Legal Status:

Last Known Address:  
 Street  
 City, State Zip:  
 County  
 Primary  
 Alternate  
 Pager  
 Description One  
 Description Two  
 Description Three

Phone Numbers:  
 Tattoos:

### CMO ENROLLMENT / DISENROLLMENT

Click here to Enroll

| Enrollment Date (click to disenroll) | Disenrollment Date (blank if enrolled) | Action | Request Status | CMO |
|--------------------------------------|--|--------|----------------|-----|
|                                      |  |        |                |     |

Click Here to Enter AFCARS Data

Click to access CMT Change/Add Function

### CMT AUTHORIZATIONS STATUS

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SIS  
67 73  
SIS-62-23

| Edit | Status | Date Reviewed | CMO | Provider | CMT | Start Date | Stop Date |
|------|--------|---------------|-----|----------|-----|------------|-----------|
| Edit |        |               |     |          |     |            |           |
| Edit |        |               |     |          |     |            |           |
| Edit |        |               |     |          |     |            |           |

### PROVIDER PLACEMENTS

Records found: 3. Displaying records 1-3.

| Provider | Admission Date | Release Date | LOS |
|----------|----------------|--------------|-----|
|          |                |              |     |
|          |                |              |     |

### PARENT / GUARDIAN

| Name | Relation Type | Parent | Legal Guardian | Domicile | Parental Rights Terminated | Emergency Contact | Phone Number | Address | Contact Restrictions |
|------|---------------|--------|----------------|----------|----------------------------|-------------------|--------------|---------|----------------------|
|      |               |        |                |          |                            |                   |              |         |                      |
|      |               |        |                |          |                            |                   |              |         |                      |

Marks/Scars/Tattoos

Reference Information

CMO Case Mgr.   
 Committing County

DHHS Case ID Number   
 DHHS/CPN Case Worker   
 DHHS Personal ID (PID)

Referring County Wayne

Initial Detention Level   
 Initial Risk Level   
 Initial Security Level

| Committing / Admitting Offense | Offense Date | Offense | Disposition | Adj. Date |
|--------------------------------|--------------|---------|-------------|-----------|
|                                |              |         |             |           |

Click for entire Offense Note: selecting an offense from the full list will update the committing offense for this client. however, it will History not show up here until you reload this screen.

Abuse/Neglect History

Neglect History: Is there a history of Protective Services abuse/neglect involving this child?   
 Unknown

Abuse Neglect Type:

Is the case currently open? No

Court and County:

# of Court Documented Neglect/Abuse Complaints:

Out of Home: Has the child ever been placed out of the home by the Court due to Abuse/Neglect?   
 No

How Long with dates?: From To

With whom? Identify type of placement made by Court direction:

Neglect Court Ward: Was the child made a ward of the court, due to Neglect/Abuse?

Dates of TCW Neglect(Temporary Court Ward) Disposition:

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59  
 62  
 23  
 S15-62-23

Is this Juvenile the parent of a child: [redacted] No

Currently Pregnant? [redacted] N/A

Due Date if yes:

**Other Information:**

Any Gang Affiliation: [redacted] Unknown Gang Name:

U. S. Citizen: [redacted] Unknown

Native American/Indian Ancestry [redacted] If yes, which tribe?

Multi-Racial More: [redacted] \*If Yes, Select Two or More:  White  Black  A/A  API  Hispanic  Arabic/Chaldean

Title IV-E Eligible:  Yes  No  Unknown

Date Applied For  
Date Approved

Social Security Eligible: [redacted] Unknown

Compliant Court Order [redacted] NA

Date Received [redacted]

Birth Certificate:  Received  Applied For  N/A Reason Date:

On Suicide Watch (At Admission): [redacted] Unknown

Number Of Previous Out-of-Home Placements: [redacted]

Truancy History (from placement): [redacted] Unknown Number of Truancies:

On Truancy Status at Admission: [redacted] Unknown

Living Status Prior to this Admission: Parents Home/Own Home [redacted]

Provider Number (Of prior living situation): Parent's Home

Does Family Have Private Medical Insurance? [redacted] Unknown (If Yes, click here to enter information)

Date Medical Authorization (FIA-3762) Given: [redacted]

Marital Status: [redacted]

**School Information:**

School Name and Address Last Grade Completed [Click here to add new school info](#)

Record Number: [redacted]

County [redacted]

District [redacted]

School Name/Address:

School Info

[redacted]

IEPC Completed? Nolf Yes, Date

Education Designation Designation:

Education Type: [redacted]

**FAMILY INFORMATION**

Zip Code of Parent's/Legal Guardian Home: [redacted]

Family Type: [redacted]

Marital Status of Biological Parents: [redacted]

Female Juvenile Pregnant Currently: [redacted]

000112

SIS  
6/2/23  
SIS: 6/2/23

Staff Code :

### COURT INFORMATION

Records found: 3. Displaying records 1-3.

| Edit | JAC EntryDate | Court Hearing Date | JAC Reg.Date | Legal Status | Referral Type | Reason for Admission |
|------|---------------|--------------------|--------------|--------------|---------------|----------------------|
| Edit |               |                    |              |              |               |                      |
| Edit |               |                    |              |              |               |                      |
| Edit |               |                    |              |              |               |                      |

Comments / Other Information:

82 23

S15-62-23



62 23

SIS-62-23

# Intake Record

## Wayne County

[Redacted]

### CLIENT INFO

Date of Birth / Age : [Redacted]  
 [Redacted]  
 CMO : [Redacted]  
 [Redacted]  
 Enrollment : [Redacted]  
 Primary Provider : [Redacted]  
 [Redacted]  
 Case Manager : [Redacted]  
 Legal Status : [Redacted]  
 Hghst Adj Offense : -  
 [Redacted]  
 CMT / Int Option : [Redacted]  
 [Redacted]  
 Initial Detention Level : [Redacted]  
 Initial Risk Level : [Redacted]  
 Initial Security Level : [Redacted]  
 Recip ID (Medicaid #) : [Redacted]

Client Number# : [Redacted]  
 Court File# : [Redacted]  
 Court ID# : [Redacted]  
 Neglect Wardship Termination Date# : [Redacted]  
 Dually Involved : [Redacted]  
 SSN : [Redacted]  
 FIA Case# : [Redacted]  
 JAC Registration Date : [Redacted]  
 Committing County : [Redacted]  
 Current Risk Level : -  
 Current Sec Level : -  
 Most Recent Probation Plan : -  
 Funding Source : [Redacted]

[Redacted]

| Creation Date: | Placed Current Risk Level & Date | Current Security Level & Date | Highest Adj. Offense |
|----------------|----------------------------------|-------------------------------|----------------------|
| [Redacted]     | [Redacted]                       | [Redacted]                    | [Redacted]           |

| Name       | Name   | Mugshot not available     |
|------------|--|---------------------------|
| [Redacted] | [Redacted]   | [Redacted]                |
| Domicile   | Client Number<br>AKAs<br>Lives with:<br>Original Address:<br>Relation Type | Click for Mug Shot Views: |

SIS 62 23

SIS-62-23

| Edit | Status | Date Reviewed | CMO | Provider | CMT | Start Date | Stop Date |
|------|--------|---------------|-----|----------|-----|------------|-----------|
| Edit |        |               |     |          |     |            |           |
| Edit |        |               |     |          |     |            |           |

### PROVIDER PLACEMENTS

Records found: 2. Displaying records 1-2.

| Provider | Admission Date | Release Date | LOS |
|----------|----------------|--------------|-----|
|          |                |              |     |
|          |                |              |     |

### PARENT / GUARDIAN

| Name | Relation Type | Parent | Legal Guardian | Domicile | Parental Rights Terminated | Emergency Contact | Phone Number | Address | Contact Restrictions |
|------|---------------|--------|----------------|----------|----------------------------|-------------------|--------------|---------|----------------------|
|      |               |        |                |          |                            |                   |              |         |                      |

Marks/Scars/Tattoos

#### Reference Information

|                           |                         |
|---------------------------|-------------------------|
| CMO Case Mgr.             | DHHS Case ID Number     |
| Committing County         | DHHS/CPN Case Worker    |
| Referring County          | DHHS Personal ID (PID)  |
| JAC Assessment Specialist | Initial Detention Level |
|                           | Initial Risk Level      |
|                           | Initial Security Level  |

| Committing / Admitting Offense | Offense Date | Offense | Disposition | Adj. Date |
|--------------------------------|--------------|---------|-------------|-----------|
|                                |              |         |             |           |

Click for entire Offense Note: selecting an offense from the full list will update the committing offense for this client. however, it will History not show up here until you reload this screen.

#### Abuse/Neglect History

Neglect History:  Yes  No  Unknown

Is there a history of Protective Services abuse/neglect involving this child?

Abuse Neglect Type:

Is the case currently open?:  Yes  No

Court and County:

# of Court Documented Neglect/Abuse

Complaints:

Out of Home:  Yes  No

Has the child ever been placed out of the home by the Court due to Abuse/Neglect?

How Long with dates?: From To

With whom? Identify type of placement made by Court direction:

Neglect Court Ward: Was the child made a ward of the court, due to Neglect/Abuse?  Yes  No

Dates of TCW Neglect(Temporary Court Ward) Disposition:

Is this Juvenile the parent of a child:  Yes  No

Currently Pregnant?  Yes  No  N/A

Due Date if yes:

#### Other Information:

Any Gang Affiliation:  Yes  No  Unknown Gang Name:

000116

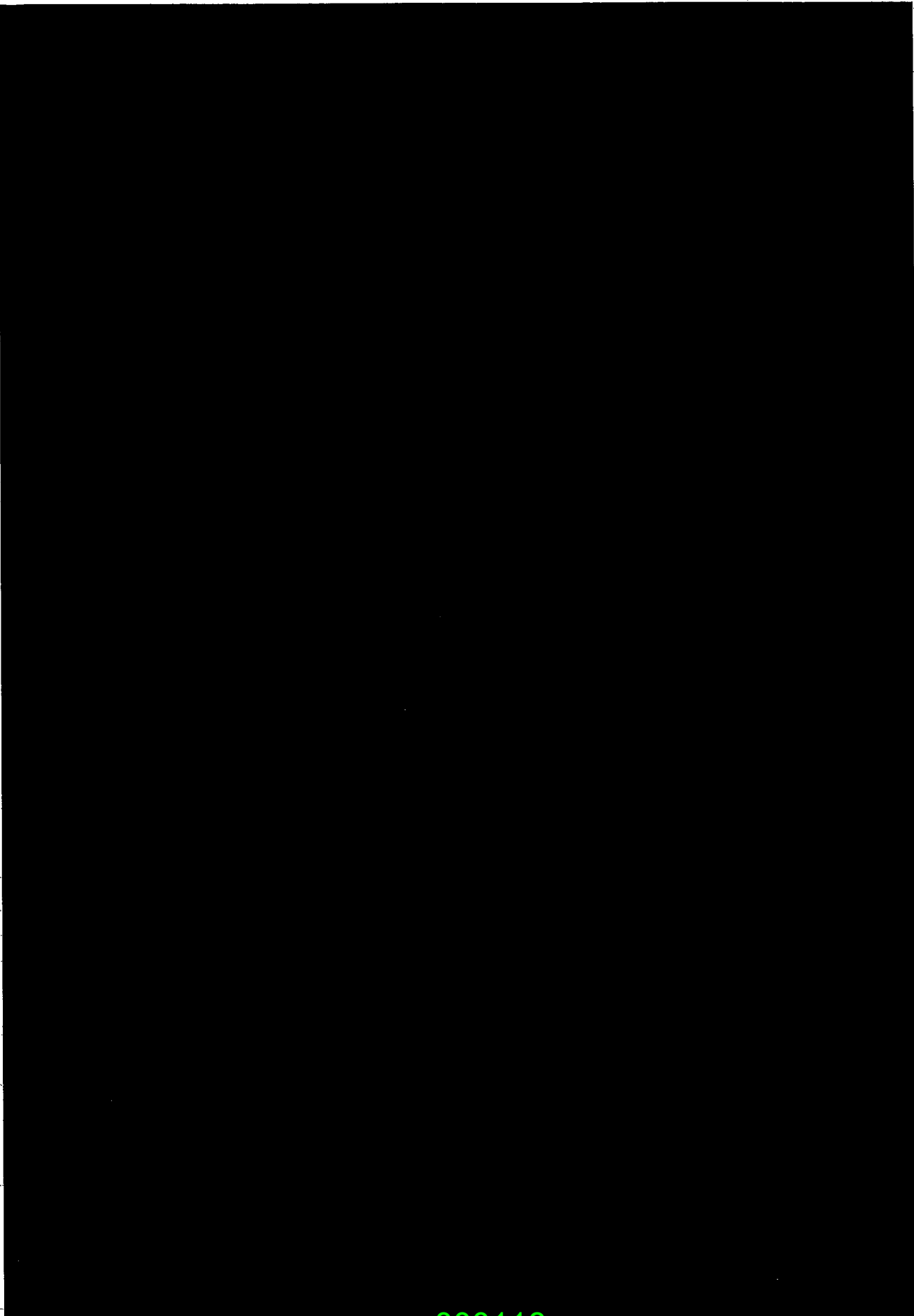
SIS-62-23

| Edit | JAC<br>EntryDate | Court<br>Hearing<br>Date | JAC<br>Reg.Date | Legal Status | Referral Type | Reason for Admission |
|------|------------------|--------------------------|-----------------|--------------|---------------|----------------------|
| Edit | [REDACTED]       |                          |                 |              |               |                      |

Comments / Other Information:

SIS  
02-23  
SIS-BA-23

3/15/23, 11:38 AM



515-621-23

515  
62  
23

# **Exhibit 4**

**CORRECTIVE ACTION PLAN (CAP)**

Michigan Department of Health and Human Services  
 Division of Child Welfare Licensing

|   |                                 |                           |
|---|---------------------------------|---------------------------|
| Facility Name<br><b>Wayne County Juvenile Detention Center</b>  | License #<br><b>CE820414010</b> | Date<br><b>03/21/2023</b> |
| Type of Inspection<br><input type="checkbox"/> Renewal/Interim <input checked="" type="checkbox"/> Special Investigation# <b>2023C0000167</b> |                                 |                           |

|   |                    |                          |
|---|--------------------|--------------------------|
| Inspecting/Investigating consultant name<br><b>Christopher Barr</b><br>Michigan Department of Health and Human Services – Division of Child Welfare Licensing |                    |                          |
| Address<br><b>3501 Hamtramck Blvd</b>   |                    |                          |
| City<br><b>Hamtramck</b>  | State<br><b>MI</b> | Zip Code<br><b>48211</b> |

|                               |
|-------------------------------|
| Description of CAP (Optional) |
|-------------------------------|

|   |
|---|
| In response to the above noted licensing inspection/investigation, please accept the following corrective action plan to bring the facility into compliance with licensing rules. |
|---|

| Licensing Rule Violation  | Is this a subsequent violation for the same rule within 2 years?<br><br>Yes No | Plan for compliance achievement. If this is a subsequent violation for the same rule, explain why the previous CAP was unsuccessful.  | Individual responsible for CAP implementation | Time frame for implementation  | Plan for ongoing maintenance, including time frame                         | Date implemented or completed on |
|---|--|---|---|--|--|----------------------------------|
| <p>R 400.4158 Discipline. Rule 158. CCI Rule 400.4407 Facility and premises maintenance. (1) A facility and premises shall be maintained in a clean, comfortable, and safe condition. The facility shall be located on land that is properly drained. (2) An institution shall prohibit all cruel and severe discipline, including any of the following:<br/>(a) Any type of corporal</p> |  | <ol style="list-style-type: none"> <li>1. MDHHS directs JDC to begin utilizing day programming, such as Team Wellness day programming. (within 7 days of CAP acceptance</li> <li>2. MDHHS will be provided unlimited and ongoing access to the entirety of all youth</li> </ol> | <p>Melissa Fernandez, CA</p>                  | <ol style="list-style-type: none"> <li>1. Within 7 days of CAP acceptance</li> <li>2. Immediately</li> </ol> | <p>Stated items will continue and will be documented for verification.</p> |                                  |

|  |  |   |  |                       |  |  |
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| <p>punishment inflicted in any manner.</p> <p>(b) Disciplining a group for the misbehavior of individual group members.</p> <p>(c) Verbal abuse, ridicule, or humiliation.</p> <p>(d) Denial of any essential program services, including adoption planning.</p> <p>(e) Withholding of food or creating special menus for behavior management purposes.</p> <p>(f) Denial of visits or communications with family.</p> <p>(g) Denial of opportunity for at least 8 hours of sleep in a 24-hour period.</p> <p>(h) Denial of shelter, clothing, or essential personal needs.</p> <p>(3) Residents</p> |  | <p>case files, including all assessments, reports, evaluations, progress notes, etc.</p> <p>3. <i>MDHHS will be provided unlimited and ongoing access to all areas of the facility which house youth on a 24/7 basis. MDHHS staff shall be allowed to possess and use phones and computers while on-site.</i></p> |  | <p>3. Immediately</p> |  |  |
|--|--|---|--|-----------------------|--|--|

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|--|--|--|--|-----------------------|--|--|
| <p>shall not be permitted to discipline other resident</p> |  | <p>4. Chief Administrator will provide documentation by noon each Monday indicating which days they were present on-site at the facility the preceding week (Saturday - Sunday). This documentation will include a "punch list" of required daily checks completed (to include mattresses/blankets/clean and well-fitting clothes,</p> |  | <p>4. Immediately</p> |  |  |
|--|--|--|--|-----------------------|--|--|

|  |  |   |  |   |  |  |
|--|--|---|--|---|--|--|
|  |  | <p>meals provided, clean rooms, designated showers completed, rec time completed etc. for each youth)</p> <p>5. A training plan will be developed for all staff to include trauma informed training and restraint training and provided to MDHHS (within 7 days)</p> <p>6. The Chief Administrator must attest that the agency is in full complianc</p> |  | <p>5. Within 7 days of CAP acceptance</p> |  |  |
|--|--|---|--|---|--|--|

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|  |  | <p>e with<br/>licensing<br/>rule R<br/>400.4158(<br/>1)(b)(i)(<br/>that food<br/>cannot be<br/>withheld)</p> <p>7. Minimum<br/>shower<br/>3xweek<br/>for all<br/>youth.<br/>All youth<br/>will be<br/>provided<br/>with<br/>appropria<br/>te<br/>hygiene<br/>items as<br/>required<br/>by rule<br/>400. 4148<br/>including<br/>a<br/>toothbrus<br/>h and<br/>toothpast<br/>e daily.</p> <p>8.<br/>Recreatio<br/>n time<br/>will<br/>permitted<br/>to all<br/>youth.<br/>Facility<br/>will<br/>assess</p> |  | <p>6. Within 7<br/>days of CAP<br/>acceptance</p> <p>7. Immediately</p> |  |  |
|--|--|--|--|---|--|--|

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|--|--|---|--|--|--|--|
|  |  | <p>any opportunities for outside recreation for small groups (perhaps 3-5).</p> <p>9. Ensuring youth have recipient rights access and training staff on the process to allow youth access.</p> <p>10. Establish a youth advisory council with a small number of youth as members of the council.</p> <p>11. If there are soiled towels, linens,</p> |  | <p>8. Within 7 days of CAP acceptance</p> <p>9. Immediately</p> <p>10. Within 7 days of CAP acceptance</p> |  |  |
|--|--|---|--|--|--|--|

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|--|--|--|--|--|--|--|
|  |  | <p>clothing,<br/>etc.<br/>clean<br/>ones<br/>will be<br/>provided<br/>when<br/>needed,<br/>at<br/>minimum<br/>once per<br/>week.<br/>Operations manager<br/>and<br/>supervisors will<br/>ensure<br/>this is<br/>completed<br/>as part<br/>of the<br/>punch<br/>list.</p> <p>12. Staff are<br/>to do<br/>checks as<br/>prescribed in the<br/>rules. If<br/>a youth<br/>floods<br/>their<br/>cell or<br/>there is<br/>a water<br/>leak,<br/>staff<br/>clean and<br/>sanitize</p> |  | <p>11. Immediately</p> <p>12. Immediately</p> <p>13. Immediately</p> |  |  |
|--|--|--|--|--|--|--|

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|  |  | <p>room and document in the log book. This item must be completed weekly</p> <p>13. Youth who refuse to eat or are viewed to be malnourished will receive a dietary consult and follow all recommendations and document. Consultations must be completed with 48-hours of noticing signs of malnutrition.</p> <p>14. In compliance with rule</p> |  | <p>14. Immediately</p> <p>15. Immediately</p> |  |  |
|--|--|--|--|---|--|--|

|  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|
|  |  | <p>400.4150 )<br/>Any<br/>incident<br/>resulting<br/>in<br/>serious<br/>injury of<br/>a<br/>resident<br/>or<br/>illness<br/>requiring<br/>inpatient<br/>hospitali-<br/>zation,<br/>shall be<br/>reported<br/>to the<br/>parent/<br/>legal<br/>guardian,<br/>responsib-<br/>le<br/>referring<br/>agency,<br/>and the<br/>licensing<br/>authority<br/>and chief<br/>administr-<br/>ator as<br/>soon as<br/>possible,<br/>but not<br/>more than<br/>24 hours<br/>after the<br/>incident</p> <p>15. If the<br/>sheriff's</p> |  |  |  |  |
|--|--|--|--|--|--|--|

|  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|
|  |  | <p>dept.<br/> engages<br/> with any<br/> youth,<br/> the<br/> facility<br/> will<br/> notify<br/> DCWL, per<br/> the rule<br/> requireme<br/> nt, "as<br/> soon as<br/> possible<br/> but not<br/> more than<br/> 24 hours<br/> after the<br/> incident"<br/> . Any<br/> suspected<br/> abuse or<br/> neglect<br/> will be<br/> reported<br/> to<br/> centraliz<br/> ed intake<br/> immediate<br/> ly.</p> |  |  |  |  |
|  |  |  |  |  |  |  |
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|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |

**Corrective Action Plans must be signed by the Chief Administrator.**

**The Chief Administrator must sign the initial corrective action plan (required).**

|           |       |      |
|-----------|-------|------|
| Signature | Title | Date |
|-----------|-------|------|

|           |       |      |
|-----------|-------|------|
| Signature | Title | Date |
|-----------|-------|------|

|           |       |      |
|-----------|-------|------|
| Signature | Title | Date |
|-----------|-------|------|

|           |       |      |
|-----------|-------|------|
| Signature | Title | Date |
|-----------|-------|------|

**Please accept my signature as confirmation this corrective action plan has been fully implemented.  
(Must be signed by the Chief Administrator).**

|           |       |      |
|-----------|-------|------|
| Signature | Title | Date |
|-----------|-------|------|