

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

Interim Final

Date of Report 10/21/2021

Auditor Information

Name: Latera M. Davis	Email: laterad@yahoo.com
Company Name: Just4Consultants, LLC	
Mailing Address: PO Box 1105	City, State, Zip: Grayson, GA 30017
Telephone: 404-457-8953	Date of Facility Visit: September 23-24,2021

Agency Information

Name of Agency: Project More, Inc.		Governing Authority or Parent Agency (If Applicable): <small>Click or tap here to enter text.</small>	
Physical Address: 830 Grand Avenue		City, State, Zip: New Haven Connecticut 06511	
Mailing Address: SAA		City, State, Zip: SAA	
The Agency Is:	<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
Agency Website with PREA Information: https://www.projectmore.org/prea			

Agency Chief Executive Officer

Name: Dennis W. Daniels	Telephone: 203-848-3118
Email: dennis.daniels@projectmore.org	

Agency-Wide PREA Coordinator

Name: John Massari	Telephone: 203-848-3118
Email: john.massari.projectmore.org	
PREA Coordinator Reports to: Morris Moreland/Vice President	Number of Compliance Managers who report to the PREA Coordinator: 3

Facility Information

Name of Facility: Walter Brooks House

Physical Address: 690 Howard Avenue

City, State, Zip: New Haven, CT, 06519

Mailing Address (if different from above):
SAA

City, State, Zip: SAA

The Facility Is:

Military

Private for Profit

Private not for Profit

Municipal

County

State

Federal

Facility Website with PREA Information: <https://www.projectmore.org/prea>

Has the facility been accredited within the past 3 years? Yes No

If the facility has been accredited within the past 3 years, select the accrediting organization(s) – select all that apply (N/A if the facility has not been accredited within the past 3 years):

ACA

NCCHC

CALEA

Other (please name or describe: [Click or tap here to enter text.](#))

N/A

If the facility has completed any internal or external audits other than those that resulted in accreditation, please describe:

NA

Facility Director

Name: Redell Thomas

Email: redell.thomas@projectmore.org

Telephone: 203-848-3118

Facility PREA Compliance Manager

Name: John Massari

Email: John.Massari@projectmore.org

Telephone: NA

Facility Health Service Administrator N/A

Name: NA

Email: NA

Telephone: NA

Facility Characteristics	
Designated Facility Capacity:	67
Current Population of Facility:	48
Average daily population for the past 12 months:	45
Has the facility been over capacity at any point in the past 12 months?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Which population(s) does the facility hold?	<input type="checkbox"/> Females <input checked="" type="checkbox"/> Males <input type="checkbox"/> Both Females and Males
Age range of population:	18+
Average length of stay or time under supervision	5 months
Facility security levels/resident custody levels	Level 3
Number of residents admitted to facility during the past 12 months	137
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for <i>72 hours or more</i> :	136
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for <i>30 days or more</i> :	125
Does the audited facility hold residents for one or more other agencies (e.g. a State correctional agency, U.S. Marshals Service, Bureau of Prisons, U.S. Immigration and Customs Enforcement)?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Select all other agencies for which the audited facility holds residents: Select all that apply (N/A if the audited facility does not hold residents for any other agency or agencies):	<input type="checkbox"/> Federal Bureau of Prisons <input type="checkbox"/> U.S. Marshals Service <input type="checkbox"/> U.S. Immigration and Customs Enforcement <input type="checkbox"/> Bureau of Indian Affairs <input type="checkbox"/> U.S. Military branch <input checked="" type="checkbox"/> State or Territorial correctional agency <input type="checkbox"/> County correctional or detention agency <input type="checkbox"/> Judicial district correctional or detention facility <input type="checkbox"/> City or municipal correctional or detention facility (e.g. police lockup or city jail) <input type="checkbox"/> Private corrections or detention provider <input type="checkbox"/> Other - please name or describe: Click or tap here to enter text. <input type="checkbox"/> N/A
Number of staff currently employed by the facility who may have contact with residents:	34
Number of staff hired by the facility during the past 12 months who may have contact with residents:	5

Number of contracts in the past 12 months for services with contractors who may have contact with residents:	0
Number of individual contractors who have contact with residents, currently authorized to enter the facility:	0
Number of volunteers who have contact with residents, currently authorized to enter the facility:	0

Physical Plant

<p>Number of buildings:</p> <p>Auditors should count all buildings that are part of the facility, whether residents are formally allowed to enter them or not. In situations where temporary structures have been erected (e.g., tents) the auditor should use their discretion to determine whether to include the structure in the overall count of buildings. As a general rule, if a temporary structure is regularly or routinely used to hold or house residents, or if the temporary structure is used to house or support operational functions for more than a short period of time (e.g., an emergency situation), it should be included in the overall count of buildings.</p>	2
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<p>Number of resident housing units:</p> <p>Enter 0 if the facility does not have discrete housing units. DOJ PREA Working Group FAQ on the definition of a housing unit: How is a "housing unit" defined for the purposes of the PREA Standards? The question has been raised in particular as it relates to facilities that have adjacent or interconnected units. The most common concept of a housing unit is architectural. The generally agreed-upon definition is a space that is enclosed by physical barriers accessed through one or more doors of various types, including commercial-grade swing doors, steel sliding doors, interlocking sally port doors, etc. In addition to the primary entrance and exit, additional doors are often included to meet life safety codes. The unit contains sleeping space, sanitary facilities (including toilets, lavatories, and showers), and a dayroom or leisure space in differing configurations. Many facilities are designed with modules or pods clustered around a control room. This multiple-pod design provides the facility with certain staff efficiencies and economies of scale. At the same time, the design affords the flexibility to separately house residents of differing security levels, or who are grouped by some other operational or service scheme. Generally, the control room is enclosed by security glass, and in some cases, this allows residents to see into neighboring pods. However, observation from one unit to another is usually limited by angled site lines. In some cases, the facility has prevented this entirely by installing one-way glass. Both the architectural design and functional use of these multiple pods indicate that they are managed as distinct housing units.</p>	0
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Number of single resident cells, rooms, or other enclosures:	0
Number of multiple occupancy cells, rooms, or other enclosures:	8
Number of open bay/dorm housing units:	8
Does the facility have a video monitoring system, electronic surveillance system, or other monitoring technology (e.g. cameras, etc.)?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Has the facility installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology in the past 12 months?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

Medical and Mental Health Services and Forensic Medical Exams

Are medical services provided on-site?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Are mental health services provided on-site?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Where are sexual assault forensic medical exams provided? Select all that apply.	<input type="checkbox"/> On-site <input checked="" type="checkbox"/> Local hospital/clinic <input type="checkbox"/> Rape Crisis Center <input type="checkbox"/> Other (please name or describe: Click or tap here to enter text.)

Investigations

Criminal Investigations

Number of investigators employed by the agency and/or facility who are responsible for conducting CRIMINAL investigations into allegations of sexual abuse or sexual harassment:	0
When the facility received allegations of sexual abuse or sexual harassment (whether staff-on-resident or resident-on-resident), CRIMINAL INVESTIGATIONS are conducted by: Select all that apply.	<input type="checkbox"/> Facility investigators <input type="checkbox"/> Agency investigators <input checked="" type="checkbox"/> An external investigative entity
Select all external entities responsible for CRIMINAL INVESTIGATIONS: Select all that apply (N/A if no external entities are responsible for criminal investigations)	<input checked="" type="checkbox"/> Local police department <input type="checkbox"/> Local sheriff's department <input type="checkbox"/> State police <input type="checkbox"/> A U.S. Department of Justice component <input type="checkbox"/> Other (please name or describe: Click or tap here to enter text.) <input type="checkbox"/> N/A

Administrative Investigations

Number of investigators employed by the agency and/or facility who are responsible for conducting ADMINISTRATIVE investigations into allegations of sexual abuse or sexual harassment?	1
When the facility receives allegations of sexual abuse or sexual harassment (whether staff-on-resident or resident-on-resident), ADMINISTRATIVE INVESTIGATIONS are conducted by: Select all that apply	<input type="checkbox"/> Facility investigators <input checked="" type="checkbox"/> Agency investigators <input type="checkbox"/> An external investigative entity
Select all external entities responsible for ADMINISTRATIVE INVESTIGATIONS: Select all that apply (N/A if no external entities are responsible for administrative investigations)	<input type="checkbox"/> Local police department <input type="checkbox"/> Local sheriff's department <input type="checkbox"/> State police <input type="checkbox"/> A U.S. Department of Justice component <input type="checkbox"/> Other (please name or describe: Click or tap here to enter text.) <input checked="" type="checkbox"/> N/A

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.

Walter Brooks House (WBH), part of Project More, Inc. agreed to participate in a Prison Rape Elimination Act (PREA) audit, conducted by auditor (Latera Davis), on behalf of Diversified Correctional Services.

Site Review Location: The site review for this audit took place at the Walter Brooks House facility located at 690 Howard Ave, New Haven, CT 06519. The facility is in the eastern section of the state. The auditor conducted pre-audit work prior to arrival at the facility. Pre-audit work included but was not limited to review of the Pre-Audit Questionnaire (PAQ), documentation review on the agency (thumb drive), email correspondence, and telephone calls.

A certified PREA audit was conducted at the Walter Brooks House facility located in New Haven, CT on 9/23-9/24, 2021. The Walter Brooks House facility is operated by Project More, Inc. It should be noted that the Walter Brooks House is identified as transitional facility, that is contracted to provide services for the Connecticut Department of Corrections. The Walter Brooks House hereinafter may be referred to as a facility or program. It should be noted that, for the purpose of this audit report, the clients housed at the facility will be called "residents" for the duration of the report.

The auditor used a triangular approach, by connecting the PREA audit documentations, on-site observation, facility walk through, practice, interviewed staff, residents, and local and national advocates to make determinations for each standard.

Pre-onsite Audit Phase

Posting: On 7/13/2021, the auditor provided the audit notice to the agency PREA coordinator (PC), with instruction to post the required PREA Audit Notice of the upcoming audit prior to the audit for confidential communications. The PREA Coordinator confirmed via email that the notices were posted on the same day that the auditor sent the notices. During the onsite inspection the auditor observed the notices throughout the facility. The auditor did not receive communication from any residents.

Pre-Audit Questionnaire (PAQ): In order to prepare for the audit process, pre-kick off email correspondence occurred with the agency's PREA Coordinator in June 2021. As the auditor reviewed the materials provided by the facility, any outstanding documents were communicated directly with the agency PREA coordinator and facility Director. Completed documents were submitted or discussed via telephonic and email.

The Pre-Audit Questionnaire was completed and sent to the auditor as required. The completed Pre-Audit Questionnaire (PAQ) was submitted on 8/13/2021. Additional documentation received included agency policies, procedures, forms, education materials, training curriculum, organizational charts,

posters, brochures and other PREA related materials were also provided. The lead auditor reviewed all the documentation submitted by the facility and prepared a list of issues based on the evidence provided.

The auditor completed a documentation review using the Pre-Audit Questionnaire (PAQ), internet search, policies and procedures review, and additional documentation provided via email correspondence; to include both the agency and the facility policy and procedures, agency mission statement, daily population report, and schematic/layout for the facility. The auditor was provided a list of requested documents for the on-site review. As the auditor reviewed the materials provided by the facility, the content/documents were organized and any outstanding issues/concerns were addressed via telephonic and email correspondence, with the agency PREA coordinator. It should be noted that a list of random and special categorized residents was provided during the on-site review.

Website Review: Prior to the on-site portion of the audit, the auditor conducted a website review of the facility. There were no public articles found on the facility.

Prior to the on-site portion of the audit, the auditor was made aware that the facility did not house female residents or residents who were held for immigration purposes. Email communication was sent to the PREA coordinator requesting the following information in preparation for the site review:

- Staffing Plan/Documentation of deviation for the staffing plan
- Annual Reviews
- Logs of exigent circumstances for cross gender pat down searches
- Staff training logs
- Written materials used for effective communication about PREA residents with disabilities or limited reading skills
- Documentation of staff training on PREA complaint practices for residents with disabilities
- Documentation of investigators who have completed specialized investigative training
- Documentation of mental health and medical staff that have completed specialized training
- Screening instrument used to determine risk for victimization
- Documentation of use of screening information to inform housing, bed, work, education and facility assignments with the goal of keeping separate those residents with a high risk of being sexually abusive
- Sample resident grievances (on-site will review general grievances filed)
- Resident handbook
- Documentation of notifications of abuse while confined at another facility (if applicable)
- Facility institutional plan (coordinated plan)
- Retaliation reports (all investigation files, last 12 months)
- Documentation when segregated housing was used to house residents who have alleged to have suffered sexual abuse (if applicable)
- Sample of investigations of alleged sexual abuse complaints completed by the agency
- Sample of investigations of alleged sexual abuse complaints completed by outside agency
- Sample of documentation of any substantiated or unsubstantiated complaints
- Sample of documentation of notifications
- Sample records of terminations, resignations, or other sanctions against staff—allegations of sexual abuse or sexual harassment—within the last 12 months – (may request to review more sexual harassment while on site)
- Reports of sexual abuse of residents by contractors or volunteers
- Sample records of disciplinary actions against residents for sexual conduct with staff
- Sample records of disciplinary actions against residents for sexual conduct against other residents (need substantiated abuse or harassment allegations)

- Documentation of sexual abuse incident reviews
- A summary of all incidents within the past 12 months (log)
- Rosters
- Notice of auditor post-English/Spanish (received)
- Residents with disabilities
- Residents who are limited English proficient (LEP)
- LGBTI residents
- Residents in segregated housing (PREA related)
- Residents who reported sexual abuse
- Residents who reported sexual victimization during risk screening
- Staff roster
- Specialized staff list
- Staff personnel documentation
- Resident documentations
- List of contractors who have contact with residents
- List of volunteers who have contact with residents
- PREA reassessments (all sexual abuse cases)

On-Site Audit Phase

Team Composition/Entrance

The audit team consisted of the auditor (Latera Davis). On 9/23/2021 at approximately 1:00 pm the auditor arrived at the facility to conduct an entrance meeting with the agency PREA Coordinator, facility director and several administrative staff; along with beginning the on-site process (physical plant inspection and interviews).

Entrance Meeting

The entrance meeting served as initial introductions and on-site logistics with the facility leadership. The auditor reiterated the PREA Resource Center's (PRC) expectations of the on-site process and written reports, along with the audit goals. The auditor provided an overview of the expectations during the on-site audit and transparency to discuss any identified issues or concerns. The team also established a process to make corrections on-site, if necessary and post on-site follow up.

Prior to the on-site audit and upon conclusion of the entrance meeting, the auditor was provided resident and employee documentation to review. Resident and staffing lists were also provided allowing the audit team to make randomized selections of interview participants. The Walter Brooks House staff work 8-hour shifts; with three respective shifts.

Day One: The auditor conducted the physical plant site inspection along with staff and resident interviews; along with file review.

Day Two: The auditor completed the remaining interviews (resident and staff) and file review. Upon completion of assigned tasks, auditor returned to the assigned office to discuss site observation, informal and formal interviews, file review, and necessary corrective actions. Day two also served as the close out conference.

Interviews: Due to COVID-19, and the need to take extra safety precautionary measures; resident and informal auditor contact during the walk through was limited. The auditor was able to have informal discussion

with two residents while conducting the physical plant inspection. During the informal discussion, the residents reported being aware of PREA.

For the formal interviews, the auditor selected names of all staff who were at work during the onsite process, and the facility staff prepared the residents and staff members for interview in a staged manner. For all completed interviews, appropriate PREA-interview protocols were utilized, and standard advisory statements were communicated with the interviewing audit team member recording responses by hand or typed.

On the first day of the on-site audit there were 44 residents reported at the facility. Staff interviews were based on who was at the facility on the days of the audit, varying staff shifts, and positions/roles held. Over the two days being on-site, 18 interviews were conducted with staff that have specialized roles and responsibilities. It should be noted that this also included staff that have dual role responsibilities. The interviews were conducted privately in several different meeting rooms and the protocols used included but were not limited to incident review team members, mental health staff, screening staff, security first responder, agency head, staff who supervise residents in isolation, agency contract administrator, HR administrator, intake staff, PREA coordinator, intermediate or higher-level staff, facility director, medical staff, and staff who monitor for retaliation. The facility did not have any approved volunteers at the facility.

Along with the specialized staff and eight random staff. Random staff were chosen by retrieving a list of staff from every shift, including new and more tenured staff. A total of 5 targeted resident interviews were identified. There were no residents housed for the sole purpose of immigration. It was also reported that there were no residents segregated for risk of sexual victimization, which was confirmed through staff and resident interviews, as well as site review by audit team members. The interviews were conducted primarily in an empty offices or staff offices and telephonic communication.

The sampling strategy included interviewing all residents which included a selection of targeted residents within the sample of participants. Interviews were conducted using the Department of Justice (DOJ) protocols to assess the resident's knowledge of PREA and reporting mechanisms available to them at the facility.

Category of Residents	Number of Interviews conducted
Random residents	6
Targeted residents	5
Total Residents Interviewed	
Breakdown of Targeted Residents Interviewed	
Residents with disabilities (3)	3
Residents who are blind, deaf, or hard of hearing	0
Residents who are LEP	0
Residents with cognitive disabilities (2)	2
Residents who are LGB	0
Residents who Identify as transgender or intersex	0
Residents who reported sexual abuse/harassment that occurred at the facility	0
Residents who reported sexual victimization during risk screening	0
Resident segregated housing for sexual victimization	0
Category of Staff Interviewed *** It Should Be Noted That Some Interviews Conducted Duplication of The Same Staff.	

Random staff	8
Specialized staff	18
Agency head	1
Facility director	1
PREA compliance manager	
PREA coordinator	1
Total Staff Interviewed	(Total Interviewed)
Breakdown of Specialized Staff	
Contract administrator	1
Intermediate or higher-level staff responsible for conducting and documenting unannounced rounds	N/A
Medical staff	NA
Mental health staff	NA
Non-medical staff involved in cross gender searches (f applicable)	NA
Volunteers Who Have Contact with Residents	0
Contractors Who Have Contact Residents	Multiple Attempts-Unavailable
Administrative Investigators	1
Intake	1
Staff Who Perform Risk for Victimization and Abusiveness	1
Staff Who Screen Resident in Segregated Housing	NA
Designated Staff Members Charged with Monitoring for Retaliation	2
Staff responsible for risk screening	1
First Responders	8
Incident Review Team	2
HR Administrator	1

Site Review: The auditor conducted a comprehensive site review of the facility. Residents had access on-site and could be present. The director, assisted in escorting the auditor throughout the center during the inspection.

During the site review, the following areas were inspected:

- Administrative Offices
- Cafeteria
- Recreation (Common area)
 - Open area
 - Job Developer Office
- Housing (14 rooms)
 - Multiple Occupancy
 - 1 handicap room (has additional locks on bathroom doors)
 - All rooms have a private bathroom and showers

During the day hours, there was a limited number of residents onsite. The auditor noted that shower and toilet areas allow residents to shower ensuring their privacy from staff direct viewing. The auditor was provided unimpeded access to all parts of the facility and all secure rooms and storage areas in the

facility. The auditor spoke informally with residents and staff during the site inspection which covered administration, Intake, reception, living rooms, recreation area, dining area, programming areas, visitation areas, storage rooms, closets, etc.

The Walter Brooks House is a level three transitional center for males in Connecticut. The center provides short term transitional services.

The auditor inspected facility doors, restrooms, and office areas. The areas were consistently secured and locked. The auditor noted placement and coverage of video monitoring and technology, along with surveillance cameras, and reviewed for potential blind spots. Inspections of bathroom and shower areas were conducted, with observation of possible cross-gender viewing. There is a centralized camera viewing area in the administrative office.

There were no locations of concern identified during the tour. It should be noted that many of the residents are not onsite during the day, due to work schedules, and they are allowed more freedom of movement than in a penal institution. It should also be noted that female staff work out of the administrative area and do not provide direct services in the housing area. However, while conducting the inspection, the Director consistently made announcement of a “female presence” prior to entering a room.

The PREA audit requires the auditor to conduct outreach to relevant national and local advocacy organizations. To communicate with community-based or victim advocates who may have insight into relevant conditions in the facility. The following national advocacy, State, and/or community advocacy organizations were contacted.

Advocacy Organization	Date Received
Just Detention International (JDI)	8/23/2021
Women and Families Center	Multiple Messages no response

The auditor asks the advocacy organizations the following questions:

How many residents reported sexual abuse and/or sexual harassment in the last 12 months?

Have you received any reports on the facility in the last 12 months?

Documentation Review and Sampling

Documents Reviews: During the site review, documentation review included, but was not limited to the auditor review of personnel files, training records, resident intake, screening, and PREA education records; and any other related documents that covered the prior 12-month period. The documentation review process was covered by the auditor. The PAQ reported zero investigations.

Document Sampling

Complete Resident Roster	X (44 residents)
Residents with disabilities	5 (3 physical/2 cognitive)
Residents who are LEP	None Identified
LGBTI Residents	None Identified
Residents who Reported Sexual Abuse	None Identified
Residents/residents who reported sexual victimization during risk screening	None Identified

Complete Staff Roster	X (22)
Specialized Staff List	X
All Contractors who have contact with residents	X (3)
All Volunteers who have contact with residents	0
All grievances made in the 12 months preceding the audit	0-it was reported that grievances are not maintained
All incident reports from the 12 months preceding the audit	0
All allegations of sexual abuse and sexual harassment reported for investigation in the 12 months preceding the audit	0
All hotline calls made during the 12 months preceding the audit	0

Investigations Review

	Sexual Abuse		Sexual Harassment	
	Resident on Resident	Staff on Resident	Resident on Resident	Staff on Resident
Hotline	0	0	0	0
Grievance	0	0	0	0
Reports to Staff	0	0	0	0
Anonymous 3 rd party	0	0	0	0

Grievances: The Walter Brooks House has grievance boxes located throughout the facility to include the housing area. The facility director reported that they rarely receive any grievances and provided a sample of one from last year (non PREA related).

Informational Consolidation: The auditor met frequently with agency leadership, throughout the two days to consolidate information and ensure that the interviews, documentation reviews, and facility observations supported a compliance determination for the required PREA standards. When additional information was requested to establish compliance, the management team was responsive and made every effort to deliver documentation. The facility staff was receptive to providing additional documentation along with noted concerns in documentation review.

Exit Briefing

The audit team conducted an exit meeting on 9/24/2021, at which preliminary findings of the review were discussed with the facility leadership team. During the exit, the auditor provided an overview of the on-site inspection results and discussion of follow up requested information.

Post-Onsite Audit Phase

Upon return from the on-site phase of the audit, the auditor, and the agency PREA coordinator agreed to communicate by email and telephone during the post-audit phase, regarding any identified need for additional documentation, as well as clarification of questions that arose while collating data.

Communication with the agency PREA Coordinator began immediately upon the conclusion of the on-site audit. Communication was ongoing, with responses provided consistently both by email and

telephone. Documentation and clarification communication emails facilitated the ability to process both the Interim and Final Reports.

Audit Section of the Compliance Tool: The auditor continued to review documentation and interview notes gathered while on-site and compile information to enter the audit portion of the compliance tool. Detailed information from the audit interviews were integrated into relevant sections of the standards. To ensure all standards were thoroughly analyzed, the auditor proceeded standard by standard, determining compliance or non-compliance.

Interim Audit Report: The auditor completed entry of data into and determination of standard compliance on the Audit Compliance Tool and began writing of the Interim Report. The Interim Report included reference to policies and procedures, agency and facility reports, and supplementary documentation provided by the facility and during the site review, supporting information gathered during site review, as well as aggregated and de-identified information regarding interviews conducted for the purposes of this audit. The auditor incorporated evidence gathered on-site and through documentation review as proof for the conclusion of whether the facility exceeded, met, or did not meet the standard of review.

Final Audit Report: 10/21/2021

Facility Characteristics

The auditor's description of the audited facility should include details about the facility type, demographics and size of the resident, 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.

Facility Demographics

Total staff: 34 current staff (several were on leave)

Volunteer – 0 ***services not functioning at this time due to COVID-19

Contractors – Maintenance (3)-not onsite

Security Level: Minimum-Transitional Center

The Walter Brooks House is a 67-bed, male only, work release program. The facility opened in 1995 and is funded by Connecticut Department of Correction. The program exists to fully support clients in their re-entry into the community. Program staff assist clients in obtaining employment, saving money, remaining drug and alcohol free, attending all required programming and obtaining identification, while also aiding in the development of a positive attitude and increased self-respect. All clients are assigned a case manager who will assist them in meeting their program goals. Referrals must be 18 years of age or older.

Program Services:

- Employment
- Supportive Housing Assistance
- General Substance Abuse Education

Length of Stay: 6-12 months

Summary of Audit Findings

The summary should include the number and list of standards exceeded, number of standards met, and number and list of standards not met.

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

Standards Exceeded

Number of Standards Exceeded: 3
List of Standards Exceeded: 115.211; 115.221; 115.233

Standards Met

Number of Standards Met: 40

Standards Not Met

Number of Standards Not Met: 0
List of Standards Not Met: Click or tap here to enter text.

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.

The following evidence was analyzed in making compliance determination:

1. Documents:
 - a. Pre-Audit Questionnaire (PAQ)
 - b. Policy:
 - i. Standard 115.211 Prevention Planning, *Zero tolerance policy of sexual abuse and sexual harassment; PREA Coordinator*
 - c. Organizational Chart

- 2. Interviews:
 - a. PREA Coordinator

Findings (By Provision):

115.211(a). As reported in the PAQ, the agency has a written policy that mandates zero tolerance in all forms of sexual abuse and sexual harassment. Policy Prevention Planning, *Zero tolerance policy of sexual abuse and sexual harassment; PREA Coordinator*, states that “the Project MORE residential programs shall have a zero tolerance policy for all forms of resident on resident and staff on resident sexual abuse or sexual harassment.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.211(b). As reported in the PAQ, the agency employs or designates an upper-level, agency-side PREA coordinator. Policy Prevention Planning, *Zero tolerance policy of sexual abuse and sexual harassment; PREA Coordinator*, states that Project MORE, Inc. (PMI) shall designate an agency wide PREA Coordinator. The interviewed PREA Coordinator reported that they have enough time to manage their PREA duties. Some ways that they manage the duties include conducting unannounced site visits, camera reviews, training staff, conducting background checks on all hires and five-year updates for staff. If there were issues it would be dealt with immediately. It was further reported that, initially I will speak to my immediate supervisor to explain the issue and how I plan to handle it.

Documentation review for compliance: Policy and organization chart. A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

Corrective Action:

No corrective action is recommended for this standard.

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.) 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.

The following evidence was analyzed in making compliance determination:

1. Documents:
 - a. Pre-Audit Questionnaire (PAQ)
 - b. Policy:
 - i. Standard 115.21 Prevention Planning Policy, *Contracting with other entities for the confinement of Residents*
 - c. Memo: No Contract for Services
2. Interviews:
 - a. Contract Administrator

Findings (By Provision):

115.212(a). As reported in the PAQ, the agency has entered or renewed one contract for the confinement of residents. Policy, Standard 115.21 Prevention Planning Policy, *Contracting with other entities for the confinement of Residents*, states that "should PMI contract for the confinement of its residents with a private agency or other entity, including another government agency, shall include in any new contract or renewal the entity's obligation to adopt and comply with its PREA standards".

A memo was provided dated March 1, 2021 indicated that "Project More, Inc. does not contract, for confinement of its residents, with private agencies or other entities, including other government agencies. In the future, if it is determined that Project More, Inc., must contract with an outside agency it will be our responsibility that the contract is compliant with PREA Standard 115.212".

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.212(b). As reported in the PAQ, the agency requires the contracts to monitor the contracts compliance with PREA standards. There were zero contracts that that the agency did not require to monitor for the compliance of PREA standards. The interviewed contract administrator stated that Project MORE does not contract for the confinement of its residents with private agencies. The Walter Brooks House is a contracted entity for the Connecticut DOC. The audits will be forwarded to the Connecticut DOC.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.212(c). As reported in the PAQ, there were zero contracts that that the agency did not require to monitor for the compliance of PREA standards. The interviewed contract administrator confirmed the above.

Corrective Action:

No corrective action is recommended for this standard.

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 facility have a documented staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse?
- Yes No In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: The physical layout of each facility? Yes No
- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: The composition of the resident population? Yes No
- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: The prevalence of substantiated and unsubstantiated incidents of sexual abuse? Yes No
- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Any other relevant factors? 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.

The following evidence was analyzed in making compliance determination:

1. Documents:
 - a. Pre-Audit Questionnaire (PAQ)
 - b. Staffing Plan
 - c. Annual Staffing Plan (dated June 7, 2021)
2. Interviews:
 - a. PREA Coordinator

b. Director

Findings (By Provision):

115.213(a). As reported in the PAQ, the agency requires each facility it operates to develop, document and make its best efforts to comply on a regular basis with a staffing plan. Since the last PREA audit the average daily number of residents was 54, and the number of residents in which the staffing plan was predicated was 67.

The interviewed PREA Coordinator reported that when assessing the staffing plan, we will look at the location of the cameras, which are in common areas, location of potential victims and abusers, and monitoring all contracts. It was further reported that there have only been two PREA related allegations ever reported at the facility.

The interviewed director reported that the program has a staffing plan. The program has adequate staffing levels to include 24/7 coverage. The program has three shifts, and the staff includes a director, assistant director, three case managers, numerous part-time residential monitors, employment specialist, and kitchen staff. The program has video monitoring with 30 cameras in and outside the facility. The staffing plan is documented. The interviewed director also reported that the staffing plan will include the layout of the facility, the composition of the client population, Connecticut DOC requirements (1:28 ratio), and camera locations. Checking for compliance occurs with unannounced visits and camera reviews.

The auditor reviewed the staffing plan along with video monitoring while conducting the onsite inspection. The plan along with adequate video coverage was appropriate.

115.213(b). As reported in the PAQ, there were no deviations in the staffing plan. The interviewed director reported that the facility would document all instances of non-compliance with the staffing plan.

115.213(c). As reported in the PAQ, the facility conducts an annual review of the staffing plan. The auditor reviewed a copy of the 2021 annual staffing plan. The interviewed PREA Coordinator reported that they work with the Program Director to complete the staffing plan.

Corrective Action:

No corrective action is recommended for this standard.

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 the facility does not have female 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 the facility does not have female 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? (N/A if the facility does not have female residents). Yes No NA

115.215 (d)

- Does the facility have policies 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 have procedures that enables 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

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 following evidence was analyzed in making compliance determination:

1. Documents:
 - a. Pre-Audit Questionnaire (PAQ)
 - b. Policy:
 - i. Standard 115.215 Prevention Planning Policy Prevention Planning, *Limits to cross-gender viewing and search*
 - ii. Project More, Inc., Residential Programs, Search Procedures
 - c. Employee Training Manual
2. Interviews:
 - a. PREA Coordinator
 - b. Random Staff (8)
 - c. Random Sample of Residents (11)

Findings (By Provision):

115.215 (a). As reported in the PAQ, the facility does not conduct cross-gender strip or cross-gender visual body cavity searches of residents. There have been zero instances in the past 12 months were staff conducted cross-gender strip or cross-gender visual body searches of residents. Policy Prevention Planning, *Limits to cross-gender viewing and searches*, states that "PMI shall not allow staff to conduct cross-gender pad down searches". Additionally, the policy states that "medical practitioners entering the facility are exempt from this ban".

A review of the appropriate documentation and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.215 (b). NA-the facility houses male residents.

115.215 (c). NA-the facility houses male residents.

115.215 (d). As reported in the PAQ, the facility has implemented policies and procedures that enable residents to dress, shower, perform bodily functions, and change clothing without non-medical staff of the opposite gender viewing their breasts, buttocks, or genitals except in exigent circumstances. Policy Prevention Planning, *Limits to cross-gender viewing and searches*, states 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”.

Eight random staff were interviewed. All of the staff reported that female staff do not go in the housing area. Therefore, the male residents are always able to dress, shower, and toilet without being viewed by staff of the opposite gender. It should also be noted that when conducting the site inspection, the program director consistently made announcements that I (female) was entering the room.

Eleven random sample of residents were interviewed. All of the interviewed residents reported that female staff do not come in the housing area. The residents also reported that no staff could see them fully naked when they toilet, shower, or change clothes.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.215 (e). As reported in the PAQ, the facility has a policy prohibiting staff from searching or physically examining a transgender or intersex resident for the sole purpose of determining the resident’s genital status. Policy Prevention Planning, *Limits to cross-gender viewing and searches*, states that “transgender and intersex residents will be given the opportunity to shower, dress and use the bathroom separately from other residents”.

Eight random staff were interviewed. The staff reported that they are not allowed to search or physically examine a transgender or intersex resident to determine their genital status. The residents are transferred to the program from another penal institution therefore such identification would already be made.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.215 (f). As reported in the PAQ, 90% of staff who have received training on conducting cross-gender pat-down searches and searches of transgender and intersex residents in a professional manner with security needs. However, Policy Prevention Planning, *Limits to cross-gender viewing and searches*, states that “Project MORE will not authorize any form of cross gender search, cavity search or strip search on any residents”.

Eight random staff were interviewed. The staff reported that the female staff does not conduct searches. Male staff will conduct pat down searches of male residents. All but one staff reported that they have been trained on conducting searching of transgender residents in a professional and respectful manner. When probed, the auditors described a process where they typically use the wand to search a resident.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

Corrective Action:

No corrective action is recommended for this standard.

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.

The following evidence was analyzed in making compliance determination:

1. Documents:
 - a. Pre-Audit Questionnaire (PAQ)
 - b. Policy:
 - i. Standard 115.216 Prevention Planning, *Residents with disabilities and residents who are Limited English Proficient*
 - c. Interpreter and Translators Inc., Contract
2. Interviews:
 - a. Administrative Human Resources
 - b. Agency Head
 - c. Residents with disabilities

Findings (By Provision):

115.216 (a). As reported in the PAQ, the agency has established procedures to provide disabled residents 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. Policy Prevention Planning, *Residents with disabilities and residents who are Limited English Proficient*, states that "PMI shall take appropriate steps regarding equal opportunity of disabled residents to participate in or benefit from all efforts to prevent, detect, and respond to sexual abuse and sexual harassment". The facility has a contract with Interpreters and Translators, Inc.

The interviewed agency head stated that Project MORE has a contract with an outside provider to provide translation services. In any situation where a resident may not understand something, staff is aware that a call to that provider must occur. Residents with disabilities are required to attend all scheduled meetings, appointments, etc. If required, staff will have utilized one of the agency vehicles to transport them.

Five residents who that were identified as disabled were interviewed. Only one resident reported having cognitive delays that impacted their ability to read and understand. The resident reported that the staff read the information to them and will assist with reading information to them if needed.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.216 (b). As reported in the PAQ, the agency has established procedures to provide residents with limited English proficiency equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse or sexual harassment.

Five residents who that were identified as disabled were interviewed. Only one resident reported having cognitive delays that impacted their ability to read and understand. The resident reported that the staff read the information to them and will assist with reading information to them if needed.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.216 (c). As reported in the PAQ, the agency policies prohibit other use of resident interpreters, resident readers, or other type 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, or the investigation of the residents' allegations. In the past 12 months, there were zero instances where resident interpreters or readers were used to report allegations of sexual abuse or

sexual harassment. Policy Prevention Planning, *Residents with disabilities and residents who are Limited English Proficient*, states that “the facility shall not rely on resident interpreters, readers or other types of client assistance except on limited circumstances where an extended delay could compromise a resident’s safety”.

Eight random staff were interviewed. The staff reported that they were unaware of residents serving as interpreters for each other to report sexual abuse. The staff stated that they are not sure if there is a policy against it, but they have never seen it happen before. Two staff reported that they would still have to get an interpreter to get a direct statement from the victim.

Five residents who that were identified as disabled were interviewed. Only one resident reported having cognitive delays that impacted their ability to read and understand. The resident reported that the staff read the information to them and will assist with reading information to them if needed.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

Corrective Action:

No corrective action is recommended for this standard.

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 who may have contact with residents? Yes No
- Does the agency consider any incidents of sexual harassment in determining whether 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)

- 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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The following evidence was analyzed in making compliance determination:

1. Documents:
 - a. Pre-Audit Questionnaire (PAQ)
 - b. Policy:
 - i. Standard 115.217 Prevention Planning, *Hiring and promotion decisions*
 - ii. Project More, Inc., Policy and Procedure, Recruitment Practices
 - c. Background Report
 - d. Request to Attain Information from other employers (4)
 - e. Release of Information PREA (blank)—need completed
 - f. PREA Hire Questionnaire
 - g. Memo: Update to Application
- Interviews:
 - a. Administrative Human Resources

Findings (By Provision):

115.217 (a). As reported in the PAQ, the agency policy prohibits hiring or promoting anyone who may have contact with residents and prohibits enlisting the services of any contractor who may have contact with residents 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 refuse; or
3. Has been civilly or administratively adjudicated to have engaged in the activity described in paragraph (a) (2).

Policy Prevention Planning, *Hiring and promotion decisions*, provides guidance on the above. The auditor reviewed four background checks of new hires in the last 12 months. A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.217 (b). As reported in the PAQ, the agency policy requires that before it hires any new employees who may have contact with residents, criminal background record checks are conducted. In the past 12 months, the number of persons hired who may have contact with residents who have had criminal background record checks is 6. "PMI shall perform a criminal background records check before enlisting the services of any contractor who may have contact with residents". The auditor reviewed one criminal background check on a maintenance staff conducted in the last 12 months.

The interviewed human resources staff stated any applicant that has either an arrest or been terminated from a position due to a sexual offense will not be offered a position in the agency.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.217 (c). As reported in the PAQ, the agency policy requires the consideration of 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. Policy Prevention Planning, *Hiring and promotion decisions*, states that, "before hiring new staff, the PMI will conduct a criminal background investigation". Additionally, the policy states that "PMI will 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". The auditor reviewed four criminal background checks and four requests for information from a former employer in the last 12 months. The auditor reviewed one criminal background check on a maintenance staff conducted in the last 12 months.

The interviewed human resources staff stated that Project MORE has a maintenance crew that does most of the contractor work. Criminal background checks are conducted on the contracted staff.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.217 (d). As reported in the PAQ, the agency policy requires that a criminal background record check will be completed before enlisting the services of any contractor who may have contact with residents. In the past 12 months, there were zero contracts for services where criminal background record checks were contacted on all staff covered in the contract who might have contact with residents. Policy Prevention Planning, *Hiring and promotion decisions*, states that, "PMI shall perform a criminal

background records check before enlisting the services of any contractor who may have contact with residents”. The auditor reviewed one criminal background check on a maintenance staff conducted in the last 12 months.

The interviewed human resources staff stated that Project MORE has a maintenance crew that does most of the contractor work. Criminal background checks are conducted on the contracted staff.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.217 (e). As reported in the PAQ, the agency policy requires that either criminal background record checks be conducted at least every five years for current employees and contractors who may have contact with residents, or who may have contact with residents, or that a system is in place for otherwise capturing such information for current employees. Policy Prevention Planning, *Hiring and promotion decisions*, states that, “PMI shall wither conduct criminal background records check at least every five years on current employees and contractors”. The auditor reviewed a five-year background check on one staff that was conducted in the last 12 months.

The interviewed human resources staff stated that background forms are in the Employment Application. A staff person will forward the paperwork to Coeus Global who conduct the background check. Background checks are done for existing employees every five years.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.217 (f). Policy Prevention Planning, *Hiring and promotion decisions*, states that, “PMI shall impose upon employees a continuing affirmative duty to disclose any such misconduct”. Additionally, the policy states that “PMI shall ask all applicants and current employees about previous misconducts of a sexual nature”.

The interviewed human resources staff that All potential applicants are asked if they have ever been arrested or terminated from employment to a sexual offense. All Applications have a form where the applicant is asked three questions.

- Have you ever engaged in sexual abuse in prison, jail, lockup, community confinement facility, juvenile facility or other institution?
- Have you ever been convicted of engaging or attempting to engage in sexual activity in the community, by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse?
- Have you ever been civilly or administratively adjudicated to have engaged in the activity described in b?

It was also reported that the facility imposes upon employees a continuing affirmative duty to disclose any such previous misconduct. A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.217 (g). As reported in the PAQ, the agency policy states that material omission regarding such misconduct, or the provision of materially false information, shall be grounds for termination. Policy

Prevention Planning, *Hiring and promotion decisions*, states that, "Omission regarding such misconduct or the provision of materially false information shall be grounds for termination".

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.217 (h). The interviewed human resources staff stated that a former employee applies for work at another institution, upon request from that institution, the facility will provide information on substantiated allegations of sexual abuse or sexual harassment involving the former employee.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

Corrective Action:

No corrective action is recommended for this standard.

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.

The following evidence was analyzed in making compliance determination:

1. Documents:
 - a. Pre-Audit Questionnaire (PAQ)
 - b. Policy:
 - i. Project More Inc., Standard 115.218 Prevention Planning, *Upgrades to facilities and technologies*
 - c. Memo: No More Cameras Added
2. Interviews:
 - a. PREA Coordinator
 - b. Director
 - c. Agency Head

Findings (By Provision):

115.218 (a). As reported in the PAQ, the agency has not acquired new facilities or has made substantial expansions since the last PREA audit. Policy Prevention Planning, *Upgrades to facilities and technologies*, states 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".

The interviewed agency head stated that should modifications be required, the program director along with the PREA Coordinator will review plans to look at the following:

- Location of cameras. Ensure that there are no blind spots in common areas.
- Will additional staff be required-may be a problem with the funding source.
- Location of beds and dressers. When staff conducts their rounds will their view be blocked.

The interviewed director reported that any expansion would be considered if the funding was available.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.218 (b). As reported in the PAQ, the facility has no installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology since the last PREA audit. A memo was provided that stated "this letter is to inform you that the Walter Brooks House has not added more cameras since the last PREA audit".

The interviewed agency head stated that the following staff have the ability to conduct camera reviews:

- President/CEO
- Vice President
- PREA Coordinator
- Program Director

It was also reported that cameras can be reviewed for a period of 30 days. The interviewed director stated that the facility currently has 30 cameras at the facility. The cameras cover the outside of the building and in all common areas. During the onsite inspection, the auditor observed the camera locations, and no cameras were located that impeded on the privacy of a resident to dress, shower, or toilet.

During the onsite inspection the auditor observed the location of the cameras in the common areas and the administrative staff's ability to monitor the cameras. The facility director also reported that camera activity could be monitored from his phone.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

Corrective Action:

No corrective action is recommended for this standard.

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? (N/A if agency *always* makes a victim advocate from a rape crisis center available to victims.) Yes No NA
- 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 agency 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? (N/A if agency *always* makes a victim advocate from a rape crisis center available to victims.) 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 following evidence was analyzed in making compliance determination:

1. Documents:
 - a. Pre-Audit Questionnaire (PAQ)
 - b. Policy:
 - i. Project More, Inc., Standard 115.221, Responsive Planning, *Evidence protocol and forensic medical examinations*
 - c. MOU Women and Families Center (WFC)
 - d. Office of Victim Services SANE Services (University of Connecticut)
 - e. Correspondence: Yale University Trained Nursing
 - f. Yale Sexual Harassment and Assault Respond and Education Information on Advocacy Support (SHARE)
2. Interviews:
 - a. PREA Coordinator
 - b. Random Sample of Staff (8)

Findings (By Provision):

115.221 (a). As reported in the PAQ, the agency facility is responsible for conducting administrative investigations. The New Haven Police Department is responsible for conducting criminal investigations. It was also reported that when conducting a sexual abuse investigation, the agency investigators follow a uniform evidence protocol. Policy Responsive Planning, *Evidence protocol and forensic medical examinations*, states that "PMI facilities shall contact local authorities to investigate allegations of sexual abuse". The policy further states that "PMI shall request that the investigating agency abide by all PREA requirements and standards".

Eight random staff were interviewed. The interviewed staff reported that they understood the agency's protocol for obtaining usable physical evidence if a resident alleges sexual abuse. Some of the ways would include keeping people away from the evidence, get the victim to a safe location near staff, don't allow the resident to go to the bathroom, brush teeth, or change clothes, and keep the area closed off until investigation arrives. The interviewed staff reported that the director and the PREA Coordinator are responsible for conducting the initial investigations.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.221 (b). NA-there are no youth housed at the placement.

115.221 (c). As reported in the PAQ, the facility offers all residents who experience sexual abuse access to forensic medical examinations, and they are offered without financial cost to the victim. There have been no reported forensic medical exams conducted in the past 12 months. Policy Responsive Planning, *Evidence protocol and forensic medical examinations*, states that "PMI shall offer victims of sexual abuse access to a forensic medical examination. This will be of no cost to the resident".

The facility provided information on the State of Connecticut's Office of Victim Services Sexual Assault Forensic Examiners program, describing victims access to forensic examinations, along with Yale Universities Sexual Harassment and Assault Response & Education (SHARE) program. The Yale program provides forensic medical examinations.

The facility has multiple resources to provide a victim who has experienced sexual abuse; hence exceeding the requirements.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.221 (d). As reported in the PAQ, the facility attempts to make a victim advocate from a rape crisis center available to the victim, either in person or by other means. Policy Responsive Planning, *Evidence protocol and forensic medical examinations*, states that "PMI shall make available to the resident a victim advocate". The auditor reviewed a MOU between Project MORE, Inc., and Women and Families Center (WFC). The MOU indicates that: WFC "will provide:

- Training to Project MORE staff as requested.
- Provide individual counseling and support groups to Project MORE
- Accompaniment of Systems support through medical, police and legal proceedings

Additionally, the facility provided information on the State of Connecticut's Office of Victim Services Sexual Assault Forensic Examiners program, describing victims access to forensic examinations. The facility has multiple resources to provide a victim who has experienced sexual abuse; hence exceeding the requirements.

The interviewed PREA Coordinator reported that the facility has an MOU covering the above mentioned. There were no reported allegations of sexual abuse at the facility in the last 12 months.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.221 (e). As reported in the PAQ, if requested by victim, a victim advocate, qualified agency staff member, or qualified community-based organization staff member accompanies and support the victim

through the forensic medical examination process and investigatory interviews and provides emotional support, crisis intervention, information, and referrals. Policy Responsive Planning, *Evidence protocol and forensic medical examinations*, states that “as requested by the victim, “the victim advocate, qualified PMI staff member, or qualified staff from a community-based agency shall accompany and support the victim through the forensic medical examination process and investigatory reviews and shall provide emotional support, crisis intervention, information and referrals.

The auditor reviewed a MOU between Project MORE, Inc., and Women and Families Center (WFC). The MOU indicates that: WFC “will provide:

- Training to Project MORE staff as requested.
- Provide individual counseling and support groups to Project MORE
- Accompaniment of Systems support through medical, police and legal proceedings

Additionally, the facility provided information on the State of Connecticut’s Office of Victim Services Sexual Assault Forensic Examiners program, describing victims access to forensic examinations. The facility has multiple resources to provide a victim who has experienced sexual abuse; hence exceeding the requirements.

The interviewed PREA Coordinator stated that Project MORE has an MOU with the local Women and Families Center to provide additional support. There were no reported allegations of sexual abuse at the facility in the last 12 months.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.221 (f). As reported in the PAQ the agency has requested that the investigative agency follow the requirements of paragraphs 115.221 (a). The policy further states that “PMI shall request that the investigating agency abide by all PREA requirements and standards”. There were no reported allegations of sexual abuse in the last 12 months.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.221 (g). N/A the auditor is not required to audit this standard.

115.221 (h). N/A the auditor is not required to audit this standard.

Corrective Action:

No corrective action is recommended for this standard.

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 the policy 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.

The following evidence was analyzed in making compliance determination:

1. Documents:
 - a. Pre-Audit Questionnaire (PAQ)
 - b. Policy:
 - i. Project More, Inc., Standard 115.222, Responsive Planning, *Policies to ensure referrals for allegations for investigations*
 - c. 2019 Example PREA Report (example)
 - d. Annual Report
 - e. Statement from PD NO PREA Allegations and Investigators Specialized Training
2. Interviews:
 - a. PREA Coordinator
 - b. Investigative Staff
 - c. Agency Head

Findings (By Provision):

115.222 (a). As reported in the PAQ, the agency ensures that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment. During the past 12 months, there were zero allegations of sexual abuse and sexual harassment that was received. *Responsive Planning, Policies to ensure referrals for allegations for investigations*, states that “PMI shall ensure that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment”.

The interviewed agency head stated that all allegations are investigated by the agency PREA Coordinator. The PREA Coordinator will interview all parties-alleged victim and perpetrator, staff and witnesses if any. A decision will be based on the evidence provided:

- Grievance form if one was filed.
- Statements from staff and witnesses.
- The PREA Coordinator will look at past complaints or issues.
- The PREA Coordinator will review case books for information.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.222 (c). The agency provided correspondence with the local PD indicating their role in conducting sexual abuse and sexual harassment allegations, completing and providing documentation on specialized training for sexual abuse investigations.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.222 (d). N/A the auditor is not required to audit this standard.

115.222 (e). N/A the auditor is not required to audit this standard.

Corrective Action:

No corrective action is recommended for this standard.

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 confinement? Yes No
- Does the agency train all employees who may have contact with residents on: The common reactions of sexual abuse and sexual harassment victims? 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.

The following evidence was analyzed in making compliance determination:

1. Documents:
 - a. Pre-Audit Questionnaire (PAQ)
 - b. Policy:
 - i. Standard 115.231 Training and Education, *Employee Training*
 - c. Staff Training Manual
 - d. Training Certificates (1)
 - e. Training Statements (29)
 - f. Staff Training Roster (2/1.2020-4)
2. Interviews:
 - a. Random staff (8)

Findings (By Provision):

115.231 (a). As reported in the PAQ, the agency trains all employees who may have contact with residents on the following matters:

- Agency's zero-tolerance policy for sexual abuse and sexual harassment;
- How to fulfill their responsibility under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures;
- The right of residents to be free from sexual abuse and sexual harassment;
- The right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment;
- The dynamics of sexual abuse and sexual harassment in confinement;
- The common reactions of sexual abuse and sexual harassment victims;
- How to detect and respond to signs of threatened and actual sexual abuse;
- How to avoid inappropriate relationships with residents;
- How to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender-nonconforming residents; and
- How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities.

Training and Education, *Employee Training* policy, further confirms the above requirements.

Eight random staff were interviewed that could articulate being trained on the above areas. All but one staff reported that they have received refresher training in the last year. When probed, the staff was able to articulate some of the signs of a sexual abuse or sexual harassment victim and how to communicate effectively with a resident that may be lesbian, gay, bisexual, transgender, intersex, or gender non-conforming. The auditor reviewed the *Staff Training Manual* which covered all of the above referenced topics. Thirty completions of PREA training certificates that were completed in the last 12 months was reviewed.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.231 (b). As reported in the PAQ, the training is tailored to the gender of the residents at the facility. It was also reported that employees who are reassigned from facilities housing the opposite gender are given additional training.

115.231 (c). As reported in the PAQ, there are 33 staff employed by the facility, how may have contact with residents, who were trained or retrained on the PREA requirements. It was also reported that that between trainings the agency provides employees who may have contact with residents with information about current policies regarding sexual abuse and sexual harassment. Training and Education, *Employee Training* policy states that "PMI shall provide training quarterly for all new facility employees" and PMI shall provide refresher training every two years to ensure all employees know the agency's current sexual abuse and sexual harassment policies and procedures". Thirty completions of PREA training certificates that were completed in the last 12 months was reviewed.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.231 (d). As reported in the PAQ, the agency documents that employee who may have contact with residents understand the training they have received through employee signature or electronic verification. Training and Education, *Employee Training* policy states that "PMI shall document training through employee signature or electronic verification that the employee understands the training

received". Thirty completions of PREA training certificates that were completed in the last 12 months was reviewed.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

Corrective Action:

No corrective action is recommended for this standard.

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.

The following evidence was analyzed in making compliance determination:

1. Documents:
 - a. Pre-Audit Questionnaire (PAQ)
 - b. Policy:
 - i. Project More, Inc., Standard 115.232, Training and Education, *Volunteer and contractor training*
 - c. Contractor or Volunteer Signed Statements (3)
2. Interviews:
 - a. Volunteer/Contractor (unable to locate)

Findings (By Provision):

115.232 (a). As reported in the PAQ, all volunteers and contractors who have contact with residents have been trained on their responsibilities under the agency’s policies and procedures regarding sexual abuse/harassment prevention, detection, and response. There were zero volunteers and individual contractors who have contact with residents, who have been trained in agency policies and procedure regarding sexual abuse/harassment prevention, detection, and response. Training and Education, *Volunteer and contractor training* policy states that “all program volunteers/interns shall receive training outlined in Standard 115.231. Contractors shall be trained on their responsibilities under PMIs sexual abuse and sexual harassment prevention, detection, and response policies and procedures”.

The contracted maintenance staff were not onsite during the audit. The auditor made multiple attempts to reach a contracted staff, however no calls were returned.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.232 (b). As reported in the PAQ, the level and type of training provided to volunteers and contractors is based on the services they provide and level of contact they have with residents. The contracted maintenance staff were not onsite during the audit. The auditor made multiple attempts to reach a contracted staff, however no calls were returned.

A review of the appropriate documentation and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.232 (c). As reported in the PAQ, the agency maintains documentation confirming that volunteers/contractors understand the training they have received. Employee PREA Training Acknowledgement forms for three maintenance staff was reviewed. The contracted maintenance staff were not onsite during the audit. The auditor made multiple attempts to reach a contracted staff, however no calls were returned.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

Corrective Action:

No corrective action is recommended for this standard.

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.

The following evidence was analyzed in making compliance determination:

1. Documents:
 - a. Pre-Audit Questionnaire (PAQ)
 - b. Policy:
 - i. Project More, Inc., Standard 115.233, Training and Education, *Resident Education*
 - c. Resident Handbook (Handbook Acknowledgement)-37
 - d. Resident PREA Education Acknowledgement -20
 - e. WFC Brochures
2. Interviews:
 - a. Intake staff
 - b. Random Sample of Residents (11)

Findings (By Provision):

115.233 (a). As reported in the PAQ, residents receive information at time of intake about the zero-tolerance policy and how to report incidents or suspicion of sexual abuse or harassment. There were 137 residents admitted to the facility during the past 12 months who were given information at intake. Training and Education, *Resident Education* policy states that “during the intake process, residents shall receive information explaining PMIs zero tolerance policy regarding sexual abuse and sexual harassment”.

The interviewed intake staff reported at intake, the staff goes over the zero-tolerance policy with the residents. There is a portion of the intake packet that covers definitions and how to notify or report allegations of sexual abuse and sexual harassment. The staff reported that the content is covered with the resident and then they have the resident sign acknowledging their understanding of the material. The auditor reviewed 28 signed receipts of education (Project MORE Sexual Assault and Custodial Misconduct forms). Upon review, the auditor found that the facility did an excellent job providing PREA related education, resources and material to residents immediately upon arrival at the facility. Ongoing information was available to the residents throughout the facility.

Eleven random residents were interviewed. All but one interviewed resident could recall the facility's going over the rules against sexual abuse and harassment. For those residents that could recall, the information was provided upon the same day of arrival.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.233 (b). There were 137 residents admitted to the facility during the past 12 months who were given information at intake. Of the 137/125 length of staff was for more than 30 days. As previously stated, offender education occurs at intake. Upon review of the Resident Handbook, residents are provided information on the following:

- What do you do if you have been sexually assaulted
- What is sexual assault
- Examples of sexual assault
- How to prevent sexual assault
- How to make a report

The interviewed intake staff reported that the resident handbook covers the above material. The intake staff will read the PREA policy with the resident and have them sign an acknowledgement form. Usually, the resident receives the information immediately however no more than 24 hours.

Eleven random residents were interviewed. All of the interviewed residents were placed at the facility in the last year and transferred from another facility.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.233 (c). As reported in the PAQ, resident PREA education is available in formats accessible to all residents, including those that are:

- Limited English proficient
- Deaf
- Visually impaired
- Otherwise disabled
- Limited in their reading skills

Training and Education, *Resident Education* policy states that "staff will ensure that all residents education regarding sexual abuse and sexual harassment accessible to all residents, including those who are limited English proficient, deaf, visually impaired, or otherwise disabled as well as residents who have limited reading skills".

The auditor reviewed a copy of the resident handbook, sexual assault services brochure (English/Spanish), along with signed receipt (20) of PREA education and Handbook Acknowledgement (37).

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.233 (d). As reported in the PAQ, the agency maintains documentation of resident participation in PREA education sessions. Training and Education, *Resident Education* policy states that “during the intake the residents will be required to sign a form stating they have been informed of the PMIs policy regarding sexual abuse and sexual harassment”.

The auditor reviewed a copy of the resident handbook, sexual assault services brochure (English/Spanish), along with signed receipt (20) of PREA education and Handbook Acknowledgement (37).

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.233 (e). As reported in the PAQ, the agency ensures that key information about the agency’s PREA policies is continuously and readily available or visible through posters, resident handbooks, or other written formats. Training and Education, *Resident Education* policy states that “key information will be readily available to residents. This can be down through a combination of posters, client handbook, handout or other written format”.

The auditor reviewed a copy of the resident handbook, sexual assault services brochure (English/Spanish), along with signed receipt (20) of PREA education and Handbook Acknowledgement (37). During the onsite inspection the auditor observed the following: PREA Posters in Spanish and English, contact information for outside reporting entities, and emotional support/advocacy organizations.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

Corrective Action:

No corrective action is recommended for this standard.

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 receive 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.

The following evidence was analyzed in making compliance determination:

1. Documents:
 - a. Pre-Audit Questionnaire (PAQ)
 - b. Policy:
 - i. Project More, Inc., Standard 115.234, Training and Education, *Specialized Training: Investigation*
 - c. Training Certificates (2)
 - d. Correspondence with New Haven Police Department
2. Interviews:
 - a. Investigative Staff

Findings (By Provision):

115.234 (a). As reported in the PAQ, the agency policy requires that investigators are trained in conducting sexual abuse investigations in confinement settings. Training and Education, *Specialized Training: Investigation*, states that “PMI shall ensure that, to the extent, the agency/program itself conducts sexual abuse investigations, its investigator (s) have received training in conducting such investigations”.

The agency provided correspondence with the local PD indicating their role in conducting sexual abuse and sexual harassment allegations, completing and providing documentation on specialized training for sexual abuse investigations. Additionally, two certifications of completion of specialized training were reviewed.

The interviewed investigative staff reported that they received training specific to conducting sexual abuse investigations in confinement settings. The training consisted of: PREA Investigating Sexual Abuse in Confinement Settings (NIC), PREA Coordinators Roles and Responsibilities, and various PREA Resource Center webinars.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.234 (b). The agency provided documentation of two staff who have completed the specialized training for investigations. The interviewed investigator reported that the training consisted of:

- Techniques for interviewing sexual abuse victims.
- Proper use of Miranda and Garrity warnings.
- Sexual abuse evidence collection in confinement settings.
- The criteria and evidence required to substantiate a case for administrative or prosecution referral.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.234 (c). As reported in the PAQ, the agency maintains documentation showing that investigators have completed the required training. The agency has two administrative investigators who is currently employed who have completed the required training.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.234 (d). N/A the auditor is not required to audit this provision.

Corrective Action:

No corrective action is recommended for this standard.

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? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)
 Yes No NA
- 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? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.) Yes No NA
- 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? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.) Yes No NA
- 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? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)
 Yes No NA

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 does not employ medical staff or the medical staff employed by the agency 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? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.) Yes No NA

115.235 (d)

- Do medical and mental health care practitioners employed by the agency also receive training mandated for employees by §115.231? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners employed by the agency.) Yes No NA
- 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 if the agency does not have any full- or part-time medical or mental health care practitioners contracted by or volunteering for the agency.) 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 following evidence was analyzed in making compliance determination:

1. Documents:
 - a. Pre-Audit Questionnaire (PAQ)
 - b. Statement-No Applicable

Findings (By Provision):

115.235 (a). NA- the agency does not have onsite medical and mental health services. The agency provided a statement that "PMI has no full or part-time medical and/or mental health care practitioners who work regularly in its facilities".

115.235 (b). NA- the agency does not have onsite medical and mental health services. The agency provided a statement that "PMI has no full or part-time medical and/or mental health care practitioners who work regularly in its facilities".

115.235 (c). NA- the agency does not have onsite medical and mental health services. The agency provided a statement that "PMI has no full or part-time medical and/or mental health care practitioners who work regularly in its facilities".

115.235 (d). NA- the agency does not have onsite medical and mental health services. The agency provided a statement that “PMI has no full or part-time medical and/or mental health care practitioners who work regularly in its facilities”.

Corrective Action:

No corrective action is recommended for this standard.

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.

The following evidence was analyzed in making compliance determination:

1. Documents:
 - a. Pre-Audit Questionnaire (PAQ)
 - b. Policy:
 - i. Project More, Inc., Standard 115.241, Screening for Risk of Sexual Victimization and Abusiveness, *Screening for risk of victimization and abusiveness*
 - c. PREA Risk Assessment-20
 - d. PREA Risk Reassessment (19)
 - e. Updated Reassessment form (1)
2. Interviews:
 - a. Random Sample of Residents (11)

b. Staff who perform screening for risk of victimization and abusiveness

Findings (By Provision):

115.241 (a). As reported in the PAQ, the agency has a policy that requires screening (upon admission to a facility or transferred to another facility) for risk of sexual abuse victimization or sexual abusiveness toward other residents. Screening for Risk of Sexual Victimization and Abusiveness, *Screening for risk of victimization and abusiveness* policy states that “all residents shall be assessed during the intake and upon transfer to another facility for their risk of being sexually abused by other residents or sexually abusive toward other residents”.

The interviewed staff responsible for risk screening reported that the residents are screened for risk of sexual abuse victimization or sexual abusiveness towards others at intake. The auditor reviewed 20 PREA Risk Assessments that were completed. Based on the intake date, the tool was typically completed on the same day of placement at WBH, and no later than 24 hours.

115.241 (b). According to the PAQ, the policy requires that residents be screened for risk of sexual victimization or risk of sexual abusing other residents within 72 hours of their intake. Screening for Risk of Sexual Victimization and Abusiveness, *Screening for risk of victimization and abusiveness* policy states that “intake screenings shall take place within 72 hours of arrival”. The interviewed staff responsible for risk screening reported that residents are screened usually on the same day as their arrival at the facility.

Eleven random sample of residents were interviewed. Approximately half of the residents could recall being asked questions about history of victimization or abusiveness. The auditor reviewed 20 PREA Risk Assessments that were completed. Based on the intake date, the tool was typically completed on the same day of placement at WBH, and no later than 24 hours.

115.241 (c). As reported in the PAQ, the facility uses an objective risk assessment (*PREA Risk Assessment Form*). Screening for Risk of Sexual Victimization and Abusiveness, *Screening for risk of victimization and abusiveness* policy states that “such assessments shall be conducted using an objective screening instrument”. The auditor reviewed 20 PREA Risk Assessments that were completed. The tool asks open and closed ended questions, there is a scoring system, along with a variety of questions that addresses victimization and abusiveness.

115.241 (d). Screening for Risk of Sexual Victimization and Abusiveness, *Screening for risk of victimization and abusiveness* policy states that the instrument shall include the following:

- Whether the resident has a mental, physical or developmental disability.
- The age of the resident.
- The physical build of the resident.
- Whether the resident has previously been incarcerated.
- Whether the resident’s criminal history is exclusively nonviolent.
- Whether the resident has prior convictions for sex offense.
- Whether the resident is perceived to be gay, bisexual, transgender, intersex, or gender non conforming.
- Whether the resident has previously experienced sexual victimization.
- The residents own perception of vulnerability.

The interviewed staff responsible for risk screening reported that the above-mentioned areas are considered when conducting the screening. The process for conducting the initial screening involves

going over the zero-tolerance policy with the resident, ask a series of questions and complete a physical screening. The auditor reviewed 20 PREA Risk Assessments that were completed. The tool asks open and closed ended questions, there is a scoring system, along with a variety of questions that addresses victimization and abusiveness. All of the above-mentioned areas were covered in the screening tool.

115.241 (e). Screening for Risk of Sexual Victimization and Abusiveness, *Screening for risk of victimization and abusiveness* policy states that “that the intake shall consider prior acts of sexual abuse, prior convictions for violent offenses and history of prior institutional violence of sexual abuse, as known to the agency, in residents for risk of being sexually abusive”. The auditor reviewed 20 PREA Risk Assessments that were completed. All of the above-mentioned areas were covered in the screening tool. The interviewed staff responsible for risk screening reported that the above-mentioned areas are considered when conducting the screening. The process for conducting the initial screening involves going over the zero-tolerance policy with the resident, ask a series of questions and complete a physical screening.

115.241 (f). As reported in the PAQ, the policy requires that the facility reassess each resident’s risk of victimization or abusiveness within a set time period, not to exceed 30 days after the resident’s arrival at the facility, based upon any additional, relevant information received by the facility since the intake screening. Screening for Risk of Sexual Victimization and Abusiveness, *Screening for risk of victimization and abusiveness* policy further confirms the requirement to reassess within 30 days.

The interviewed staff responsible for risk screening reported that the reassessments are completed within 30 days. The auditor reviewed a sample of 19 PREA Risk Reassessments. The forms were consistently completed within 30 days.

Eleven random sample of residents were interviewed. Three of the interviewed residents arrived at the facility within the last three weeks of the onsite interview. The other eight residents could not recall being asked the questions again. Upon review with the agency PREA Coordinator, the agency added a signature line for the reassessment to confirm receipt. The newly updated and completed form was provided for the auditor to review.

115.241 (g). As reported in the PAQ, the policy requires that residents risk level be reassessed when warranted due to a referral, request, incident of sexual abuse, or receipt of additional information that bears on the resident’s risk of sexual victimization or abusiveness. Screening for Risk of Sexual Victimization and Abusiveness, *Screening for risk of victimization and abusiveness* policy states that “a resident’s risk level shall be reassessed 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 interviewed staff responsible for risk screening reported that residents risk level is reassessed, and it is reassessed for victimization and predator.

Eleven random sample of residents were interviewed. Three of the interviewed residents arrived at the facility within the last three weeks of the onsite interview. The other eight residents could not recall being asked the questions again. Upon review with the agency PREA Coordinator, the agency added a signature line for the reassessment to confirm receipt. The newly updated and completed form was provided for the auditor to review.

115.241 (h). As reported in the PAQ, the policy prohibits disciplining residents for refusing to answer the questions regarding:

- Whether or not the resident has a mental, physical, or developmentally disability;

- Whether or not the resident is or is perceived to be gay, lesbian, bisexual, transgender, intersex, or gender non-conforming;
- Whether or not the resident has previously experienced sexual victimization; and
- The resident's own perception of vulnerability.

Screening for Risk of Sexual Victimization and Abusiveness, *Screening for risk of victimization and abusiveness* policy states that "residents will not 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".

The interviewed staff responsible for risk screening reported that residents are not disciplined for refusing to respond.

115.241 (i). Screening for Risk of Sexual Victimization and Abusiveness, *Screening for risk of victimization and abusiveness* policy states that "the agency shall have appropriate controls regarding the dissemination of sensitive information on any resident". The interviewed staff responsible for risk screening along with the agency PREA Coordinator reported that only the assigned case manager and director will have access to the resident's risk screening.

Corrective Action:

No corrective action is recommended for this standard.

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? (N/A if the agency has a dedicated facility, unit, or wing solely for the placement of LGBT or I residents pursuant to a consent decree, legal settlement, or legal judgement.) Yes No NA
- 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? (N/A if the agency has a dedicated facility, unit, or wing solely for the placement of LGBT or I residents pursuant to a consent decree, legal settlement, or legal judgement.) Yes No NA
- 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? (N/A if the agency has a dedicated facility, unit, or wing solely for the placement of LGBT or I residents pursuant to a consent decree, legal settlement, or legal judgement.)

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 following evidence was analyzed in making compliance determination:

1. Documents:
 - a. Pre-Audit Questionnaire (PAQ)
 - b. Policy:
 - i. Project More, Inc., Standard 115.242, Training and Education, *Use of Screening Information*
 - ii. Standard 115.215 Prevention Planning Policy Prevention Planning, *Limits to cross-gender viewing and search*
 - c.
2. Interviews:
 - a. PREA Coordinator
 - b. Staff who perform screening for risk of victimization and abusiveness

Findings (By Provision):

115.242 (a). As reported in the PAQ, the agency/facility uses information from the risk screening to inform housing, bed, work, education, and program assignments with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive. Training and Education, *Use of Screening Information*, policy further confirms the above requirement.

The interviewed staff responsible for risk screening reported that the agency uses the information from the risk screening to show risk, determine where to place them in the facility. For example, a predator or victim may be placed on the 1st floor closer to staff offices. The interviewed investigator stated that clients who are considered a potential victim are located on the first floor. It is the Program Director's responsibility to inform staff. A potential abuser will be located on either the second or third floor. Again, the Program Director will notify staff.

115.242 (b). As reported in the PAQ, the agency/facility makes individualized determination about how to ensure the safety of residents. Training and Education, *Use of Screening Information*, policy states that the goal of the risk screening is to ensure the safety of all facility residents”. The interviewed staff responsible for risk screening reported that the agency uses the information from the risk screening to show risk, determine where to place them in the facility. For example, a predator or victim may be placed on the 1st floor closer to staff offices.

115.242 (c). As reported in the PAQ, the agency/facility makes housing and program assignments for transgender or intersex residents in the facility on a case-by-case basis. Training and Education, *Use of Screening Information*, policy states that “all residents deemed high risk, to include transgender, gay; bisexual and intersex residents shall be placed in one of the first-floor rooms or in a room close to the program main office”.

The interviewed PREA Coordinator stated that all transgender and intersex clients are considered potential victims and will be housed on the first floor. Regarding community assignments, staff will verify the appointment, allow the client a reasonable time outside the facility and provide proof. If possible the client will not have another client attend an appointment at the same location and time. In house assignment, the client should be supervised by staff who will observe the assignment. Such placement would consider the residents safety along with managing potential security problems.

115.242 (d). The interviewed staff responsible for risk screening reported that transgender and intersex residents’ views would be taken into consideration. It was also reported that the worker was not aware of a transgender resident being placed at their facility. The interviewed PREA Coordinator stated that as soon as possible, the client will meet with the PREA Coordinator, Program Director and assigned Case Manager. Topics will include security, use of showers and bathrooms, pat down searches and how the client wants to be addressed. The client is encouraged to state concerns to staff.

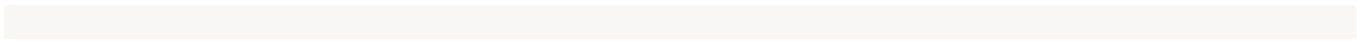
115.242 (e). Policy Prevention Planning, *Limits to cross-gender viewing and searches*, states that “transgender and intersex residents will be given the opportunity to shower, dress and use the bathroom separately from other residents. The interviewed staff responsible for risk screening reported that all residents are given the opportunity to shower separately from others. It was also reported that in the handicap bathrooms there are additional security locks.

The interviewed investigator stated that transgender and intersex residents are able to shower separately. The client would be housed in the handicap room where the shower/bathroom can be locked from the inside.

115.242 (f). There were no transgender or intersex residents at the facility during the onsite inspection. The interviewed PREA Coordinator stated that they are unaware of any consent decree, legal settlement or legal judgement associated with gay, lesbian, bisexual or transgender residents. It was also reported that clients are housed based on the Risk Assessment and what bed is available. “At Risk” clients are placed on the first floor, so staff is able to more closely monitor them.

Corrective Action:

No corrective action is recommended for this standard.



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.

The following evidence was analyzed in making compliance determination:

1. Documents:
 - a. Pre-Audit Questionnaire (PAQ)
 - b. Policy:
 - i. Project More, Inc., Standard 115.251, Screening for Risk of Sexual Victimization and Abusiveness, *Resident Reporting*
 - c. Resident Handbook
2. Interviews:
 - a. PREA Coordinator
 - b. Random sample of residents (11)
 - c. Random Staff (8)

Findings (By Provision):

115.251 (a). As reported in the PAQ, the agency has established procedures allowing for multiple internal ways for residents to report privately to agency officials about:

- Sexual abuse or sexual harassment;
- Retaliation by other residents or staff for reporting sexual abuse and sexual harassment; and
- Staff neglect or violation of responsibilities that may have contributed to such incidents.

Screening for Risk of Sexual Victimization and Abusiveness, *Resident Reporting* policy states that "PMI shall provide multiple ways for residents to privately report sexual abuse and sexual harassment, retaliation by other residents or staff for reporting sexual abuse and sexual harassment, and staff neglect or violation of responsibilities that may have contributed to such incidents". The resident handbook provides information on the agencies zero tolerance policy for sexual abuse and sexual harassment.

Eight random staff were interviewed. All of the staff stated that residents could privately report by telling staff, contact the hotline, call the advocacy number on the posters, or tell family members. Eleven random sample of residents were interviewed. All of the residents could describe at least one way that they could make a report of sexual abuse or sexual harassment. The various ways described included: call the hotline, call the police, and tell staff.

115.251 (b). As reported in the PAQ, the agency provides at least one way for residents to report abuse or harassment to a public or private entity or office that is not part of the agency. Screening for Risk of Sexual Victimization and Abusiveness, *Resident Reporting* policy states that "residents shall be informed of at least one way to report sexual abuse or sexual harassment to a public or private entity or office that is not part of PMI". The resident handbook provides residents with various methods to report sexual abuse and sexual harassment. Such methods include:

- Verbally to any Walter Brooks House or Project MORE staff.
- In writing to any Walter Brooks House or Project MORE staff.

- Submit a grievance-signed or anonymous.
- Having a family member or friend contact facility staff or other Project MORE staff.
- Contact CT DOC or Parole verbally or in writing.
- Contacting Senior Project MORE staff by calling 203-865-5700.
- Contacting the Women and Families Sexual Assault Crisis Service at 1-888-999-5534-English, 1-888-568-8332-Spanish
- Go directly to the Women and Families office located at 1440 Whalley Avenue, New Haven, CT 06515.

The interviewed PREA Coordinator stated that there are posters on the facility wall stating where clients can report, in addition to having information in the handbook. During the onsite inspection the auditor observed this process. It was also reported that if a resident contacts an outside source, the facility may not always know that a report was being made.

Eleven random sample of residents were interviewed. All of the residents could describe at least one way that they could make a report of sexual abuse or sexual harassment. The various ways described included: call the hotline, call the police, and tell staff. All but one of the residents believed that they could make a report without having to give their name.

115.251 (c). As reported in the PAQ, the agency has a policy mandating that staff accept reports of sexual assault and sexual harassment made verbally, in writing, anonymously, and from third parties. Staff are required to document verbal reports. Screening for Risk of Sexual Victimization and Abusiveness, *Resident Reporting* policy states that “staff shall accept reports made verbally, in writing, anonymously, and from third parties”.

Eight random staff were interviewed. The staff reported that when a resident alleges sexual abuse they can do so verbally, in writing, anonymously or through a third party. The staff reported that if a resident makes a verbal report, they will document and notify their supervisors immediately.

Eleven random sample of residents were interviewed. All of the residents reported that they could report sexual abuse or sexual harassment either in person or in writing. The residents also reported someone else could make a report for them if needed.

115.251 (d). As reported in the PAQ, the agency does not have an established procedures for staff to privately report sexual abuse and sexual harassment of residents. However, while onsite and during the interviews with staff, there is a process in place for staff to privately report.

Eight random staff were interviewed. All of the staff stated that they could privately report to the shift supervisor, director or the PREA Coordinator. When probed, half of the staff also stated that they could call the hotline.

Corrective Action:

No corrective action is recommended for this standard.

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

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.

The following evidence was analyzed in making compliance determination:

1. Documents:
 - a. Pre-Audit Questionnaire (PAQ)
 - b. Policy:
 - i. Project More, Inc., Standard 115.252 Reporting, *Exhaustion of administrative remedies*
 - ii. Project More, Inc., Policy and Procedure, Resident Grievance
 - c. Resident Handbook

Findings (By Provision):

115.252 (a). As reported in the PAQ, the agency has an administrative procedure for dealing with resident grievances regarding sexual abuse. Reporting, *Exhaustion of administrative remedies*, policy states that "PMI shall establish procedures which will provide residents of all facilities with a way of resolving sexual harassment and sexual abuse allegations through a grievance process. A resident may submit a grievance either in writing or verbally".

115.252 (b). As reported in the PAQ, agency policies or procedure allows a resident to submit a grievance regarding an allegation of sexual abuse at any time, regardless of when the incident is alleged to have occurred. Reporting, *Exhaustion of administrative remedies* policy, states that "there will be no time limit regarding the submission of the grievance".

115.252 (c). As reported in the PAQ, the agency policy and procedure does not allow an resident to submit a grievance alleging sexual abuse without submitting it to the staff member who is subject to the complaint however they will not refer it to the staff member who is the subject of the complaint. Reporting, *Exhaustion of administrative remedies* policy, states that "a resident submitting a grievance is not required to submit it to a staff member who would be the subject of the complaint".

115.252 (d). As reported in the PAQ, the agency policy and procedure requires that a decision on the merits of any grievance or portion of a grievance alleging sexual abuse be made within 90 days of the filing of the grievance. There have been zero reported grievances filed that alleges sexual abuse. Reporting, *Exhaustion of administrative remedies* policy, states that the final decision shall be made within 30 days of the submission of the grievance. The time can be extended for a period of up to 70 days, if more time is required”.

115.252 (e). As reported in the PAQ, the agency policy and procedure does not permit third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, to assist residents in filing a request for administrative remedies relating to allegations of sexual abuse and to file such requests on behalf of residents. However, policy Reporting, *Exhaustion of administrative remedies* policy, states that third parties: may assist a resident in submitting a grievance, third party grievances may be given to any PMI staff member and should a resident decline to have a grievance processed, PMI will document that decision. The auditor further clarified with the facility director the process for residents to file a grievance.

115.252 (f). As reported in the PAQ, the agency has a policy and established procedures for filing an emergency grievance alleging that a resident is subject to a substantial risk of imminent sexual abuse. Reporting, *Exhaustion of administrative remedies* policy, states that an emergency grievance:

- Any resident may submit an emergency grievance if that resident is subject to imminent sexual abuse.
- The PREA Coordinator will be immediately contacted and will instruct staff to have that resident placed under their supervision.
- The PREA Coordinator will begin the investigation and have a response within 48 hours.
- A final determination will be submitted within five calendar days. The final decision will stated if the resident is in immediate risk.
- All final determinations will document all action taken be the agency, PREA Coordinator, staff and referring source.

115.252 (g). As reported in the PAQ, the agency has a written policy that limits its ability to discipline a resident for filing a grievance alleging sexual abuse to occasions where the agency demonstrates that the resident filed the grievance in bad faith. Reporting, *Exhaustion of administrative remedies* policy, states that “should it be determined that the resident filed a grievance in bad faith, that person would be subjected to disciplinary action. That action would be determined by the seriousness of the allegation, how well or poorly the resident had done in the facility, and converse with the referring source”.

Corrective Action:

No corrective action is recommended for this standard.

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.

The following evidence was analyzed in making compliance determination:

1. Documents:
 - a. Pre-Audit Questionnaire (PAQ)
 - b. Policy:
 - i. Project More, Inc., Standard 115.253, Reporting, Residents Access to Outside Confidential Support Services
 - c. MOU Women and Families Center (WFC)
 - d. WFC Brochure
 - e. PREA Posters

- f. Resident PREA Brochures
 - g. Resident Handbook (PREA)
 - h. Memo: Resident Services (4 providers)
 - i. APT Foundation Letter
 - j. APT Email Correspondence
2. Interviews:
- a. Random sample of residents (11)

Findings (By Provision):

115.253 (a). As reported in the PAQ, the facility provides residents with access to outside victim advocates for emotional support services related to sexual abuse. Reporting, *Residents Access to Outside Confidential Support Services* policy, states that “PMI shall provide residents with access to outside victim advocates for confidential emotional support services related to sexual abuse”. Additionally, the policy states that “residents will have mailing address, telephone numbers, hotline telephone numbers available of local, State, or national advocacy organizations”

During the onsite inspection the auditor observed the following: posted hotline numbers, brochures, and posters. The agency provided a memo stating that “there are four providers that provide services for our residential clients”. One of the provides APT Foundation provided a statement that says, “the APT Foundation agrees to report any potential PREA qualifying event reported to our staff by a person who is also receiving services at Project MORE”. The statement further indicates that the APT staff have a basic understanding of PREA standards, including reporting requirements.

Eleven random sample of residents were interviewed. Four of the 11 residents were aware of services available outside of this facility for dealing with sexual abuse, if needed. Only two of the four residents could describe services, such as groups, outpatient counseling, and advocacy services. Two residents could recall the facility giving mailing addresses and telephone numbers for outside services. The four residents reported that they have their own phones and could have confidential conversations with outside services.

115.253 (b). As reported in the PAQ, the facility does not inform residents, prior to giving them access to outside support services, the extent to which such communications will be monitored. Reporting, *Residents Access to Outside Confidential Support Services* policy, states that “residents who contact an outside advocate may be done without staff knowledge”. The auditor reviewed a MOU between Project MORE, Inc., and Women and Families Center (WFC). The MOU indicates that: WFC “will provide:

- Training to Project MORE staff as requested.
- Provide individual counseling and support groups to Project MORE
- Accompaniment of Systems support through medical, police and legal proceedings

Eleven random sample of residents were interviewed. Four of the 11 residents were aware of outside services. The four residents reported that they have their own numbers and felt that they could have confidential communication with the outside services.

115.253 (c). As reported in the PAQ, the agency or facility maintains memorandum of understanding (MOUs) or other agreements with community service to providers that can provide residents with emotional support services related to sexual abuse. Reporting, *Residents Access to Outside Confidential Support Services* policy, states that “PMI will maintain or attempt to maintain a memorandum of understanding with a community provider to provide 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 auditor reviewed a MOU between Project MORE, Inc., and Women and Families Center (WFC). The MOU indicates that: WFC "will provide:

- Training to Project MORE staff as requested.
- Provide individual counseling and support groups to Project MORE
- Accompaniment of Systems support through medical, police and legal proceedings

Corrective Action:

No corrective action is recommended for this standard.

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.

The following evidence was analyzed in making compliance determination:

1. Documents:
 - a. Pre-Audit Questionnaire (PAQ)
 - b. Policy:
 - i. Project More, Inc., Standard 115.254, Reporting, *Third-Party Reporting*
 - c. Memo: No Third-Party Reports
 - d. Staff Training Manual
 - e. Website
 - f. Offender Manual

Findings (By Provision):

115.254 (a). As reported in the PAQ, the agency or facility provides a method to receive third-party reports on resident sexual abuse or sexual harassment. Said information is publicly distributed. Reporting, *Third-Party Reporting* policy states that “PMI shall establish a method to receive third party reports of sexual abuse and sexual harassment”. The policy further describes various methods in which a third party can make a report:

- By mail to the facility or main office.
- By telephone call to the facility, or other facility or main office.
- 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 member.
- By e-mail to any agency staff person.
- By having any other agency contact the facility, other facility, or main office by mail, telephone, e-mail or in person.

The auditor reviewed the website, offender manual and staff training manual which provided various methods for third-party reports. The agency provided a memo that stated, “this letter is to inform you that Project MORE has never received a third-party contact regarding sexual abuse or sexual harassment in any of our residential facilities”.

Corrective Action:

No corrective action is recommended for this standard.

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 or not it is part of the agency? Yes No
- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding retaliation against residents or staff who reported an incident of sexual abuse or sexual harassment? Yes No
- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding any staff neglect or violation of responsibilities that may have contributed to an incident of sexual abuse or sexual harassment or retaliation? Yes No

115.261 (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.

The following evidence was analyzed in making compliance determination:

1. Documents:
 - a. Pre-Audit Questionnaire (PAQ)
 - b. Policy:
 - i. Project More, Inc., Standard 115.261, Official Response Following a Resident Report, *Staff and agency reporting duties*

- c. PREA Staff Training Manual
- d. 2019 Example PREA Report
- e. Memo: No PREA Allegations
- f. Memo: No Reports made to the local law enforcement

2. Interviews:

- a. PREA Coordinator
- b. Director
- c. Random Staff (8)

Findings (By Provision):

115.261 (a). As reported in the PAQ, the agency requires all staff to report immediately and according to agency policy any knowledge, suspicion, or information they receive regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether it is part of the agency. Official Response Following a Resident Report, *Staff and agency reporting duties* policy provides guidance of the above requirement.

Eight random staff were interviewed. The staff reported that the procedure for reporting any information related to a resident sexual abuse incident is to notify the director or the PREA Coordinator immediately. The auditor reviewed the: employee training manual to further confirm the agency duty to report.

115.261 (b). As reported in the PAQ, agency policy prohibits staff from revealing any information related to a sexual abuse report to anyone other than to the extent necessary to make treatment, investigation, and other security and management decisions. Official Response Following a Resident Report, *Staff and agency reporting duties* policy states that “apart from reporting to designated supervisors, staff shall not reveal 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”.

As previously stated, eight random staff were interviewed. The staff reported that the procedure for reporting any information related to a resident sexual abuse incident is to notify the director or the PREA Coordinator immediately. The auditor reviewed the: employee training manual to further confirm the agency duty to report.

115.261 (c). N/A the facility does not have onsite medical or mental health staff.

115.261 (d). Official Response Following a Resident Report, *Staff and agency reporting duties* policy states that “If the alleged victim is under 18 years of age or considered a vulnerable adult under a state or vulnerable person’s statute, the agency shall report the allegation to the designated State or local services agency under applicable mandatory reporting laws”.

The interviewed director reported that when an allegation of sexual abuse or sexual harassment is made by someone under the age of 18, the PREA Coordinator will contact DCF. It should be noted that the facility does not house residents under the age of 18 at this time. The interviewed PREA Coordinator reported that during PREA training staff is instructed to contact the PREA Coordinator regarding both situations. I would either contact CT Department of Children and Families for a person under 18, or CT Department of Social Services for a vulnerable adult.

115.261 (e). There were no PREA related allegations in the last 12 months; however, the agency provided an allegation that occurred in 2019 to show the process of reporting to the outside investigative agency. A memo was provided stating “this letter is to inform you that there have been no instances

where the New Haven Police Department have been contacted regarding sexual assault on one of the agency residential clients”.

The interviewed director reported that all allegations of sexual abuse and sexual harassment, including third-party and anonymous sources are reported directly to the designated facility investigator.

Corrective Action:

No corrective action is recommended for this standard.

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.

The following evidence was analyzed in making compliance determination:

1. Documents:
 - a. Pre-Audit Questionnaire (PAQ)
 - b. Policy:
 - i. Project More, Inc., Standard 115.262, *Official Response Following a Resident Report*
 - c. Memo: No PREA Incidents
 - d. Employee Training Manual
2. Interviews:

- a. Agency Head
- b. Random Sample of Staff (8)
- c. Director

Findings (By Provision):

115.262 (a). As reported in the PAQ, when the facility learns that an resident is subject to a substantial risk of imminent sexual abuse, it takes immediate action to protect the resident. In the past 12 months, there were zero times that the facility determined that a resident was subject to a substantial risk of imminent sexual abuse. A memo was provided stating “this letter is to inform you that there have been no instances where the New Haven Police Department have been contacted regarding sexual assault on one of the agency residential clients”.

Official Response Following a Resident Report policy states that “When PMI learns that a resident is subject to a substantial risk of imminent sexual abuse, immediate action will be taken to protect the resident”. The policy further states that staff shall do the following:

- Inform the supervisor on duty.
- Bring the resident into the main office.
- Contact the Program Director and explain the situation.
- Contact the agency PREA Coordinator and explain the situation.
- The PREA Coordinator will contact PMI Administrative staff.
- Contact the referral source and explain the situation.

The employee training manual further reiterates the above-mentioned process. The interviewed agency head stated that if there is imminent risk of sexual abuse, the resident would be monitored by staff. The resident will be placed in the main office and staff will not leave them alone. The PREA Coordinator would be contacted to investigate. The outcome would be based on the results of the investigation.

The interviewed director reported that when they learn that a resident is subject to a substantial risk of imminent sexual abuse, the protective measures taken include inform supervisor on duty, bring the resident to the main office and place him under staff supervision, contact the program director, contact the PREA Coordinator, and the PREA Coordinator will contact the agency administration and the Connecticut DOC. All staff onsite are considered first responders. Eight staff were interviewed. All staff interviewed could clearly articulate their duty to report, respond and protect the residents.

Corrective Action:

No corrective action is recommended for this standard.

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.

The following evidence was analyzed in making compliance determination:

1. Documents:
 - a. Pre-Audit Questionnaire (PAQ)
 - b. Policy:
 - i. Project More, Inc., Standard 115.263, Official Response Following a Resident Report, *Reporting to other confinement facilities*
 - c. Memo: No PREA Incidents
 - d. Employee Training Manual
2. Interviews:
 - a. Director
 - b. Agency Head

Findings (By Provision):

115.263 (a). As reported in the PAQ, the agency has a policy requiring that, upon receiving an allegation that an resident was sexually abused while confined at another facility, the head of the facility must notify the head of the facility or appropriate office of the agency or facility where sexual abuse is alleged to have

occurred. During the past 12 months, there were zero reported allegations of sexual abuse that the facility received from other facilities.

Official Response Following a Resident Report, *Reporting to other confinement facilities* policy further confirms the above requirement. The agency provided a memo that states “this letter is to inform you that there has never been a reported PREA incident where a current resident was sexually abused or harassed at another facility”.

Upon review of the Employee Training Manual, the agency provides staff with additional guidance on the process.

115.263 (b). As reported in the PAQ, the agency policy requires the facility head provides such notification as soon as possible, but no more than 72 hours after receiving the allegation.

115.263 (c). As reported in the PAQ, the facility documents that it has provided such notifications within the 72 hours of receiving the allegation.

115.264 (d). As reported in the PAQ, the facility policy requires that allegations received from other facilities and agencies are investigated in accordance with the PREA standards. During the past 12 months, there was zero allegations of sexual abuse that the facility received from other facilities. The interviewed agency head stated that the agency PREA Coordinator would speak to the other agency and conduct an agency investigation. At this time the agency head is unaware of such reports being made.

The interviewed director reported that if the facility receives an allegation from another facility or agency that an incident of sexual abuse or sexual harassment occurred in the facility, the PREA Coordinator will speak with the PREA Coordinator at the other facility. The PREA Coordinator will also contact the Connecticut DOC to report the allegation. A request would be made for the incident report. Any client named on the report and while still at the Walter Brooks House will be interviewed. Any agency report will be forwarded to the other facility and to the Connecticut DOC. The WBH has not had any examples of another facility or agency reporting such allegations.

Corrective Action:

No corrective action is recommended for this standard.

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.

The following evidence was analyzed in making compliance determination:

1. Documents:
 - a. Pre-Audit Questionnaire (PAQ)
 - b. Policy:
 - i. Project More, Inc., Standard 115264, Official Response Following a Resident Report, *Staff first responder duties*
 - ii. Project More, Inc., *Sexual Assault Incident Coordinated Response Plan*
 - c. Employee Training Manual
2. Interviews:
 - a. Random Sample of Staff (8)

Findings (By Provision):

115.264 (a). As reported in the PAQ, the agency has a first responder policy for allegations of sexual abuse. Upon learning of an allegation that a resident was sexually abused, the first security staff member to respond to the report shall be required to:

- Separate the alleged victim and abuser;
- Preserve and protect any crime scene until appropriate steps can be taken to collect any evidence;
- If the abuse occurred within a time period that still allows for the collection of physical evidence, 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; and/or;
- If the abuse occurred within a time period that still allows for the collection of physical evidence, 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.

Official Response Following a Resident Report, *Staff first responder duties* policy states that “upon learning of an allegation that a resident was sexually abused, the first staff member to respond will have requirements he must respond to”. The policy further states that first responders shall:

- Separate the victim from the abuser.
- The victim will be kept in the staff office under staff supervision.
- The abuser must remain in his room, also under staff supervision.
- Staff will then contact the Program Director and the PMI PREA Coordinator.
- Preserve and protect the crime scene until appropriate steps can be taken to collect any evidence.
- Staff will close off any room that the alleged abuse took place. Residents will not be allowed to enter the room until appropriate steps are taken to collect evidence.

The above-mentioned policy provides guidance on preserving evidence. Such guidance includes:

If the abuse occurred within a time period that would allow for the collection of physical evidence, request that the alleged victim and alleged abuser not take any action that could destroy physical evidence, including as appropriate:

- Washing
- Brushing teeth
- Changing clothes
- Smoking
- Urinating or defecating
- Drinking or eating unless medically indicated

In the past 12 months, there were zero allegations of resident sexual abuse. Upon review of the Employee Training Manual and Sexual Assault Incident Coordinated Response Plan, staff is provided clear guidance on the process.

115.264 (b). As reported in the PAQ, the policy requires that if the first staff responder is not a security staff member, that responder shall be required to:

- Request that the alleged victim not take any actions that could destroy physical evidence; and/or
- Notify security staff.

There were zero allegations that a resident was sexually abused made in the past 12 months. Upon review of the Employee Training Manual and Sexual Assault Incident Coordinated Response Plan, staff is provided clear guidance on the process.

Eight random staff were interviewed. The interviewed staff reported that if they are the first person to be alerted that a resident has allegedly been the victim of sexual abuse, their responsibility is to tell the supervisors and PREA Coordinator, separate parties, check the scene, and always keep the parties safe. When probed the staff reported that they would only tell necessary staff of the incident.

Corrective Action:

No corrective action is recommended for this standard.

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.

The following evidence was analyzed in making compliance determination:

1. Documents:
 - a. Pre-Audit Questionnaire (PAQ)
 - b. Policy:
 - i. Project More., Inc., Standard 115.265 Official Response Following a Resident Report, *Coordinated Response*
 - ii. Project More, Inc., Sexual Assault Incident Coordinated Response Plan
2. Interviews:
 - a. Director

Findings (By Provision):

115.265 (a). As reported in the PAQ, the facility developed a written institutional plan to coordinate actions taken in response to an incident of sexual abuse. Official Response Following a Resident Report, *Coordinated Response* policy states that “the PMI shall ensure a coordinated response to any incident of sexual abuse among staff, first responders, and Agency leadership. The policy along with the Sexual Assault Incident Coordinated Response Plan provides a step-by-step process on the facility response to an allegation of sexual assault.

The interviewed director reported that facility has a coordinated response plan for incidents of sexual abuse. The plan is covered in the employee PREA training.

Corrective Action:

No corrective action is recommended for this standard.

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.

The following evidence was analyzed in making compliance determination:

1. Documents:
 - a. Pre-Audit Questionnaire (PAQ)
 - b. Statement: Standard is NA
2. Interviews:
 - a. PREA Coordinator
 - b. PREA compliance manager
 - c. Agency Head

Findings (By Provision):

115.266 (a). As reported in the PAQ, the agency, facility, or any other government entity responsible for collective bargaining on the agency's behalf has not entered into or renewed any collective bargaining agreement or other agreement since August 20, 2012, or since the last PREA audit, whichever is later. The agency provided a statement indicating that "PMI is a private, not-for-profit agency. The agency staff is not unionized. PMI does not enter into collective bargaining agreement with staff. The interviewed agency head further confirmed the above stating that Project MORE is a non-union employer.

115.266 (b). The provision is not required to be audited.

Corrective Action:

No corrective action is recommended for this standard.

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.

The following evidence was analyzed in making compliance determination:

1. Documents:
 - a. Pre-Audit Questionnaire (PAQ)
 - b. Policy:
 - i. Standard 115.267, Official Response Following a Resident Report, *Agency protection against retaliation*
 - ii. Project More, Inc., Policy and Procedure, Prison Rape Elimination Act (PREA) Compliance Policies
 - c. Handbook or Training
 - d. Sample PREA Investigations 2019
 - e. Memo: No PREA Allegations
2. Interviews:
 - a. Director
 - b. Designated Staff Charged with Monitoring Retaliation (2)
 - c. Agency Head

Findings (By Provision):

115.267 (a). As reported in the PAQ, the facility has 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. The agency has designated staff charged with monitoring for retaliation. Official Response Following a Resident Report, *Agency protection against retaliation* policy states that “PMI shall protect all residents and staff who report sexual abuse or sexual harassment or cooperate with any investigation from retaliation by other residents or staff”. The policy further states that “the PREA Coordinator and Program Director will monitor retaliation”.

115.267 (b). Official Response Following a Resident Report, *Agency protection against retaliation* policy provides guidance on the agency providing multiple protective 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.

The interviewed agency head reported that they rely on the PREA Coordinator. In the past the PREA Coordinator has transferred residents to another program, had a resident removed and the coordinator will look into letters to the referral source, check letters to court, and review staff annual reviews.

The interviewed director reported that the following measures will be taken to protect residents and staff from retaliation:

- Transfer a resident to another facility
- Place the residents on different floors
- Request the removal of a resident
- Suspend or terminate staff

The interviewed staff designated to monitor for retaliation is the program director and the agency PREA Coordinator. Both staff reported that Retaliation is covered in staff PREA training, and the role of the monitor is to ensure resident and staff safety. All staff. Staff is aware that this is serious. Some of the actions that could be taken are:

- a. Residents can be transferred to another program.
- b. Residents involved in a PREA incident will be placed on different floors.
- c. A request can be made to CT DOC regarding the remand of a resident.
- d. If warranted staff can be suspended or terminated.
- e. Staff may be sent to a position in another facility.
- f. Emotional support is always made available to all those involved in an incident – staff and residents.

It was also reported that as soon as the incident occurs, contact is initiated with the client. While the facility did not have an allegation of sexual abuse or sexual harassment in the last 12 months a sample case of an allegation of sexual harassment that occurred in 2019 was provided to show compliance with the practice of the provision.

115.267 (c). As reported in the PAQ, the facility monitors for retaliation for 90 days, and will continue monitoring past 90 days if needed. There were zero reported incidents of retaliation reported in the last 12 months. Official Response Following a Resident Report, *Agency protection against retaliation* policy states that “PMI’s obligation to monitor shall terminate if the agency determines that the allegation is unfounded”. It further states that PMI will monitor the following:

- Staff and resident disciplinary reports.
- Housing or program changes.
- Negative performance reviews.
- Resident misconducts.
- Reassignment of staff
- Transfer to another facility
- Provide emotional support

While the facility did not have any reported allegations of sexual abuse in the last 12 months an allegation that occurred in 2019 was provided to show the agencies process to monitor for retaliation.

The interviewed director and PREA Coordinator are responsible for monitoring for retaliation. It was reported that the PREA Coordinator monitors the following:

- Housing or program changes for a resident
- Looking at disciplinary reports for clients and staff

- Negative performance reviews for staff
- Resident letter to court or referral source

It was also reported that the monitoring would occur for 90 days or as long it takes.

115.267 (d). While the facility did not have any reported allegations of sexual abuse in the last 12 months an allegation that occurred in 2019 was provided to show the agencies process to monitor for retaliation. The interviewed staff charged with monitoring for retaliation reported that the following would be reviewed to detect possible signs of retaliation:

- Housing or program changes for a resident
- Looking at disciplinary reports for clients and staff
- Negative performance reviews for staff
- Resident letter to court or referral source

115.267 (e). Official Response Following a Resident Report, *Agency protection against retaliation* policy states that the agency will “protect individuals who cooperate in investigations who express fear of retaliation”. The interviewed agency head stated that a resident may be transferred to another facility without prejudice or placed in a first floor room for closer monitoring. Should a staff member express concern, the person may be transferred to another agency facility.

115.267 (f). N/A-the auditor is not required to audit this provision.

Corrective Action:

No corrective action is recommended for this standard.

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.

The following evidence was analyzed in making compliance determination:

1. Documents:
 - a. Pre-Audit Questionnaire (PAQ)
 - b. Policy:
 - i. Project More, Inc., Standard 115.271, Investigations, *Criminal and Administrative Investigations*
 - c. Sample PREA Report 2019
 - d. Memo: No PREA Incidents
 - e. Memo: No Incidents Reported to New Haven PD

2. Interviews:
 - a. PREA Coordinator
 - b. Director
 - c. Investigative Staff

Findings (By Provision):

115.271 (a). As reported in the PAQ, the agency/facility has a policy related to criminal and administrative agency investigations. Investigations, *Criminal and Administrative Investigations*, policy states that “PMI shall conduct administrative investigations into allegations of sexual abuse and sexual harassment in a prompt, thorough, and objective manner, including third-party anonymous reports”. The policy further states that “when sexual abuse is alleged, PMI shall contact the New Haven Police Department who shall conduct a criminal investigation”. Memos were provided indicating that the facility has not had any PREA related allegations in the last 12 months, nor were there any PREA related allegations referred to the New Haven PD. A case that was referred in 2019 was provided to show the response process of sexual harassment allegation. The allegation was promptly referred to the New Haven PD, investigated, and follow up occurred with the facility.

The interviewed investigative staff stated that the PREA investigation will begin as soon as the PREA Coordinator arrives onsite. If a third party were to make a report, it would be immediately investigated.

115.271 (b). The agency provided correspondence with the local PD indicating their role in conducting sexual abuse and sexual harassment allegations, completing, and providing documentation on specialized training for sexual abuse investigations. Additionally, three certifications of completion of specialized training were reviewed. The agency has two administrative investigators who is currently employed who have completed the required training.

The interviewed investigative staff stated that investigators are trained to conduct sexual abuse investigations in confinement settings.

115.271 (c). Investigations, *Criminal and Administrative Investigations*, policy states that “when an allegation of sexual abuse or sexual harassment has been reported, the investigator(s) shall gather and preserve direct and circumstantial evidence, to include any available physical and DNA evidence, any available electronic monitoring data and interview alleged victim(s), suspected perpetrators and witnesses. Any prior complaints and reports regarding the alleged perpetrator will be reviewed”.

As previously stated, memos were provided indicating that the facility has not had any PREA related allegations in the last 12 months, nor were there any PREA related allegations referred to the New Haven PD. A case that was referred in 2019 was provided to show the response process of sexual harassment allegation. The allegation was promptly referred to the New Haven PD, investigated, and follow up occurred with the facility.

The interviewed investigative staff stated that the first steps in initiating an investigation would include: separating both parties. The response would be immediately. The process is as follows:

- a. Staff will initially contact the program Director then the PREA Coordinator
- b. The PREA Coordinator will inform staff to cordon off the crime scene
- c. The PREA Coordinator will contact CT DOC and the agency administration.

- d. The PREA Coordinator will interview staff, then the alleged victim, the alleged perpetrator and any witnesses.
- e. The PREA Coordinator will inquire if there were any prior complaints or reports involving all involved.
- f. If required a review of program cameras
- g. Once completed a report will be submitted to CT DOC.

Direct and circumstantial evidence would include the following:

- a. Written letters
- b. Cell phone photos or texts
- c. Medical reports if required
- d. Resident misconducts and/or letters to court, parole etc.
- e. Written statements from the alleged victim and alleged perpetrator
- f. Review of security cameras, if needed

115.271 (d). Investigations, *Criminal and Administrative Investigations*, policy states that “should the quality of the evidence appear to support criminal prosecution, PMI shall conduct compelling interviews only after consulting with prosecutors as to whether compelled interviews may be obtained for further criminal prosecution”. As previously stated, memos were provided indicating that the facility has not had any PREA related allegations in the last 12 months, nor were there any PREA related allegations referred to the New Haven PD. A case that was referred in 2019 was provided to show the response process of sexual harassment allegation. The allegation was promptly referred to the New Haven PD, investigated, and follow up occurred with the facility.

While the facility has not experienced referring a case to prosecutors, however if needed the agency would contact the State’s attorney.

115.271 (e). Investigations, *Criminal and Administrative Investigations*, policy states “the credibility of an alleged victim, suspect, or witness shall be assessed on an individual basis, and shall not be determined by a person’s status as a resident or staff. PMI shall not require a resident who alleges sexual abuse to submit to a polygraph examination or any other truth telling device as a condition for processing the investigation”.

The interviewed investigative staff stated that the credibility of a witness is based on a preponderance of evidence. Under no circumstances would the facility require a resident to submit to polygraph test.

115.271 (f). Investigations, *Criminal and Administrative Investigations*, policy states “Administrative Investigations will include the following:

1. An effort to determine whether staff actions and/or failures contributed to the abuse.
2. Document in a written report to include a description of the physical and testimonial evidence, the reasoning behind credible assessments and investigative facts and findings”.

There were no allegations of sexual abuse or sexual harassment reported in the last 12 months. The interviewed investigative staff stated that onsite interviews would determine whether staff actions or failures contributed to sexual abuse. Such actions would be reviewed during the 30-day review. The following information is included in the reports:

- Location of the incident

- Type of Incident
- Person against whom the incident is reported
- Alleged victim
- Witnesses
- Persons notified – title, date, time and contacted by who
- Description of the incident
- Witness statements, if required
- Any evidence
- Counseling referrals, if required
- Outcome

115.271 (g). Investigations, *Criminal and Administrative Investigations*, policy states “Criminal Investigations:

1. Shall be conducted by the New Haven Police Department.
2. The NHPD will interview alleged victims(s), suspects, witnesses and staff.
3. Evidence will be collected.
4. Conduct that appears to be criminal shall be referred for prosecution.

As previously stated, memo’s were provided indicating that the facility has not had any PREA related allegations in the last 12 months, nor were there any PREA related allegations referred to the New Haven PD. A case that was referred in 2019 was provided to show the response process of sexual harassment allegation. The allegation was promptly referred to the New Haven PD, investigated, and follow up occurred with the facility.

The interviewed investigator reported that currently there have been no criminal investigation at the facility. If one did occur the PREA Coordinator would follow the documentation in #17. The report would also add any medical information, police reports etc.

115.271 (h). As reported in the PAQ, substantiated allegations of conduct that appear to be criminal are referred for prosecution. There were zero number of substantiated allegations of conduct that appear to be criminal that were referred for prosecution since the last PREA audit. As previously stated, Investigations, *Criminal and Administrative Investigations*, policy provides guidance on the referral for prosecution.

There were no allegations of sexual abuse or sexual harassment reported in the last 12 months. The interviewed investigator reported that cases would be referred for prosecution when there has been proof of a crime.

115.271 (i). As reported in the PAQ, the agency retains all written reports pertaining to the administrative or criminal investigation of alleged sexual assault or sexual harassment for as long as the alleged abuser is incarcerated or employed by the agency, plus five years. Investigations, *Criminal and Administrative Investigations*, policy states “PMI shall retain all written records from all sources for as long as the alleged abuser is incarcerated or employed by the agency, plus five years.

As previously stated, memos were provided indicating that the facility has not had any PREA related allegations in the last 12 months, nor were there any PREA related allegations referred to the New Haven PD. A case that was referred in 2019 was provided to show the response process of sexual harassment allegation. The allegation was promptly referred to the New Haven PD, investigated, and follow up occurred with the facility. The facility provided adequate documentation to show record retention.

115.271 (j). Investigations, *Criminal and Administrative Investigations*, policy states “the departure of the alleged abuser or victim from employment or control of the facility or agency shall not provide a basis for terminating an investigation”. There were no reported allegations of sexual abuse or sexual harassment in the last 12 months. The interviewed investigator reported that when a staff member alleged to have committed sexual abuse terminates employment prior to a completed investigation or a victim leaves a facility the investigation would continue.

115.271 (k). The auditor is not required to audit this provision.

115.271 (l). Investigations, *Criminal and Administrative Investigations*, policy states “PMI shall cooperate with the New Haven Police Department investigators and endeavor to remain informed regarding the progress of the investigation”. As previously stated, a memo was provided indicating that the facility has not had any PREA related allegations in the last 12 months, nor were there any PREA related allegations referred to the New Haven PD. A case that was referred in 2019 was provided to show the response process of sexual harassment allegation. The allegation was promptly referred to the New Haven PD, investigated, and follow up occurred with the facility.

The interviewed director reported that the PREA Coordinator will inform the director who will notify the appropriate staff. The interviewed investigator reported that when New Haven PD conducts the investigation, the PREA Coordinator would act as the point of contact between the agency and the police department.

Corrective Action:

No corrective action is recommended for this standard.

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.

The following evidence was analyzed in making compliance determination:

1. Documents:
 - a. Pre-Audit Questionnaire (PAQ)
 - b. Policy:
 - i. Standard 115.272, Investigations, Evidentiary Standard for administrative investigations
 - c. NIC Training Certificate (2)
2. Interviews:
 - a. Investigative Staff

Findings (By Provision):

115.272 (a). As reported in the PAQ, the agency imposes a standard of a preponderance of evidence or a lower standard of proof when determining whether allegations of sexual abuse or sexual harassment are substantiated. Investigations, *Evidentiary Standard for administrative investigations* states that:

PMI shall impose no higher standard than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated.

PMI will not make a determination as to whether allegations of sexual assault are substantiated. This determination shall be at the discretion of the local authorities conducting the investigation.

There were no allegations of sexual abuse or sexual harassment reported in the last 12 months; however, the facility provided a sample investigation packet from 2019, showing the process of referral, interviews, investigation, and determination of findings. The interviewed investigator reported that a preponderance of evidence is used to substantiate allegations of sexual abuse or sexual harassment.

Corrective Action:

No corrective action is recommended for this standard.

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 the agency's 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.

The following evidence was analyzed in making compliance determination:

1. Documents:
 - a. Pre-Audit Questionnaire (PAQ)
 - b. Policy:
 - i. Project More, Inc., Standard 115.273, Investigations, *Reporting to Residents*
 - c. Memo: No PREA Investigations
 - d. Sample Notification 2019 (2)
2. Interviews:
 - a. Director
 - b. Investigative staff

Findings (By Provision):

115.273 (a). As reported in the PAQ, the agency has a policy requiring that any resident who alleges that he or she suffered sexual abuse in an agency facility is informed, verbally or in writing, as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded following an investigation by the agency. Investigations, *Reporting to Residents* policy states that "Following an investigation into a resident's allegation of sexual abuse suffered at a PMI facility, the resident shall be informed as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded".

The interviewed director and investigative staff reported that the facility will notify a resident who makes an allegation of sexual abuse when the allegation has been determined to be substantiated, unsubstantiated, or unfounded following an investigation.

There were zero reported criminal and/or administrative investigations of alleged resident sexual abuse that were completed by the facility in the past 12 months.

115.273 (b). As reported in the PAQ if an outside entity conducts the investigation, the agency will request the relevant information from the investigation entity in order to inform the resident of the outcome

of the investigation. There were zero reported allegations of sexual abuse in which an outside entity investigated. Investigations, *Reporting to Residents* policy states that “If PMI did not conduct the investigation, it shall request the relevant information from the investigating agency in order to inform the resident”.

115.273 (c). As reported in the PAQ, following a resident’s allegation that a staff member has committed sexual abuse against the resident, the facility subsequently informs the resident (unless unfounded) whenever:

- The staff member is no longer posted within the residents unit;
- The staff member is no longer employed at the facility;
- The agency learns that the staff member has been indicated on a charge related to sexual abuse within the facility; or
- The agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility.

Investigation, *Reporting to Residents* policy provides guidance on the above-mentioned requirements for notification. While there were no reported allegations of sexual abuse or sexual harassment reported in the last 12 months the facility provided an example from 2019 that involved a resident and staff member. Upon completion of the investigation, appropriate notification was made to involved parties.

115.273 (d). As reported in the PAQ, the following an resident’s allegation that he or she has been sexually abused by another resident in an agency facility, the agency subsequently informs the alleged victim whomever the agency learns that the alleged abuser has been indicated on a charge related to sexual abuse within the facility; or the agency learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility. Investigation, *Reporting to Residents* policy provides guidance on the above-mentioned requirements for notification. There were no reported allegations of sexual abuse and sexual harassment involving residents reported in the last 12 months.

115.273 (e). As reported in the PAQ, the agency has a policy that all notifications to residents described under this standard are documented. Investigation, *Reporting to Residents* policy provides guidance on the above-mentioned requirements for notification. There were zero allegations of sexual abuse, therefore zero notifications made in the past 12 months. While there were no reported allegations of sexual abuse or sexual harassment reported in the last 12 months the facility provided an example from 2019 that involved a resident and staff member. Upon completion of the investigation, appropriate notification was made to involved parties.

115.273 (f). The auditor is not required to audit this provision of the standard.

Corrective Action:

No corrective action is recommended for this standard.

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.

The following evidence was analyzed in making compliance determination:

1. Documents:
 - a. Pre-Audit Questionnaire (PAQ)
 - b. Policy:
 - i. Project More, Inc., Discipline, *Discipline Sanctions for Staff*
 - c. Staff Manual
 - d. Memo: No staff fired due to PREA

Findings (By Provision):

115.76 (a). As reported in the PAQ, staff is subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies. Discipline, *Discipline Sanctions for Staff* policy states that “PMI staff shall be subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies”. The employee training manual provides staff with adequate notice of what disciplinary actions could be taken related to allegations of sexual abuse and sexual harassment.

115.76 (b). Discipline, *Discipline Sanctions for Staff* policy states that “termination shall be the presumptive disciplinary sanction for staff who engages in sexual abuse. Disciplinary sanctions for violating agency policies relating to sexual abuse or sexual harassment (other than engaging in sexual abuse) shall be commensurate with the nature and circumstances of the act committed, the staff member's disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories”.

As reported in the PAQ, there were zero staff in the last 12 months who violated the agency policy on sexual abuse or sexual harassment. Upon review of the investigation files, there were no allegations that involved a staff member being substantiated for allegations of sexual abuse or sexual harassment.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.76 (c). As previously stated in the Discipline, *Discipline Sanctions for Staff* policy states that disciplinary shall be commensurate with the nature and circumstances of the acts committed. As reported in the PAQ, disciplinary sanctions for violations of the agency policies relating to sexual abuse or sexual harassment are commensurate with the nature and circumstances of the acts committed, the staff members disciplinary history, and the sanctions imposed are comparable offenses by other staff with similar histories. There were zero staff in the last 12 months who have been disciplined short of termination, for violations of the agency sexual abuse or sexual harassment policies.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.76 (d). Discipline, *Discipline Sanctions for Staff* policy states that “all termination of 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”.

As reported in the PAQ, 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 resignations, are reported to law enforcement agencies, unless the activity was clearly not criminal, and to any relevant licensing bodies.

There were zero staff in the last 12 months who have been reported to law enforcement or licensing boards following their termination (or resignation prior to termination) for violating agency sexual abuse or sexual harassment policies.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

Corrective Action:

No corrective action is recommended for this standard.

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.

The following evidence was analyzed in making compliance determination:

1. Documents:
 - a. Pre-Audit Questionnaire (PAQ)
 - b. Policy:
 - i. Project More, Inc., Standard 115.277, Discipline, *Corrective action for contractors and volunteers*
 - c. Project More Inc., Contractors and Volunteers (PREA Statement) Blank
 - d. Maintenance Employee Acknowledgement (3)
2. Interviews:
 - a. Director

Findings (By Provision):

115.277 (a). As reported in the PAQ, the agency policy requires that any contractor or volunteer who engages in sexual abuse be reported to law enforcement agencies and to relevant licensing bodies. There have been zero contractors or volunteers who have been reported to law enforcement for engaging in sexual abuse of residents. Policy Discipline, *Corrective action for contractors and volunteers*' states that "Any contractor or volunteer who engages in sexual abuse shall be prohibited from contact with residents and shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and to relevant licensing bodies". The auditor reviewed three maintenance acknowledgements of PREA forms, indicating the facilities response to ensure contracted/volunteer staff are aware of their responsibilities related to sexual abuse and sexual harassment.

115.277 (b). As reported in the PAQ, the facility takes appropriate remedial measures and considers 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. Policy Discipline, *Corrective action for contractors and volunteers*' states that "PMI shall take appropriate measures and shall consider whether to prohibit further contact with residents, in the case of any other violation of sexual abuse or sexual harassment policies by contractor or volunteer". The auditor reviewed three maintenance acknowledgements of PREA forms, indicating the facilities response to ensure contracted/volunteer staff are aware of their responsibilities related to sexual abuse and sexual harassment.

The interviewed director reported that Project MORE has a zero-tolerance policy towards sexual abuse and sexual harassment. Any volunteer or intern who has been found to have committed sexual abuse/harassment will be terminated. In the case of an intern a report will be sent to the school. If the volunteer or intern has a license that licensing body will be contacted. The agency has a maintenance crew that handles the vast majority of contract work. They have all received PREA training. Should one of our maintenance staff or outside contractor been found to have sexually abused/harassed a client they will either be terminated or not allowed to enter any agency facility. Any licensing body will be contacted. All cases will be referred to the New Haven Police Department unless the activity was clearly not criminal. If deemed criminal, the New Haven Police Department would be contacted.

Corrective Action:

No corrective action is recommended for this standard.

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)

- If the agency prohibits all sexual activity between residents, 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.

The following evidence was analyzed in making compliance determination:

1. Documents:
 - a. Pre-Audit Questionnaire (PAQ)
 - b. Policy:
 - i. Project More, Inc., Standard 115.278, Discipline, *Intervention and disciplinary sanctions for residents*
 - c. MOU: Women and Families Center (WFC)
2. Interviews:
 - a. Director

Findings (By Provision):

115.278 (a). As reported in the PAQ, residents are subject to disciplinary sanctions only pursuant to a formal disciplinary process following an administrative finding that a resident engaged in resident-on-resident sexual abuse. Discipline, *Intervention and disciplinary sanctions for residents*' policy states that "Residents shall 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".

115.278 (b). Discipline, *Intervention and disciplinary sanctions for residents* policy states that "sanctions shall be commensurate with the nature and circumstances of the abuse committed, that and the residents disciplinary history, and the sanctions imposed for the comparable offenses by other residents with similar histories".

The interviewed director reported that the facility would request remand for any resident who it was determined committed sexual abuse. If it was deemed criminal the New Haven Police Department would be contacted. The resident would be removed or transferred.

115.278 (c). Discipline, *Intervention and disciplinary sanctions for residents* policy states that "the disciplinary process shall 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"

115.278 (d). As reported in the PAQ, the facility offers therapy, counseling, or other interventions designed to address and correct the underlying reasons or motivations for abuse. Discipline, *Intervention and disciplinary sanctions for residents* policy states that "PMI does not offer in-house-therapy.

However, should a resident or staff member require therapy or counseling, arrangements will be made with an outside agency to provide services”.

115.278 (e). As reported in the PAQ, the agency discipline residents for sexual conduct with staff only upon finding that the staff member did not consent to such contact. Discipline, *Intervention and disciplinary sanctions for residents* policy states that “PMI shall sanction a resident for sexual contact with staff only upon finding that the staff member did not consent to such contact”.

115.278 (f). As reported in the PAQ, the agency prohibits disciplinary action for a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred, even if an investigation does not establish evidence sufficient to substantiate the allegation. Discipline, *Intervention and disciplinary sanctions for residents* policy states that “For the purpose of disciplinary action – a report of sexual abuse made in good faith based on a reasonable belief that the alleged conduct shall not constitute falsely reporting an incident or lying”.

115.278 (g). As reported in the PAQ, the agency prohibits all sexual activity between residents.

Corrective Action:

No corrective action is recommended for this standard.

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.

The following evidence was analyzed in making compliance determination:

1. Documents:
 - a. Pre-Audit Questionnaire (PAQ)
 - b. Policy:
 - i. Project More, Inc., Standard 115.283, *Medical and Mental Care*
 - c. MOU Women and Families Center (WFC)
2. Interviews:
 - a. Random Staff (11)

Findings (By Provision):

115.282 (a). As reported in the PAQ, resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment crisis intervention services. The facility does not have onsite medical and mental health services. All services are coordinated with the local hospital and community-based rape crisis centers. Policy, *Medical and Mental Care*, provides guidance on the agencies response to provides residents who have been victims of sexual abuse with appropriate medical and mental health treatment services. It further states that STI services will be coordinated with Yale New Haven Hospital. Additionally the facility has an MOU with Women and Families Center to provide victim advocacy and supportive services.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.282 (b). All random sample of staff interviewed are considered first responders. The 11 interviewed staff discussed their responsibility to notify the director and that the director or PREA Coordinator would determine next steps for follow up services.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.282 (c). As reported in the PAQ, resident victims of sexual abuse while incarcerated are 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. The facility does not have onsite medical and mental health services. All services are coordinated with the local hospital and community-based rape crisis centers. Policy, *Medical and Mental Care*, provides guidance on the agencies response to provides residents who have been victims of sexual abuse with appropriate medical and mental health treatment services. It further states that STI services will be coordinated with Yale New Haven Hospital.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.282 (d). As reported in the PAQ, treatment services are provided to every victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. The facility does not have onsite medical and mental health services. All services are coordinated with the local hospital and community-based rape crisis centers.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

Corrective Action:

No corrective action is recommended for this standard.

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. *Note: in “all-male” facilities, there may be residents who identify as transgender men who may have female genitalia. Auditors should be sure to know whether such individuals may be in the population and whether this provision may apply in specific circumstances.*) 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. *Note: in “all-male” facilities, there may be residents who identify as transgender men who may have female genitalia. Auditors should be sure to know whether such individuals may be in the population and whether this provision may apply in specific circumstances.*) 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.

The following evidence was analyzed in making compliance determination:

1. Documents:
 - a. Pre-Audit Questionnaire (PAQ)
 - b. Policy:
 - i. Project More, Inc., Standard 115.283, *Medical and Mental Care*
 - c. MOU Women and Families Center (WFC)

Findings (By Provision):

115.283 (a). As reported in the PAQ, the facility does not offer medical and mental health evaluations, and, as appropriate, treatment to all residents who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility. Policy, *Medical and Mental Care*, provides guidance on the agencies response to provides residents who have been victims of sexual abuse with appropriate medical and mental health treatment services. The facility does not have onsite medical and mental health services. All services are coordinated with the local hospital and community-based rape crisis centers. There were no reported allegations of sexual abuse in the last 12 months.

115.283 (b). The facility does not have onsite medical and mental health services. Policy, *Medical and Mental Care*, provides guidance on the agencies response to provides residents who have been victims of sexual abuse with appropriate medical and mental health treatment services. The policy further reiterates the process of referring and securing community-based services. All services are coordinated with the local hospital and community-based rape crisis centers. There were no reported allegations of sexual abuse in the last 12 months.

115.283 (c). The facility does not have onsite medical and mental health services. Policy, *Medical and Mental Care*, provides guidance on the agencies response to provides residents who have been victims of sexual abuse with appropriate medical and mental health treatment services. The policy further reiterates the process of referring and securing community-based services. All services are coordinated with the local hospital and community-based rape crisis centers. There were no reported allegations of sexual abuse in the last 12 months.

115.283 (d). NA-the facility only houses male residents.

115.283 (e). NA-the facility only houses male residents

115.283 (f). As reported in the PAQ, resident victims of sexual abuse while incarcerated are offered tests for sexually transmitted infections as medically appropriate. The facility does not have onsite medical and mental health services. All services are coordinated with the local hospital and community-based rape crisis centers. There were no reported allegations of sexual abuse in the last 12 months.

115.283 (g). There were no reported allegations of sexual abuse in the last 12 months.

115.283 (h). As reported in the PAQ, the facility attempts to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history and offers treatment when deemed appropriate by mental health practitioners. The facility does not have onsite medical and mental health services. Policy, *Medical and Mental Care*, provides guidance on the agencies response to provides residents who have been victims of sexual abuse with appropriate medical and mental health treatment services. It further states that STI services will be coordinated with Yale New Haven Hospital. The policy further reiterates the process of referring and securing community-based services. All services are coordinated with the local hospital and community-based rape crisis centers. There were no reported allegations of sexual abuse in the last 12 months.

Corrective Action:

No corrective action is recommended for this standard.

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.

The following evidence was analyzed in making compliance determination:

1. Documents:
 - a. Pre-Audit Questionnaire (PAQ)
 - b. Policy:
 - i. Project More, Inc., Standard 115.286, *Data Collection and Review*
 - c. October 2019 Incident Review
2. Interviews:
 - a. PREA Coordinator
 - b. Director
 - c. Incident Review Team (2)

Findings (By Provision):

115.286 (a). As reported in the PAQ, the facility conducts a sexual abuse incident review at the conclusion of every criminal or administrative sexual abuse investigation, unless the allegation has been determined to be unfounded. In the past 12 months there were zero criminal and/or administrative investigations of alleged sexual abuse completed at the facility, excluding unfounded incidents. Policy *Data Collection and Review* provides guidance on the agency responsibility to conduct an incident review at the conclusion of a sexual abuse investigation.

While the facility did not have an allegation of sexual abuse in the last 12 months, an incident review from 2019 was reviewed to show compliance with the provision.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.286 (b). As reported in the PAQ, the facility ordinarily conducts criminal and/or administrative sexual abuse investigations within 30 days. Policy *Data Collection and Review* provides guidance on the agency responsibility to conduct an incident review within 30 days of the conclusion of the investigation.

While the facility did not have an allegation of sexual abuse in the last 12 months, an incident review from 2019 was reviewed to show compliance with the provision.

115.286 (c). As reported in the PAQ, the sexual abuse incident review team included upper-level management officials and allows for input from line supervisors, investigators, and medical and mental health practitioners. The interviewed director reported that the facility has a sexual abuse review team. The team includes the director, PREA Coordinator, assigned case manager and involved staff. Policy *Data Collection and Review* further reiterates the staff who is responsible to be a part of the incident review team. While the facility did not have an allegation of sexual abuse in the last 12 months, an incident review from 2019 was reviewed to show compliance with the provision.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.286 (d). As reported in the PAQ, the facility prepares a report of its findings from sexual abuse incident reviews including but not limited to determination made and any recommendations for improvement and submits such report to the facility head and PREA compliance manager. The interviewed director reported that the review team will consider the following:

- Will the program need to change its policies to prevent, detect or respond to an incident.
- Was the incident motivated by race, ethnicity, gender, sexual minority or gang affiliation.
- Examine the area the incident took place. Were physical barriers in the area?
- Was there adequate staff on duty.
- Do we need to augment technology.
- Are there any other considerations.

Policy *Data Collection and Review* provides guidance on the agency responsibility to conduct an incident review and the above requirements on what is considered in the review. While the facility did not have an allegation of sexual abuse in the last 12 months, an incident review from 2019 was reviewed to show compliance with the provision.

Two members of the incident review team were interviewed. Both individuals reported that the above areas are considered when conducting the incident review. The areas where the incident happened would be assessed. The staffing levels along with viewing video footage would be taken into consideration for the incident review. The interviewed PREA Coordinator reported that the incident review takes place 30 days after the results of the investigation. The review includes the above-mentioned items. It was further reported that there have only been two PREA related allegations therefore there has not been enough to notice trends. Any action taken would depend on the findings and corrective action would be done as soon as possible.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.286 (e). As reported in the PAQ, the facility implements the recommendations for improvement or documents reasons for not doing so. Policy *Data Collection and Review* states that “all recommendations will be implemented, provided adequate resources are available, or shall document reasons for not doing so”.

Corrective Action:
No corrective action is recommended for this standard.

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.

The following evidence was analyzed in making compliance determination:

1. Documents:
 - a. Pre-Audit Questionnaire (PAQ)
 - b. Annual Report
 - c. SSV Report (2020)
 - d. Policy:
 - i. Project More, Inc., Standard 115.289, *Data Collection and Review*
 - ii. Policy No. 111, *Prison Rape Elimination Act (PREA) Compliance Policies*
 - e. SSV 2020

Findings (By Provision):

115.287 (a/c). As reported in the PAQ, the agency collects, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions. Policy No. 111, *Prison Rape Elimination Act (PREA) Compliance Policies*, provides guidance on the agencies collection of uniform data.

115.287 (b). As reported in the PAQ, the standardized instrument includes, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence (SSV) conducted by the Department of Justice. The auditor reviewed the submitted 2020 SSV report to show compliance with the provision.

115.287 (d). As reported in the PAQ, the agency aggregates the incident-based sexual abuse data at least annually. The auditor reviewed a copy of the agency annual report and the 2020 SSV report to show compliance with the standard.

115.287 (e). NA-the agency does not contract for the confinement of its residents.

115.287 (f). As reported in the PAQ, the agency provided the Department of Justice (DOJ) with data from the previous calendar year upon request. The auditor reviewed the submitted 2020 SSV report to show compliance with the provision.

Corrective Action:

No corrective action is recommended for this standard.

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.

The following evidence was analyzed in making compliance determination:

1. Documents:
 - a. Pre-Audit Questionnaire (PAQ)
 - b. Policy:
 - i. Project More, Inc., Standard 115.289, *Data Collection and Review*
 - ii. Policy No. 211, *Prison Rape Elimination Act (PREA) Compliance Policies*
 - c. Annual Report
 - d. Website
2. Interviews:
 - a. PREA Coordinator
 - b. Agency Head

Findings (By Provision):

115.288 (a). As reported in the PAQ, the agency reviews data collected and aggregate in order to assess and improve the effectiveness of its sexual abuse prevention, detection, response policies, and training, including:

- Identifying problem areas;
- Taking corrective action on an ongoing basis; and
- Preparing an annual report of its findings from its data review and any corrective actions for each facility, as well as the agency as a whole

Policy No. 111, *Prison Rape Elimination Act (PREA) Compliance Policies*, provides guidance on the agencies responsibility to collect, review and store data. The interviewed agency head reported that reviewing of incidents would depend on what information was received. The agency will look to make changes in any of the following areas:

- Cameras-do we need to add them or reposition them.
- Do we need to change staff. Are some staff more proactive then others.
- The staffing pattern may need to change. Are there more incidents at certain times as opposed to others.
- Do staff need additional training.
- If incidents occurred outside the agency do we need to transport residents to appointments.

The interviewed PREA Coordinator reported that the facility has three floors which allows staff to move clients around if required. Facility data would be the initial Risk Assessment – all at risk clients are placed on the first floor. Data is secured in the PREA Coordinators office. Data is in a locked file cabinet in a locked office. Corrective action is ongoing. It will be based on incidents, the 30 day after incident report and any other pertinent information received. It was further reported that the annual report will state any corrective action taken. This includes the other two CT residential facilities.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.288 (b). As reported in the PAQ, the annual report does not include a comparison of the current year's data and corrective actions with those from prior years. In addition, the annual report does not provide an assessment of the agency's progress in addressing sexual abuse. Upon further review of the agency annual report, it was found that the agency does include a comparison of the current years data and corrective actions from previous years reports. Policy No. 111, *Prison Rape Elimination Act (PREA) Compliance Policies*, provides guidance on the agencies responsibility to collect, review and store data.

115.288(c). As reported in the PAQ, the agency makes its annual report readily available to the public at least annually through its website. The annual reports are approved by the agency head. The interviewed agency head further confirmed that all annual reports are presented to them for comments and review. The auditor reviewed a copy of the annual report along with the website (<https://www.projectmore.org/prea>) to show compliance with the provision.

115.288. (d). As reported in the PAQ, when the agency redacts material from an annual report for publication, the redactions are limited to specific materials where publication would present a clear and specific threat to the safety and security of the facility. The interviewed PREA Coordinator reported that no names or incident specific information is included in the annual report. The agency does not indicate the nature of the material redacted. The auditor reviewed a copy of the annual report to show compliance with the provision.

Corrective Action:

No corrective action is recommended for this standard.

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.

The following evidence was analyzed in making compliance determination:

1. Documents:
 - a. Pre-Audit Questionnaire (PAQ)
 - b. Policy:
 - i. Project More, Inc., Standard 115.289, *Data Collection and Review*
 - ii. Project More, Inc., Policy and Procedure, Prison Rape Elimination Act (PREA) Compliance Policies
 - c. Website
 - d. Annual Report
2. Interviews:
 - a. PREA Coordinator

Findings (By Provision):

115.289 (a). As reported in the PAQ, the agency ensures that incident-based and aggregate data are securely retained. The interviewed PREA Coordinator indicated that the agency does ensure that the data collected is securely retained.

Policy Data Collection and Review and Prison Rape Elimination act (PREA) Compliance Policies provides guidance on the collection of incident-based and aggregate data.

115.289 (b). As reported in the PAQ, the agency policy requires that aggregated sexual abuse data from facilities under its direct control and private facilities with which it contracts be made readily available to the public at least annually through its website. *Policy Data Collection and Review and Prison Rape Elimination act (PREA) Compliance Policies* provides guidance on the collection of incident-based and aggregate data.

The auditor reviewed the website along with the agency report to show compliance with the provision.

115.289 (c). As reported in the PAQ, before making aggregated sexual abuse data publicly available, the agency removes all personal identifiers. Additionally, the agency maintains sexual abuse data collected for at least 10 years after the date of initial collection, unless federal, state, or local law requires otherwise. The auditor reviewed the website along with the agency report to show compliance with the provision.

115.289 (d). The auditor reviewed the website along with the agency report to show compliance with the provision.

Corrective Action:

No corrective action is recommended for this standard.

AUDITING AND CORRECTIVE ACTION

Standard 115.401: Frequency and scope of audits

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

115.401 (a)

- During the prior three-year audit period, did the agency ensure that each facility operated by the agency, or by a private organization on behalf of the agency, was audited at least once? (*Note: The response here is purely informational. A "no" response does not impact overall compliance with this standard.*) Yes No

115.401 (b)

- Is this the first year of the current audit cycle? (*Note: a "no" response does not impact overall compliance with this standard.*) Yes No
- If this is the second year of the current audit cycle, did the agency ensure that at least one-third of each facility type operated by the agency, or by a private organization on behalf of the agency, was audited during the first year of the current audit cycle? (N/A if this is **not** the *second* year of the current audit cycle.) Yes No NA
- If this is the third year of the current audit cycle, did the agency ensure that at least two-thirds of each facility type operated by the agency, or by a private organization on behalf of the agency, were audited during the first two years of the current audit cycle? (N/A if this is **not** the *third* year of the current audit cycle.) Yes No NA

115.401 (h)

- Did the auditor have access to, and the ability to observe, all areas of the audited facility? Yes No

115.401 (i)

- Was the auditor permitted to request and receive copies of any relevant documents (including electronically stored information)? Yes No

115.401 (m)

- Was the auditor permitted to conduct private interviews with residents? 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.

The following evidence was analyzed in making compliance determination:

1. Documents:
 - a. Pre-Audit Questionnaire (PAQ)

Findings (By Provision):

115.401 (a). The Project More, Inc. website contains the results of all the PREA audits conducted.

115.401 (b). As reported by the PREA Coordinator, the IDOC is in Cycle 3 Audit Year 3.

115.401 (h). During the inspection of the physical plant the auditor and was escorted throughout the facility by director. The auditor was provided unfettered access throughout the institution. Specifically, the auditor was not barred or deterred entry to any areas. The auditor had the ability to freely observe, with entry provided to all areas without prohibition. Based on review of documentation the facility is compliant with the intent of the provision.

115.401 (i). During the on-site visit, the auditor was provided access to all documents requested. All documents requested were received to include, but not limited to employee and resident files, sensitive documents, and investigation reports. Based on review of documentation the facility is compliant with the intent of the provision.

115.401 (m). The auditor was provided private rooms throughout the facility to conduct interviews. The staff staged the residents in a fashion that the auditor did not have to wait between interviews. The rooms provided for resident interviews were soundproof and somewhat visually confidential from other residents which was judged to have provided an environment in which the offenders felt comfortable to openly share PREA-related content during interview. It should also be noted that additional precautionary measures were taken to ensure proper social distancing due to the COVID-19.

A review of the appropriate documentation and interviews with staff indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.401 (n). Residents were able to submit confidential information via written letters to the auditing agency PO Box or during the interviews with the auditor. The auditor did not receive any correspondence from the residents of Walter Brooks House.

Corrective Action:
No corrective action is recommended for this standard.

Standard 115.403: Audit contents and findings

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

115.403 (f)

- The agency has published on its agency website, if it has one, or has otherwise made publicly available. The review period is for prior audits completed during the past three years PRECEDING THIS AGENCY AUDIT. 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 following evidence was analyzed in making compliance determination:

1. Documents:
 - a. Website

Findings (By Provision):

115.403 (f). The Walter Brooks House posts its PREA Audit reports on the Agency website. The reports are available for review at <https://www.projectmore.org/prea>. There is a link to the Final PREA reports. The facility is compliant with the intent of the standard.

Corrective Action:
No corrective action is recommended for this standard.

AUDITOR CERTIFICATION

I certify that:

- The contents of this report are accurate to the best of my knowledge.
- No conflict of interest exists with respect to my ability to conduct an audit of the agency under review, and
- I have not included in the final report any personally identifiable information (PII) about any resident or staff member, except where the names of administrative personnel are specifically requested in the report template.

Auditor Instructions:

Type your full name in the text box below for Auditor Signature. This will function as your official electronic signature. Auditors must deliver their final report to the PREA Resource Center as a searchable PDF format to ensure accessibility to people with disabilities. Save this report document into a PDF format prior to submission.¹ Auditors are not permitted to submit audit reports that have been scanned.² See the PREA Auditor Handbook for a full discussion of audit report formatting requirements.

Latera M. Davis

10/21/2021

Auditor Signature

Date

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

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