

## Prison Rape Elimination Act (PREA) Audit Report Community Confinement Facilities

Interim       Final

**Date of Report**    November 20, 2017

### Auditor Information

|   |   |
|---|---|
| <b>Name:</b> Robert Lanier                                  | <b>Email:</b> rob@diversifiedcorrectionalservices.com |
| <b>Company Name:</b> Diversified Correctional Services, LLC |   |
| <b>Mailing Address:</b> P.O. Box 452                        | <b>City, State, Zip:</b> Blackshear, GA 31516         |
| <b>Telephone:</b> 912-281-1525                              | <b>Date of Facility Visit:</b> September 25-26, 2017  |

### Agency Information

|   |                                   |  |  |
|---|-----------------------------------|--|--|
| <b>Name of Agency:</b><br>Project MORE, Inc.  |                                   | <b>Governing Authority or Parent Agency (If Applicable):</b><br>Project MORE, Inc.                                   |  |
| <b>Physical Address:</b> 830 Grande Avenue  |                                   | <b>City, State, Zip:</b> New Haven, CT 06511   |  |
| <b>Mailing Address:</b> Same as above   |                                   | <b>City, State, Zip:</b> Same as above   |  |
| <b>Telephone:</b> 203-865-5700  |                                   | <b>Is Agency accredited by any organization?</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
| <b>The Agency Is:</b>   | <input type="checkbox"/> Military | <input type="checkbox"/> Private for Profit  | <input checked="" type="checkbox"/> Private not for Profit |
| <input type="checkbox"/> Municipal  | <input type="checkbox"/> County   | <input type="checkbox"/> State   | <input type="checkbox"/> Federal                           |
| <b>Agency mission:</b> To provide structured process to reintegrate offenders into the community. |                                   |  |  |
| <b>Agency Website with PREA Information:</b> projectmore.org                                      |                                   |  |  |

### Agency Chief Executive Officer

|  |                                |
|--|--------------------------------|
| <b>Name:</b> Dennis W. Daniels               | <b>President/CEO</b>           |
| <b>Email:</b> dennis.daniels@projectmore.org | <b>Telephone:</b> 203-848-3111 |

### Agency-Wide PREA Coordinator

|   |                                      |
|---|--------------------------------------|
| <b>Name:</b> John Massari                 | <b>Title:</b> Residential Specialist |
| <b>Email:</b> joh.massari@projectmore.org | <b>Telephone:</b> 203-848-3118       |

|   |   |
|---|---|
| <b>PREA Coordinator Reports to:</b><br>Vice President Morris Moreland | <b>Number of Compliance Managers who report to the PREA Coordinator</b> Three |
|---|---|

**Facility Information**

**Name of Facility:**      Walter Brooks House

**Physical Address:**      690 Howard Avenue, New Haven, CT 00519

**Mailing Address (if different than above):**      Click or tap here to enter text.

**Telephone Number:**      203-777-8627

|                         |                                   |   |  |
|-------------------------|-----------------------------------|---|--|
| <b>The Facility Is:</b> | <input type="checkbox"/> Military | <input type="checkbox"/> Private for Profit | <input checked="" type="checkbox"/> Private not for Profit |
|-------------------------|-----------------------------------|---|--|

|                                    |                                 |                                |                                  |
|------------------------------------|---------------------------------|--------------------------------|----------------------------------|
| <input type="checkbox"/> Municipal | <input type="checkbox"/> County | <input type="checkbox"/> State | <input type="checkbox"/> Federal |
|------------------------------------|---------------------------------|--------------------------------|----------------------------------|

|                       |   |  |   |
|-----------------------|---|--|---|
| <b>Facility Type:</b> | <input type="checkbox"/> Community treatment center                       | <input type="checkbox"/> Halfway house                         | <input type="checkbox"/> Restitution center |
|                       | <input type="checkbox"/> Mental health facility                           | <input type="checkbox"/> Alcohol or drug rehabilitation center |   |
|                       | <input checked="" type="checkbox"/> Other community correctional facility |  |   |

**Facility Mission:**      To provide a structured process to reintegrate clients into the community. Goals are to have residents employed, have savings, an appropriate place to reside and remain drug and alcohol free.

**Facility Website with PREA Information:**      projectmore.org

**Have there been any internal or external audits of and/or accreditations by any other organization?**       Yes       No

**Director**

|                            |                        |
|----------------------------|------------------------|
| <b>Name:</b> Redell Thomas | <b>Title:</b> Director |
|----------------------------|------------------------|

|   |                                |
|---|--------------------------------|
| <b>Email:</b> redell.thomas@projectmore.org | <b>Telephone:</b> 203-996-7297 |
|---|--------------------------------|

**Facility PREA Compliance Manager**

|                            |                        |
|----------------------------|------------------------|
| <b>Name:</b> Redell Thomas | <b>Title:</b> Director |
|----------------------------|------------------------|

|                             |                                 |
|-----------------------------|---------------------------------|
| <b>Email:</b> same as above | <b>Telephone:</b> same as above |
|-----------------------------|---------------------------------|

**Facility Health Service Administrator**

|   |                   |
|---|-------------------|
| <b>Name:</b> N/A Program does not have health care staff on site. | <b>Title:</b> N/A |
|---|-------------------|

|                   |                       |
|-------------------|-----------------------|
| <b>Email:</b> N/A | <b>Telephone:</b> N/A |
|-------------------|-----------------------|

| <b>Facility Characteristics</b>   |  |   |   |
|---|--|---|---|
| <b>Designated Facility Capacity:</b> 67   |  | <b>Current Population of Facility:</b> 65                                       |   |
| <b>Number of residents admitted to facility during the past 12 months</b>   |  |   | 181   |
| <b>Number of residents admitted to facility during the past 12 months who were transferred from a different community confinement facility:</b>   |  |   | 0   |
| <b>Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 30 days or more:</b>   |  |   | 172   |
| <b>Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 72 hours or more:</b>  |  |   | 178   |
| <b>Number of residents on date of audit who were admitted to facility prior to August 20, 2012:</b>   |  |   | 0   |
| <b>Age Range of Population:</b>   | <input checked="" type="checkbox"/> Adults | <input type="checkbox"/> Juveniles  | <input type="checkbox"/> Youthful residents |
|   | 18 years and older, male only              | N/A   | N/A   |
| <b>Average length of stay or time under supervision:</b>  |  |   | 6 months                                    |
| <b>Facility Security Level:</b>   |  |   | Minimum                                     |
| <b>Resident Custody Levels:</b>   |  |   | Unknown                                     |
| <b>Number of staff currently employed by the facility who may have contact with residents:</b>  |  |   | 32  |
| <b>Number of staff hired by the facility during the past 12 months who may have contact with residents:</b>   |  |   | 9   |
| <b>Number of contracts in the past 12 months for services with contractors who may have contact with residents:</b>   |  |   | 0   |
| <b>Physical Plant</b>   |  |   |   |
| <b>Number of Buildings:</b> 2   |  | <b>Number of Single Cell Housing Units:</b> 0                                   |   |
| <b>Number of Multiple Occupancy Cell Housing Units:</b>   |  | 14  |   |
| <b>Number of Open Bay/Dorm Housing Units:</b>   |  | 0   |   |
| <b>Description of any video or electronic monitoring technology (including any relevant information about where cameras are placed, where the control room is, retention of video, etc.):</b> |  |   |   |
| Thirty (30) cameras placed strategically throughout the house; MORSE Watchman documents security rounds.  |  |   |   |
| <b>Medical</b>  |  |   |   |
| <b>Type of Medical Facility:</b>  |  | No medical facilities on site; no medical staff, Healthcare is community based. |   |
| <b>Forensic sexual assault medical exams are conducted at:</b>  |  | Yale New Haven Hospital   |   |
| <b>Other</b>  |  |   |   |

|  |          |
|--|----------|
| <b>Number of volunteers and individual contractors, who may have contact with residents, currently authorized to enter the facility:</b> | <b>5</b> |
| <b>Number of investigators the agency currently employs to investigate allegations of sexual abuse:</b>                                  | <b>3</b> |

# Audit Findings

## Audit Narrative

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

The PREA Audit of Project MORE, Inc., Walter Brooks House, was a comprehensive process beginning with communications via email with the Agency's PREA Coordinator starting months prior to the on-site audit. These communications included both phone calls and emails. The Notice of PREA Audit, to be conducted on September 25-26, 2017, was forwarded for posting in areas accessible to staff, residents, contractors, volunteers, and interns. Confirmation of posting was provided. The auditor did not receive any communication as a result of posting the Notice of PREA Audit. During the onsite PREA Audit, Notices of PREA Audit were observed posted in multiple locations throughout the facility, accessible to staff, residents, contractors, visitors and volunteers. Communications continued and the Pre-Audit Questionnaire and "flash drive" were provided thirty days prior to the on-site audit. The auditor began the review of the "flash drive" that contained agency policies and procedures. The "flash drive" did not contain any documentation to confirm practice but was replete with policies and procedures. The auditor listed the documentation required for the on-site audit and the PREA Coordinator, who was always responsive to any request, assured the auditor the information would be available. He indicated that the facility maintains all the PREA Standard Files and the documentation to confirm practice was located in those files so copying the auditor specified sample numbers would not be a problem. The auditor printed out each of the policies for review. The provided information gave the auditor a good understanding of the operation of this community confinement program.

Based on the size, capacity and complexity of the Walter Brooks House the auditor determined the audit would require at least 16 hours. The rated capacity of the facility is 67 residents and the logistics for getting them to interviews is simple. Staffing in this program is minimal and determined, in part, by the contract with the Department of Correction. The program is located in a large renovated house in a residential area of New Haven. Touring the facility would require minimal time because of the size of the house and the fact that living quarters are all under one roof in a residential home. The program is not complex and there are no medical staff or mental health staff assigned to this program. These services are provided in the community. The program's role is to prepare residents for reintegration back into the community following incarceration.

To ensure time was used wisely, the PREA Coordinator and the Auditor developed an agenda to guide the audit process. The PREA Coordinator is a knowledgeable PREA Coordinator. A former Program Director for Walter Brooks House, he was invaluable in informing the auditor about the operations of this facility. Interviews later with staff from Walter Brooks and two additional programs operated by Project MORE indicated that the PREA Coordinator is the "go to" person related to all PREA matters and because of his experience in operating these programs he is called for a host of other issues related to community confinement operations.

The auditor provided the program, prior to the on-site audit, a list of documents the auditor would need to review. The list was extensive. The auditor needed additional samples to support the practices and to demonstrate that the practices had been institutionalized. The PREA Coordinator related again that the documentation was located in individual PREA Standard Files and copies could be made.

Reviewed documents included multiple policies and procedures, training rosters for all staff, staff training topics and manual, PREA Acknowledgments for staff, rosters identifying background check dates for all employees, investigation files, examples of victimization screenings and reassessments, rosters documenting all resident training on PREA, Resident Handbook, multiple resident population reports and staffing reports, staffing plans, sexual assault checklists, MOU with the local advocacy organization, NIC training certificates, and other documentation.

The auditor conducted a complete tour of the facility going into every area. The program is equipped with 30 video cameras located strategically throughout the house. The Program Director indicated he added 6-8 cameras since the last PREA Audit. Cameras generally covered the long halls enabling the security office to see who is coming and going on each floor. Additional locations of cameras will not be discussed for security reasons. Cameras generally cover storage room doors that were locked. During the tour all doors that were required to be locked were locked and secured. The PREA Coordinator indicated that Directors review video footage at random. The Agency Vice President explained to the auditor that he can view all video cameras from remote locations and via his phone. He indicated he often watches the cameras from home. During a complete tour of the entire facility the auditor observed that in each room there is a toilet and a shower. The toilets and showers are separated from each other and each has a door. The showers have doors and full-length shower curtains affording the maximum privacy while showering and using the restroom. Bedrooms were multiple occupancy. There were no cameras in the bedrooms or restrooms/showers. The facility uses the MORSE Watchman Tour System to document security rounds. Station strips are located in each room and must be swiped or scanned to record the station and time the staff person made the check at that station.

Multiple PREA posters were observed prominently displayed throughout the house. These included notices of the zero-tolerance policy and how to report. Included were the numbers to the DOC PREA Hotline and the CT State Police.

Sixteen (16) residents, randomly selected from an alpha roster of residents in the facility, were interviewed. The facility provided the auditor a written document asserting that as a result of the intake screening and assessment, Walter Brooks House did not have any limited English proficient residents, residents who identified as being gay, bisexual or transgender, any residents who reported sexual abuse or sexual harassment in this facility or previously, and none who were identified as cognitively challenged. The auditor interviewed residents from each floor of the house. The sample included residents who were employed in the community as well as those who had not yet located employment.

A total of twenty-one (24) staff were interviewed. These included ten (14) random staff, and ten (10) special category staff. These included: Two (2) staff performing admissions; one (1) staff

performing orientation and victimization screening, the Agency Director's Designee, PREA Coordinator, Program Director, an Investigator, Agency Human Resources Staff, one (1) upper-level management staff, and an intern. Multiple calls were place to the Sexual Assault Resource Center/Woman and Family Center and messages left.

Following the onsite audit, the auditor made numerous requests to the PREA Coordinator for additional information. These requests are documented in multiple emails back and two. The PREA Coordinator was very responsive to any requests and responded expeditiously. During the onsite audit, the auditor reviewed previously requested documents and asked for copies to take with him to have documentation if the PRC ever needed to audit his process to see how he arrived at his assessment for each standard

## Facility Characteristics

*The auditor's description of the audited facility should include details about the facility type, demographics and size of the inmate, resident or detainee population, numbers and type of staff positions, configuration and layout of the facility, numbers of housing units, description of housing units including any special housing units, a description of programs and services, including food service and recreation. The auditor should describe how these details are relevant to PREA implementation and compliance.*

The Walter Brooks House began operations on July 5, 1995. At that time the facility had 16 beds. The present site began operations in August 2004. At that time the facility expanded to 67 beds. These beds are funded by the Connecticut Department of Correction. In June 2016 we received permission from CT DOC to add two federally funded beds. Currently, the facility can house 69 residents at full capacity.

The program consists of two buildings. The one- story building houses our commercial kitchen and our dining area. There are sufficient freezers and refrigerators on site. The kitchen staff prepares three meals daily for the residents. The dining area has a big screen TV. During the day it is tuned to CNN news. It is also utilized, in the evening, for sporting events, unless there is a group. The basement is where our paper goods are stored.

The facility is handicap accessible.

The three -story building consists of the following:

- First Floor- Staff offices, common area where residents are searched upon entry to the facility. There is a day room that has a pool table, chess and checkers tables. There are also two residential rooms. One is a three- bed handicap room and has a handicap bathroom. The second room holds six residents, two of which are Federal residents. There is also a bathroom and shower in the day room.
- The second and third floors each have six apartments with five residents each. All rooms in the facility has a bathroom with shower.
- The basement has the industrial washers and driers along with a universal weight machine and free weights.

The facility is a work release program. Residents, if able, are expected to become employed. There is a person on staff whose responsibility is to assist them in gaining employment. It is Walter Brooks' Goal that when a resident is discharged from the facility he is employed, has savings, has an appropriate place to reside and have remained drug and alcohol free. Residents who discharge to Parole in the greater New Haven area will participate, with the authorization from the Department of Parole New Haven office.



The average stay for a resident is between four to six months. There are some that will stay less, and others will remain on site for more.

Staffing at Walter Brooks consists of the following:

- Residential Director – works Monday – Friday, however he is on call 24 hours per day, seven days per week. Director Thomas has over 20 years of residential experience.
- Case Managers: three full time, with a case manager supervisor, and a part time (20 hours per week) second shift case manager.
- On site Employment Specialist who works Monday-Friday, however, he is expected to work additional hours if required.
- On site Full Time Residential Monitor works Monday-Friday on First Shift.
- There are four kitchen staff. The Kitchen Manager owned his own restaurant at one time and supervises a staff of three-part time cooks.
- The Assistant Director supervises the second shift. His shift has between four to five -part time Residential Monitors. Some staff have over 10 years of experience at the facility.
- There is a part time (10 hours per week) Substance Abuse Counselor and part time (5 hours per week) Thinking for a Change group facilitator.
- Third shift has a Full Time Shift Supervisor and two- part time Residential Monitors.
- Each week end shift has a three- person crew. Each shift has a Supervisor and two- part time staff.
- Full Time staff will work 40 hours per week, part time staff, depending on their schedule, will usually work 16 hours per week.

The Walter Brooks House is the largest halfway house in Connecticut. It has been in operation since July 1995. Residents who are employed are required to save a majority of their salary. It is not unusual for the facility residents to save more than \$200,000 per year. There have been residents who have discharged with over \$10,000 in savings.

Residents in this facility may have cell phones that they use to communicate with potential and actual employees, families and anyone else they choose to communicate with. Too, residents may go on passes into the community where they search for employment and go to scheduled appointments. Residents have such access to the community they can make reports of sexual abuse or sexual harassment anytime either via phone or in person. Visitation is allowed and again, residents are permitted to maintain contact with visitors on their approved visitors list.

This facility affords residents privacy while using the restroom and showering. Each bedroom has its single occupancy shower and single occupancy restroom behind closed doors and showers with curtains.

Staff make periodic rounds as required. These are security type rounds and the MORSE Watchman is used to document and verify the rounds were made. Stations to be swiped while making the rounds are in each bedroom. These rounds serve also as a deterrent to sexual activity. Cameras throughout the facility are monitored in the security office and may be viewed remotely by the Vice President of the company.

## Summary of Audit Findings

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

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

**Number of Standards Exceeded:** 0

Click or tap here to enter text.

**Number of Standards Met:** 42

All of the standards were rated “Met”, these included: 115.211, 115.212, 115.213, 115.215, 115.216, 115.217, 115.218, 115.221, 115.222, 115.231, 115.232, 115.233, 115.234, 115.235, 115.241, 115.242, 115.243, 115.251, 115.252, 115.253, 115.254, 115.261, 115.262, 115.263, 115.264, 115.265, 115.266, 115.267, 115.271, 115.272, 115.273, 115.276, 115.277, 115.278, 115.282, 115.283, 115.286, 115.287, 115.288, 115.289, 115.401, 115.405

**Number of Standards Not Met:** 0

Click or tap here to enter text.

## Summary of Corrective Action (if any)

**115.213 Supervision and Monitoring:** Staff conduct rounds every two hours and use the Morse Watchman System in which the staff scan strips that are located in the resident rooms. The PREA Coordinator documented unannounced PREA rounds however review of the agency’s policy required the program manager and/or designee to conduct the rounds a twice a month. The President and Vice President have access to viewing the cameras via their laptops or their telephones. An informal interview with the Vice President indicated he views the cameras from home often.

Unannounced rounds were documented by the PREA Coordinator and multiple rounds were documented and provided. The program manager, while verbally indicating they made unannounced rounds, did not have documentation to confirm it. The auditor asked for documentation that the program managers were conducting their rounds in compliance with policy. That information was provided expeditiously and within 45 days prior to the final report.

**115.217 Hiring and Promotion Decisions:** The administration was conducting reference checks and documenting them and, in a sense, were making their best efforts to contact all prior employers regarding an applicant's work history however the questions did not address any information on substantiated allegations of sexual abuse or any resignations during a pending investigation into an alleged sexual abuse, consistent with Federal, State and Local Laws. The PREA Coordinator in a corrective action, consulted with Human Resources and has implemented a questionnaire that specifically asks the former employers the PREA questions for previous employers. The facility later provided documentation that the form has been implemented.

**115.253 Resident Access to Outside Confidential Support Services:** Interviews with residents indicated they were not aware of the outside advocacy organization. On October 17, 2017, the PREA Coordinator forwarded training rosters with signatures of residents indicating they have re-trained the residents in the role of the program and how to access it. That information was provided to residents upon admission and is posted throughout the facility however residents, when asked, could not identify any such agency nor the services they would provide, beyond that it would probably involve some counseling.

## PREVENTION PLANNING

### Standard 115.211: Zero tolerance of sexual abuse and sexual harassment; PREA coordinator

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

#### 115.211 (a)

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

#### 115.211 (b)

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

Yes  No

### Auditor Overall Compliance Determination

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

### Instructions for Overall Compliance Determination Narrative

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

Project Moore Policy III, Prison Rape Elimination Act (PREA) Compliance Policies mandates a zero tolerance toward all forms of sexual abuse and sexual harassment.

Zero tolerance is reaffirmed in the Walter Brooks House, Standard 115.211 Prevention Planning, Zero Tolerance. This asserts the Walter Brooks House has a zero-tolerance policy for all forms of resident on resident and staff on resident sexual abuse or sexual harassment. Project MORE Policy 111, Prison Rape Elimination Act Compliance Policies, mandates a zero tolerance toward all forms of sexual abuse and sexual harassment. It also affirms the procedures contained in the policies outline the agency's approach to preventing, detecting, and responding to such conduct beginning with the policy statement followed by the PREA related definitions of prohibited behaviors regarding sexual abuse and sexual harassment. The cumulative policies and procedures include the agency's efforts and plan to reduce and prevent sexual abuse and sexual harassment. Agency policy requires that staff are subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies and that termination is the presumptive disciplinary sanction for staff who has engaged in sexual abuse. Penalties and sanctions for contractors, volunteers and interns includes prohibiting contact with residents and that they will be reported to law enforcement unless the activity was clearly not criminal, and to relevant licensing bodies. The resident handbook provides that residents guilty of violating the Walter Brooks House or Project MORE zero tolerance policies will be subject to appropriate disciplinary action and/or referred to law enforcement for criminal investigation.

The reviewed Project MORE Training Manual, provided to all staff, affirms, among other items, resident's right to be free from sexual abuse and sexual harassment and staff and resident's rights to be free from retaliation for reporting sexual abuse or sexual harassment.

The resident handbook, given to each resident upon admission into the program, informs residents that Walter Brooks House has a zero-tolerance policy for all forms of sexual abuse and sexual harassment, including conduct and/or threats between residents and conduct and/or threats between residents and staff, volunteers, contractors and volunteers. The program manual also asserts the program has a zero-tolerance for any form of retaliation against those who report or cooperate in a sexual abuse or sexual

harassment investigation. The handbook also states that any individual who is found in violation of these policies will be subject to appropriate disciplinary action and/or will be referred to law enforcement for criminal investigation.

Interviews with 15 randomly selected staff and specialized staff, including three staff from the food services section, all articulated that the agency and program has a zero tolerance for any form of sexual abuse, sexual harassment and retaliation for reporting or cooperating with an investigation. All of them related they are trained to and required to report any suspicion, knowledge, information or allegation of sexual abuse or sexual harassment. In addition to verbally reporting it to their shift supervisor, they indicated they would document the report in writing as directed by their supervisor.

Interviewed residents likewise were aware of the agency and program's zero tolerance for any form of sexual activity, including sexual assault/abuse and sexual harassment. They also pointed out zero tolerance is included in their handbook and through multiple posters located throughout the facility. The auditor observed multiple posters throughout the facility, including those asserting a Zero Tolerance for sexual abuse, sexual misconduct, sexual harassment or retaliation.

The policy, in Staffing, paragraph 1. requires the agency to designate an upper-level, agency-wide, Prison Rape Elimination Act Coordinator, with sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards in all its programs and facilities. Duties of the coordinator are also outlined and discussed.

A MEMO dated October 22, 2014 written by the Project MORE President/CEO designates the agency's PREA Coordinator. It affirms the PREA Coordinator will have sufficient time and authority to develop, implement and oversee efforts to comply with the PREA Standards in all its community confinement facilities. The rationale for this appointment is the PREA Coordinator's experience with the organization, the numerous supervisory positions previously held as well as the Coordinator's experience in working with the PREA Standards. The PREA Coordinator reports directly the Vice President of Project MORE, which gives him access to the highest levels of authority in the organization. Interviews indicated the PREA Coordinator has the complete support of the agency's President/CEO and the Vice President. The PREA Coordinator is responsible for implementing the PREA Standards and for ensuring continued compliance.

An interview with the PREA Coordinator confirmed he is knowledgeable of the PREA Standards. He indicated he provides the training to staff and is the resource person who is called with any PREA related issues. He also indicated he has the support of the agency administration and with PREA implemented, has the time and authority to perform his PREA related duties. Interviews with staff confirmed they knew and were very familiar with the PREA Coordinator. They related he does the PREA training, conducts investigations and is the "go to" person with any PREA related issues.

The auditor relied on the following to determine compliance:

- Project MORE Prison Rape Elimination Act (PREA) Compliance Policies
- Walter Brooks House, Standard 115.211 Prevention Planning, Zero Tolerance.
- Project MORE Training Manual
- Resident Handbook
- Staff Interviews
- Resident Interviews
- Interviews with the PREA Coordinator

- Reviewed Memo from the President/CEO

## Standard 115.212: Contracting with other entities for the confinement of residents

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

### 115.212 (a)

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

### 115.212 (b)

- Does any new contract or contract renewal signed on or after August 20, 2012 provide for agency contract monitoring to ensure that the contractor is complying with the PREA standards? (N/A if the agency does not contract with private agencies or other entities for the confinement of residents OR the response to 115.212(a)-1 is "NO".)  Yes  No  NA

### 115.212 (c)

- If the agency has entered into a contract with an entity that fails to comply with the PREA standards, did the agency do so only in emergency circumstances after making all reasonable attempts to find a PREA compliant private agency or other entity to confine residents? (N/A if the agency has not entered into a contract with an entity that fails to comply with the PREA standards.)  Yes  No  NA
- In such a case, does the agency document its unsuccessful attempts to find an entity in compliance with the standards? (N/A if the agency has not entered into a contract with an entity that fails to comply with the PREA standards.)  Yes  No  NA

### Auditor Overall Compliance Determination

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

### Instructions for Overall Compliance Determination Narrative

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

Project MORE, the agency, does not contract with any other entity for the confinement of any resident(s). The Connecticut Department of Correction contracts with Project MORE to provide housing and services to Department of Correction inmates who are transitioning back into the community. The auditor requested to see the contract with Project MORE. Paragraph 44., Prison Rape Elimination Act (PREA), of that contract, requires all contractors providing residential services to adhere to the federal Prison Rape Elimination Act of 2003, Public Law 108-79. The contract also requires that all contractor providing residential services must comply with CT DOC policies and procedures as they relate to PREA standards for contracted residential community programs, as such policies and procedures are delineated and maintained in the CTDOC Parole and Community Services Residential Provider Manual. The reviewed PREA Audit of Walter Brooks House indicated the program was previously audited by a certified PREA Auditor and that the program achieved full compliance with the standards.

Walter Brooks House Policy, Prevention Planning, Contracting with Other Entities for the Confinement of Residents, asserted that should Project MORE contract for the confinement of its residents with a private agency or other entity, including another governmental agency, the agency will include in any new contract or renewal, the entity's obligation to adopt and comply with its PREA standards. Policy does provide for these exceptions: 1) Emergency situations in which all reasonable attempts to find a private agency or other entity in compliance with PREA standards have failed. 2) In such a case PMI shall document its unsuccessful efforts to find an entity in compliance with the standard.

The auditor relied on the following in determining a rating for this standard:

- Contract between Connecticut Department of Correction and Project MORE
- Walter Brooks House Policy, Prevention Planning, Contracting with Other Entities for the Confinement of Residents

## **Standard 115.213: Supervision and monitoring**

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

#### **115.213 (a)**

- Does the agency develop for each facility a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse?  
 Yes  No
- Does the agency document for each facility a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse?  
 Yes  No

- Does the agency ensure that each facility's staffing plan takes into consideration the physical layout of each facility in calculating adequate staffing levels and determining the need for video monitoring?  Yes  No
- Does the agency ensure that each facility's staffing plan takes into consideration the composition of the resident population in calculating adequate staffing levels and determining the need for video monitoring?  Yes  No
- Does the agency ensure that each facility's staffing plan takes into consideration the prevalence of substantiated and unsubstantiated incidents of sexual abuse in calculating adequate staffing levels and determining the need for video monitoring?  Yes  No
- Does the agency ensure that each facility's staffing plan takes into consideration any other relevant factors in calculating adequate staffing levels and determining the need for video monitoring?  Yes  No

#### 115.213 (b)

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

#### 115.213 (c)

- In the past 12 months, has the facility assessed, determined, and documented whether adjustments are needed to the staffing plan established pursuant to paragraph (a) of this section?  Yes  No
- In the past 12 months, has the facility assessed, determined, and documented whether adjustments are needed to prevailing staffing patterns?  Yes  No
- In the past 12 months, has the facility assessed, determined, and documented whether adjustments are needed to the facility's deployment of video monitoring systems and other monitoring technologies?  Yes  No
- In the past 12 months, has the facility assessed, determined, and documented whether adjustments are needed to the resources the facility has available to commit to ensure adequate staffing levels?  Yes  No

#### Auditor Overall Compliance Determination

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



## Instructions for Overall Compliance Determination Narrative

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

Agency Policy, Prison Rape Elimination Act (PREA) Compliance Policies, Staffing, Paragraph 2., asserts the agency will develop and document a staffing plan that provides for adequate levels of staffing, and where applicable, video monitoring to protect clients/residents against sexual abuse. Policy tracks the standards in asserting that when calculating adequate staffing levels and determining the need for video monitoring, agencies will take into consideration the physical layout of each facility; the composition of the resident population; the prevalence of substantiated and unsubstantiated incidents of sexual abuse and any other relevant factors. Any deviations from the staffing plan are required to be justified and documented. Staff, who were interviewed, indicated the staffing is required by the contract with DOC and the facility does not start a shift without the minimum staffing.

Walter Brooks House, Prevention Planning Policy, Supervision and Monitoring, describes that program's staffing plan. Staff coverage, by policy, is required 24 hours per day seven days a week. Staff are required to be alert at all times. Policy requires adequate staff on site to ensure the safety of residents. The site-specific staffing plan provides for three shifts (8AM-4PM); (4PM-12AM); and (12AM-8AM). Staffing is predicated upon a maximum capacity of 67. The approved staffing for Walter Brooks, according to an interview with the Program Director, is also predicated upon the requirements of the contract. The Connecticut Department of Correction requires a 1:28 staff to resident ratio. The staffing level at this facility, according to the Program Director is a Director, Assistant Director, Kitchen Supervisor, Job Development Staff, 4 Case Managers and twenty-five (25) resident monitors (providing direct supervision). An interview with the Agency PREA Coordinator indicated that the staffing for Walter Brooks House is as follows: 1<sup>st</sup> Shift: Director, three (3) Case Managers, one (1) Employment Specialist, and three (3) Kitchen Staff; 2<sup>nd</sup> Shift: One (1) Assistant Director, a Part-Time Case Manager and three (3) Resident Monitors; and 3<sup>rd</sup> Shift: three (3) resident monitors.

Interviews with the PREA Coordinator and the Program Director confirmed there are no occasions where the minimum staffing levels were not maintained. The Program Director related if he has to come in to cover a shift, he does that. Project MORE Facility Operating Procedures, asserts that the facility will be staffed and operational 24 hours per day and for staff to conduct hourly rounds. The facility, it should be noted, have recently received the MORSE Watchman with stations placed strategically throughout the facility to ensure that staff are checking all areas of the program every two hours. As staff make the rounds, they swipe the station, electronically registering the time the staff was at that particular station. Deviations are documented. Interviewed staff confirmed they are required to and are documenting rounds every two hours. These rounds are documented using the MORSE Watchman, scanning the strategically placed strips to ensure staff cover the vulnerable areas of the house.

The Walter Brooks Prevention Planning Policy, Supervision and Monitoring, stated the program has thirty (30) security cameras located inside and outside the facility. Case Manager Offices are in a central location with a space that serves as an intake area and area where residents report to be signed in and out of the program to go to work or job searches. Video Camera Monitors are housed in

this location and are visible to Resident Monitors working in the area as well as the Case Managers, Assistant Director and Director. Project MORE Transitional Housing Program Policy, Camera Reviews, requires the Project MORE Programs to ensure camera reviews occur consistently and are coordinated by Supervisors, Program Managers, and Program Operation Directors. Procedures require camera reviews to be conducted by the Program Manager and/or designee, on a weekly basis via the established Camera Review Form. Reviews should be conducted Monday for the previous weekend and include all shifts. Program Operations Directors are required to conduct camera reviews on a monthly basis via the established Camera Review Form. Reviews are required to be documented and maintained in binders.

The facility provided Staffing Plan Assessments for 2016 and 2017. These were dated March 2, 2016 and February 19, 2017. The assessment addresses all of the items required by the PREA Standards, including: 1) A review of the facility staffing plan to ensure it provides an adequate level of staffing; 2) Prevailing staffing patterns; 3) the facility video monitoring system is deployed and used to protect residents against sexual abuse; 4) Other monitoring technologies that might be available; 5) The facility has the resources available to commit to ensure adherence to the staffing plan; and 6) The facility has a policy and practice requiring intermediate and higher level supervisors to conduct and document unannounced round to identify and deter staff sexual abuse and harassment. The current staff to resident ratio was determined to be 1:10. The assessment also documented there have been no findings of inadequacy by the referring sources. The assessment, on page two, documented that the Staffing Plan considered: 1) the residential population; 2) the number and placement of supervisory staff; 3) any applicable Federal, State or local laws; and 4) past substantiated and unsubstantiated sexual abuse incidents. In assessing the video monitoring system, the assessment documented 30 operational cameras as well as their locations (the locations are not going to be documented in this report in the interest of security). The plan documented that the facility has the resources assigned and committed to ensure adherence to the staffing plan. Lastly it documented that the facility has a staffing plan to ensure that intermediate and supervisors complete unannounced rounds. The assessment documented review of the Facility Operating Procedures requiring specific staff to conduct unannounced rounds; where documentation is completed; review of the documentation; interviews with staff and with residents. The assessment is signed by the PREA Coordinator and PREA Compliance Manager.

Project MORE Transitional Programs Policy, entitled, "Unannounced Site Visits", requires the company to ensure unannounced site visits occur consistently and are coordinated by Supervisors, Program Managers and Program Operations Directors. Procedures require those unannounced visits be conducted by the Program Manager or his/her designee, a minimum of twice a month, one of which should be a weekend. Requirements for the Residential Supervisor and Program Operations Directors are specified. Policy and Procedures require that staff are prohibited from alerting other staff members that supervisory rounds are being made unless the announcement is related to the legitimate operational functions of the facility. Documentation to confirm rounds are maintained in binders which are reviewed as part of ongoing supervision of the Program Managers and Program Operations Directors.

The PREA Coordinator documented seventeen (17) unannounced rounds in compliance with PREA Standard 115.213. These were documented on the Project MORE, Inc, Unannounced Rounds form. Additionally, facility staff use the Morse Watchman System to electronically document unannounced

rounds every two hours. Interviews with the Shift Supervisor indicated he conducts unannounced rounds of the entire building and logs them in the logbook.

The auditor relied on the following to determine a rating for this standard:

- Prison Rape Elimination Act (PREA) Compliance Policies, Staffing, Paragraph 2.
- Walter Brooks House, Prevention Planning Policy, Supervision and Monitoring
- Site Specific Staffing Plan
- Annual Staffing Plan Reviews for 2016 and 2017
- Reviewed Staffing Rosters
- Project MORE Transitional Programs Policy, entitled, “Unannounced Site Visits”
- Reviewed Unannounced Rounds (17)
- Interviews with Upper-Level Staff Performing Unannounced Rounds

## Standard 115.215: Limits to cross-gender viewing and searches

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

### 115.215 (a)

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

### 115.215 (b)

- Does the facility always refrain from conducting cross-gender pat-down searches of female residents, except in exigent circumstances? (N/A if less than 50 residents)   
Yes  No  NA
- Does the facility always refrain from restricting female residents’ access to regularly available programming or other outside opportunities in order to comply with this provision? (N/A if less than 50 residents)  Yes  No  NA

### 115.215 (c)

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

### 115.215 (d)

- Does the facility implement policies and procedures that enable residents to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks?  Yes  No
- Does the facility require staff of the opposite gender to announce their presence when entering an area where residents are likely to be showering, performing bodily functions, or changing clothing?  Yes  No

#### 115.215 (e)

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

#### 115.215 (f)

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

#### Auditor Overall Compliance Determination

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

#### Instructions for Overall Compliance Determination Narrative

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The reviewed Pre-Audit Questionnaire documented that the program does not conduct cross-gender strip and visual body cavity searches of inmates. Interviews with both staff and residents confirmed cross-gender strip searches or body cavity searches do not occur in this program.

Project MORE, Inc. Policy, 115.215, Prevention Planning, Limits to Cross-Gender Viewing and Searches, requires that Project MORE Inc. does not allow staff to conduct cross-gender strip searches, cross-gender body cavity searches or cross-gender pat down searches. Policy exempts medical practitioners from this ban.

The procedures to implement this policy require that PMI facilities do not conduct strip or body cavity searches. It also prohibits cross-gender pat down searches and states “staff will only conduct male on male or female on female pat down searches.” Furthermore, policy asserts that PMI does not authorize or allow cross gender viewing and searches. There is one female employed by Walter Brooks House. That staff is a case manager and interviews with residents confirmed she does not conduct any searches and rarely comes upstairs where males are housed and when she comes she is accompanied by a male staff.

The facility does not conduct cross-gender strip and visual body cavity searches of inmates. The referral source, the Connecticut Department of Correction, prohibits strip and visual body cavity searches of residents. One-hundred percent of the interviewed staff confirmed that staff are prohibited from performing any strip search, including same sex strip and visual body cavity searches. One-hundred percent of the interviewed residents also affirmed that they have never been strip searched in this facility. There is only one female staff employed at the facility, a case manager. She cannot even conduct a “pat search” involving touch. This was confirmed by interviews with the case manager, random staff and the Program Director. Residents also stated, in their interviews, that they have never been searched by the female staff nor have they ever observed a cross gender search.

The Pre-Audit Questionnaire documented there were no cross-gender strip and visual body cavity searches. Interviews with staff indicated the program is prohibited from conducting any form of strip search or visual body cavity searches. One-hundred percent (100%) of the interviewed residents confirmed they have never been strip searched in this program nor have they heard of anyone being strip searched.

The program does not have any medical staff, either full-time, part-time, or per diem. Residents needing medical care are treated in the community by community providers. The Pre-Audit Questionnaire documented that there were no strip or visual body cavity searches conducted at the facility at all, including the reporting period. This was also confirmed through interviews with staff and residents.

The facility does not house female residents. Walter Brooks House is a work release program for male offenders. This was confirmed by interviews, the reviewed Pre-Audit Questionnaire and observation.

The facility is prohibited by the referral and funding source from conducting any form of strip or visual body cavity search of residents of the Walter Brooks House. Agency policy, Project MORE, Inc., Residential Programs, Policies and Procedures 422, Search Procedures, A.1, requires that only properly trained staff will conduct searches, regardless of type. Paragraph 2., requires staff of the same sex to conduct the searches. Page three (3) of the policy addresses Frisk or Pat Searches and requires the search be conducted in the presence of another staff person. Interviews with both residents and

staff confirmed that there are no cross-gender searches including cross-gender strip and visual body cavity searches.

Project MORE, Inc. Policy, 115.215, Prevention Planning, Limits to Cross-Gender Viewing and Searches, requires that Project MORE Inc. does not allow staff to conduct cross-gender strip searches, cross-gender body cavity searches or cross-gender pat down searches. Policy exempts medical practitioners from this ban.

The procedures to implement this policy require that PMI facilities do not conduct strip or body cavity searches. It also prohibits cross-gender pat down searches and states “staff will only conduct male on male or female on female pat down searches.” Furthermore, policy asserts that PMI does not authorize or allow cross gender viewing and searches.

Interviewed staff at this facility related they are not allowed to conduct any strip or body cavity search. They also stated they had never performed such a search nor had they ever seen such a search. They also indicated they can perform “pat searches” If a female is used to perform a search for contraband, she is prohibited from touching the resident but may require the resident to empty his pockets, turn the inside out, shake his pants at the waist and then “wand” the resident with the metal detector. One-hundred percent of the interviewed residents confirmed that staff do not perform any strip or body cavity searches. A female case manager, the only female employed at the facility related she can “wand” the resident with a metal detector but never to put her hands on him or touch him during a search. Resident monitor staff related they were trained by the PREA Coordinator to conduct the pat searches and to conduct all searches in a professional and respectful manner.

Again, one-hundred percent (100%) of the interviewed staff related they are not allowed to conduct to search a transgender or intersex resident for the sole purpose of determining the resident’s genital status.

PMI Policy 115.215 Prevention Planning, Limits to Cross-Gender Viewing and Searches, prohibits cross gender viewing. It also affirms that residents will be given the opportunity to shower, perform bodily functions, and to change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when viewing is incidental to routine checks.

The PREA Training Curriculum provided to the auditor for review contained a section entitled “Cross Gender Supervision”. This asserts that residents are allowed to shower, use the bathroom and change their clothing without being viewed by a non-medical member of the opposite sex.

Interviews with residents confirmed they are never naked in full view of staff when changing clothing, during showers and while using the restroom. During a complete tour of the entire facility, the auditor observed that in each room there is a toilet and a shower. The toilets and showers are separated from each other and each has a door. The showers have doors and full -length shower curtains affording the maximum privacy while showering and using the restroom.

Staff of the opposite gender are required to announce their presence when entering an area where residents are likely showering, performing bodily functions of changing clothing. The PREA Training Curriculum requires that if a member of the opposite sex is to enter a room, there will be an announcement on the PA system that a member of the opposite sex will be on the floor. A member of the staff will accompany the opposite sex staff. Staff, then, are required to knock on the door and announce why they are there.

Interviewed staff related that the only female staff employed at the facility (a case manager) rarely goes upstairs on the living unit but rather calls the residents who are on her caseload to come down to her office where the security area is located.

All the interviewed residents stated that they facility only has one female staff and they have never seen her upstairs. Residents stated staff are very respectful and always knock on their doors prior to coming in to ensure they are fully dressed.

Transgender or intersex residents, in compliance with policy, will be given the opportunity to shower, perform bodily functions, and to change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks or genitalia, except in exigent circumstances, or when viewing is incidental to routine checks.

Every interviewed staff, when asked if they are prohibited from searching or physically examining a transgender or intersex for the sole purpose of determining the resident's genital status. Staff also stated they receive a referral packet from the Connecticut Department of Correction and this information would have already have been determined. An interview with the PREA Coordinator indicated the agency, at their Virginia Wells Transitional House, had received a transgender female, however the information preceded the placement. Interviews with the PREA Coordinator, Program Director and random staff confirmed the program does not have any transgender or intersex residents at this time. There are no medical staff at the Walter Brooks Homes.

The reviewed policy and interviews with staff indicated that transgender or intersex residents are not searched or physically examined for the sole purpose of determining the resident's genital status.

The auditor relied on the following in determining a rating for this standard:

- Project MORE, Inc. Policy, 115.215, Prevention Planning, Limits to Cross-Gender Viewing and Searches
- Interviews with residents
- Interviews with staff
- Observation

## **Standard 115.216: Residents with disabilities and residents who are limited English proficient**

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

### **115.216 (a)**

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who are deaf or hard of hearing?  Yes  No
- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect,

and respond to sexual abuse and sexual harassment, including: Residents who are blind or have low vision?  Yes  No

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

#### 115.216 (b)

- Does the agency take reasonable steps to ensure meaningful access to all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment to residents who are limited English proficient?  Yes  No



- Do these steps include providing interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary?  
 Yes  No

### 115.216 (c)

- Does the agency always refrain from relying on resident interpreters, resident readers, or other types of resident assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the resident's safety, the performance of first-response duties under §115.264, or the investigation of the resident's allegations?  
 Yes  No

### Auditor Overall Compliance Determination

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

### Instructions for Overall Compliance Determination Narrative

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

PMI Policy, 15.216 Prevention Planning, Residents with Disabilities and Residents Who are Limited English Proficient, requires Project MORE Inc. to take appropriate steps regarding equal opportunity of disabled residents and those who are Limited English proficient to participate in or benefit from all efforts to prevent, detect and respond to sexual abuse and sexual harassment. Policy prohibits facilities from relying on resident interpreters, readers, or other types of client assistance except in limited circumstances where an extended delay could compromise a resident's safety.

Procedures affirm that PMI ensures effective communications with all residents who have a disability or who are limited English proficient. The agency, according to the procedures, must ensure that appropriate interpreters and written information are available. A list of contacts for accessing disabilities including vision impairment, hearing impairment, speech impairment, Non-English speakers; and Google translator are provided.

Paragraph C. of the procedures require the Program Director or client Case Manager to contact the agencies needed.

The Case Manager indicated, in an interview, that there were no disabled residents assigned to the facility during the past 12 months. The Program Director stated, if there was a need for any interpretive or translation services, the "Main" office would provide that.

The reviewed victimization assessments did not indicate the presence of any LEP residents, disabled residents, residents who alleged sexual abuse, including previous victimization, or any residents identifying as bisexual or transgender. One resident, who was gay, was interviewed.

Project MORE Policy, Prevention Planning, Residents with disabilities and residents who are limited English proficient, II. Procedures requires PMI to ensure effective communications with all residents who have a disability or who are limited English proficient. For Non-English speakers, staff are provided Language Line and ABC Languages Services. Procedures state in Paragraph C. that it will be the responsibility of the Program Director or client Case Manager to contact the agencies listed. The auditor observed the postings of these agencies and their contact information.

Interviews with staff consistently indicated the staff would not rely on another resident for interpretive services, unless it appeared to be an emergency. They also stated they have multiple staff who are bilingual.

The Director and staff indicated they have not had any allegations for sexual abuse nor the need for an interpreter in the past 12 months.

None of the interviewed residents was limited English proficient.

The reviewed PMI Policy, Prevention Planning, Residents with Disabilities and Residents Who are Limited English Proficient, prohibits the facilities from relying on resident interpreters, readers, or other types of client assistance except in limited circumstances where an extended delay could compromise a resident's safety.

The auditor relied upon the following in determining a rating for this standard:

- Project MORE Policy, Prevention Planning, 115.216, Residents with disabilities and residents who are limited English proficient.
- Reviewed Vulnerability Assessments
- Interviews with staff
- Interviews with residents

## Standard 115.217: Hiring and promotion decisions

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

### 115.217 (a)

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

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

#### 115.217 (b)

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

#### 115.217 (c)

- Before hiring new employees, who may have contact with residents, does the agency: Perform a criminal background records check?  Yes  No
- Before hiring new employees, who may have contact with residents, does the agency: Consistent with Federal, State, and local law, make its best efforts to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse?  Yes  No

#### 115.217 (d)

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

#### 115.217 (e)

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

#### 115.217 (f)

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

#### 115.217 (g)

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

#### 115.217 (h)

- Unless prohibited by law, does the agency provide information on substantiated allegations of sexual abuse or sexual harassment involving a former employee upon receiving a request from an institutional employer for whom such employee has applied to work? (N/A if providing information on substantiated allegations of sexual abuse or sexual harassment involving a former employee is prohibited by law.)  Yes  No  NA

#### Auditor Overall Compliance Determination

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

#### Instructions for Overall Compliance Determination Narrative

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Project MORE Inc. Policy, 115.217, Hiring and Promotion Decisions, requires that PMI will not hire or promote anyone nor enlist the services of a contractor who:

- 1) Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility or other institution.

- 2) Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refused.
- 3) Has been civilly or administratively adjudicated to have engaged in engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refused.

Project MORE, Policy Number 302, Recruitment Practices, Paragraph 12., prohibits the agency from hiring or promoting anyone who may have contact with clients/residents and not enlist the services of any contractor: 1) who may have contact with clients/residents, who have 1) engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42USC,1997); 2) Has been convicted of engaging or attempting to engage in sexual activity in the facility by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or has been civilly or administratively adjudicated to have engaged in the sexual activity. The agency will ask all applicants and employees directly about previous sexual misconduct described this section (of policy) in written applications or interviews for hiring or promotions and in any interview or written self-evaluations conducted as part of reviews of current employees.

The agency imposes upon employees a continuing affirmative duty to disclose any such misconduct. Falsifying or failing to provide such information such information is grounds for termination.

This policy, Number 302, Recruitment Practices, Paragraph 13., affirms the agency requires programs to consider any incidents or sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any contractor, who may have contact with clients/residents.

Paragraph 14, of Policy Number 302, requires that before hiring new employees who may have contact with clients/residents, the agency will 1) Perform a criminal background records check; and 2) Consistent with Federal, State, and local law, the Agency is required to make its best efforts to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse.

PMI procedures requires the agency ask all applicants and current employees about previous misconducts of a sexual nature. Procedures allow this to be done in writing on an application or during an interview for hiring or promotion. Omissions regarding such misconduct or the provision of materially false information is grounds for termination. Too, then the PMI imposes upon employees a continuing affirmative duty to disclose any such misconduct.

Prior to hiring new staff, procedures require a criminal background investigation is conducted. Likewise, procedures require that before enlisting the services of any contractor who may have contact with residents, a background investigation is conducted.

PMI Procedures for Policy 115.217, Prevention Planning, Hiring and Promotion Decisions, require the agency to make its best efforts to contact all prior employers for information on substantial allegations of sexual abuse or any resignations during a pending investigation of an alleged sexual abuse, consistent with Federal, state and local laws.

Policy requires the agency to conduct a criminal background records check at least every five years on current employees and contractors.

PMI will, unless prohibited by law, will provide information on substantiated allegations of sexual abuse or sexual harassment involving a former employee upon receiving a request from an institutional employee for whom such employee has applied to work. This is confirmed in PREA Procedures, 115.217 and Project MORE, Policy Number 302, Recruitment Practices.

The agency provided sixteen requested background clearance packages. Every package contained the PREA related questions asked of applicants as well as the results of the criminal records check conducted by the State of Connecticut State Police Bureau or Identification.

There was documentation of contacting previous employers in an effort to confirm the agency made its best efforts to contact all prior employers for information on substantiated allegations of sexual abuse or any resignations during a pending investigation of an alleged sexual abuse, consistent with Federal, State and Local Laws however the forms are not specific in asking those questions. The PREA Coordinator in a corrective action, consulted with Human Resources and has implemented a questionnaire that specifically asks the former employers the PREA questions for previous employers.

The agency provided the auditor the master employment roster documenting the dates of the employee's background check. All the listed employees had documented background checks with dates of the checks.

## Standard 115.218: Upgrades to facilities and technologies

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

#### 115.218 (a)

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

#### 115.218 (b)

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

### Auditor Overall Compliance Determination

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

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

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

### **Instructions for Overall Compliance Determination Narrative**

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

Project MORE Policy, 115.218, Prevention Planning, Upgrades to Facilities and Technologies, requires that when installing a new or updating a video monitoring system, electronic surveillance system, or other monitoring technology, PMI shall consider how such technology may enhance the facilities ability to protect residents from sexual abuse and Procedures require that when designing, or acquiring any new facility and in planning any substantial expansion or modification to the WBH, PMI shall consider the effect of the design, acquisition, expansion, or modification upon the programs ability to protect residents from sexual abuse.

Procedures also require that when installing a new or updating a video monitoring system, electronic surveillance system, or other monitoring technology, The Walter Brooks House and PMI shall consider how such technology may enhance the facilities ability to protect residents from sexual abuse.

This is reiterated in Project MORE Policy, Number 111, Prison Rape Elimination Act Compliance Policies, paragraphs 1 and 2.

An interview with the Agency PREA Coordinator confirmed the agency definitely considers how any proposed modifications to the facility would impact safety and designs would be developed to enhance safety, including how those changes would impact security and the sexual safety of residents. The only changes to technology since the last PREA Audit was the installation of the MORSE Watchman. With this system, strips are posted in each room. When making their rounds, staff are required to scan the strip documenting the time of the tour. An interview with the Program Director also confirmed that the facility has added an additional six (6) to eight (8) video cameras since the last PREA Audit. He indicated the facility currently has 30 cameras strategically located throughout the facility.

The auditor relied on the following in determining a rating for this standard:

- Project MORE Policy, 115.218, Prevention Planning, Upgrades to Facilities and Technologies
- Project MORE Policy, Number 111, Prison Rape Elimination Act Compliance Policies, paragraphs 1 and 2.
- Interviews with the PREA Coordinator, Agency Head's Designee, and Program Director

## RESPONSIVE PLANNING

### Standard 115.221: Evidence protocol and forensic medical examinations

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

#### 115.221 (a)

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

#### 115.221 (b)

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

#### 115.221 (c)

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



#### 115.221 (d)

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

#### 115.221 (e)

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

#### 115.221 (f)

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

#### 115.221 (g)

- Auditor is not required to audit this provision.

#### 115.221 (h)

- If the agency uses a qualified agency staff member or a qualified community-based staff member for the purposes of this section, has the individual been screened for appropriateness to serve in this role and received education concerning sexual assault and forensic examination issues in general? (Check N/A if agency attempts to make a victim advocate from a rape crisis center available to victims per 115.221(d) above.)  Yes  No  NA

#### Auditor Overall Compliance Determination

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

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

### **Instructions for Overall Compliance Determination Narrative**

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

Project MORE, Inc. conducts administrative investigations however the New Haven Police is the agency with the authority to conduct investigations of all allegations or incidents that appear to be criminal in nature. Project MORE, Inc. Policy 115.221, Responsive Planning, Evidence Protocol and Forensic Medical Examinations, I., requires PMI facilities to contact local authorities to investigate allegations of sexual abuse. The PREA Coordinator for the agency is responsible for conducting administrative investigations and for serving as a support to local law enforcement in conducting investigations of sexual abuse. This staff has successfully completed the National Institute of Corrections (NIC) on-line training for conducting sexual abuse investigations in confinement settings.

Interviews with staff confirmed they are knowledgeable of who is responsible for conducting investigations and that they would all contact the PREA Coordinator who would contact the New Haven Police. The PREA Coordinator related he is always on call and even if out of town directs staff on actions they need to take. The Program Director for Walter Brooks has completed the NIC on-line training for conducting sexual abuse investigations in confinement settings.

The responding investigative agency is the New Haven Police Department. This is confirmed by interviews with the Program Director, the PREA Coordinator and a number of staff.

The New Haven Police Department conducts criminal investigations. The Agency (Project MORE) Chief Executive Officer sent a letter to the Chief of Police in New Haven requesting that they follow a uniform protocol when investigating sexual abuse investigations in any of the PMI programs. The Chief has not yet responded. The PREA Coordinator conducts administrative investigations and will assist, as needed, the New Haven Police in conducting criminal investigations.

The reviewed agency coordinated response plan addresses actions for first responders to follow to ensure that evidence is preserved and protected in a consistent manner for the police investigators.

Walter Brooks House residents, if sexually assaulted, are sent to the Yale New Haven Hospital for a forensic exam. Sexually Assault Nurse Examiners at that hospital are available to conduct forensic examinations. This was confirmed through interviews with staff. There have never been any sexual assaults at the program since its inception therefore they have not had to use the hospital for a forensic examination.

The agency provided emails reaching out to access the services of a Sexual Assault Nurse Examiner. The Women and Families Center advised the facility that the exam would be conducted at an emergency room and that the appropriate facility would be at either Yale or St. Raphael's.

Written procedures for the Walter Brooks House provide for access to forensic medical examination: Project MORE, Inc. will offer victims of sexual abuse access to a forensic medical exam via Yale New

Haven Hospital. These exams will be performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs). In the unlikely event that either a SAFE or SANE cannot be available, the exam will be performed by other qualified medical practitioners. The Walter Brooks House will document its efforts and there is no cost to the resident.

The Walter Brooks House offers victims of sexual abuse access to a forensic medical examination. This is no cost to the resident. Too, the Walter Brooks House, will also attempt to make available a victim advocate to the resident.

Reviewed Walter Brooks Policy and Procedure and interviews with the Director and Case Manager indicated the facility provides a means for forensic exams to be conducted in a hospital that has Sexual Assault Nurse Examiners. The facility/program has not had any incidents requiring a forensic exam during the past twelve (12) months. This was confirmed through interviews with random staff, the Program Director, and reviewed incident reports.

The reviewed Walter Brooks Procedures, as written in policy, provides for the following:

- A. Access to forensic medical examination: Project MORE, Inc. will offer victims of sexual abuse access to a forensic medical exam via Yale New Haven Hospital. These exams will be performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs). If either a SAFE or SANE cannot be available, the exam will be performed by other qualified medical practitioners. The Walter Brooks House will document its efforts and there is no cost to the resident.

The reviewed Walter Brooks Policy and Procedures requires the forensic exams to be performed by a Sexual Assault Nurse Examiner or a Sexual Assault Forensic Examiner. The Yale New Haven hospital provides Sexual Assault Nurse Examiners however in the unlikely event a SANE was not available, procedures require (as noted above) that the exam will be performed by a qualified medical practitioner. In those instances, procedures do require Walter Brooks to document its efforts to secure a Sexual Assault Forensic Examiner or a Sexual Assault Nurse Examiner.

The PREA Coordinator provided the auditor a Memo dated September 1, 2017, affirming that, if there was a sexual assault on site at the Walter Brooks House, the victim would be transported to the Yale New Haven Hospital Emergency Room.

The reviewed Pre-Audit Questionnaire, reviewed incident reports, and interviews with staff, including the Program Director, Case Manager as well as the Agency's PREA Coordinator indicated there have been no incidents of sexual assault requiring a forensic examination.

The agency has a Memorandum of Understanding (MOU) between the Agency and the Women and Families Center. The reviewed MOU affirms that the Women and Families Center will provide training to Project MORE staff as requested; provide individual counseling and support groups at Project MORE and Accompaniment through the forensic exam process and investigatory reviews and will provide emotional support, crisis intervention, information and referrals. The MOU was dated 2014. The reviewed Women and Families brochure explains the organization (Sexual Assault Crisis Services) provides support to survivors of sexual violence, their family and friends. It also affirms they provide a 24 -hour toll free confidential support hotline; crisis intervention; support groups; accompaniment and systems support through medical, police and legal proceedings and opportunities for citizens to volunteer and/or serve as an intern. The brochure, given to residents and posted throughout the facility,

provides the 24- hour toll free sexual assault crisis hotline; a toll- free number for English and a separate one for Spanish. The posting asserts that all services are free and confidential. Another side of the brochure states the agency will meet the victim at the hospital to provide support during the forensic exam; meet them at the police department to provide support when they give their statement; attend court hearings with them; provide short term counseling; and provide for disabled or LEP victims by providing bilingual counselors, signing counselors and TTY access.

Project MORE posted a listing of multiple Rape Crisis Organizations in the area, including their regular phone numbers and their hotline numbers as well as their mailing addresses.

This facility does not have medical staff. Residents are seen in the community by private providers.

The auditor relied on the following in determining a rating for this standard:

- Project MORE, Inc. Policy 115.221, Responsive Planning, Evidence Protocol and Forensic Medical Examinations, I.
- Reviewed letter from PROJECT MORE President to Chief of Police, New Haven
- Coordinated Response Plan
- Memorandum of Understanding with Women and Families Center
- Reviewed Memo from PREA Coordinator re: Yale New Haven Emergency Room
- Reviewed Women and Family Center's Brochure
- Reviewed Rape Crisis Center Posters with contact information
- Reviewed Memo to re: SANE
- Interviews with the PREA Coordinator, Program Manager and random staff
- Interviews with residents

## **Standard 115.222: Policies to ensure referrals of allegations for investigations**

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

### **115.222 (a)**

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

### **115.222 (b)**

- Does the agency have a policy and practice in place to ensure that allegations of sexual abuse or sexual harassment are referred for investigation to an agency with the legal authority to

conduct criminal investigations, unless the allegation does not involve potentially criminal behavior?  Yes  No

- Has the agency published such policy on its website or, if it does not have one, made the policy available through other means?  Yes  No
- Does the agency document all such referrals?  Yes  No

#### 115.222 (c)

- If a separate entity is responsible for conducting criminal investigations, does such publication describe the responsibilities of both the agency and the investigating entity? [N/A if the agency/facility is responsible for conducting criminal investigations. See 115.221(a.)]  
 Yes  No  NA

#### 115.222 (d)

- Auditor is not required to audit this provision.

#### 115.222 (e)

- Auditor is not required to audit this provision.

### Auditor Overall Compliance Determination

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

### Instructions for Overall Compliance Determination Narrative

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

This program has not had any PREA related allegations, either sexual abuse, sexual misconduct or sexual harassment during the past twelve (12) months and even prior to that time. This was confirmed through the reviewed PAQ, the reviewed Project MORE Annual Report, and through interviews with the PREA Coordinator, Program Director, random staff and residents.

PMI Policy, 115.222, Responsive Planning, Policies to Ensure Referrals of Allegations for Investigations, requires PMI to ensure that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment.

Walter Brooks House procedures require all allegations of sexual abuse to be referred to the New Haven Police Department and local authorities will be responsible for conducting criminal investigations. Allegations that involve potentially criminal behavior will be referred to the police department. All referrals will be documented.

The agency website provides information related to reporting allegations for investigation. The website states Project M.O.R.E., Inc., shall ensure that all allegations of sexual abuse or sexual harassment are referred for investigation to an agency with the legal authority to conduct criminal investigations, unless the allegation does not involve potentially criminal behavior. The website also provided multiple ways for viewers to report.

The PREA Coordinator and the Program Director provided documentation to confirm they have been trained (NIC On-Line) to conduct sexual abuse investigations in confinement settings. Interviews confirmed they are trained and knowledgeable of that process.

The auditor relied on the following in determining a rating for this standard”

- PMI Policy, 115.222, Responsive Planning, Policies to Ensure Referrals of Allegations for Investigations
- Reviewed PQ
- Interviews with the PREA Coordinator (NIC Trained for Investigating Sexual Abuse in Confinement Settings)
- Interviews with staff
- Interviews with residents
- Reviewed Project MORE Incident Reports
- The reviewed Agency Website

## TRAINING AND EDUCATION

### Standard 115.231: Employee training

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

#### 115.231 (a)

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

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

#### 115.231 (b)

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

#### 115.231 (c)

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

#### 115.231 (d)

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

### Auditor Overall Compliance Determination

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

### Instructions for Overall Compliance Determination Narrative

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

Project MORE, Policy Number 111, Prison Rape Elimination Act (PREA) Compliance Policies and Project MORE Inc., Policy, 115.231, Training and Education, Employee Training, requires that the facility train all employees who may have contact with residents on the following:

1. The agency/facility's zero tolerance policy for sexual abuse and sexual harassment.
2. How to fulfill their responsibilities under PMI sexual abuse and sexual harassment prevention, detection, reporting and response policies and procedures.
3. The resident's right to be free from sexual abuse and sexual harassment.
4. The right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment.
5. The dynamics of sexual abuse and sexual harassment victims.
6. The common reactions of sexual abuse and sexual harassment victims.
7. How to detect and respond to signs of threatened and actual sexual abuse.
8. How to avoid inappropriate relationships with residents.
9. How to communicate effectively with lesbian, gay, bisexual, transgender, intersex or gender non-conforming residents.
10. How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities.

Both policies require that training is required to be tailored to the gender of the facility residents.

All current employees who have not received PREA training must be trained within one year of the effective date of the PREA standards. PMI policy requires PMI to conduct new staff PREA Training annually.

Too, employees are required to receive additional training if transferred from a male only facility to a female only facility and vice versa.

The procedures promulgated by PMI requires PMI to provide training annually for all new facility employees and refresher training every two years to ensure all employees know and understand the agency's current sexual abuse and sexual harassment policies and procedures. In years in which an employee does not receive refresher training, PMI provides refresher information on current sexual



abuse and sexual harassment policies. Any new PREA or PMI sexual abuse and/or sexual harassment policies must be passed on to staff and will be incorporated in all trainings.

The provided Project MORE, INC. Staff Training Manual covers all the topics required in the PREA Standards and provides staff with vital information, based on the PREA Standards, that benefits them in their work in preventing, detecting, responding and reporting allegations of sexual abuse and sexual harassment,

PMI procedures require the PMI to document all training through employee signature or electronic verification that the employee understands the training received.

Twelve (12) pages of Training Rosters with staff signatures were provided for review.

Fourteen (14) of fourteen (14) random staff confirmed they were trained in all the topics required by the PREA Standards. Interviewed staff related they receive PREA Training at least twice a year and that it is conducted in a class facilitated by the Agency PREA Coordinator. The facility does not employ any medical or mental health staff.

The auditor relied upon the following in determining a rating for this standard:

- Project MORE, Policy Number 111, Prison Rape Elimination Act (PREA) Compliance Policies
- Project MORE Inc., Policy, 115.231, Training and Education, Employee Training
- Project MORE, INC., Staff Training Manual
- Twelve (12) Pages of Training Rosters documenting PREA Training
- Interviews with fourteen (14) random staff.
- Interviews with the Agency PREA Coordinator

### **Standard 115.232: Volunteer and contractor training**

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

##### **115.232 (a)**

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

##### **115.232 (b)**

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

##### **115.232 (c)**

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

## Auditor Overall Compliance Determination

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

## Instructions for Overall Compliance Determination Narrative

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

Project MORE, Inc. Policy, 115.232, Training and Education, Volunteer and Contractor Training, requires that the facility ensure that all volunteers and contractors who have contact with residents have been trained in their responsibilities under PMI's sexual abuse and sexual harassment prevention detection, and response policies and procedures.

Project MORE Policy, Number 111, Prison Rape Elimination Act (PREA) Compliance Policies, goes on to state the level and type of training they receive is based on the services they provide and the level of contact with clients/residents, but all volunteers and contractors who have contact with clients/residents shall be notified of the agency's zero tolerance policy regarding sexual abuse and sexual harassment and informed hot to report such incidents. The Agency is required to maintain documentation confirming that volunteers and contractors understand that training they have received.

The Procedures outlined in II. of the policy reiterate that contractors will be informed of their responsibilities under PMI's sexual abuse and sexual harassment policies and procedures. All contractors will receive a copy of their PREA responsibilities and a signed copy will be kept in the file with the program.

Additionally, the procedure requires that volunteers receive the training that is required for employees in Standard 115.231.

The auditor reviewed thirteen (13) PREA Acknowledgments and an interview with a volunteer confirmed that minimally they are trained in the zero- tolerance policy and how to report sexual abuse and sexual harassment.

The reviewed Project MORE, Inc., Prison Rape Elimination Act, (PREA Acknowledgment Statement) Form informs the contractor and volunteer of the following: 1) the zero-tolerance policy; 2) resident's right to be free from sexual abuse and sexual harassment; 3) that Project MORE will investigate all allegations of sexual abuse and sexual harassment made by residents, staff or third parties; 4) that any individual who engages in sexual abuse or sexual harassment will be immediately prohibited from contact with agency residents; 5) that such conduct will be reported to local authorities and licensing bodies as applicable; 6) if they are informed by a resident that he/she was abused the following is

required: a. Protect the Resident and b. Contact Staff; and 7) persons becoming aware of a resident being sexual abused or sexually harassed my contact any staff or contact the CT Sexual Abuse Hotline. The form is signed by the contractor/volunteer and a staff.

The auditor relied upon the following in determining a rating for this standard:

- Project MORE Policy, 115.232, Training and Education, Volunteer and Contractor Training
- Project MORE Policy, Number 111., Prison Rape Elimination Act (PREA) Compliance Policies
- PREA Acknowledgments for contractors and volunteers
- An interviewed volunteer
- Interviews with the Walter Brooks Program Manager
- Interviews with the Project MORE PREA Coordinator

## Standard 115.233: Resident education

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

### 115.233 (a)

- During intake, do residents receive information explaining: The agency's zero-tolerance policy regarding sexual abuse and sexual harassment?  Yes  No
- During intake, do residents receive information explaining: How to report incidents or suspicions of sexual abuse or sexual harassment?  Yes  No
- During intake, do residents receive information explaining: Their rights to be free from sexual abuse and sexual harassment?  Yes  No
- During intake, do residents receive information explaining: Their rights to be free from retaliation for reporting such incidents?  Yes  No
- During intake, do residents receive information regarding agency policies and procedures for responding to such incidents?  Yes  No

### 115.233 (b)

- Does the agency provide refresher information whenever a resident is transferred to a different facility?  Yes  No

### 115.233 (c)

- Does the agency provide resident education in formats accessible to all residents, including those who: Are limited English proficient?  Yes  No
- Does the agency provide resident education in formats accessible to all residents, including those who: Are deaf?  Yes  No

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

#### 115.233 (d)

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

#### 115.233 (e)

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

#### Auditor Overall Compliance Determination

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

#### Instructions for Overall Compliance Determination Narrative

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

PMI Policy 115.233, Training and Education, Resident Education, requires that during intake, residents receive information explaining PMI's zero tolerance policy regarding sexual abuse and sexual harassment. The residents will be informed of the following:

- 1) How to report incidents or suspicions of sexual abuse or sexual harassment.
- 2) Resident's right to be free from sexual abuse and sexual harassment.
- 3) Resident's right to be free from retaliation for reporting such incidents.

This information will be accessible to all residents, including those who are limited English proficient, deaf or visually impaired or otherwise disabled as well as residents who have limited reading skills.

Section II, Procedures, require that during the intake process, staff will provide residents with information regarding PMI's policy regarding sexual abuse and sexual harassment and ensure that all residents education regarding sexual abuse and sexual harassment area accessible to all residents.

Procedures require that Walter Brooks House will provide refresher information whenever a resident s transferred from another facility.

Key information related to PREA will be readily available to residents through a combination of posters, client handbook, handout or other written form.

Any outside source providing PREA Training will be documented.

Project MORE Policy, Policy Number 111, Prison Rape Elimination Act (PREA) Compliance Policies, Education (PREA 115.213) reiterates the, Training and Education, Resident Education Policy.

An interview with the Case Manager who conducts intake/orientation for incoming residents related that she provides each resident the PREA related pamphlet, and explains the zero- tolerance policy to them, what sexual abuse and sexual harassment is and how to report it. She related that she reads the pamphlet to them and asks if the resident has any questions. Residents then sign an "inmate acknowledgment" acknowledging that the resident has received information on the Code of Penal Discipline and Inmate Grievance Procedure and the Prison Rape Elimination Act of 2003 acknowledgment. Another case manager who conducts admissions/intake stated that the resident receives a resident handbook during the admission process as well. The intake staff, he related, have a PREA Pamphlet that tells the resident about the zero-tolerance policy; goes over the PREA Pamphlet and tells the about the zero- tolerance policy, how to report and reminds them there are PREA posters with reporting information located throughout the facility.

Interviewed residents consistently reported they received a pamphlet, PREA information sheet, and resident handbook. Staff stated the "counselor gave them those items but also explained the information in those items/documents. They also related that this information is redundant in that they have received it at other DOC facilities.

The auditor reviewed a sample of ten (10) Prison Rape Elimination Act of 2003 (PREA Acknowledgment Statements). These acknowledge Project MORE's zero- tolerance policy for all forms of sexual abuse and sexual harassment in all its facilities. It then advises residents how to report if they have been or become the victim of sexual abuse or sexual harassment in a Project MORE program or other incarceration facility. Residents are advised they may report it verbally or in writing to any agency employee or to law enforcement or have a third party contact the agency. Posters have the contact number for the Connecticut Department of Correction and the Connecticut State Police. It advises residents that the agency also has a zero-tolerance for any form of retaliation against those who report an incident of sexual abuse or sexual harassment or cooperate in a sexual abuse or sexual harassment investigation. Sanctions for those found in violation of these policies, the form states, will subject the resident to appropriate disciplinary action and/or referral to law enforcement for investigation. The PREA definitions for sexual abuse and sexual harassment are explained. The resident also acknowledges he will receive a handout explaining sexual assault.

Another acknowledgment is made by residents on a form entitled, "Walter Brooks House Treatment Plan". This acknowledges the resident has been made aware of the zero-tolerance policy and that the resident received the sexual assault and custodial misconduct form located in the client handbook. Ten (10) additional samples were provided documenting the acknowledgments.

Interviewed residents related that PREA information is on posters that are located throughout the facility.

## Standard 115.234: Specialized training: Investigations

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

#### 115.234 (a)

- In addition to the general training provided to all employees pursuant to §115.231, does the agency ensure that, to the extent the agency itself conducts sexual abuse investigations, its investigators have received training in conducting such investigations in confinement settings? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).]  Yes  No  NA

#### 115.234 (b)

- Does this specialized training include: Techniques for interviewing sexual abuse victims? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).]  Yes  No  NA
- Does this specialized training include: Proper use of Miranda and Garrity warnings? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).]  Yes  No  NA
- Does this specialized training include: Sexual abuse evidence collection in confinement settings? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).]  Yes  No  NA
- Does this specialized training include: The criteria and evidence required to substantiate a case for administrative action or prosecution referral? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).]  Yes  No  NA

#### 115.234 (c)

- Does the agency maintain documentation that agency investigators have completed the required specialized training in conducting sexual abuse investigations? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).]  Yes  No  NA

#### 115.234 (d)

- Auditor is not required to audit this provision.

### Auditor Overall Compliance Determination

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

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

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

### **Instructions for Overall Compliance Determination Narrative**

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

PMI Policy requires that to the extent the agency/program conducts sexual abuse investigations, its investigators have received training in conducting such investigations.

The Agency and Facility Procedures require that the specialized training includes:

- 1) Techniques for interviewing sexual assault victims.
- 2) Proper use of Miranda and Garrity warnings.
- 3) Sexual abuse evidence collection in confinement settings.
- 4) The criteria and evidence to substantiate a case for administrative action or for prosecution referral.

Procedures require the facility to document all specialized training.

Any state of local entity component that investigates sexual abuse in confinement settings are required to provide such training to investigators who conduct such investigations.

Certificates were provided documenting that the PREA Coordinator and the Program Director had completed the National Institute of Corrections. This training was in addition to the regular PREA training required of all other staff. The Agency PREA Coordinator does the administrative investigations for the agency, however in his absence he directs staff as he can, but the Program Director has received the specialized training and can serve as a "backup". Interviews with the PREA Coordinator and Program Manager confirmed they both could describe the training they received and what the investigation process would look like and what it would include.

A letter to the Chief of the New Haven Police Department requested that investigators conducting sexual abuse investigations in the Project MORE programs be trained to conduct sexual abuse investigations in confinement settings.

The auditor relied on the following in determining a rating for this standard:

- PMI Policy, Prison Rape Elimination Act, (PREA) Compliance Policies
- Reviewed National Institute of Corrections Certificates; PREA: Conducting Sexual Abuse Investigations in Confinement Settings
- Interviews with the PREA Coordinator
- Interviews with the Program Director

## Standard 115.235: Specialized training: Medical and mental health care

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

### 115.235 (a)

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

### 115.235 (b)

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

### 115.235 (c)

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

### 115.235 (d)

- Do medical and mental health care practitioners employed by the agency also receive training mandated for employees by §115.231?  Yes  No
- Do medical and mental health care practitioners contracted by and volunteering for the agency also receive training mandated for contractors and volunteers by §115.232? [N/A for circumstances in which a particular status (employee or contractor/volunteer) does not apply.]  Yes  No  NA

## Auditor Overall Compliance Determination



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

### Instructions for Overall Compliance Determination Narrative

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

This standard is rated satisfactory because staff understand and know the requirements of the PREA Standards related to specialized training for healthcare staff however the Walter Brooks House does not employ any medical or health care staff, either full time, part time or contracted. In the event this level of staffing is introduced by the Department of Correction, the agency acknowledges the requirements of the PREA standards relative to specialized training related to sexual abuse in confinement settings and will comply. Residents of the Walter Brooks House, if healthcare or medical treatment was needed, would be served in the community by a public or private provider. A memo from the PREA Coordinator confirmed that victims of sexual abuse would be transported to one of the Yale New Haven Emergency Rooms for an exam and any treatment required. Routine health care is provided in the community in coordination with the resident’s DOC staff/officer. Mental health is provided in the community as well and referrals are made to agencies like “The Connection”. Again, these appointments are in consultation with the resident’s parole officer or case manager.

Several of the interviewed residents indicated they were in counseling at “the Connection”.

The auditor relied on the following in determining a rating for this standard:

- Interviews with the PREA Coordinator
- Interviews with the Program Director
- Interviews with random staff
- Interviews with residents

## SCREENING FOR RISK OF SEXUAL VICTIMIZATION AND ABUSIVENESS

### Standard 115.241: Screening for risk of victimization and abusiveness

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

#### 115.241 (a)

- Are all residents assessed during an intake screening for their risk of being sexually abused by other residents or sexually abusive toward other residents?  Yes  No
- Are all residents assessed upon transfer to another facility for their risk of being sexually abused by other residents or sexually abusive toward other residents?  Yes  No

#### 115.241 (b)

- Do intake screenings ordinarily take place within 72 hours of arrival at the facility?  
 Yes  No

#### 115.241 (c)

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

#### 115.241 (d)

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has a mental, physical, or developmental disability?  Yes  No
- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: The age of the resident?  Yes  No
- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: The physical build of the resident?  Yes  No
- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has previously been incarcerated?  
 Yes  No
- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident's criminal history is exclusively nonviolent?  
 Yes  No
- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has prior convictions for sex offenses against an adult or child?  Yes  No
- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident is or is perceived to be gay, lesbian, bisexual, transgender, intersex, or gender nonconforming (the facility affirmatively asks the resident about his/her sexual orientation and gender identity AND makes a subjective determination based on the screener's perception whether the resident is gender non-conforming or otherwise may be perceived to be LGBTI)?  Yes  No

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has previously experienced sexual victimization?  Yes  No
- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: The resident's own perception of vulnerability?  Yes  No

#### 115.241 (e)

- In assessing residents for risk of being sexually abusive, does the initial PREA risk screening consider, when known to the agency: prior acts of sexual abuse?  Yes  No
- In assessing residents for risk of being sexually abusive, does the initial PREA risk screening consider, when known to the agency: prior convictions for violent offenses?  Yes  No
- In assessing residents for risk of being sexually abusive, does the initial PREA risk screening consider, when known to the agency: history of prior institutional violence or sexual abuse?  Yes  No

#### 115.241 (f)

- Within a set time period not more than 30 days from the resident's arrival at the facility, does the facility reassess the resident's risk of victimization or abusiveness based upon any additional, relevant information received by the facility since the intake screening?  Yes  No

#### 115.241 (g)

- Does the facility reassess a resident's risk level when warranted due to a: Referral?  Yes  No
- Does the facility reassess a resident's risk level when warranted due to a: Request?  Yes  No
- Does the facility reassess a resident's risk level when warranted due to a: Incident of sexual abuse?  Yes  No
- Does the facility reassess a resident's risk level when warranted due to a: Receipt of additional information that bears on the resident's risk of sexual victimization or abusiveness?  Yes  No

#### 115.241 (h)

- Is it the case that residents are not ever disciplined for refusing to answer, or for not disclosing complete information in response to, questions asked pursuant to paragraphs (d)(1), (d)(7), (d)(8), or (d)(9) of this section?  Yes  No

#### 115.241 (i)

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

### Auditor Overall Compliance Determination

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

### Instructions for Overall Compliance Determination Narrative

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

Project MORE policy, 115.241, Screening for Risk of Sexual Victimization and Abusiveness, Screening for Risk of Victimization and Abusiveness and Project MORE Policy Number 111, Prison Rape Elimination Act (PREA) Compliance Policies, (Screening, Paragraph 1) requires that all residents are assessed during intake and upon transfer to another facility for their risk of being sexually abused by other residents or sexually abusive toward other residents.

Agency procedures require that intake screening takes place within 72 hours of arrival at the program.

The assessment is required to be conducted using an objective screening instrument and includes, at a minimum, the following criteria to assess risk of sexual victimization:

- 1) Whether the resident has a mental, physical or developmental disability;
- 2) The age of the resident;
- 3) The physical build of the resident;
- 4) Whether the resident has previously been incarcerated;
- 5) Whether the resident's criminal history is exclusively non-violent;
- 6) Whether the resident has prior convictions for sex offenses;
- 7) Whether the resident is perceived to be gay, bisexual, transgender, intersex, or gender non-conforming;
- 8) Whether the resident has previously experienced sexual victimization;
- 9) The resident's own perception of vulnerability.

The assessment at intake is required to consider prior acts of sexual abuse, prior convictions for violent offenses and history of prior institutional violence or sexual abuse as known to the agency, in residents for risk of being sexually abusive.

Procedures require that within 30 days from the resident's arrival, facility staff reassess the resident's risk of victimization or abusiveness. This will be based on any additional, relevant information. Reassessments are also required when warranted due to a referral, request, incident of sexual abuse, or receipt of added information on the resident's risk of sexual victimization or abusiveness.

The agency/program complies with the PREA Standards in that residents are not to be disciplined for refusing to answer or not disclose information in response to questions in paragraph d-1,7,8, or 9 of this section.

TO protect sensitive information from being exploited, the agency is required to have appropriate controls regarding the dissemination of information on any resident. Information, according to procedures, will be disseminated to the following personnel only: 1) Program Director;2) Program Assistant Director; 3) Case Manager; and 4) the Supervising Parole/Probation Officer.

Interviewed staff who conduct those victimization/abuser assessments stated they screen every newly admitted individual, including anyone transferred from another program, within 72 hours of arrival and most often the same day. If a resident arrived at 3PM screening/assessment staff indicated the screening would be conducted the next business day. Staff stated they review the resident's referral package and transfer summary to determine if the resident's responses are credible. In addition to reviewing the referral package, the staff indicated they can go to the Connecticut Inmate Search only. However, the information gleaned from this site could include the facilities the resident has been housed in, charges, maximum sentence and any disciplinary "tickets" the inmate incurred. Staff discussed each of the items the assessment process considers. Assessments, according to staff, are conducted in private and that they keep their voices down, create a sense of comfort for the incoming resident and then ask the questions from the assessment instrument. If a resident scored 14 or higher, or even close to 14, staff related they would notify the PREA Coordinator. If a resident discloses prior victimization, staff related they would notify the PERA Coordinator and encourage the resident to accept a "follow-up" referral to mental health. These services would be provided through "The Connections" or the "Ford Clinic". The staff related that reassessments are conducted based on any additional information, any new incident, or for other reasons. These reassessments were consistently documented as occurring within 30 days of the initial assessment.

The reviewed instrument for screening is the Project MORE, INC. PREA Risk Assessment Form. It begins with a series of questions related to social skills followed by the Resident's perception of risk. In considering gender and sexual orientation, the resident is asked how he/she identifies themselves and whether they are perceived by others as being lesbian, gay, bisexual, transgender or questioning. A series of questions related to one's history of victimization, age, intellectual impairment and the presence or absence of mental health issues are assessed and asked. The screener assesses physical appearance and client behaviors, including inappropriate verbal behavior, inappropriate physical behavior, hunched fearful posture, obvious effeminate behavior in a male, speech impediment, appears dull, behavior that appears related to mental illness and any gender non-conforming appearance. The total of the first nine (9) items is scored and if a score is 14 or higher the resident is considered vulnerable to victimization. In assessing sexually aggressive behavior the following are considered: history of institutionalized predatory sexual behavior, any history of physical abuse/domestic violence, history of assault in prison, openly hostile to gay, lesbian, transgender etc., arrest or conviction of a sexual offense, intimidating or aggressive. If "yes" is entered for item number 1, the resident is designated as "Known Predator"; if "yes" to two or more items other than Number 1, the resident is designated as "Potential Predator", otherwise he is designated as "Non-Predator".

Ten (10) of ten (10) reviewed assessments documented victimization assessments conducted the same date or not later than 72 hours. None of the ten (10) reviewed assessments documented any resident as either a potential victim or predator. None of the reviewed assessments documented any resident who identified as either gay, bisexual, transgender nor did any report prior victimization. The scores were very benign, reflecting the level of custody of the residents being housed in this program. An additional ten (10) reassessments were provided. All documented no changes in the resident's status in the past 30 days.

The auditor relied on the following in determining a rating for this standard:

- Agency policy, 115.241, Screening for Risk of Sexual Victimization and Abusiveness, Screening for Risk of Victimization and Abusiveness
- Project MORE Policy Number 111, Prison Rape Elimination Act (PREA) Compliance Policies, (Screening, Paragraph 1)
- Ten (10) reviewed Risk Assessments
- Ten (10) reviewed Reassessments within 30 days of the initial screening
- Interviews with the PREA Coordinator
- Interviews with the Walter Brooks House, Program Director
- Interviews with two (2) case managers
- Interviews with residents

## Standard 115.242: Use of screening information

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

### 115.242 (a)

- Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Housing Assignments?  Yes  No
- Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Bed assignments?  Yes  No
- Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Work Assignments?  Yes  No

- Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Education Assignments?  Yes  No
- Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Program Assignments?  Yes  No

#### 115.242 (b)

- Does the agency make individualized determinations about how to ensure the safety of each resident?  Yes  No

#### 115.242 (c)

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

#### 115.242 (d)

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

#### 115.242 (e)

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

#### 115.242 (f)

- Unless placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting lesbian, gay, bisexual, transgender, or intersex residents, does the agency always refrain from placing: lesbian, gay, and bisexual residents in dedicated facilities, units, or wings solely on the basis of such identification or status?  Yes  No
- Unless placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting lesbian, gay, bisexual, transgender, or intersex residents, does the agency always refrain from placing:

transgender residents in dedicated facilities, units, or wings solely on the basis of such identification or status?  Yes  No

- Unless placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting lesbian, gay, bisexual, transgender, or intersex residents, does the agency always refrain from placing intersex residents in dedicated facilities, units, or wings solely on the basis of such identification or status?  Yes  No

### Auditor Overall Compliance Determination

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

### Instructions for Overall Compliance Determination Narrative

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

Project MORE Policy 115.242, Training and Education, Use of Screening Information, I. requires that Walter Brooks House, utilize information from the risk screening from 115.241, in determining client housing and bed assignments, work sites, education and program assignments. This will be utilized with the goal of ensuring the safety of all facility residents.

Procedures require the following:

- 1) During the initial intake, the Case Manager determines if the resident is at high risk of being a high risk sexual assault victim or abuser. This is based on the results of the risk screening.
- 2) All residents who are deemed at high risk, to include transgender, gay, bisexual, and intersex residents will be placed in one of the first floor rooms where staff will have the ability to monitor them closely.
- 3) High risk residents are required to be under staff supervision during chore assignments.
- 4) High risk residents will not be referred to employers who have hired potential PMI abusers.
- 5) High risk residents will not be referred to any educational program that has a current resident who is a potential abuser.

Interviews with the staff who conduct the vulnerability/abusiveness assessments stated if the information derived from the screening stated they are going to notify their supervisor when someone scores high on either scale and that the resident may be housed on the first floor nearer to the security office. Once the vulnerability assessment is completed the staff would alert the shift supervisor and make sure the resident is not housed in any room with a predator.



The auditor relied on the following in determining a rating for this standard:

- Project MORE Policy 115.242, Training and Education, Use of Screening Information
- Project MORE Policy Number 111, Prison Rape Elimination Act (PREA) Compliance Policies, (Screening, Paragraph 1)
- Reviewed assessments
- Interviews with staff
- Interviews with residents

## REPORTING

### Standard 115.251: Resident reporting

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

#### 115.251 (a)

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

#### 115.251 (b)

- Does the agency also provide at least one way for residents to report sexual abuse or sexual harassment to a public or private entity or office that is not part of the agency?  Yes  No
- Is that private entity or office able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials?  Yes  No
- Does that private entity or office allow the resident to remain anonymous upon request?  Yes  No

#### 115.251 (c)

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

#### 115.251 (d)

- Does the agency provide a method for staff to privately report sexual abuse and sexual harassment of residents?  Yes  No

### Auditor Overall Compliance Determination

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

### Instructions for Overall Compliance Determination Narrative

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

PMI Policy 115.251, Screening for Risk of Victimization and Abusiveness, Resident Reporting, requires Walter Brooks House to provide multiple ways for resident to privately report sexual abuse and sexual harassment, retaliation by other residents or staff for reporting sexual abuse or sexual harassment and staff neglect or violation of responsibilities that may have contributed to such incidents. Policy requires residents to be informed of at least one way to report to a public or private entity or office that is not a part of PMI.

The agency MOU with the Women and Family Center Sexual Assault Crisis Services provides for a 24 hour too free Sexual Assault Crisis Hotline. The information is provided to residents in the Sexual Assault Crisis Services brochure given to residents and posted throughout the facility. The brochure states the calls a confidential.

Project MORE Policy, Number 111, Prison Rape Elimination Act (PREA) Compliance Policies, Reporting, 1., requires that residents/clients may report abuse verbally and in writing to any staff member and reports may be made at any time regardless of when the alleged event occurred. Reports may be made anonymously by telephone or using the Suggestion/Complaint Box. Victims or third parties may make the complaint but regardless of who makes the complaint, it is required that staff take the reports seriously and document them promptly.

Agency procedures provide for the following ways for residents to report: These are included in the Resident Handbook as well.

- 1) Verbally to any facility staff or other PMI Staff.
- 2) In writing to any facility staff or other PMI Staff.
- 3) Submitting a grievance in the grievance box and the resident may sign his name or remain anonymous.
- 4) Having a family member or friend contact facility staff or other PMI Staff. This can be anonymous as well as emotional.

- 5) Contacting the Connecticut Department of Correction and/or Parole verbally or in writing.
- 6) Contact Senior PMI Staff by calling (number provided) and asking for the president or vice president.
- 7) Contacting the Sexual Abuse Crisis Services (Number provided-for Spanish and English).
- 8) Contacting the Greater New Haven Sexual Assault Crisis Service (Address and phone number provided)

The procedures also require all reports made either verbally or in writing are documented within 24 hours.

All reports are required to be documented.

The Prison Rape Elimination Act of 2003, PREA Acknowledgment Statement advises residents that they can report either verbally or in writing to any agency employee, to law enforcement, or have a third-party report to the agency.

Interviewed staff stated they take all reports seriously, report them immediately to their immediate supervisor and follow-up with a written report. Interviewed residents indicated, in their interviews, that they would tell a staff, tell a family member, or call the PREA Hotline. Most of the residents have cell phones and can call anyone they want to at any time. Others who may not have a cell phone have jobs and are out in the community on an almost daily basis while some who do not yet have jobs are allowed to go on passes to look for jobs in the community. Residents also have access to visitors and Department of Correction Staff.

The auditor relied on the following in determining a rating for this standard:

- PMI Policy 115.251, Screening for Risk of Victimization and Abusiveness, Resident Reporting
- MOU with the Women and Family Center Sexual Assault Crisis Services
- Project MORE Policy, Number 111, Prison Rape Elimination Act (PREA) Compliance Policies, Reporting, 1
- Reviewed Sexual Assault Crisis Service brochure  
Resident handbook
- Observed PREA related posters throughout the facility
- Interviews with staff
- Interviews with random residents

## **Standard 115.252: Exhaustion of administrative remedies**

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

### **115.252 (a)**

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

#### 115.252 (b)

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

#### 115.252 (c)

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

#### 115.252 (d)

- Does the agency issue a final agency decision on the merits of any portion of a grievance alleging sexual abuse within 90 days of the initial filing of the grievance? (Computation of the 90-day time period does not include time consumed by residents in preparing any administrative appeal.) (N/A if agency is exempt from this standard.)  Yes  No  NA
- If the agency determines that the 90-day timeframe is insufficient to make an appropriate decision and claims an extension of time [the maximum allowable extension of time to respond is 70 days per 115.252(d)(3)] , does the agency notify the resident in writing of any such extension and provide a date by which a decision will be made? (N/A if agency is exempt from this standard.)  Yes  No  NA
- At any level of the administrative process, including the final level, if the resident does not receive a response within the time allotted for reply, including any properly noticed extension, may a resident consider the absence of a response to be a denial at that level? (N/A if agency is exempt from this standard.)  Yes  No  NA

#### 115.252 (e)

- Are third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, permitted to assist residents in filing requests for administrative remedies relating to allegations of sexual abuse? (N/A if agency is exempt from this standard.)  
 Yes  No  NA
- Are those third parties also permitted to file such requests on behalf of residents? (If a third-party files such a request on behalf of a resident, the facility may require as a condition of processing the request that the alleged victim agree to have the request filed on his or her behalf, and may also require the alleged victim to personally pursue any subsequent steps in

the administrative remedy process.) (N/A if agency is exempt from this standard.)

Yes  No  NA

- If the resident declines to have the request processed on his or her behalf, does the agency document the resident's decision? (N/A if agency is exempt from this standard.)

Yes  No  NA

#### 115.252 (f)

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

#### 115.252 (g)

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

#### Auditor Overall Compliance Determination

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

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

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

### **Instructions for Overall Compliance Determination Narrative**

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

Project MORE Policy 115.252 Exhaustion of Administrative Remedies requires Project MORE to establish procedures providing residents with a way of resolving sexual abuse and sexual harassment allegations through a grievance process. Policy also affirms the resident does not have to submit a grievance regarding sexual harassment or sexual abuse. He/she can also verbally inform staff of any allegation if they choose.

Procedures for Policy 115.252 allows the following:

- Residents may submit a grievance regarding sexual abuse or sexual harassment and there is no time limit regarding the submission of the grievance.
- Residents may place the grievance in a grievance box, handing it to a program staff, handing it to any agency staff or have a third party present the grievance.
- Residents are not required to submit the grievance to a staff who would be the subject of the complaint. Residents may give the grievance to the Program Director, unless that person is the subject of the complaint, or to a Project MORE administrative staff.
- Once a grievance is submitted, the PREA Coordinator will immediately begin an investigation.
- The final decision will be based on the merits of the grievance with a final decision made within 30 days of the submission of the grievance. The period may be extended for a period of up to 70 days if more time is required.
- The resident submitting the grievance will be notified, in writing, of any decision and/or extension.
- If the resident does not receive a written response within the allotted time, this does not mean the grievance is denied.

Paragraph II H. Third Parties provides for the following:

- Third parties may assist a resident in submitting a grievance. Third parties include fellow residents, staff members, family, attorney and outside advocate.
- Third parties may submit a grievance on behalf of a resident. It may be submitted to any Project MORE staff.
- If a resident declined to have a third- party grievance processed, staff will document the decision

Paragraph II.I., Emergency Grievances provides for the following:

- A resident may submit/file an emergency grievance if the resident is subject to imminent risk of sexual abuse.
- The agency PREA Coordinator will be contacted regarding any Emergency Grievances. The PREA Coordinator will instruct staff to place the resident under staff observation.

- The PREA Coordinator will initiate an investigation immediately and will have a response within 48 hours.
- A final determination will be submitted within five calendar days and the final decision will state if the resident is in immediate risk.
- All final determinations will document all action taken by the agency. This includes the PREA Coordinator, agency and the referring source.

Paragraph J. provides for disciplinary action if a resident filed a grievance in bad faith. The action would be determined by the seriousness of the allegation, how well or poorly that resident has done in the facility, and converse with the referring source.

The Walter Brooks House did not have any allegations of sexual abuse or sexual harassment during the past 12 months.

Interviewed residents were generally aware that the grievance process was one way they could report sexual abuse and sexual harassment as well as retaliation.

## Standard 115.253: Resident access to outside confidential support services

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

#### 115.253 (a)

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

#### 115.253 (b)

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

#### 115.253 (c)

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

## Auditor Overall Compliance Determination

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

## Instructions for Overall Compliance Determination Narrative

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

PMI Policy, 115.253, Reporting, Residents Access to Outside Confidential Support Services, I. requires PMI to provide residents with access to outside victim advocates for confidential emotional support services related to sexual abuse.

Residents are required to be provided mailing addresses, telephone numbers, hotline telephone numbers available of local, State, or national advocacy organizations. This is to enable reasonable communications between residents and these organizations.

PMI facilities are required, in compliance with policy and the PREA Standards, to maintain or attempt to maintain a memorandum of understanding with a community provider to provide a confidential support related to sexual abuse. All copies of agreements or documentation showing attempts to enter into such agreements will be kept on file. The agency has a MOU with the Women and Families Center. This MOU, dated June 3, 2014, affirms the Women and Families Center (WFC) will provide individual counseling and support groups at Project MORE and provide accompaniment and support through medical, police and legal proceedings.

Residents are given the Sexual Assault Crisis Services brochure that provides residents with valuable information related to sexual assault and the services of the Women and Families Center (Sexual Assault Crisis Services)/ The brochure specifically states the organization offers the following:

- A 24- hour toll free confidential hotline
- Crisis intervention, immediate crisis counseling to victims over the hotline
- Support groups; and
- Accompaniment and Systems' support through medical, police and legal proceedings.

The contact information for the New Haven Women and Family Center as well as those in Meriden and Middletown, is provided. The 24-hour toll free number is provided. These is one number to call for English and one for Spanish.

They also assert that all their services are free.



Procedures require that residents who contact an outside advocate may do so at any time without staff knowledge. The extent to which reports of sexual abuse will be forwarded to authorities will be in accordance with mandatory reporting laws.

Any PMI facility will allow a resident the use of a program office to make the call in confidence. Clients also have access to cell phones and can use those as well. Additionally, clients are out in the community on an almost daily basis either going to work or looking for work or on personal passes giving them community access almost daily.

The Resident Handbook provides the resident with multiple ways to report, both internally and externally. Ways to report to outside confidential support organizations include the Women and Families Sexual Assault Crisis Service. Residents are provided, in the handbook, the phone numbers for the organization as well as the physical location of the Center to enable residents “go directly to the Women and Families Office (address provided). The information is provided, as well, on postings throughout the facility.

Although the facility provided the contact information, none of the residents who were interviewed knew of a specific outside agency who could provide counseling and support to victims of sexual abuse. The auditor discussed the issue with the PREA Coordinator who agreed that as Corrective Action, the agency would have each facility retrain residents in the role of the Women and Family Center, Sexual Assault Crisis Services and how to contact them if they ever needed them.

On October 17, 2017, the PREA Coordinator forwarded training rosters with signatures of residents indicating they have re-trained the residents in the role of the program and how to access it. That information was provided to residents upon admission and is posted throughout the facility however residents, when asked, could not identify any such agency nor the services they would provide, beyond speculating that it would probably involve some counseling.

The auditor relied on the following in determining a rating for this standard:

- PMI Policy, 115.253, Reporting, Residents Access to Outside Confidential Support Services, I.
- MOU with the Women and Families Center
- Sexual Assault Crisis Services brochure
- The Resident Handbook
- Corrective Action Plan – training rosters documenting refresher training for residents on the role of the Women and Family Center (Sexual Assault Crisis Center)
- Interviews with the PREA Coordinator
- Interviews with residents

## **Standard 115.254: Third-party reporting**

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

### **115.254 (a)**

- Has the agency established a method to receive third-party reports of sexual abuse and sexual harassment?  Yes  No

- Has the agency distributed publicly information on how to report sexual abuse and sexual harassment on behalf of a resident?  Yes  No

### Auditor Overall Compliance Determination

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

### Instructions for Overall Compliance Determination Narrative

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

PMI Policy, 115.254, Reporting, Third Party Reporting, I. requires PMI to establish a method to receive third party reports of sexual abuse and sexual harassment. PMI policy requires the agency to distribute information on how to report sexual abuse and sexual harassment on behalf of a resident.

II. Procedures for that same policy, requires PMI to accept third party report of sexual abuse and sexual harassment and provides the following ways for anyone to make a third- party report:

- 1) By mail to the facility or main office.
- 2) By telephone call to the facility, other facility or main office.
- 3) In person-coming directly to the facility and speaking directly to any staff person, or going to another facility or main office and speak to any agency staff member.
- 4) By e-mail to any agency staff person.
- 5) By having any other agency contact the facility, other facility or main officer by mail, telephone, e-mail or in person.

Project MORE Policy, Number One, Prison Rape Elimination Act (PREA) Compliance Policies, Reporting, 1., in describing ways for residents to make reports of sexual abuse or sexual harassment, states "The Victim or a third party may make the complaint" and goes on to require of staff that regardless of who makes the complaint, it must be taken seriously and documented promptly.

The Project MORE website provides ways for viewers to report enabling third party reporting. These include:

- 1) Verbally or in writing to any Project MORE staff person.
- 2) Having a family member or friend contact any agency staff person.
- 3) Contact the resident's referring source, Department of Correction, Office of Adult Probation, Department of Parole or Court.
- 4) Contact the Sexual Assault Crisis Services, (Number for English and Spanish provided).

5) Contact anonymously by telephone or letter by family or friend.

The Resident Handbook advises residents that a report may be made by having a facility member or friend contact facility staff or other Project MORE staff.

The reviewed Pre-Audit Questionnaire and interviews with staff confirmed there have been no allegations of either sexual abuse or sexual harassment during the past twelve (12) months.

Interviewed residents stated they were aware that a third party could make a report for them however they indicated they would make the report themselves if it ever happened to them.

Interviewed staff stated they have been trained to take reports of sexual abuse and sexual harassment from any source, including a third party.

The auditor relied on the following in determining a rating for this standard:

- PMI Policy, 115.254, Reporting, Third Party Reporting, I.
- Project MORE Policy, Number One, Prison Rape Elimination Act (PREA) Compliance Policies, Reporting, 1
- Project MORE Website
- Walter Brooks Resident Handbook
- Pre-Audit Questionnaire
- Interviewed residents
- Interviewed staff

## OFFICIAL RESPONSE FOLLOWING A RESIDENT REPORT

### Standard 115.261: Staff and agency reporting duties

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

#### 115.261 (a)

- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether it is part of the agency?  Yes  No
- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding retaliation against residents or staff who reported an incident of sexual abuse or sexual harassment?  Yes  No
- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding any staff neglect or violation of responsibilities

that may have contributed to an incident of sexual abuse or sexual harassment or retaliation?

Yes  No

#### 115.261 (b)

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

#### 115.261 (c)

- Unless otherwise precluded by Federal, State, or local law, are medical and mental health practitioners required to report sexual abuse pursuant to paragraph (a) of this section?  Yes  No
- Are medical and mental health practitioners required to inform residents of the practitioner's duty to report, and the limitations of confidentiality, at the initiation of services?  Yes  No

#### 115.261 (d)

- If the alleged victim is under the age of 18 or considered a vulnerable adult under a State or local vulnerable persons statute, does the agency report the allegation to the designated State or local services agency under applicable mandatory reporting laws?  Yes  No

#### 115.261 (e)

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

#### Auditor Overall Compliance Determination

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

#### Instructions for Overall Compliance Determination Narrative

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

Policy 115.261, Official Response Following a Resident Report, Staff and Agency Reporting Duties, I. and Project MORE, Policy Number 1., Prison Rape Elimination Act (PREA) Compliance Policies, Staff and Agency Reporting Duties, requires all PMI staff to report immediately and according to agency policy, any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency; retaliation against clients/residents or staff who reported such an incident; and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation.

Policy also provides for confidentiality in reporting and requires, apart from reporting to designated supervisors or officials, staff are prohibited from revealing any information related to a sexual abuse report to anyone other than to the extent necessary to make treatment, investigation, and other security and management decisions.

Medical and mental health practitioners, unless precluded by Federal, State, or local law, are required to report sexual abuse and to inform residents of a practitioner's duty to report, and the limits of confidentiality, at the initiation of services.

The agency will report any incidents involving an alleged victim under 18 years of age or considered a vulnerable adult under a state or vulnerable person's statute, to the designated State or local services agency under the applicable mandatory reporting laws.

The Staff Training Manual section entitled: "Reporting of a Sexual Assault or Sexual Harassment Incident" states these are required to be reported immediately to a supervisor:

- Any knowledge, suspicion or information regarding a sexual assault or sexual harassment incident
- Any staff neglect or violation of responsibilities that may have contributed to an incident
- Any retaliation of staff or resident for reporting a sexual assault or sexual harassment incident

Staff are trained to report all incidents up the chain of command from line staff, to immediate supervisor, to program coordinator to PREA Coordinator to Administrative Staff and Referring Staff.

Agency procedures for implementing the policy require the Program Director or designee to report all allegations of sexual abuse or sexual harassment to the PREA Coordinator. If the program receives an allegation that a resident was sexually abused while confined at another facility, the agency PREA Coordinator will notify the head of the facility or appropriate office of the facility where the alleged incident occurred. This notification must be provided as soon as possible but not later than 72 hours after receiving the allegation. PMI requires all allegations and notifications are documented and investigated in accordance with the PREA Standards.

Interviewed staff were adamant that they are trained to report "everything", including suspicions, as well as knowledge or reports made from any source, including reports made verbally, in writing, anonymously and through third parties. They indicated they would also be required to complete a written statement or report prior to the end of their shift.

Interviews with residents indicated they would most likely make a report to a staff person and they believed the staff would take the report seriously and do something about it.

There have been no allegations of sexual abuse, sexual harassment or retaliation made during the past twelve (12) months. This was confirmed through reviewing the Pre-Audit Questionnaire, reviewing a memo from the PREA Coordinator and interviewing both staff and residents.

The auditor relied on the following in determining a rating for this standard:

- Policy 115.261, Official Response Following a Resident Report, Staff and Agency Reporting Duties, I.
- Project MORE, Policy Number 1., Prison Rape Elimination Act (PREA) Compliance Policies, Staff and Agency Reporting Duties
- Staff Training Manual, Reporting of a Sexual Assault or Sexual Harassment Incident
- Interviews with staff

## Standard 115.262: Agency protection duties

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

### 115.262 (a)

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

### Auditor Overall Compliance Determination

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

### Instructions for Overall Compliance Determination Narrative

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

Agency policy 115.262, Official Response Following a Residential Report, Agency Protection Duties, I. requires that when PMI staff learn that a resident is subject to a substantial risk of imminent sexual abuse, immediate action will be taken to protect the resident.

Agency procedures require that once the facility learns that one of its residents is subject to a substantial risk of sexual abuse staff will 1) Inform the Supervisor on duty; 2) Bring the Resident to the main office; 3) Contact the Program Director and explain the situation; 4) Contact the agency PREA

Coordinator and explain the situation; 5) The PREA Coordinator will contact PMI Administrative Staff and 6) Contact the referral source and explain the situation.

If the sexual assault is to be committed by another facility resident, the potential victim will not be out of sight by staff, while the alleged assaulter will be confined to his room. The PREA Coordinator will conduct an investigation and report his findings to the referral source.

If an investigation shows the assault was imminent, the PREA Coordinator will request the removal of the resident who would have committed the assault. In the event the assault was to occur while the resident was off site, the resident will be placed on lockdown. The referral source and the New Haven Police Department would be contacted.

Project MORE Policy, Number 1, Prison Rape Elimination Act (PREA) Compliance Policies, Reporting, 1., states it is mandatory that, pending investigation, it is mandatory that every reasonable effort be taken to protect the victim from further abuse. In that same policy, Victim Support, paragraph 1, requires that when a staff feels that a resident/client may be subject to a substantial risk of imminent sexual abuse or retaliation, immediate actions must be taken to protect the resident/client. Actions staff may take, according to policy, are:

- Removing the alleged abusers from contact with victims
- Monitoring resident, including by direct observation, if necessary
- Transferring victims/abusers to other facilities if operationally possible
- Segregation of victims/abusers during transportation
- Actively monitoring the conduct and treatment of residents/clients or staff who have reported abuse and of residents/clients who have reported to have suffered abuse for any signs of retaliation

The Staff Training Manual states, Project MORE, will employ multiple protection measures including the following:

- Transferring a resident to another facility
- If necessary, request removal of a resident (via the funding source)
- If warranted, suspend or terminate the staff (if a staff is involved)
- Remove alleged staff to another facility, if possible
- Remove alleged resident or staff from contact with the victim; and
- Provide emotional support for staff or resident

The PREA Coordinator provided a letter dated September 1, 2017, affirming there have been no instances where a resident was at risk of imminent sexual abuse. The PREA Coordinator also provided a statement asserting the steps to be taken if a resident was at substantial risk of imminent sexual abuse.

One-hundred percent of the interviewed staff asserted they would respond to any allegation or information that a resident was at substantial risk of imminent sexual abuse. They also indicated they would keep the resident with them or in line of sight and report it to their supervisor and keep the resident with them until a decision was made by the supervisor about where to place them. Staff stated the resident would probably be placed on the first floor where he could be near the security office and in view of cameras.

An interview with the Program Coordinator indicated if a resident is at risk, scored 14 or more on the victimization scale or whose assessment indicated that he may be a potential predator, would be

placed on the first floor where they could be monitored more closely. The agency would not use segregated housing or any form of isolation.

The auditor relied on the following in determining a rating for this standard:

- Agency policy 115.262, Official Response Following a Residential Report, Agency Protection Duties, I.
- Project MORE Policy, Number 1, Prison Rape Elimination Act (PREA) Compliance Policies, Reporting, 1.,
- Staff Training Manual
- The PREA Coordinator provided a letter dated September 1, 2017
- Interview with Program Director
- Interview with PREA Coordinator
- Interviews with staff
- Interviews with residents

## Standard 115.263: Reporting to other confinement facilities

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

### 115.263 (a)

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

### 115.263 (b)

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

### 115.263 (c)

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

### 115.263 (d)

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

### Auditor Overall Compliance Determination

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



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

**Instructions for Overall Compliance Determination Narrative**

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

Upon receiving an allegation that a resident was sexually abused while confined in another facility, the Program Director/designee, once notified of the allegation, will contact the head of the facility or appropriate office of the agency where the allegation occurred. This is required in PMI Policy 115.263, Official Response Following a Residential Report, Reporting to Other Confinement Facilities.

Section II. of that policy, Procedures, requires the staff receiving an allegation immediately contact the Program Director or designee and PMI's PREA Coordinator. The staff receiving the report of alleged abuse is required to complete a detailed incident report including all the items required in policy. The Program Director, designee or PREA Coordinator will contact the head of the facility, or appropriate office where the alleged abuse took place. This action is required to occur as soon as possible but not later than 72 hours after receiving the allegation. The incident report is faxed or emailed to the proper individual. A copy of the fax receipt/email along with the resident report is placed in the resident's file. The PREA Coordinator then documents that the notification has been made.

Interviews with the PREA Coordinator and Program Director confirmed that if a resident alleged sexual abuse or sexual harassment while at another facility the Program Director in consultation with the PREA Coordinator would notify the Director of the sending facility, determine if the allegation had been reported at the sending facility and if not initiate an investigation. If a resident reported at another facility that he was abused while at Walter Brooks House, the Program Director would ensure his staff cooperated completely with any investigation, including taking witness statements or pulling video or whatever they needed to do to cooperate with the investigators.

A memo from the PREA Coordinator dated September 7,2017, asserted that Project MORE, since implementing PREA prior to 2014, has not had any instances where a resident has informed staff that they were sexually abused or harassed in another jail, prison, lockup or community confinement facility.

Interviews with both the PREA Coordinator and Program Director confirmed that there were no allegations of sexual abuse from a sending facility that a resident was abused in that facility nor were there any allegations from other programs that a resident was sexual abused or sexually harassed while in the Walter Brooks House.

The auditor relied on the following in determining a rating for this standard:

- PMI Policy 115.263, Official Response Following a Residential Report, Reporting to Other Confinement Facilities.
- Memo from the PREA Coordinator dated September 7,2017
- Interviews with the PREA Coordinator
- Interviews with the Program Director

## Standard 115.264: Staff first responder duties

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

### 115.264 (a)

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

### 115.264 (b)

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

### Auditor Overall Compliance Determination

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

### Instructions for Overall Compliance Determination Narrative

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

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

Project MORE is required by policy to take immediate action upon learning that a resident was sexually abused via the staff first responder.

Section II. Procedures of PMI Policy, 115.264, Official Response Following a Resident Report, Staff First Responder Duties, require the following actions upon learning a resident was sexually abused:

1. Separate the victim from the abuser.
2. The victim will be kept in the staff office under staff supervision.
3. The abuser must remain in his/her room under staff supervision.
4. Ensure that both victim and alleged abuser do not destroy any physical evidence by requesting that they not take a shower, brush their teeth, eat, drink, urinate, defecate, change clothing, smoke etc.
5. Preserve and protect the crime scene. Close off the room or area where the alleged abuse took place. Residents or staff are not allowed to enter the area unless cleared by law enforcement.
6. Contact the Program Director and the Project MORE PREA Coordinator.

Paragraph B., II. Procedures, Preserving the Crime Scene, stresses the necessity and importance of keeping pertinent evidence uncontaminated until it can be recorded and collected. The Shift Supervisor is responsible for protecting the crime scene. Duties include:

1. Placing a note on the room or area the alleged assault occurred. The note will state that no one is allowed to enter the room or area.
2. The note will also state that nothing can be removed from the room or area.
3. If staff is available that person will be placed in front of the door or area the alleged assault occurred.
4. The room or area will be handed over to the New Haven Police Department on their arrival.
5. Each agency facility will have, on site, a list of those who have a need to enter the area.

If the first staff responder is not a security staff member, the staff will be responsible for requesting that the alleged victim not take any actions that could destroy physical evidence by requesting they not shower, brush teeth, eat, drink, urinate, defecate, change clothing, smoke etc. Once that is completed, that staff will notify security staff.

The Staff Training Manual, First Responder duties requires staff to 1) separate the alleged victim and abuser (not leave the victim alone, keep the alleged perpetrator under supervision); 2) Preserve and protect the crime scene until evidence can be collected; 3) If the abuse occurred within a time frame that still allows for the collection of physical evidence, staff are to request the victim and abuser not wash, bathe, brush teeth, change clothing, use the bathroom (not wipe), or eat.

The reviewed Project MORE PREA Incident Report Checklist lists actions to be taken with regard to the victim and to making immediate notifications. A series of basic questions is asked of the victim to find out what happened. It includes questions like: who assaulted/harassed you; when did it occur; Where did it occur; and, if a sexual assault was is anal, oral or other. Then the resident is asked when they last time they showered; have they changed clothes; and have they brushed their teeth.

Staff consistently, in their interviews, described steps they would take if they were the first staff to become aware a resident was the victim of sexual abuse. These steps included separating the victim

(staff said they would take the victim to an office for privacy), cordon off the room or ensure no one entered an area that might be a crime scene and request the victim not to take any actions that would contaminate or degrade evidence, including eating or drinking, showering, bathing, or brushing teeth, urinating or defecating or changing clothes. They also said they would report it immediately to their supervisor. Non-security staff were interviewed. These included three food services staff. Each of them could articulate the same basic steps as those required of security staff. There are no medical or mental health staff assigned to the program.

There have been no allegations of sexual assault or sexual harassment during the past twelve (12) months. This was confirmed through interviews with the PREA Coordinator, Program Director, and other staff. None of the interviewed residents disclosed sexual assault or sexual harassment during their interviews.

The PREA Coordinator provided a memo documenting there have been no allegations of either sexual abuse or sexual harassment during the past twelve months in the Walter Brooks House. The reviewed Annual PREA Report, July 1, 2016 to June 30, 2017, documented there have been no allegations of sexual abuse or sexual harassment during the fiscal year.

The auditor relied on the following in determining a rating for this standard:

- Section II. Procedures of PMI Policy, 115.264, Official Response Following a Resident Report, Staff First Responder Duties
- Paragraph B., II. Procedures, Preserving the Crime Scene
- The Staff Training Manual, First Responder duties
- Project MORE PREA Incident Report Checklist
- Memo from the PREA Coordinator
- Annual Report – July 1, 2016 to June 30, 2017
- Interviews with the PREA Coordinator
- Interviews with the Program Director
- Interviews with random staff, both security and non-security

## Standard 115.265: Coordinated response

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

### 115.265 (a)

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

### Auditor Overall Compliance Determination

Exceeds Standard (*Substantially exceeds requirement of standards*)

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

### **Instructions for Overall Compliance Determination Narrative**

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

Project MORE, Inc., Policy, 115.365, Official Response Following a Resident Report, Coordinated Response, I. asserts that PMI will ensure a coordinated response to any incident of sexual abuse among staff, first responders and Agency leadership.

Section II., Procedures, list the first responder duties and investigative responsibilities. The facility does not have mental health or medical staff on site.

First Responder duties, upon learning that a resident was sexually abused, include the following:

1. Not leave the victim alone.
2. Call the staff in charge to request assistance from the Program Director or designee, PREA Coordinator or senior management staff.
3. Call 911 and arrange transportation to a local hospital.
4. Separate the alleged victim and abuser.
5. Preserve and protect the crime scene.
6. Contact the Connecticut Sexual Assault Crisis Center to arrange for a sexual assault advocate to meet the resident at the hospital.

Paragraph 2. Preserve the Crime Scene, requires that if the abuse occurred within a time period that would allow for the collection of physical evidence, request that the alleged victim and abuser not take any action that could destroy physical evidence, including not washing, brushing teeth, changing clothes, and smoking, urinating, defecating or eating unless medically indicated.

First responders are required to use the PREA Incident Check Sheet to ensure first responder duties have been fulfilled. The PREA Incident Check Sheet was discussed at length in standard 115.264, Staff First Responder Duties.

Paragraph B., Investigative Responsibilities, requires PMI to rely on the local and/or state authorities to investigate allegations of sexual abuse.

Paragraph C., Responsibilities of PMI Leadership, addresses the responsibilities of PMI Leadership in response to an allegation of sexual abuse. These actions include the following;

1. All PMI staff must immediately report to the PREA Coordinator, Program Director/designee, the HR Director or any supervisor or manager or management staff, any knowledge, suspicions or information regarding a) an incident of sexual abuse that occurred in the program; 2) Retaliation

- against residents or staff who reported an incident of sexual abuse; 3) any staff neglect or violation of responsibility that may have contributed to such an incident or retaliation.
2. All reports of sexual abuse that are received from third parties are required to be received and responded to according to policies by all staff.
  3. PMI staff, as soon as practical, must report all allegations of sexual abuse, including third party and anonymous reports to the local authorities for further investigation.
  4. Walter Brooks House staff, on learning of a sexual abuse or suspecting a sexual abuse, must immediately notify the PREA Coordinator, Program Director or designee, the HR Director, or a supervisor, manager, or senior management staff. Specific instructions are provided, and these include:
    - a) Staff receiving the notice will immediately notify the PREA Coordinator, if not already initially notified.
    - b) The PREA Coordinator will notify the PMI Administration as soon as possible but not later than the end of the business day or the date the allegation was received.
    - c) PMI Senior Management will institute the Incident Report Process and Contact local authorities to begin a criminal investigation, if they have not already been contacted.
  5. The Program Supervisor/Director, upon receiving an allegation that a resident has been sexually abused, will contact the PREA Coordinator and document the report and notification in the Communication Log.
  6. The PREA Coordinator will notify the Administration of PMI and keep records of the details of notifications.

The reviewed Sexual Abuse Incident Coordinated Response Plan documents ten (10) actions for first responders to take; dating and giving the times the actions were completed (and initialing the action); shift supervisor actions including contacting the Program Director and PREA Coordinator, assigning staff to preserve the crime scene, assure the abuser and victim are under supervision, requesting they not take any action that might, destroy evidence) and complete an incident report; and program director, who is responsible for ensuring first responder and shift supervisor have completed their tasks, ensuring the victim has been transported to Yale New Haven Hospital, ensure staff accompanies the victim, contact the Women and Families Center and Complete the Incident Report and actions to be taken by the PREA Coordinator, including the required tasks have been completed by the first responders and shift supervisor, contacting the PMI Administration, Contacting the CT DOC or CSSD, ensuring incident reports are completed, reviewing incident reports, ensuring crisis intervention if required and convening the PREA Incident Review Team within 30 days of completion of the investigation.

Policy also prohibits staff, apart from reporting to designated supervisors or agency officials, from revealing any information related to sexual abuse to report to anyone other than to the extent necessary, as specified in agency policy, to make treatment, investigation, and other security and management decisions. This is required in Policy 115. 365, Official Response Following an Allegation of Sexual Abuse, Coordinated Response Plan.

The PREA Coordinator stated that all staff have copies of the Coordinated Response Plan. Interviews with random security staff, random non-security staff, the Program Manager and PREA Coordinator, confirmed that each is aware of their roles and responsibilities in responding to allegations of sexual abuse.

The auditor relied on the following in determining the rating for this standard:

- Project MORE, Inc., Policy, 115.365, Official Response Following a Resident Report, Coordinated Response, I.
- Paragraph 2. Preserve the Crime Scene
- Paragraph C., Responsibilities of PMI Leadership
- The reviewed Sexual Abuse Incident Coordinated Response Plan
- Policy 115. 365, Official Response Following an Allegation of Sexual Abuse, Coordinated Response Plan.
- Memo from PREA Coordinator confirming there have been no allegations of sexual abuse during the past 12 months
- Interviews with random security staff, random non-security staff, PREA Coordinator and Program Director

## Standard 115.266: Preservation of ability to protect residents from contact with abusers

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

### 115.266 (a)

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

### 115.266 (b)

- Auditor is not required to audit this provision.

### Auditor Overall Compliance Determination

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

### Instructions for Overall Compliance Determination Narrative

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

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

Project MORE, Inc., is a private, not-for-profit agency. A statement provided by the PREA Coordinator affirmed that agency staff are not unionized. The statement also states that PMI does not enter into collective bargaining agreements with staff. Reviewed agency policies and procedures and interviews with the Agency PREA Coordinator who also served as the Agency Head's designee due to his absence, confirmed that the agency has the ability to remove from contact, any staff who violates any of the agency's sexual abuse or sexual harassment policies.

Project MORE Policy, 111, Prison Rape Elimination Act (PREA) Compliance Policies, Discipline, requires that staff are subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies.

Interviews with the Program Manager and PREA Coordinator confirmed staff would be separated immediately if they are involved in an allegation of sexual abuse and placed on no-contact status.

The auditor relied on the following in determining a rating for this standard:

- Project MORE Policy, 111, Prison Rape Elimination Act (PREA) Compliance Policies, Discipline
- Interviews with the Project Manager and PREA Coordinator
- Interviews with staff

## **Standard 115.267: Agency protection against retaliation**

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

#### **115.267 (a)**

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

#### **115.267 (b)**

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

#### **115.267 (c)**

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor the conduct



and treatment of residents or staff who reported the sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff?  Yes  No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor the conduct and treatment of residents who were reported to have suffered sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff?  Yes  No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Act promptly to remedy any such retaliation?  Yes  No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor any resident disciplinary reports?  Yes  No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor resident housing changes?  Yes  No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor resident program changes?  Yes  No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor negative performance reviews of staff?  Yes  No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor reassignments of staff?  Yes  No
- Does the agency continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need?  Yes  No

#### 115.267 (d)

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

#### 115.267 (e)

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

#### 115.267 (f)

- Auditor is not required to audit this provision.

## Auditor Overall Compliance Determination

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

## Instructions for Overall Compliance Determination Narrative

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

PMI Policy, Retaliation, I., affirms that PMI protects all residents and staff who report sexual abuse or sexual harassment or cooperate with any investigation from retaliation by other residents or staff.

The PREA Coordinator and Program Director are designated in policy as the staff responsible for monitoring retaliation.

The procedures, outlined in policy requires that PMI will implement the following, depending on the need, to protect all residents and staff from retaliation:

- 1) Transfer the victim or abuser to another facility;
- 2) Transfer staff to another agency residential facility or program, if operationally possible.
- 3) Removal of alleged staff or resident from contact with the victim.
- 4) Provide emotional support services for residents and/or staff that fear retaliation for reporting the incident.
- 5) Segregation during any transportation.
- 6) Consult with the referral source.
- 7) Actively monitor the conduct and treatment of residents or staff who have reported and/or PRE
- 8) Protect individuals who cooperate in investigations who express fear of retaliation.

Agency procedures require the PREA Coordinator, along with the Program Director, to monitor the conduct and treatment of the resident(s) and/or staff who reported the incident. Monitoring is required for a period of 90 days following the incident.

The Walter Brooks House retaliation monitoring includes the following:

- 1) Staff and resident disciplinary reports
- 2) Housing changes or program changes
- 3) Negative performance reviews
- 4) Resident misconducts
- 5) Reassignment of staff

The Project MORE Policy, Number 111, Prison Rape Elimination Act (PREA) Compliance Policies, Staffing, c. requires if an individual who cooperates with an investigation and express fear of retaliation the facility will take measures to protect against retaliation. Monitoring will occur for 90 days. Monitoring will include:

- Recent Disciplinary Reports
- Housing changes
- Periodic status checks
- Program changes, negative cases notes or progress reports
- Staff reassignments
- Negative performance reviews

Procedures also require Walter Brooks House to monitor beyond 90 days if the initial monitoring indicates a continuing need. In the case of residents, each monitoring shall include their Monthly Reports. However, PMI's obligation to monitor terminates if the agency determines if the allegation is unfounded.

The PREA Coordinator related he is going to meet with the resident or staff immediately after an allegation is made. This is a face-to-face meeting in which the PREA Coordinator lets the resident/staff know that he is available at any time they may feel they are being retaliated against. The Monitor related the items he is going to monitor if it is a resident or if it involves a staff member. His description was consistent with the policies.

There have been no allegations of either sexual abuse or sexual harassment during the past twelve (12) months. This was confirmed through interviews with the PREA Coordinator, Program Director, and a memo from the PREA Coordinator asserting there have been no allegations during the past 12months. The reviewed Annual Report for the past fiscal year documented no allegations of either sexual abuse or sexual harassment involving the Walter Brooks House.

The auditor relied on the following in determining the rating for this standard:

- Project MORE Policy, Retaliation, 115.267, 1.
- Project MORE Policy Number 111, Prison Rape Elimination Act (PREA) Compliance Policies
- Interviews with the PREA Coordinator and Program Manager
- Interviews with the Program Director

## INVESTIGATIONS

### Standard 115.271: Criminal and administrative agency investigations

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

#### 115.271 (a)

- When the agency conducts its own investigations into allegations of sexual abuse and sexual harassment, does it do so promptly, thoroughly, and objectively? [N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations. See 115.221(a).]  Yes  No  NA
- Does the agency conduct such investigations for all allegations, including third party and anonymous reports? [N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations. See 115.221(a).]  Yes  No  NA

#### 115.271 (b)

- Where sexual abuse is alleged, does the agency use investigators who have received specialized training in sexual abuse investigations as required by 115.234?  Yes  No

#### 115.271 (c)

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

#### 115.271 (d)

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

#### 115.271 (e)

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

#### 115.271 (f)

- Do administrative investigations include an effort to determine whether staff actions or failures to act contributed to the abuse?  Yes  No

- Are administrative investigations documented in written reports that include a description of the physical evidence and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings?  Yes  No

#### 115.271 (g)

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

#### 115.271 (h)

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

#### 115.271 (i)

- Does the agency retain all written reports referenced in 115.271(f) and (g) for as long as the alleged abuser is incarcerated or employed by the agency, plus five years?  Yes  No

#### 115.271 (j)

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

#### 115.271 (k)

- Auditor is not required to audit this provision.

#### 115.271 (l)

- When an outside entity investigates sexual abuse, does the facility cooperate with outside investigators and endeavor to remain informed about the progress of the investigation? [N/A if an outside agency does not conduct administrative or criminal sexual abuse investigations. See 115.221(a).]  Yes  No  NA

#### Auditor Overall Compliance Determination

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

## Instructions for Overall Compliance Determination Narrative

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

Walter Brooks House has not had an allegation of either sexual abuse, sexual misconduct or sexual harassment during the past twelve months. This was confirmed through interviews with the PREA Coordinator and Program Director, a review of the Pre-Audit Questionnaire and a memo provided by the PREA Coordinator documenting that there were no allegations of sexual abuse or sexual harassment during the agency. past 12 months.

PMI Policy, 115.271 Investigations, Criminal and Administrative Investigations, I. states that Project MORE, Inc. will conduct administrative investigations into allegations of sexual abuse and sexual harassment in a prompt, thorough, and objective manner, including third party and anonymous reports. Project MORE Policy, Number 111, Prison Rape Elimination Act (PREA) Compliance Policies, Referrals of Allegations for Investigations, requires an administrative investigation be completed for all allegations of sexual harassment and where there is a belief that a criminal act may have taken place, the Program Director will be the point of contact with the investigating unit. The investigating unit for allegations that appear to be criminal is the New Haven Police Department. The Staff Training Manual "Response Policies and Procedures Regarding Sexual Assault or Sexual Harassment", requires all allegations of sexual assault and sexual harassment to be investigated AND that there will be no screening process to determine whether an allegation is credible. Basic requirements are that the investigations be prompt; include interviews with alleged victims, suspects and witnesses; a review of security camera video; inquiry into prior complaints; and gathering direct and circumstantial evidence. The training manual states "An appropriate and consistent response will assist in maintaining program credibility."

The New Haven Police Department is the agency that may conduct criminal investigations regarding sexual abuse and sexual harassment.

When a sexual assault is alleged, Project MORE will use investigators who have received specialized training in sexual abuse investigations in confinement settings and in compliance with Standard 115.334. The Agency President/CEO wrote a letter to the Chief of Police requesting that all investigations be conducted in compliance with the PREA Standards and for collecting evidence. Too, it requested that all investigators conducting sexual abuse investigations receive or have completed specialized training in conducting sexual abuse investigations in confinement settings.

115.271 Investigations, Criminal and Administrative Agency Investigations, II. Procedures, describe the actions for staff to take relative to ensuring the incident is investigated either criminally or administratively.

Investigator(s) will protect the crime scene, include any physical and DNA evidence, any electronic monitoring data and interview alleged victim(s) and suspected perpetrators and witnesses. Prior complaints and reports regarding the alleged perpetrator is reviewed. If the quality of the evidence appears to support criminal prosecution, Project MORE will conduct compelled interviews only after

consulting with prosecutors as to whether compelled interviews may be obtained for further criminal prosecution.

In compliance with the PREA Standards and investigative techniques, the credibility of an alleged victim, suspect, or witness will be assessed on an individual basis, and will not be determined by a person's status as a resident or staff nor will Project MORE require a resident who alleges sexual abuse to submit to a polygraph exam or any other truth telling device as a condition for processing the investigation.

Administrative investigations include the following components:

- 1) An effort to determine whether staff actions and/or failure contributed to the abuse.
- 2) Written reports to include a description of the physical and testimonial evidence, the reasoning behind credible assessments and investigative facts and findings.

Criminal investigations are documented in written reports that contain a thorough description of physical, testimonial and documentary evidence and attach copies of all documentation evidence when possible. Allegations of conduct that appear to be criminal are required to be referred for prosecution. This determination will be made by the New Haven Police Department.

Administratively Project MORE will retain all written reports regarding the incident for as long as the alleged abuser is incarcerated or employed by the agency, plus five years.

Procedures also require that the departure of the alleged abuser or victim from the Walter Brooks House or agency will not be the basis for ending the investigation,

When an outside agency investigates sexual abuse, agency staff will cooperate with outside investigators and endeavor to remain informed of the progress of the investigation.

There have been no allegations of either sexual abuse or sexual harassment during the past twelve (12) months. This was confirmed through reviewing the PAQ, reviewing a memo from the PREA Coordinator, reviewing the Agency's Annual Report, and interviews with the PREA Coordinator and the Program Manager.

An interview with the Program Manager and PREA Coordinator confirmed they both have completed the National Institute of Corrections on-line training, PREA: Investigating Sexual Abuse in Confinement Settings. They also stated if an allegation appears to be criminal in nature, they will call in the New Haven Police Department to conduct the investigation. The New Haven Police Department is the agency with legal authority and responsibility for conducting criminal investigations. Their role (Program Director and PREA Coordinator) then would be to support the police investigators and to immediately preserve the crime scenes, including any potential evidence on the victim and abuser as well as in the area/room where the alleged act occurred. After the investigation, their role is to maintain contact with the Police Department to stay abreast of the progress of the investigation and at the conclusion of the investigation, to conduct a Sexual Abuse Incident Review. They described their responsibilities in conducting administrative investigations. Both staff were very knowledgeable of the investigative process and stated that the credibility of an alleged victim, alleged abuser or a witness is based solely on the evidence and where the evidence leads. Too, they indicated the departure of a staff or resident prior to the conclusion of an investigation would not stop the investigation, nor would the resignation of a staff stop an investigation.

The auditor relied on the following in determining a rating for this standard:

- PMI Policy, 115.271 Investigations, Criminal and Administrative Investigations, I.
- Project MORE Policy, Number 111, Prison Rape Elimination Act (PREA) Compliance Policies
- NIC Certificates for the Program Manager and PREA Coordinator
- Letter to the New Haven Chief of Police
- Memo from PREA Coordinator documenting no allegations of sexual abuse or sexual harassment at Walter Brooks House in the past 12 months
- Reviewed Project MORE Annual Report
- Interviews with the PREA Coordinator
- Interviews with the Program Manager
- Staff Training Manual

## Standard 115.272: Evidentiary standard for administrative investigations

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

### 115.272 (a)

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

### Auditor Overall Compliance Determination

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

### Instructions for Overall Compliance Determination Narrative

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

PMI Policy requires that the Walter Brooks House impose no higher standard than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated.

Policy requires that a determination as to whether allegations of sexual assault are substantiated is at the discretion of the local authorities conducting the investigations and not the Project MORE Staff.



II. Procedures, A., describes the elements of an investigation and states then that the greater weight of the evidence will be used to decide who may be at fault. This preponderance is based on the more convincing evidence and its probable truth or accuracy.

Interviews with the Program Manager and the PREA Coordinator confirmed that the standard for substantiating a case of sexual abuse or sexual harassment is the preponderance of the evidence.

There were no investigations required as the result of any incident or allegation of sexual abuse or sexual harassment at Walter Brooks House because there were no allegations made during the past twelve (12) months and even prior to that. This was confirmed through interviews with the PREA Coordinator, Program Director, and reviewed Annual Report and SSV Reports.

The auditor relied on the following in determining a rating for this standard:

- Project MORE Policy, 115.272
- Project MORE Policy 115,272m II. Procedures
- Interviews with the Program Manager and PREA Coordinator (both investigators)
- NIC Training Certificates for the Program Manager and the PREA Coordinator
- Reviewed Agency's Annual Report
- Reviewed Walter Brooks House SSV Report

## Standard 115.273: Reporting to residents

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

### 115.273 (a)

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

### 115.273 (b)

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

### 115.273 (c)

- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The staff member is no longer posted within the resident's unit?  Yes  No
- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the

resident has been released from custody, does the agency subsequently inform the resident whenever: The staff member is no longer employed at the facility?  Yes  No

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

#### 115.273 (d)

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

#### 115.273 (e)

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

#### 115.273 (f)

- Auditor is not required to audit this provision.

#### Auditor Overall Compliance Determination

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

#### Instructions for Overall Compliance Determination Narrative

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

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

PMI Policy, 115.273, Investigations, Reporting to Residents, I., Policy, requires that following an investigation into a resident's allegations of sexual abuse suffered at the Walter Books House, the resident will be informed as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded. In the event PMI did not conduct the investigation, PMI will request the relevant information from the investigating agency in order to inform the resident.

The procedures outlined in II. of the policy, requires that following a resident's allegation and an investigation PMI shall inform the resident the following if the allegation was against a staff:

1. The allegation was unfounded.
2. The allegation was substantiated and the staff is either no longer posted at the facility or is no longer employed at the agency.
3. Staff may have been indicted on a charge of sexual abuse.

Following a resident's allegation and an investigation the Walter Brooks Home will inform the resident the following if the allegation was against another resident:

1. The allegation was unfounded.
2. The allegation was substantiated and the alleged abuser has been indicted on a charge of sexual abuse.
3. The alleged abuser has been convicted of sexual abuse.

Following a resident's allegation that a staff member has committed a sexual abuse against a resident will inform the resident whenever:

1. The staff member is no longer posted at the resident's facility.
2. The staff member is no longer employed at the facility.
3. The agency has learned the staff member has been indicted on charges.
4. The agency has learned the staff member has been convicted on a charge of sexual assault.

All notifications or attempted notifications must be documented.

The Walter Brooks Home obligation to report under this standard will terminate if the resident is released from the agency's custody

There have been no allegations of sexual abuse or sexual harassment at Walter Brooks House in the past 12 months. This was confirmed by interviews with the Program Director and PREA Coordinator as well as the reviewed memo from the PREA Coordinator reporting that there were no allegations in the past 12 months. This was also confirmed through reviewing the Walter Brooks SSV and the Agency's Annual Report.

The auditor relied on the following in determining a rating for this standard:

- PMI Policy, 115.273, Investigations, Reporting to Residents, I.,
- Reviewed Memo from the PREA Coordinator documenting no allegations of sexual abuse/sexual harassment at Walter Brooks House
- Interviews with the PREA Coordinator and Program Director

## DISCIPLINE

### Standard 115.276: Disciplinary sanctions for staff

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

#### 115.276 (a)

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

#### 115.276 (b)

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

#### 115.276 (c)

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

#### 115.276 (d)

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

#### Auditor Overall Compliance Determination

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

#### Instructions for Overall Compliance Determination Narrative

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

Project MORE Policy, Number 111., Prison Rape Elimination Act (PREA) Compliance Policies), asserts that staff will be subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies.

The presumptive disciplinary action for staff who engages in sexual abuse, as stated in this policy, is termination. Disciplinary sanctions for violating agency policies relating to sexual abuse or sexual harassment (other than engaging in sexual abuse) will be commensurate with the nature and circumstances of the act committed, the staff member's disciplinary history, and the sanctions imposed for comparable offense by other staff with similar histories.

Terminations for violations of sexual abuse or sexual harassment policies or resignations by staff who would have been terminated if not for their resignation, shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and to any relevant licensing bodies.

Section II., Procedures require all allegations of sexual abuse and sexual harassment against residents will be forwarded to the agency PREA Coordinator. All complaints will be documented, and the information required to be documented is provided. Procedures also require that the PREA Coordinator conducts the investigation with the disposition of each case forwarded to The Director of Human Resources and President/CEO. If the conclusion is that the allegation is valid, immediate and appropriate corrective action will take place.

Disciplinary actions can, according to procedures, range from verbal or written warnings up to termination, depending on the circumstances and, if applicable, law enforcement agencies will be contacted.

The PREA Coordinator provided a memo stating there have been no allegations of sexual abuse or sexual harassment at Walter Brooks House during the past 12 months and before that. This was confirmed with the Program Director and through reviews of the Agency's Annual Report and Walter Brooks SSV Reports.

The auditor relied on the following in determining a rating for this standard:

- Project MORE Policy, Number 111., Prison Rape Elimination Act (PREA) Compliance Policies
- Reviewed memo from the PREA Coordinator confirming there were no allegations of sexual abuse or sexual harassment during the past twelve (12) months
- Interviews with the PREA Coordinator and the Walter Brooks House Program Director
- Interviews with random staff
- PMI Agency Annual Report
- SSV Walter Brooks

## **Standard 115.277: Corrective action for contractors and volunteers**

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

### 115.277 (a)

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

### 115.277 (b)

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

### Auditor Overall Compliance Determination

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

### Instructions for Overall Compliance Determination Narrative

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

PMI Policy, 115.277, Discipline, Corrective Action for Contractors and Volunteers, I., states that Project MORE will ensure a prompt response to any allegation of sexual abuse or sexual harassment to a contractor or volunteer.

Project MORE Policy, Number 111, Prison Rape Elimination Act (PREA) Compliance Policies, paragraph 5, requires that any contractor or volunteer who engages in sexual abuse will be prohibited from contact with clients/residents and shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and to relevant licensing bodies. The agency must take appropriate remedial measures, and consider whether to prohibit further contact with clients/residents in the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer.

Agency procedures require all contractors and volunteers to read and read and sign a form stating that Project MORE's zero tolerance policy regarding sexual abuse and sexual harassment. Any contractor

or volunteer who engages in sexual abuse or sexual harassment will immediately prohibited from contact with residents and will be reported to law enforcement agencies, unless the activity was clearly not criminal, and to relevant licensing bodies.

Project MORE will take appropriate remedial measures and consider whether to prohibit further contact with residents, in the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer. The remedial measures the agency may use includes:

- 1) Placing the volunteer or contractor on a probationary period for 90 days.
- 2) Issues either a written or verbal warning (in writing) to the volunteer or contractor.
- 3) Inform the contractor's employer, in writing of the incident.
- 4) Provide additional training to the volunteer or contractor.

PREA Acknowledgment statements documented contractors and volunteers understanding of the zero-tolerance policy and how to report as well as the sanction for violating any agency policy related to sexual abuse or sexual harassment.

The PREA Coordinator provided a MEMO dated September 1, 2017 stating that there have been no instances at the Project MORE Residential Facilities where contractors or volunteers have engaged in sexual abuse or sexual harassment of residents.

The PREA Coordinator stated, in an interview, related any contractor or volunteer would be "dismissed", "stopped from coming in the facility" and the allegations would be investigated. This was confirmed in an interview with the Program Manager. The reviewed Annual Report and SSV for Walter Brooks confirmed there were not allegations against any contractor or volunteer at the time of those reports.

Contractors/volunteers were observed reviewing and signing their PREA Acknowledgement statements coming into the program. All contractors complete the required PREA Acknowledgment upon entry into the facility.

The auditor relied on the following in determining a rating for the standard:

- PMI Policy, 115.277, Discipline, Corrective Action for Contractors and Volunteers, I.
- Project MORE Policy, Number 111, Prison Rape Elimination Act (PREA) Compliance Policies, paragraph 5,
- Reviewed PREA Acknowledgment Statements
- Reviewed Annual Report
- Reviewed SSV Report
- Interviews with the Program Director
- Interviews with random staff, who may work the front office (entry control)
- Interview with an Intern/Volunteer

## **Standard 115.278: Interventions and disciplinary sanctions for residents**

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

**115.278 (a)**

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

**115.278 (b)**

- Are sanctions commensurate with the nature and circumstances of the abuse committed, the resident's disciplinary history, and the sanctions imposed for comparable offenses by other residents with similar histories?  Yes  No

**115.278 (c)**

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

**115.278 (d)**

- If the facility offers therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse, does the facility consider whether to require the offending resident to participate in such interventions as a condition of access to programming and other benefits?  Yes  No

**115.278 (e)**

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

**115.278 (f)**

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

**115.278 (g)**

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

**Auditor Overall Compliance Determination**

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



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

### **Instructions for Overall Compliance Determination Narrative**

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

Project MORE Policy, Number 111, Prison Rape Elimination Act (PREA) Compliance Policies, paragraph 6, requires that residents/clients are subject to disciplinary sanctions pursuant to a formal disciplinary process following an administrative finding that the resident engaged in resident-on-resident sexual abuse or following a criminal finding of guilt for resident-on-resident sexual abuse.

The PMI Policy 115.278, Discipline, Disciplinary Sanctions for Residents, I. Policy, requires that residents will be subject to disciplinary sanctions pursuant to a formal disciplinary process following an administrative finding that a resident engaged in resident-on-resident sexual abuse or following a criminal finding of guilt for a resident-on-resident sexual abuse.

Policy requires sanctions to be commensurate with the nature and circumstances of the abuse committed, with the resident's disciplinary history, and the sanctions imposed for comparable offenses by other residents with similar history.

Additionally, policy requires the disciplinary process to consider whether a resident's mental disabilities or mental illness contributed to his/her behavior when determining what type of sanction, if any, should be imposed.

Also, policy requires Project MORE to sanction a resident for sexual contact with a staff only upon finding that the staff member did not consent to such contact.

Procedures require, as well, that all allegations be investigated by PMI and the agency will discipline a resident for sexual contact with staff only upon finding that the staff member did not consent to such contact. The New Haven Police Department will be contacted to investigate sexual abuse investigations.

Procedures indicated the facility does not offer in-house therapy or counseling however if a resident requires therapy or counseling, arrangements will be made for an outside agency to provide services.

Procedures also indicate that, for the purposes of disciplinary action, a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred shall not constitute falsely reporting an incident or lying.

The Program Director, in an interview, stated that based on the outcome of the investigation, if the allegations were substantiated, the resident would most likely be incarcerated if the charges had been sexual assault or sexual abuse. The resident would be referred for prosecution by the New Haven Police Department. If the charges that were substantiated were sexual harassment charges, the

resident may or may not be disciplined in-house. He may be transferred out of the program, or face some sort of restriction, including restricted privileges, which is the most used sanction for other violations. The funding source would be involved in the decision.

There have been no allegations of either sexual abuse or sexual harassment during the past twelve (12) months at the Walter Brooks House. This was confirmed through interviews with the Program Manager, the PREA Coordinator, random staff, the reviewed agency annual report and a MEMO from the PREA Coordinator stating there were no allegations of sexual abuse or sexual harassment at Walter Brooks House in the past twelve (12) months.

The reviewed Prison Rape Elimination Act of 2003, PREA Acknowledgment Statements informs residents that any person who is found in violation of the PREA Policies will be subject to appropriate disciplinary action and/or will be referred to law enforcement for criminal investigation. A sample of ten (10) acknowledgement statements were requested and provided.

The auditor relied on the following in determining a rating for this standard:

- Project MORE Policy, Number 111, Prison Rape Elimination Act (PREA) Compliance Policies, paragraph 6,
- PMI Policy 115.278, Discipline, Disciplinary Sanctions for Residents, I. Policy
- Interview with the Program Director
- Interview with the PREA Coordinator
- Interviews with residents
- Reviewed Memo from the PREA Coordinator confirming there were no allegations of sexual abuse or sexual harassment at Walter Brooks House in the past 12 months
- Reviewed annual report

## MEDICAL AND MENTAL CARE

### Standard 115.282: Access to emergency medical and mental health services

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

#### 115.282 (a)

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

#### 115.282 (b)

- If no qualified medical or mental health practitioners are on duty at the time a report of recent sexual abuse is made, do security staff first responders take preliminary steps to protect the victim pursuant to § 115.262?  Yes  No

- Do security staff first responders immediately notify the appropriate medical and mental health practitioners?  Yes  No

#### 115.282 (c)

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

#### 115.282 (d)

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

#### Auditor Overall Compliance Determination

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

#### Instructions for Overall Compliance Determination Narrative

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

PMI Policy, 115. 282, Medical and Mental Health Care, Access to Emergency Medical and Mental Health Services, I., requires that resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services, the nature and scope of which are determined by medical and mental health practitioners according to their professional judgment.

Project MORE, Inc. does not have and qualified medical or mental health practitioners on staff or contract at their facilities. Residents who have been sexually assaulted will be taken to the hospital, Yale/New Haven for treatment at the emergency room and for a forensic exam. An advocate may be provided to accompany the resident if requested. Staff will take steps to protect the resident victim and notify the appropriate medical and mental health practitioners.

A MEMO from the PREA Coordinator, dated September 1, 2017, states that "should there be a sexual assault on site, the victim would be transported to one of the Yale New Haven Hospital Emergency Rooms". Too, it asserts that any resident who requests medical care or mental health treatment will be referred to a provider.

Treatment will be provided without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising from the incident.

In PMI Facilities that house female residents, residents who have become pregnant or all gender residents who have a sexually transmitted disease will be referred to Yale New Haven Hospital. Staff will accompany the resident to the hospital and contact an outside provider for counseling and support services. That agency is the Women's and Families Center.

There have been no sexual assaults at Walter Brooks House during the past twelve (12) months. This was confirmed through interviews with the Program Manager, PREA Coordinator and the reviewed Memo from the PREA Coordinator documenting that there have been no allegations of sexual abuse or sexual harassment in the past 12 months, and the reviewed annual report.

The auditor relied on the following in determining a rating for this standard:

- PMI Policy, 115. 282, Medical and Mental Health Care, Access to Emergency Medical and Mental Health Services, I.
- Memo from the PREA Coordinator confirming no allegations of sexual abuse
- Memo from PREA Coordinator re: Emergency Access to Health Care
- Reviewed annual report
- Interviews with the PREA Coordinator, Project Manager and random staff

## **Standard 115.283: Ongoing medical and mental health care for sexual abuse victims and abusers**

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

### **115.283 (a)**

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

### **115.283 (b)**

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

### **115.283 (c)**

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

### **115.283 (d)**

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

#### 115.283 (e)

- If pregnancy results from the conduct described in paragraph § 115.283(d), do such victims receive timely and comprehensive information about and timely access to all lawful pregnancy-related medical services? (N/A if all-male facility.)  Yes  No  NA

#### 115.283 (f)

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

#### 115.283 (g)

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

#### 115.283 (h)

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

### Auditor Overall Compliance Determination

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

### Instructions for Overall Compliance Determination Narrative

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

Project MORE Policy, 115.283, Medical and Mental Health Care, Ongoing Medical and Mental Health Care for Sexual Abuse Victims and Abusers, requires the agency to offer medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse.

Agency procedures, for the same policy, require that once it has been determined that a resident has been the victim of sexual abuse, PMI staff will make appropriate referrals to medical and mental health for evaluation and treatment for the client.

If the resident agrees to the referral, PMI staff will contact the appropriate provider and if the resident declines the client will sign a statement stating that.

Counseling may be provided on site or at any outside location. On site counseling will be held in a private secure office. Staff will transport residents to outside counseling and medical appointments.

All known resident on resident abusers will be referred for a mental health evaluation and/or treatment within 60 days of learning of such abusive history. Residents who may have become pregnant (only males are housed at Walter Brooks House) or who have a STD will be referred to Yale New Haven Hospital. Staff accompany the resident to the hospital and will contact an outside provider for counseling and support. All referrals and appointments will be documented in the resident's file.

None of the reviewed victimization assessments documented either prior victimization or prior abuse.

The auditor relied on the following in determining a rating for this standard:

- PMI Policy, 115. 282, Medical and Mental Health Care, Access to Emergency Medical and Mental Health Services, I.
- Interviews with Case Managers
- Interviews with the Project Manager
- Interviews with the PREA Coordinator
- Reviewed Screening Assessments

## DATA COLLECTION AND REVIEW

### Standard 115.286: Sexual abuse incident reviews

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

#### 115.286 (a)

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

#### 115.286 (b)

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

#### 115.286 (c)

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

#### 115.286 (d)

- Does the review team: Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse?  Yes  No
- Does the review team: Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; gang affiliation; or other group dynamics at the facility?  Yes  No
- Does the review team: Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse?  Yes  No
- Does the review team: Assess the adequacy of staffing levels in that area during different shifts?  Yes  No
- Does the review team: Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff?  Yes  No
- Does the review team: Prepare a report of its findings, including but not necessarily limited to determinations made pursuant to §§ 115.286(d)(1) - (d)(5), and any recommendations for improvement and submit such report to the facility head and PREA compliance manager?  Yes  No

#### 115.286 (e)

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

#### Auditor Overall Compliance Determination

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

#### Instructions for Overall Compliance Determination Narrative

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

Agency policy 115.286, requires a sexual abuse incident review at the conclusion of every sexual abuse investigation.

Procedures require the review to occur within 30 days of the conclusion of the investigation.

Incident review team members include the PREA Coordinator, Program Director, upper-level management, and any staff that was involved in the investigation, any outside medical and/or mental health practitioners, if available and applicable.

Agency procedures require the review team to consider the following items and/or take actions stated below:

1. If the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse.
2. Whether the incident of allegation was motivated by race; ethnicity; lesbian, gay, bisexual, transgender, or intersex identification, status or perceived status; or gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility.
3. Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse.
4. Assess the adequacy of staffing levels in that area during different shifts,
5. Assess whether monitoring technology should be deployed or augmented to supplement staff supervision.
6. Prepare a report of its findings and recommendations for improvement and submit a report to PMI's President and PREA Coordinator.

The team's findings are documented in a report and copies will be given to all members.

Recommendations will be implemented, provided adequate resources are available. If the recommendations are not implemented, the reasons for not doing so are documented

Project MORE Policy, Number 111, Prison Rape Elimination Act (PREA) Compliance Policies, Data Collection, Review, and Storage, Paragraph 1., affirms the agency will conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation, including where the allegation has not been substantiated, unless the allegation has been determined to be unfounded. Such review will ordinarily occur within 30 days of the conclusion of the investigation. The team includes upper-level management officials with input from line supervisors, investigators, and medical or mental health practitioners. The review team will consider the following:

1. Whether the allegation or investigation includes a need to change policy or practice to better prevent, detect or respond to sexual abuse;
2. Whether the incident or allegation was motivated by race, ethnicity, gender identity (lesbian, gay, bisexual, transgender, or intersex identification), status or perceived status, or gang affiliation, or was motivated or otherwise caused by other group dynamics at the facility;
3. Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area enabled abuse;
4. Assess the adequacy of staffing levels in that area during different shifts; and
5. Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff.



Policy requires a report of findings and recommendations for improvement and to submit the report to the President/CEO and PREA Coordinator. The agency will implement the findings or document the reasons for not doing so.

Members of the incident review team confirmed the process although they have not had any allegations during the past twelve (12) months. These interviews included the Program Manager and the PREA Coordinator.

The Program Manager reported that the Walter Brooks House has not had any allegations of sexual abuse or sexual harassment during the past twelve (12) months. This was also confirmed in an interview with the PREA Coordinator and documented in a MEMO stating that. The reviewed annual report documented that there were no allegations of sexual abuse or sexual harassment during the reporting period.

- Agency policy 115.286,
- Project MORE Policy, Prison Rape Elimination Act (PREA) Compliance Policies
- Memo from the PREA Coordinator documenting no allegations of sexual abuse or sexual harassment at Walter Brooks House during the past twelve (12) months
- Interviews with the Project Manager and PREA Coordinator

## Standard 115.287: Data collection

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

#### 115.287 (a)

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

#### 115.287 (b)

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

#### 115.287 (c)

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

#### 115.287 (d)

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

#### 115.287 (e)

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

#### 115.287 (f)

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

### Auditor Overall Compliance Determination

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

### Instructions for Overall Compliance Determination Narrative

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

PMI Policy requires the PREA Coordinator to collect accurate, uniform data for every allegation of sexual abuse at facilities under the direct control using a standardized instrument and set of definitions. It also requires that all information will be kept in a secure and confidential areas.

Agency Procedures requires at a minimum that PMI will use the latest Survey of Sexual Violence questionnaire conducted by the Department of Justice in collecting data. Too, PMI maintains, reviews and collects data as needed from all available incident based reports, investigation files and sexual abuse incident reviews. This data includes all of PMIs residential facilities. The company does not contract for the confinement of residents

Project MORE Policy, 111., Prison Rape Elimination Act (PREA) Compliance Policies, affirms the agency is required to collect accurate uniform data for every allegation of sexual abuse using a standardized instrument and set of definitions. It also requires the incident-based data collected to include, at a minimum, the data necessary to answer all questions form the most recent version of the Survey of Sexual Violence conducted by the Department of Justice. To do this, the agency maintains,

reviews and collects data, as needed, from available incident based documents including reports, investigation files, and sexual abuse incident reviews.

Data is collected, aggregated and reviewed, to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices and training, including the following:

- 1) Identifying problem areas
- 2) Taking corrective action on an ongoing basis
- 3) Preparing an annual report of its findings and corrective actions
- 4) The report of the annual data includes a comparison of the current year's data and corrective actions with those from prior years and provides an assessment of the agency's progress in addressing sexual abuse. The report is approved by the President/CEO and made readily available to the public, with all personal identifiers removed.

The PREA Coordinator provided SSV reports for Walter Brooks documenting the required information. The SSV reflects the facility had no allegations in 2016 and interviews and provided documentation confirmed there have been no allegations during the 12 months preceding the audit. The facility does contract with or have any private facilities for the confinement of any residents. The agency does collect the required data for each of its three facilities and the PREA Coordinator provided SSV reports for each of those for review.

The auditor relied on the following in determining a rating for this standard:

- Project MORE Policy, 111., Prison Rape Elimination Act (PREA) Compliance Policies
- Reviewed annual report
- Reviewed SSV Reports
- Interviews with the PREA Coordinator

## Standard 115.288: Data review for corrective action

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

#### 115.288 (a)

- Does the agency review data collected and aggregated pursuant to § 115.287 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Identifying problem areas?  Yes  No
- Does the agency review data collected and aggregated pursuant to § 115.287 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Taking corrective action on an ongoing basis?  Yes  No
- Does the agency review data collected and aggregated pursuant to § 115.287 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Preparing an annual report of its findings and corrective actions for each facility, as well as the agency as a whole?  Yes  No

### 115.288 (b)

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

### 115.288 (c)

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

### 115.288 (d)

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

### Auditor Overall Compliance Determination

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

### Instructions for Overall Compliance Determination Narrative

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

PMI will review data collected and aggregated pursuant to standard 115.287. This will be done to access and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices and training.

Agency procedures affirm, data collection will identify problem areas which will enable the agency to take corrective action on an ongoing basis.

PMI prepares an annual report of its findings along with corrective action plans for each facility, as well as the agency as a whole. The report will include a comparison of the current year's data and corrective actions with those from prior years and provide an assessment of the agency's progress in addressing sexual abuse. It is approved by the agency President/CEO and the report will be made available to the public through the agency website. Information in the report may be deleted when publication would

present a clear and specific threat in the safety and security of the facility however, the report must indicate the nature of the material redacted.

The auditor relied on the following in determining a rating for this standard:

- Project MORE Policy, 111., Prison Rape Elimination Act (PREA) Compliance Policies
- Reviewed annual report
- Reviewed SSV Reports
- Interviews with the PREA Coordinator

## Standard 115.289: Data storage, publication, and destruction

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

### 115.289 (a)

- Does the agency ensure that data collected pursuant to § 115.287 are securely retained?  
 Yes  No

### 115.289 (b)

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

### 115.289 (c)

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

### 115.289 (d)

- Does the agency maintain sexual abuse data collected pursuant to § 115.287 for at least 10 years after the date of the initial collection, unless Federal, State, or local law requires otherwise?  Yes  No

### Auditor Overall Compliance Determination

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

## Instructions for Overall Compliance Determination Narrative

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

PMI Policy, 115.289, Data Collection and Review, Data Storage, Publication, and Destruction, I. Policy and Project MORE Policy, Number 111, Prison Rape Elimination Act (PREA) Compliance Policies, state that PMI will ensure that data collected pursuant to standard 115.287 are securely retained. PMI will make all aggregated sexual abuse data, from its facilities available to the public. Project MORE does not contract with private facilities. The information will be posted on the agency webpage and agency will ensure all personal identifiers are removed.

The Annual Reports are available on the agency's website and the PREA report is available on the Department of Correction Website.

Policy requires the agency to maintain sexual abuse data for at least 10 years after the date of the initial collection, unless Federal, State or local law requires otherwise.

Procedures provide for all data collected pursuant to the standard are stored in a locked secure location and PMI will make all aggregated sexual abuse data from the Walter Brooks House readily available to the public at least annually via its website with all personal identifiers removed. The PREA Coordinator will be responsible for destroying these files after 10 years after initial collection date, unless Federal, State or local law requires otherwise.

The auditor relied on the following in determining a rating for this standard:

- PMI Policy 115.289, Data Collection and Review, Data Storage, Publication and Destruction
- Project MORE Policy, Number 111, Prison Rape Elimination Act (PREA) Compliance Policies
- Reviewed Project MORE Website
- Reviewed Connecticut Department of Correction Website
- Interviews with the PREA Coordinator

## AUDITING AND CORRECTIVE ACTION

### Standard 115.401: Frequency and scope of audits

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

#### 115.401 (a)

- During the three-year period starting on August 20, 2013, and during each three-year period thereafter, did the agency ensure that each facility operated by the agency, or by a private

organization on behalf of the agency, was audited at least once.? (N/A before August 20, 2016.)  
 Yes  No  NA

#### 115.401 (b)

- During each one-year period starting on August 20, 2013, did the agency ensure that at least one-third of each facility type operated by the agency, or by a private organization on behalf of the agency, was audited?  Yes  No

#### 115.401 (h)

- Did the auditor have access to, and the ability to observe, all areas of the audited facility?  Yes  No

#### 115.401 (i)

- Was the auditor permitted to request and receive copies of any relevant documents (including electronically stored information)?  Yes  No

#### 115.401 (m)

- Was the auditor permitted to conduct private interviews with inmates, residents, and detainees?  Yes  No

#### 115.401 (n)

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

### Auditor Overall Compliance Determination

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

### Instructions for Overall Compliance Determination Narrative

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

Project MORE Policy, 115.401, Audits, Frequency and Scope of Audits, requires that during the three-year period beginning August 20, 2013 and during each three-period thereafter, PMI will ensure that

each facility operated by the agency is audited at least once. Policy acknowledges that the Department of Justice may send a recommendation to PMI for an expedited audit if the Department has reasons to believe that a facility may be experiencing problems related to sexual abuse.

Procedures delineated in this policy required that during an audit the auditor will review at a minimum, a sampling of relevant documents and other records and information for the most recent one-year period. Auditors will have access to all areas of the audited program and permitted to request and receive copies of any relevant documents, including electronically stored information. The PMI acknowledges in the procedures that the auditor interviews a representative sample of residents, staff, supervisors and administrators, a sampling of any video tapes and other electronically available data that may be relevant. The program acknowledges the auditor can conduct private interviews with residents. Residents of the PMI programs can send confidential information or correspondence to the auditor in the same manner as if they were communicating with legal counsel.

The auditor was provided unfettered access to all areas of the program, residents, staff, and contractors, interns or volunteers as well as any documentation requested by the auditor. A notice or PREA Audit had been posted six weeks prior to the onsite audit and during the on-site audit these were observed posted throughout the facility. The auditor did not receive any communication from anyone, including staff, residents, volunteers, interns or visitors. The auditor requested numerous follow-up documents over a 30 plus day period. These were provided expeditiously.

The auditor relied on the following in determining a rating for this standard:

- Project MORE Policy, 115.401, Audits, Frequency and Scope of Audits
- Observations made during the tour of all areas of the program
- Reviewed documentation provided prior to, during and following the on-site audit
- Interviews with the PREA Coordinator
- Interviews with staff
- Interviews with residents

## Standard 115.403: Audit contents and findings

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

#### 115.403 (f)

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

### Auditor Overall Compliance Determination



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

### **Instructions for Overall Compliance Determination Narrative**

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

The Project MORE, Inc. Community Confinement program at Walter Brooks is a community confinement program contracted through the Connecticut Department of Correction (DOC) and the report is subsequently posted on the DOC website. The auditor reviewed the Connecticut Department of Correction website and the PREA Report previously conducted by G4S.

## AUDITOR CERTIFICATION

I certify that:

- The contents of this report are accurate to the best of my knowledge.
- No conflict of interest exists with respect to my ability to conduct an audit of the agency under review, and
- I have not included in the final report any personally identifiable information (PII) about any resident or staff member, except where the names of administrative personnel are specifically requested in the report template.

### **Auditor Instructions:**

Type your full name in the text box below for Auditor Signature. This will function as your official electronic signature. Auditors must deliver their final report to the PREA Resource Center as a searchable PDF format to ensure accessibility to people with disabilities. Save this report document into a PDF format prior to submission.<sup>1</sup> Auditors are not permitted to submit audit reports that have been scanned.<sup>2</sup> See the PREA Auditor Handbook for a full discussion of audit report formatting requirements.

Robert Lanier

November 20, 2017

**Auditor Signature**

**Date**

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

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