



MICHIGAN

OFFICE OF THE AUDITOR GENERAL

AUDIT REPORT



THOMAS H. MCTAVISH, C.P.A.
AUDITOR GENERAL

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– Article IV, Section 53 of the Michigan Constitution

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Michigan
Office of the Auditor General
REPORT SUMMARY

Performance Audit

Central Michigan Correctional Facility

Department of Corrections

Report Number:
471-0276-12

Released:
September 2012

The Central Michigan Correctional Facility was formed when the Pine River Correctional Facility and Mid-Michigan Correctional Facility consolidated in October 2010. The Facility is located in St. Louis, Michigan, and houses 2,564 secure level I male prisoners. The Facility has 16 housing units as well as separate buildings for administration/healthcare, food service, school, maintenance/warehouse, and prisoner services.

Audit Objective:

To assess the effectiveness of the Department of Corrections' (DOC's) efforts to comply with selected policies and procedures related to safety and security at the Central Michigan Correctional Facility.

Audit Conclusion:

We concluded that DOC's efforts to comply with selected policies and procedures related to safety and security at the Central Michigan Correctional Facility were moderately effective. We noted one material condition (Finding 1) and eleven reportable conditions (Findings 2 through 12).

Material Condition:

The Facility did not maintain proper control over dangerous tools, equipment, and other controlled inventory items (Finding 1).

Reportable Conditions:

The Facility did not ensure that its officers performed and documented all required prisoner shakedowns and cell searches (Finding 2).

The Facility did not ensure that it performed and documented all required employee shakedowns (Finding 3).

The Facility needs to improve its controls over keys and padlocks (Finding 4).

The Facility did not document that it conducted all required radio checks and personal protection device checks (Finding 5).

The Facility did not properly complete, reconcile, and maintain gate manifests (Finding 6).

The Facility did not implement a comprehensive preventive maintenance plan. Also, the Facility did not complete preventive maintenance and other maintenance tasks in a timely manner (Finding 7).

The Facility did not always properly document the issuance and return of weapons from its arsenal (Finding 8).

The Facility did not complete all required monthly sanitation inspections (Finding 9).

The Facility did not document that it completed all required weekly fire safety inspections. Also, the Facility did not always propose corrective action plans or ensure that timely corrective action was taken on deficiencies noted in its monthly and annual fire safety inspections (Finding 10).

The Facility did not complete all required security monitoring exercises (Finding 11).

The Facility did not maintain documentation that it conducted annual criminal history checks for officers whose assignments required the use of a firearm (Finding 12).

Noteworthy Accomplishments:

In 2011, the Facility was awarded the Michigan Plaque from Keep Michigan Beautiful, Inc. for its horticulture program. The Facility indicated that the program donated vegetables to food pantries, soup kitchens, and schools and donated flats of flowers and vegetable plants to local communities.

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Agency Response:

Our audit report contains 12 findings and 14 corresponding recommendations. DOC's preliminary response indicates that the Facility agrees with all of the recommendations and has complied or will comply with them.

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A copy of the full report can be obtained by calling 517.334.8050 or by visiting our Web site at: <http://audgen.michigan.gov>



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THOMAS H. MCTAVISH, C.P.A.
AUDITOR GENERAL

September 21, 2012

Mr. Daniel H. Heyns, Director
Department of Corrections
Grandview Plaza Building
Lansing, Michigan

Dear Mr. Heyns:

This is our report on the performance audit of the Central Michigan Correctional Facility, Department of Corrections.

This report contains our report summary; description of agency; audit objective, scope, and methodology and agency responses and prior audit follow-up; comment, findings, recommendations, and agency preliminary responses; and a glossary of acronyms and terms.

The agency preliminary responses were taken from the agency's responses subsequent to our audit fieldwork. The *Michigan Compiled Laws* and administrative procedures require that the audited agency develop a plan to comply with the audit recommendations and submit it within 60 days after release of the audit report to the Office of Internal Audit Services, State Budget Office. Within 30 days of receipt, the Office of Internal Audit Services is required to review the plan and either accept the plan as final or contact the agency to take additional steps to finalize the plan.

We appreciate the courtesy and cooperation extended to us during this audit.

Sincerely,

A handwritten signature in black ink that reads "Thomas H. McTavish". The signature is written in a cursive style with a long horizontal line extending to the left.

Thomas H. McTavish, C.P.A.
Auditor General

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Description of Agency

The Department of Corrections' (DOC's) mission* is to create a safer Michigan through effective offender management and supervision in its facilities while holding offenders accountable and promoting their success. DOC's Correctional Facilities Administration is responsible for the operation of all correctional institutions.

The Central Michigan Correctional Facility is located in St. Louis, Michigan, on approximately 70 acres north of M-46 in Gratiot County. The Facility was formed when the Pine River Correctional Facility and Mid-Michigan Correctional Facility consolidated in October 2010 and is now the largest prison in Michigan, housing 2,564 secure level I* male prisoners.

The Facility has 16 separate housing units contained in 8 buildings. Prisoner housing units consist of 8-bed open bays, with 140 to 160 prisoners in each of the 16 units. In addition to the housing units, the Facility has buildings for administration/healthcare, food service, school, maintenance/warehouse, and prisoner services.

The Facility offers academic classes in adult basic education and general education development and vocational programs in the areas of business educational technology, horticulture, and building trades. The Facility also offers other programs, including prerelease preparation, psychological counseling, Thinking for a Change, Strategies for Thinking Productively, and substance abuse treatment. In addition, the Facility offers general and law library services, hobbycraft, religious services, vocational recreation programs, barbershop, and a variety of voluntary self-help programs.

The Facility's perimeter is surrounded by two 12-foot fences with rolls of razor-ribbon wire on the side and top of the exterior fence. In addition, the perimeter is monitored by an electronic detection system and is patrolled by armed personnel.

For fiscal year 2011-12, the Facility's General Fund appropriation was \$42.3 million to support 416.9 full-time equated positions. As of June 25, 2012, the Facility housed 2,542 prisoners, had the capacity to house 2,564 prisoners, had 398 employees supported by its appropriations, and had 74 employees supported by other DOC appropriations.

* See glossary at end of report for definition.

Audit Objective, Scope, and Methodology and Agency Responses and Prior Audit Follow-Up

Audit Objective

The objective of our performance audit* of the Central Michigan Correctional Facility, Department of Corrections (DOC), was to assess the effectiveness* of DOC's efforts to comply with selected policies and procedures related to safety and security at the Central Michigan Correctional Facility.

Audit Scope

Our audit scope was to examine the program and other records of the Central Michigan Correctional Facility. We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusion based on our audit objective. We believe that the evidence obtained provides a reasonable basis for our findings and conclusion based on our audit objective. Our audit procedures, conducted from April through June 2012, generally covered the period October 1, 2010 through May 31, 2012.

Audit Methodology

To establish our audit objective and to gain an understanding of the Facility's activities, we conducted a preliminary review of the Facility's operations. This included discussions with various staff regarding their functions and responsibilities; observations; and an examination of program records, policy directives, and Facility operating procedures. Also, we reviewed the warden's monthly reports to the DOC director, critical incident reports, self-audits*, and the Facility's most recent accreditation review.

To assess the effectiveness of DOC's efforts to comply with selected policies and procedures related to safety and security at the Facility, we reviewed procedures and examined records related to safety and security, including arsenal inventories and operations; gate manifests*; prisoner counts; radio checks; housekeeping sanitation; prisoner and employee shakedowns*; cell searches* and area searches*; preventive

* See glossary at end of report for definition.

maintenance; security monitoring exercises*; firearm certifications and weapons permits; and fire safety. In addition, we inventoried critical tools*, dangerous tools*, keys, and padlocks on a test basis.

When selecting activities or programs for audit, we use an approach based on assessment of risk and opportunity for improvement. Accordingly, we focus our audit efforts on activities or programs having the greatest probability for needing improvement as identified through a preliminary review. Our limited audit resources are used, by design, to identify where and how improvements can be made. Consequently, we prepare our performance audit reports on an exception basis. To the extent practical, we add balance to our audit reports by presenting noteworthy accomplishments for exemplary achievements identified during our audits.

Agency Responses and Prior Audit Follow-Up

Our audit report contains 12 findings and 14 corresponding recommendations. DOC's preliminary response indicates that the Facility agrees with all of the recommendations and has complied or will comply with them.

The agency preliminary response that follows each recommendation in our report was taken from the agency's written comments and oral discussion subsequent to our audit fieldwork. Section 18.1462 of the *Michigan Compiled Laws* and the State of Michigan Financial Management Guide (Part VII, Chapter 4, Section 100) require DOC to develop a plan to comply with the audit recommendations and to submit it within 60 days after release of the audit report to the Office of Internal Audit Services, State Budget Office. Within 30 days of receipt, the Office of Internal Audit Services is required to review the plan and either accept the plan as final or contact the agency to take additional steps to finalize the plan.

We released our prior performance audit of the Mid-Michigan Correctional Facility, Department of Corrections (47-276-98), in June 1999. Within the scope of this audit, we followed up 13 of the 14 prior audit recommendations. The Central Michigan Correctional Facility complied with 4 of the 13 prior audit recommendations. The other 9 recommendations were rewritten for inclusion in Findings 1, 2, 4, 6, 7, 9, and 12 of this audit report.

* See glossary at end of report for definition.

COMMENT, FINDINGS, RECOMMENDATIONS,
AND AGENCY PRELIMINARY RESPONSES

SAFETY AND SECURITY

COMMENT

Background: The Central Michigan Correctional Facility operates under policy directives and operating procedures established by the Department of Corrections (DOC) in addition to operating procedures developed by the Facility. These policy directives and operating procedures were designed to have a positive impact on the safety and security of the Facility as well as to help ensure that prisoners receive proper care and services. The policies and procedures address many aspects of the Facility's operations, including key, tool, and firearm security; prisoner, employee, visitor, and housing unit searches; gate manifests; prisoner counts; radio checks; security monitoring exercises; metal detector calibration; electronic perimeter tests; sanitation and food service inspections; preventive maintenance; and fire safety. Although compliance with these policies and procedures contributes to a safe and secure facility, the nature of the prison population and environment is unpredictable and inherently dangerous. Therefore, compliance with the policies and procedures will not entirely eliminate the safety and security risks.

Audit Objective: To assess the effectiveness of DOC's efforts to comply with selected policies and procedures related to safety and security at the Central Michigan Correctional Facility.

Audit Conclusion: **We concluded that DOC's efforts to comply with selected policies and procedures related to safety and security at the Central Michigan Correctional Facility were moderately effective.** Our assessment disclosed one material condition*. The Facility did not maintain proper control over dangerous tools, equipment, and other controlled inventory items* (Finding 1).

Our assessment also disclosed eleven reportable conditions* related to prisoner shakedowns and cell searches, employee shakedowns, key control, radio and personal protection device* (PPD) checks, gate manifests, preventive maintenance, the arsenal, sanitation inspections, fire safety, security monitoring exercises (SMEs), and criminal history checks (Findings 2 through 12).

* See glossary at end of report for definition.

Noteworthy Accomplishments: In 2011, the Facility was awarded the Michigan Plaque from Keep Michigan Beautiful, Inc. for its horticulture program. This organization annually recognizes programs that substantially contribute to environmental improvement, clean-up, beautification, site restoration, and historical preservation in Michigan. The Facility offers a horticulture program and indicated that it provided vegetables for the Facility's food service program and landscaping for the Facility as well as for the St. Louis Correctional Facility. The Facility indicated that the program also donated vegetables to food pantries, soup kitchens, and schools and donated flats of flowers and vegetable plants to local communities.

FINDING

1. Tool Control

The Facility did not maintain proper control over dangerous tools, equipment, and other controlled inventory items. As a result, the Facility could not locate or account for 58 dangerous tools, 36 equipment items, and 6 other controlled inventory items.

During our audit period, the Facility had 75 tool storage areas with approximately 7,500 tools. We reviewed monthly and weekly inventory reports for 15 tool storage areas for November 2010, August 2011, and May 2012. In addition, we reviewed the safeguarding of and controls over tool inventory within these 15 tool storage areas. Our review disclosed:

- a. The Facility disbanded one tool storage area in March 2011; however, it did not maintain records accounting for the disposition of all of the tools and other inventory.

DOC policy directive 04.04.120 requires that a tool turn-in report be completed whenever a tool is removed from its assigned tool storage area. Also, the Department of Technology, Management, and Budget Administrative Guide procedure 0340.05 requires that agencies examine inventories of surplus, salvage, scrap, and worthless property which is no longer required by the agency and submit it to the State Surplus Property Program.

We obtained the final tool area inventory list for the disbanded tool storage area. We determined that the tool storage area had not contained any critical

tools; however, it had contained 58 dangerous tools, including 1 hammer, 1 pair of scissors, 2 screwdrivers, 6 50-foot extension cords, and 36 equipment items that the Facility could not locate or account for.

We also obtained the master tool inventory list for the disbanded tool storage area. The master tool inventory list indicated that the tool storage area contained 2 additional 50-foot extension cords (dangerous tools) and 6 other controlled inventory items that the Facility could not locate or account for.

- b. The Facility did not document that it completed the required weekly and monthly tool inspections.

DOC policy directive 04.04.120 requires that the Facility inspect all tool storage areas to ensure that all tools are accounted for and in serviceable condition and forward the form to the appropriate work area supervisor at the end of each workweek. The policy directive also requires the Facility to conduct a monthly inspection of all tool storage areas.

For the 15 tool storage areas reviewed, we noted that the Facility did not document that it completed 88 (51.2%) of the 172 required weekly tool inspections and 29 (67.4%) of the 43 required monthly tool inspections.

- c. The Facility did not maintain accurate, up-to-date tool inventory listings.

DOC policy directive 04.04.120 requires that the Facility maintain an accurate typewritten or computer-generated tool inventory list posted in the applicable tool storage area and signed by the tool control officer and tool area manager. The policy directive also requires that the list be updated when a tool is initially assigned to or permanently removed from the tool storage area and be submitted to the tool control officer.

For the 15 tool storage areas reviewed, we noted that 11 (73.3%) tool storage areas had differences between the tools on hand and the master inventory list* maintained by the tool control officer. Also, 3 (20.0%) tool storage areas did not have an inventory list posted, and the inventory lists posted in 7 (46.7%)

* See glossary at end of report for definition.

tool storage areas did not agree with the master inventory list maintained by the tool control officer.

- d. The Facility did not always ensure that tools were properly secured, shadow-boarded, color-coded, and/or checked out.

DOC policy directive 04.04.120 requires that the Facility physically secure all tools against unauthorized access and that all tools be color-coded with paint prior to being placed in service unless the tool cannot be marked. The policy also requires that all tools be assigned a unique identification number and that a tool check-out system be used.

For the 15 tool storage areas reviewed, we noted that 6 (40.0%) tool storage areas had tools that were not appropriately secured, 7 (46.7%) tool storage areas had tools that were not properly shadow-boarded, 5 (33.3%) tool storage areas had tools that were not appropriately color-coded, and 10 (66.7%) tool storage areas had tools that were not properly checked out.

RECOMMENDATION

We recommend that the Facility maintain proper control over dangerous tools, equipment, and other controlled inventory items.

AGENCY PRELIMINARY RESPONSE

The Facility agrees with the recommendation and informed us that it has taken steps to comply. The Facility indicated that its operating procedure was revised to provide more detailed instructions regarding tool disposition and control in storage areas and that an inspector has been charged with tool control responsibilities and is educating staff while correcting deficiencies throughout the Facility. The Facility also indicated that the operations deputy performs random inspections and will submit findings with his monthly report to the warden and that the Facility post orders are being updated to reflect recent changes.

FINDING

2. Prisoner Shakedowns and Cell Searches

The Facility did not ensure that its officers performed and documented all required prisoner shakedowns and cell searches. As a result, the Facility was less likely to detect and confiscate contraband* that could compromise the safety and security of staff and prisoners.

DOC policy directive 04.04.110 requires each non-housing unit corrections officer who has direct prisoner contact to conduct pat-down searches* or clothed-body searches* of at least five randomly selected prisoners per shift. The policy directive also requires that on first and second shifts, each housing unit officer will conduct at least three randomly selected cell searches per shift and record them in the appropriate logbook.

We reviewed prisoner shakedown and cell search records for the periods February 20, 2011 through February 24, 2011; March 5, 2011 through March 9, 2011; and October 10, 2011 through October 14, 2011. Our review disclosed:

- a. The Facility did not have documentation that it completed 805 (49.1%) of the 1,640 required prisoner shakedowns.
- b. The Facility did not have documentation that it completed 246 (51.3%) of the 480 required cell searches.

RECOMMENDATION

We recommend that the Facility ensure that its officers perform and document all required prisoner shakedowns and cell searches.

AGENCY PRELIMINARY RESPONSE

The Facility agrees and informed us that it has complied. The Facility indicated that its operating procedures were revised to clarify staff responsibilities for documentation and retention. The Facility stated that its assistant that resident unit supervisors and sergeants inspect cell/shakedown logs daily and resident unit managers and captains monitor and submit supporting documentation at the end of each month to their respective deputy warden, who reviews for compliance and to ensure proper retention of documentation.

* See glossary at end of report for definition.

FINDING

3. Employee Shakedowns

The Facility did not ensure that it performed and documented all required employee shakedowns. Conducting employee shakedowns improves the likelihood of detecting and confiscating contraband and improves the safety and security of staff and prisoners. Documentation provides assurance that all required shakedowns were performed.

Facility operating procedure 04.04.110 requires that each shift perform daily random (periodic, unannounced) shakedowns of all employees entering and exiting the secured area. The procedure also requires that a minimum of five employees per shift be searched and that all employees be searched at least once per month.

We reviewed daily employee shakedown records for the periods October 10, 2011 through October 14, 2011 and February 1, 2012 through February 29, 2012. The Facility could not provide documentation that it had performed 470 (92.2%) of 510 required daily employee shakedowns.

We also reviewed monthly employee shakedown records for October 2011 and February 2012. Based on the documentation provided, the Facility did not perform 12 (10.9%) of 110 and 43 (50.6%) of 85 required employee shakedowns, respectively. In addition, the Facility could not provide any documentation that the other 318 and 384 employees were searched at least once during each of the respective months.

RECOMMENDATION

We recommend that the Facility ensure that it performs and documents all required employee shakedowns.

AGENCY PRELIMINARY RESPONSE

The Facility agrees and informed us that it has complied. The Facility indicated that written directives were provided to relevant staff and that its operating procedure has been revised. The Facility stated that shift commanders enter shakedowns daily and forward statistics to the operations deputy at the end of each

month. The Facility also stated that Facility inspectors conduct intermittent checks throughout the month and incorporate findings into the monthly report to the operations deputy, who takes corrective action as necessary and ensures that all records are retained as required.

FINDING

4. Key Control

The Facility needs to improve its controls over keys and padlocks. Proper controls would help ensure that all keys and padlocks are secured and accounted for and that any lost or missing keys and padlocks are detected and recovered in a timely manner, thereby helping to ensure the safety and security of staff and prisoners.

Our review of keys, padlocks, and the related controls as of May 2012 disclosed:

- a. The Facility did not designate high security keys with a unique identifier. Our review of two key rings that should have contained high security keys noted that none of keys were marked as high security. In addition, discussions with Facility personnel disclosed that the Facility has no keys marked as high security.

DOC policy directive 04.04.125 requires that Facility keys that control access to sensitive areas (e.g., human resource office, pharmacy and medication storage area, control center*, and bubble*); areas from which an escape could occur (e.g., tunnels, gates, and sallyports*); and areas where critical or dangerous tools or supplies are stored (e.g., arsenal, key box, and warehouse) shall be designated as "high security" and shall not be approved for use by prisoners.

- b. The Facility did not have an up-to-date inventory of keys. Our review of the master key inventory identified discrepancies with 6 (30.0%) of the 20 key rings selected. We noted that 5 key rings contained 4 to 8 additional keys and that the mug shot camera key ring was missing 1 key when compared to the master key inventory.

* See glossary at end of report for definition.

DOC policy directive 04.04.125 requires that the key control officer maintain an up-to-date inventory of all facility keys and padlocks, including a cross-reference index system identifying each security key identifier, the lock or location accessible by each key, and the key rings to which each key is assigned.

- c. The Facility did not have an up-to-date inventory of padlocks. Our review of the master key inventory identified discrepancies with 4 (40.0%) of the 10 padlocks selected. We noted 2 instances in which padlocks were in a location other than that identified on the master key inventory. We also noted that the maintenance gas cap and property room storage padlocks were missing.

DOC policy directive 04.04.125 requires that each padlock issued be inscribed with an identifier and that the location and identifier be included in the key inventory.

RECOMMENDATION

We recommend that the Facility improve its controls over keys and padlocks.

AGENCY PRELIMINARY RESPONSE

The Facility agrees and informed us that it has taken steps to comply. The Facility indicated that its operating procedure has been revised and that high security keys have been identified by the warden and are currently being stamped by the Facility locksmith. The Facility also indicated that an inspector has been assigned the task of converting the two different key systems, from the former Pine River Correctional Facility and Mid-Michigan Correctional Facility, into one functional process.

FINDING

5. Radio and PPD Checks

The Facility did not document that it conducted all required radio and PPD checks. Periodic contact with corrections officers ensures that radio and PPD equipment is in working order and helps to ensure the safety of the officers and prisoners.

Facility operating procedure 04.04.100Q requires the Facility to conduct and log status checks of radio equipment on an hourly basis during daylight hours and every 30 minutes during hours of darkness on single staff assignments. The procedure also requires that the base station test the 800 MHz radios by contacting another DOC facility or the Michigan Department of State Police at least once each shift and that the date and time of radio checks, along with the operator's name and title, be recorded in the appropriate logbook. In addition, Facility operating procedure 04.04.100J requires that staff carry a PPD when inside the secure perimeter of the Facility and that the shift commander test PPDs for all custody assignments at the beginning of each shift, with the test results for each PPD recorded on the Zone/PPD Check Test Sheet. PPDs help to ensure the safety of all volunteers and all staff who are not assigned a two-way radio.

Our review of radio and PPD checks for October 2011 disclosed:

- a. The Facility did not document that it conducted 359 (54.9%) of the 654 required radio checks.
- b. The Facility did not document that it conducted 59 (63.4%) of the 93 required 800 MHz radio checks.
- c. The Facility did not document that it conducted 338 (7.3%) of the 4,619 required PPD checks.

RECOMMENDATION

We recommend that the Facility document that it conducts all required radio and PPD checks.

AGENCY PRELIMINARY RESPONSE

The Facility agrees and informed us that it has complied. The Facility indicated that its operating procedure has been updated and that checklists outlining daily requirements are now utilized by bubble and control and communications center officers. The Facility stated that shift commanders and the operations deputy perform monthly security checks to ensure compliance and retention as appropriate.

FINDING

6. Gate Manifests

The Facility did not properly complete, reconcile, and maintain gate manifests. Failure to properly complete and reconcile gate manifests could result in critical and dangerous items being left inside the prison, thus endangering staff and prisoners. Maintaining gate manifests provides assurance that the Facility is properly monitoring and recording items entering and leaving the Facility.

Gate manifests serve as a tracking mechanism for items (tools, supplies, medications, etc.) entering and leaving the prison and are used to prevent the introduction of contraband and the theft of State property. DOC policy directive 04.04.100 requires facilities to maintain permanently bound and prenumbered logbooks. In addition, Facility operating procedure 04.04.100S requires that all gate manifests be reconciled; that the designated individual ensure that all sections of the gate manifest have been completed with dates, times, and proper signatures; that the appropriate copies of the gate manifests have been returned; and that tracking numbers match the number listed in the gate manifest log. The operating procedure also requires that all items brought through the gates shall be searched.

The Facility uses gate manifests at the east and west sallyports and the east and west front gates. We reviewed the completeness of gate manifest documentation for March 2011 and February 2012. Also, we reviewed the accuracy of 79 gate manifests prepared for the periods March 1, 2011 through March 8, 2011 and December 21, 2011 through December 27, 2011. We noted:

- a. The Facility did not maintain all gate manifest documentation. The Facility could not provide us with any gate manifests for the east front gate or the east sallyport for March 2011. The Facility was able to provide us with gate manifests for the west front gate and the west sallyport for March 2011 and for both front gates and both sallyports for February 2012. However, our review of these gate manifests noted that 15 (3.5%) of the 426 gate manifests were missing and 4 (0.9%) of the gate manifests were issued using duplicate numbers.

- b. The Facility did not properly document gate manifests. Our review noted that 48 (60.8%) of 79 gate manifests were not properly documented. Specifically, we noted:
- (1) Sixteen (43.2%) of the 37 gate manifests that indicated that the items would be left in the prison did not include documentation that the intended recipient had received the items.
 - (2) Thirty (71.4%) of the 42 gate manifests that indicated that the items would be leaving the prison were not marked by the gate officer verifying that the items actually left the prison.
 - (3) Two (2.5%) of the 79 gate manifests were not signed by the gate officer verifying that items entering the prison had been searched prior to entry.
 - (4) Three (3.8%) of the 79 gate manifests did not contain a description of the items that were entering the prison. Two of these gate manifests did not contain the required packing slip as indicated on the gate manifest, and the packing slip for the third manifest did not contain detail of the type and volume of medication being brought into the Facility.

RECOMMENDATION

We recommend that the Facility properly complete, reconcile, and maintain gate manifests.

AGENCY PRELIMINARY RESPONSE

The Facility agrees and informed us that it has complied. The Facility indicated that it assigned the responsibility for issuing all gate manifests to the east information desk officer for consistency and to provide for one sequential numbering process. Also, the Facility indicated that the 10:00 p.m. to 6:00 a.m. shift commander reconciles and accounts for all gate manifests daily and that deficiencies are submitted to the operations deputy for corrective action, follow-up, and retention as appropriate. In addition, the Facility indicated that its operating procedure was updated to reflect these changes.

FINDING

7. Preventive Maintenance

The Facility did not implement a comprehensive preventive maintenance plan. Also, the Facility did not complete preventive maintenance and other maintenance tasks in a timely manner. Timely maintenance minimizes unexpected mechanical and other maintenance interruptions that can compromise staff and prisoner safety.

A preventive maintenance plan is designed to ensure the most economical use of all equipment and the effective operation of all equipment during emergency situations. The completion of preventive and other maintenance tasks is necessary to ensure that system or equipment failure is minimized.

Our review of the Facility's preventive maintenance plan and preventive maintenance tasks during the period January 2012 through March 2012 disclosed:

- a. The Facility did not repair its alternative fuel system in a timely manner.

Facility operating procedure 04.03.100 requires the propane blending system to be evaluated yearly by a firm capable of performing installation and maintenance for proper system operation. A report of the evaluation shall be filed in the preventive maintenance annual report submitted to the Physical Plant Division, Bureau of Fiscal Management. Any deficiencies noted in the report shall be promptly corrected.

The propane blending system is a backup fuel system intended to be used in case of an emergency. The Facility informed us that the propane blending system was not operational since at least 2006. As of May 2012, the propane blending system was still not in operation; however, funds needed to repair the system were included in the Facility's fiscal year 2011-12 spending plan.

- b. The Facility did not complete all required preventive maintenance work orders within its established time frames.

We reviewed documentation of 54 preventive maintenance tasks required during the period January 2012 through March 2012. We noted that

17 (31.5%) tasks were not completed, including monthly preventative maintenance of the perimeter lights for 2 sequential months, 1 quarterly preventive maintenance of the exterior lights, and annual preventative maintenance of 5 health care equipment items. We also noted that 33 (61.1%) tasks were not completed by the due date listed on the work order. These 33 tasks were outstanding an average of 20 days past the due date, with two of the work orders taking over 60 days to complete.

- c. The Facility did not complete all required sanitation inspection work orders in a timely manner.

Our review of weekly sanitation inspections for January 2011, February 2011, November 2011, December 2011, and May 2012 for 6 Facility buildings noted that 2 sanitation inspection deficiencies were not corrected in a timely manner, including 1 deficiency that was repeated weekly for 6 months and 1 deficiency that was repeated weekly for 12 months. The Facility issued work orders to correct these items; however, timely follow-up is necessary to ensure that a safe and sanitary environment is maintained.

- d. The Facility did not complete and document the 2011 annual inspection of the Facility buildings.

Facility operating procedure 04.03.100 requires that an annual inspection be performed by the physical plant superintendent to identify needed repairs.

The Facility provided us with documentation of the 2010 inspections of the Pine River Correctional Facility and the Mid-Michigan Correctional Facility; however, it was unable to provide documentation that the 2011 inspection of the combined Central Michigan Correctional Facility had been performed.

RECOMMENDATIONS

We recommend that the Facility implement a comprehensive preventive maintenance plan.

We also recommend that the Facility complete preventive maintenance and other maintenance tasks in a timely manner.

AGENCY PRELIMINARY RESPONSE

The Facility agrees and informed us that it has taken steps to comply. The Facility indicated that it recently hired a physical plant supervisor who is revising the Facility's preventive maintenance plan and procedures to include all required tasks and inspections. The Facility also indicated that the warden holds monthly project meetings to monitor compliance with due dates and that the business manager conducts intermittent checks and reports findings in his monthly report to the warden. The Facility stated that the problems cited with the alternative fuel system were repaired in June 2012.

FINDING

8. Arsenal

The Facility did not always properly document the issuance and return of weapons from its arsenal. Properly authorizing weapon distribution and receipting the weapons being returned ensure that weapons leaving the arsenal are accounted for at all times.

Facility operating procedure 04.04.100G requires that the weapon authorization form be completed for any arsenal equipment issued.

We reviewed 165 weapon authorization records issued during the periods April 24, 2011 through April 30, 2011; May 8, 2011 through May 14, 2011; June 26, 2011 through July 2, 2011; and March 25, 2012 through March 31, 2012. We noted that 16 (9.7%) records were incomplete. Specifically, 1 record did not document authorization for the removal of the weapon from the arsenal, 8 records did not document that the weapons were returned to the arsenal, 1 record did not document the time that the weapon was removed from the arsenal, and 7 records did not document the time that the weapons were returned to the arsenal. Although we did not identify any weapons missing from the arsenal, the Facility should improve its controls over the issuance and return of weapons from its arsenal.

RECOMMENDATION

We recommend that the Facility properly document the issuance and return of weapons from its arsenal.

AGENCY PRELIMINARY RESPONSE

The Facility agrees and informed us that it has complied. The Facility indicated that its shift commanders are responsible for ensuring that the issuance and return of weapons is documented as required. The Facility also indicated that directives were posted in the arsenal and incorporated into relevant post orders and that affected staff have been trained and advised of these requirements at monthly staff meetings. In addition, the Facility indicated that the arsenal sergeant performs daily inspections and reports any deficiencies to the operations deputy.

FINDING

9. Sanitation Inspections

The Facility did not complete all required monthly sanitation inspections. Regular formalized inspections of Facility buildings and grounds are essential to ensure proper sanitation and housekeeping practices and to maintain a safe environment for staff and prisoners.

DOC policy directive 04.03.102 requires that weekly and monthly sanitation inspections be conducted in all Facility areas by staff who have received appropriate training in and are familiar with sanitation and housekeeping requirements. The policy directive also requires that the results of each inspection be documented in writing and include all deficiencies found during the inspection, corrective action taken, and recommendations for corrective action.

We reviewed monthly sanitation inspections for the period August 2011 through January 2012 for five Facility buildings. Our review disclosed that the Facility did not complete any of the six monthly inspections for the administration/healthcare building. Also, the Facility informed us that, as of May 2012, no monthly inspections of this building had been completed.

RECOMMENDATION

We recommend that the Facility complete all required monthly sanitation inspections.

AGENCY PRELIMINARY RESPONSE

The Facility agrees and informed us that it has complied. The Facility indicated that it has revised its operating procedure to provide more detailed instructions for completion, corrective action, and retention of sanitation inspections and that staff training was conducted and the proper departmental forms are now being utilized. Also, the Facility indicated that the resident unit managers conduct monthly inspections and submit findings to the deputy wardens and warden and that relevant issues are addressed at the warden's monthly executive staff meeting as needed.

FINDING

10. Fire Safety

The Facility did not document that it completed all required weekly fire safety inspections. Also, the Facility did not always propose corrective action plans or ensure that timely corrective action was taken on deficiencies noted in its monthly and annual fire safety inspections.

The completion and proper documentation of all required fire safety inspections and required follow-up would assist the Facility in identifying and correcting fire safety deficiencies to reduce the potential for loss of life, personal injury, or property damage that may result from fires, explosions, and related incidents.

Facility operating procedure 04.03.120C requires that weekly fire safety inspections of all areas of the Facility be conducted by a staff person assigned to the specific area. The procedure also requires that a plan of correction and an acceptable completion date be developed for all fire safety inspection deficiencies.

We reviewed the Facility's fire safety operations and processes; 100 (26.0%) of the 384 required weekly fire safety reports completed during August 2011, November 2011, and May 2012; and the 7 required monthly fire safety inspection reports from August 2011 through February 2012. Our review disclosed:

- a. The Facility did not document that it completed 9 (9.0%) of the 100 weekly fire safety inspections.

- b. The Facility did not propose corrective action plans for 2 (28.6%) of the 7 monthly fire safety inspections. All 7 required corrective action. These 2 inspections identified deficiencies related to missing fire dampers*.
- c. The Facility did not ensure that fire safety inspection deficiencies were corrected in a timely manner. We noted repeat deficiencies identified on all 7 of the monthly fire safety inspection reports reviewed, including 1 deficiency that was outstanding for all 5 subsequent inspections and 2 deficiencies that were outstanding for 4 subsequent inspections. In addition, we noted 4 deficiencies that were identified in the 2011 annual fire safety inspection that had also been identified in the 2010 annual fire safety inspection.

RECOMMENDATIONS

We recommend that the Facility document that it completes all required weekly fire safety inspections.

We also recommend that the Facility propose corrective action plans and ensure that timely corrective action is taken on deficiencies noted in its monthly and annual fire safety inspections.

AGENCY PRELIMINARY RESPONSE

The Facility agrees and informed us that it has taken steps to comply. The Facility indicated that staff training has been provided. The Facility also indicated that revised operating procedures providing detailed staff responsibilities, steps for corrective action, directives on repeat deficiencies, and retention requirements were submitted to the regional fire safety inspector for approval. In addition, the Facility indicated that findings are addressed at the warden's monthly executive staff meetings as needed.

FINDING

11. Security Monitoring Exercises (SMEs)

The Facility did not complete all required SMEs. Performing the required SMEs helps ensure that custody staff are adequately trained in critical security measures.

* See glossary at end of report for definition.

SMEs are developed to test the effectiveness of established procedures and the alertness of staff by simulating the condition, behavior, or emergency that the procedures were designed to prevent or control. Facility operating procedure 04.04.100D requires SMEs to be conducted as designated by the shift supervisor. For the period June 2011 through March 2012, the shift supervisor designated 510 SMEs to be conducted.

Our review of the SME tracking sheet for that period disclosed that the Facility did not complete 57 (11.2%) of the 510 required SMEs.

RECOMMENDATION

We recommend that the Facility complete all required SMEs.

AGENCY PRELIMINARY RESPONSE

The Facility agrees and informed us that it has complied. The Facility indicated that it revised its SME requirements in February 2012 and that records reflect 100% compliance since that time.

FINDING

12. Criminal History Checks

The Facility did not maintain documentation that it conducted annual criminal history checks for officers whose assignments required the use of a firearm. As a result, the Facility could not verify that it assigned only eligible officers to assignments requiring the use of a firearm.

DOC policy directive 03.03.100 prohibits employees from being issued or allowed to possess a firearm if they have been convicted of a misdemeanor crime of domestic violence or, in certain circumstances, a felony. The policy directive also requires officers to be qualified, and annually requalified, in the use of firearms before being issued firearms. In addition, Facility operating procedure 01.04.135 requires that criminal history background checks be conducted using the Law Enforcement Information Network* (LEIN) prior to an officer's firearm qualification or requalification.

* See glossary at end of report for definition.

Our review of the Facility's criminal history check procedures disclosed that the Facility documented LEIN checks for 2012; however, it could not provide documentation of LEIN checks for 2011.

RECOMMENDATION

We recommend that the Facility maintain documentation that it conducts annual criminal history checks for officers whose assignments require the use of a firearm.

AGENCY PRELIMINARY RESPONSE

The Facility agrees and informed us that it has complied. The Facility stated that, while there was a system in place, some records could not be located for the audit period. The Facility indicated that record retention requirements have been addressed with appropriate staff.

GLOSSARY

Glossary of Acronyms and Terms

area search	The act of searching common areas of the prison for contraband.
bubble	Central point of entry into and exit from a facility.
cell search	The act of going through a prisoner's cell and belongings looking for contraband.
clothed-body search	A thorough manual and visual inspection of all body surfaces, hair, clothing, wigs, briefcases, prostheses, and similar items and visual inspection of the mouth, ears, and nasal cavity. The only clothing items that may be required to be removed are outerwear (e.g., coats, jackets, and hats), shoes, and socks; however, all items should be removed from pockets.
contraband	Property that is not allowed on facility grounds or in visiting rooms by State law, rule, or DOC policy. For prisoners, this includes any property that they are not specifically authorized to possess, authorized property in excessive amounts, or authorized property that has been altered without permission.
control center	Central area of communication for a facility. The control center has contact with all officers by radio and loudspeaker.
controlled inventory item	An item that, although not a tool, needs to be strictly controlled by staff to guard against unauthorized access by prisoners.
critical tool	An item designated specifically for use by employees only or for use or handling by prisoners while under direct employee supervision. Critical tools are to be stored only in a secure area and accounted for at all times.

dangerous tool	An item that may be used or handled by prisoners while under indirect employee supervision. Dangerous tools are to be stored only in a secure area and accounted for at all times.
DOC	Department of Corrections.
effectiveness	Success in achieving mission and goals.
fire damper	A device that ensures fire does not spread through ductwork.
gate manifest	A record used to control materials and supplies entering and leaving a facility through the front gate and sallyport.
Law Enforcement Information Network (LEIN)	A computerized criminal justice database that includes a person's criminal history, including arrests, convictions, and driving record. It is maintained by the Michigan Department of State Police and interfaces with the Federal Bureau of Investigation's (FBI's) National Crime Information Center.
master inventory list	Tool inventory maintained by the tool control officer.
material condition	A reportable condition that could impair the ability of management to operate a program in an effective and efficient manner and/or could adversely affect the judgment of an interested party concerning the effectiveness and efficiency of the program.
mission	The main purpose of a program or an entity or the reason that the program or the entity was established.
pat-down search	A brief manual and visual inspection of body surfaces, clothing, briefcases, and similar items. The only clothing items that may be required to be removed are outerwear (e.g., coats, jackets, and hats) and shoes; however, all items shall be removed from pockets.

performance audit	An audit that provides findings or conclusions based on an evaluation of sufficient, appropriate evidence against criteria. Performance audits provide objective analysis to assist management and those charged with governance and oversight in using the information to improve program performance and operations, reduce costs, facilitate decision making by parties with responsibility to oversee or initiate corrective action, and contribute to public accountability.
personal protection device (PPD)	A one-way device that can signal the need for assistance when an individual is in a confrontational position. The device submits a signal to the control center indicating the area where assistance is needed.
reportable condition	A matter that, in the auditor's judgment, is less severe than a material condition and falls within any of the following categories: an opportunity for improvement within the context of the audit objectives; a deficiency in internal control that is significant within the context of the audit objectives; all instances of fraud; illegal acts unless they are inconsequential within the context of the audit objectives; significant violations of provisions of contracts or grant agreements; and significant abuse that has occurred or is likely to have occurred.
sallyport	A controlled, secure gate by which vehicles can enter the facility grounds through the perimeter fencing.
secure level I	A security classification assigned to a facility or a prisoner. The facilities house prisoners who have shown good institutional adjustment and behavior. These facilities have electronic detection systems, double fences, concertina wire, and an armed perimeter security vehicle patrolling the perimeter of the institution.

security monitoring
exercise (SME)

A systematic method of safely and effectively testing and monitoring security standards of a facility to enable staff to have an opportunity to practice the standards under controlled conditions.

self-audit

An audit performed by facility staff that enables management and staff to ensure that an operational unit complies with policy directives and takes proactive steps to correct any noncompliance. Performing self-audits is intended to maximize safe and efficient operations by DOC.

shakedown

The act of searching a prisoner, an employee, or a visitor to ensure that he/she does not have any contraband in his/her possession.

