PREA Facility Audit Report: Final

Name of Facility: Walter Brooks House
Facility Type: Community Confinement
Date Interim Report Submitted: NA
Date Final Report Submitted: 06/17/2024

Auditor Certification	
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.	☑
I have not included in the final report any personally identifiable information (PII) about any inmate/resident/detainee or staff member, except where the names of administrative personnel are specifically requested in the report template.	☑
Auditor Full Name as Signed: Adam T. Barnett	**Date of Signature:** 06/17/2024

AUDITOR INFORMATION	
Auditor name:	Barnett, Adam
Email:	adam30906@gmail.com
Start Date of On-Site Audit:	05/08/2024
End Date of On-Site Audit:	05/09/2024

FACILITY INFORMATION	
Facility name:	Walter Brooks House
Facility physical address:	690 Howard Avenue, New Haven, Connecticut - 06519
Facility mailing address:	830 Grand Avenue, New Haven, Connecticut - 06511

Primary Contact

Name:	John Massari
Email Address:	john.massari@projectmore.org
Telephone Number:	2038483118

Facility Director	
Name:	Jule Waters
Email Address:	jule.waters@projectmore.org
Telephone Number:	203-777-8627

Facility PREA Compliance Manager	
Name:	Jule Waters
Email Address:	jule.waters@projectmore.org
Telephone Number:	O: 203-777-8627

Facility Characteristics	
Designed facility capacity:	67
Current population of facility:	66
Average daily population for the past 12 months:	65
Has the facility been over capacity at any point in the past 12 months?	No
Which population(s) does the facility hold?	Males
Age range of population:	18 and older
Facility security levels/resident custody levels:	3
Number of staff currently employed at the facility who may have contact with	38

residents:	
Number of individual contractors who have contact with residents, currently authorized to enter the facility:	3
Number of volunteers who have contact with residents, currently authorized to enter the facility:	1

AGENCY INFORMATION	
Name of agency:	Project More, Inc.
Governing authority or parent agency (if applicable):	
Physical Address:	830 Grand Avenue, New Haven , Connecticut - 6511
Mailing Address:	
Telephone number:	

Agency Chief Executive Officer Information:	
Name:	
Email Address:	
Telephone Number:	

Agency-Wide PREA Coordinator Information			
Name:	John Massari	**Email Address:**	john.massari@projectmore.org

Facility AUDIT FINDINGS

Summary of Audit Findings

The OAS automatically populates the number and list of Standards exceeded, the number of Standards met, and the number and list of Standards not met.

Auditor Note: In general, no standards should be found to be "Not Applicable" or "NA." A compliance determination must be made for each standard. In rare instances where an auditor determines that a standard is not applicable, the auditor should select "Meets Standard" and include a comprehensive discussion as to why the standard is not applicable to the facility being audited.	
Number of standards exceeded:	
0	
Number of standards met:	
41	
Number of standards not met:	
0	

POST-AUDIT REPORTING INFORMATION

GENERAL AUDIT INFORMATION

On-site Audit Dates

1. Start date of the onsite portion of the audit:	2024-05-08
2. End date of the onsite portion of the audit:	2024-05-09

Outreach

10. Did you attempt to communicate with community-based organization(s) or victim advocates who provide services to this facility and/or who may have insight into relevant conditions in the facility?	(●) Yes ( ) No
a. Identify the community-based organization(s) or victim advocates with whom you communicated:	Justice Detention International National Sexual Violence Resource Center Women and Family Center

AUDITED FACILITY INFORMATION

14. Designated facility capacity:	67
15. Average daily population for the past 12 months:	65
16. Number of inmate/resident/detainee housing units:	14
17. Does the facility ever hold youthful inmates or youthful/juvenile detainees?	( ) Yes ( ) No (●) Not Applicable for the facility type audited (i.e., Community Confinement Facility or Juvenile Facility)

Audited Facility Population Characteristics on Day One of the Onsite Portion of the Audit	
Inmates/Residents/Detainees Population Characteristics on Day One of the Onsite Portion of the Audit	
36. Enter the total number of inmates/ residents/detainees in the facility as of the first day of onsite portion of the audit:	63
38. Enter the total number of inmates/ residents/detainees with a physical disability in the facility as of the first day of the onsite portion of the audit:	0
39. Enter the total number of inmates/ residents/detainees with a cognitive or functional disability (including intellectual disability, psychiatric disability, or speech disability) in the facility as of the first day of the onsite portion of the audit:	0
40. Enter the total number of inmates/ residents/detainees who are Blind or have low vision (visually impaired) in the facility as of the first day of the onsite portion of the audit:	1
41. Enter the total number of inmates/ residents/detainees who are Deaf or hard-of-hearing in the facility as of the first day of the onsite portion of the audit:	0
42. Enter the total number of inmates/ residents/detainees who are Limited English Proficient (LEP) in the facility as of the first day of the onsite portion of the audit:	2
43. Enter the total number of inmates/ residents/detainees who identify as lesbian, gay, or bisexual in the facility as of the first day of the onsite portion of the audit:	2

44. Enter the total number of inmates/ residents/detainees who identify as transgender or intersex in the facility as of the first day of the onsite portion of the audit:	0
45. Enter the total number of inmates/ residents/detainees who reported sexual abuse in the facility as of the first day of the onsite portion of the audit:	0
46. Enter the total number of inmates/ residents/detainees who disclosed prior sexual victimization during risk screening in the facility as of the first day of the onsite portion of the audit:	10
47. Enter the total number of inmates/ residents/detainees who were ever placed in segregated housing/isolation for risk of sexual victimization in the facility as of the first day of the onsite portion of the audit:	0
48. Provide any additional comments regarding the population characteristics of inmates/residents/detainees in the facility as of the first day of the onsite portion of the audit (e.g., groups not tracked, issues with identifying certain populations):	No text provided.
Staff, Volunteers, and Contractors Population Characteristics on Day One of the Onsite Portion of the Audit	
49. Enter the total number of STAFF, including both full- and part-time staff, employed by the facility as of the first day of the onsite portion of the audit:	38
50. Enter the total number of VOLUNTEERS assigned to the facility as of the first day of the onsite portion of the audit who have contact with inmates/residents/detainees:	0

51. Enter the total number of CONTRACTORS assigned to the facility as of the first day of the onsite portion of the audit who have contact with inmates/residents/detainees:	0
52. Provide any additional comments regarding the population characteristics of staff, volunteers, and contractors who were in the facility as of the first day of the onsite portion of the audit:	No text provided.

INTERVIEWS

Inmate/Resident/Detainee Interviews

Random Inmate/Resident/Detainee Interviews

53. Enter the total number of RANDOM INMATES/RESIDENTS/DETAINEES who were interviewed:	14
54. Select which characteristics you considered when you selected RANDOM INMATE/RESIDENT/DETAINEE interviewees: (select all that apply)	☐ Age ☑ Race ☑ Ethnicity (e.g., Hispanic, Non-Hispanic) ☑ Length of time in the facility ☑ Housing assignment ☑ Gender ☐ Other ☐ None
55. How did you ensure your sample of RANDOM INMATE/RESIDENT/DETAINEE interviewees was geographically diverse?	Male
56. Were you able to conduct the minimum number of random inmate/ resident/detainee interviews?	◉ Yes ○ No

57. Provide any additional comments regarding selecting or interviewing random inmates/residents/detainees (e.g., any populations you oversampled, barriers to completing interviews, barriers to ensuring representation):	No text provided.
Targeted Inmate/Resident/Detainee Interviews	
58. Enter the total number of TARGETED INMATES/RESIDENTS/DETAINEES who were interviewed:	2
As stated in the PREA Auditor Handbook, the breakdown of targeted interviews is intended to guide auditors in interviewing the appropriate cross-section of inmates/residents/detainees who are the most vulnerable to sexual abuse and sexual harassment. When completing questions regarding targeted inmate/resident/detainee interviews below, remember that an interview with one inmate/resident/detainee may satisfy multiple targeted interview requirements. These questions are asking about the number of interviews conducted using the targeted inmate/resident/detainee protocols. For example, if an auditor interviews an inmate who has a physical disability, is being held in segregated housing due to risk of sexual victimization, and disclosed prior sexual victimization, that interview would be included in the totals for each of those questions. Therefore, in most cases, the sum of all the following responses to the targeted inmate/resident/detainee interview categories will exceed the total number of targeted inmates/residents/detainees who were interviewed. If a particular targeted population is not applicable in the audited facility, enter "0".	
60. Enter the total number of interviews conducted with inmates/residents/detainees with a physical disability using the "Disabled and Limited English Proficient Inmates" protocol:	0
a. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/detainees in this category:	■ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.

b. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/ residents/detainees).	To determine if this population exists the auditor, based on information gathered from the PAQ, documentation reviewed onsite, and discussions with staff and other residents.
61. Enter the total number of interviews conducted with inmates/residents/ detainees with a cognitive or functional disability (including intellectual disability, psychiatric disability, or speech disability) using the "Disabled and Limited English Proficient Inmates" protocol:	0
a. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/ detainees in this category:	■ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.
b. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/ residents/detainees).	To determine if this population exists the auditor, based on information gathered from the PAQ, documentation reviewed onsite, and discussions with staff and other residents.
62. Enter the total number of interviews conducted with inmates/residents/ detainees who are Blind or have low vision (i.e., visually impaired) using the "Disabled and Limited English Proficient Inmates" protocol:	0

a. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/ detainees in this category:	■ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.
b. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/ residents/detainees).	To determine if this population exists the auditor, based on information gathered from the PAQ, documentation reviewed onsite, and discussions with staff and other residents.
63. Enter the total number of interviews conducted with inmates/residents/ detainees who are Deaf or hard-of-hearing using the "Disabled and Limited English Proficient Inmates" protocol:	0
a. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/ detainees in this category:	■ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.
b. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/ residents/detainees).	To determine if this population exists the auditor, based on information gathered from the PAQ, documentation reviewed onsite, and discussions with staff and other residents.
64. Enter the total number of interviews conducted with inmates/residents/ detainees who are Limited English Proficient (LEP) using the "Disabled and Limited English Proficient Inmates" protocol:	0

a. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/ detainees in this category:	■ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.
b. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/ residents/detainees).	To determine if this population exists the auditor, based on information gathered from the PAQ, documentation reviewed onsite, and discussions with staff and other residents.
65. Enter the total number of interviews conducted with inmates/residents/ detainees who identify as lesbian, gay, or bisexual using the "Transgender and Intersex Inmates; Gay, Lesbian, and Bisexual Inmates" protocol:	2
66. Enter the total number of interviews conducted with inmates/residents/ detainees who identify as transgender or intersex using the "Transgender and Intersex Inmates; Gay, Lesbian, and Bisexual Inmates" protocol:	0
a. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/ detainees in this category:	■ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.
b. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/ residents/detainees).	To determine if this population exists the auditor, based on information gathered from the PAQ, documentation reviewed onsite, and discussions with staff and other residents.

67. Enter the total number of interviews conducted with inmates/residents/ detainees who reported sexual abuse in this facility using the "Inmates who Reported a Sexual Abuse" protocol:	0
a. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/ detainees in this category:	■ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.
b. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/ residents/detainees).	To determine if this population exists the auditor, based on information gathered from the PAQ, documentation reviewed onsite, and discussions with staff and other residents.
68. Enter the total number of interviews conducted with inmates/residents/ detainees who disclosed prior sexual victimization during risk screening using the "Inmates who Disclosed Sexual Victimization during Risk Screening" protocol:	0
a. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/ detainees in this category:	■ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.
b. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/ residents/detainees).	To determine if this population exists the auditor, based on information gathered from the PAQ, documentation reviewed onsite, and discussions with staff and other residents.

69. Enter the total number of interviews conducted with inmates/residents/ detainees who are or were ever placed in segregated housing/isolation for risk of sexual victimization using the "Inmates Placed in Segregated Housing (for Risk of Sexual Victimization/Who Allege to have Suffered Sexual Abuse)" protocol:	0
a. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/ detainees in this category:	■ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.
b. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/ residents/detainees).	To determine if this population exists the auditor, based on information gathered from the PAQ, documentation reviewed onsite, and discussions with staff and other residents.
70. Provide any additional comments regarding selecting or interviewing targeted inmates/residents/detainees (e.g., any populations you oversampled, barriers to completing interviews):	No text provided.
Staff, Volunteer, and Contractor Interviews	
Random Staff Interviews	
71. Enter the total number of RANDOM STAFF who were interviewed:	9

72. Select which characteristics you considered when you selected RANDOM STAFF interviewees: (select all that apply)	☑ Length of tenure in the facility ☑ Shift assignment ☑ Work assignment ☑ Rank (or equivalent) ☑ Other (e.g., gender, race, ethnicity, languages spoken) ☐ None
If "Other," describe:	Race
73. Were you able to conduct the minimum number of RANDOM STAFF interviews?	○ Yes ◉ No
a. Select the reason(s) why you were unable to conduct the minimum number of RANDOM STAFF interviews: (select all that apply)	☐ Too many staff declined to participate in interviews. ☑ Not enough staff employed by the facility to meet the minimum number of random staff interviews (Note: select this option if there were not enough staff employed by the facility or not enough staff employed by the facility to interview for both random and specialized staff roles). ☐ Not enough staff available in the facility during the onsite portion of the audit to meet the minimum number of random staff interviews. ☐ Other
74. Provide any additional comments regarding selecting or interviewing random staff (e.g., any populations you oversampled, barriers to completing interviews, barriers to ensuring representation):	No text provided.

Specialized Staff, Volunteers, and Contractor Interviews	
Staff in some facilities may be responsible for more than one of the specialized staff duties. Therefore, more than one interview protocol may apply to an interview with a single staff member and that information would satisfy multiple specialized staff interview requirements.	
75. Enter the total number of staff in a SPECIALIZED STAFF role who were interviewed (excluding volunteers and contractors):	9
76. Were you able to interview the Agency Head?	(●) Yes ( ) No
77. Were you able to interview the Warden/Facility Director/Superintendent or their designee?	(●) Yes ( ) No
78. Were you able to interview the PREA Coordinator?	(●) Yes ( ) No
79. Were you able to interview the PREA Compliance Manager?	( ) Yes ( ) No (●) NA (NA if the agency is a single facility agency or is otherwise not required to have a PREA Compliance Manager per the Standards)

80. Select which SPECIALIZED STAFF roles were interviewed as part of this audit from the list below: (select all that apply)	☑ Agency contract administrator ☑ Intermediate or higher-level facility staff responsible for conducting and documenting unannounced rounds to identify and deter staff sexual abuse and sexual harassment ☐ Line staff who supervise youthful inmates (if applicable) ☐ Education and program staff who work with youthful inmates (if applicable) ☐ Medical staff ☐ Mental health staff ☐ Non-medical staff involved in cross-gender strip or visual searches ☑ Administrative (human resources) staff ☐ Sexual Assault Forensic Examiner (SAFE) or Sexual Assault Nurse Examiner (SANE) staff ☑ Investigative staff responsible for conducting administrative investigations ☐ Investigative staff responsible for conducting criminal investigations ☑ Staff who perform screening for risk of victimization and abusiveness ☐ Staff who supervise inmates in segregated housing/residents in isolation ☑ Staff on the sexual abuse incident review team ☑ Designated staff member charged with monitoring retaliation ☑ First responders, both security and non-security staff ☑ Intake staff

	☐ Other
81. Did you interview VOLUNTEERS who may have contact with inmates/ residents/detainees in this facility?	○ Yes ◉ No
82. Did you interview CONTRACTORS who may have contact with inmates/ residents/detainees in this facility?	○ Yes ◉ No
83. Provide any additional comments regarding selecting or interviewing specialized staff.	No text provided.

SITE REVIEW AND DOCUMENTATION SAMPLING

Site Review

PREA Standard 115.401 (h) states, "The auditor shall have access to, and shall observe, all areas of the audited facilities." In order to meet the requirements in this Standard, the site review portion of the onsite audit must include a thorough examination of the entire facility. The site review is not a casual tour of the facility. It is an active, inquiring process that includes talking with staff and inmates to determine whether, and the extent to which, the audited facility's practices demonstrate compliance with the Standards. Note: As you are conducting the site review, you must document your tests of critical functions, important information gathered through observations, and any issues identified with facility practices. The information you collect through the site review is a crucial part of the evidence you will analyze as part of your compliance determinations and will be needed to complete your audit report, including the Post-Audit Reporting Information.

84. Did you have access to all areas of the facility?	◉ Yes ○ No
Was the site review an active, inquiring process that included the following:	
85. Observations of all facility practices in accordance with the site review component of the audit instrument (e.g., signage, supervision practices, cross-gender viewing and searches)?	◉ Yes ○ No

86. Tests of all critical functions in the facility in accordance with the site review component of the audit instrument (e.g., risk screening process, access to outside emotional support services, interpretation services)?	(●) Yes ( ) No
87. Informal conversations with inmates/ residents/detainees during the site review (encouraged, not required)?	(●) Yes ( ) No
88. Informal conversations with staff during the site review (encouraged, not required)?	(●) Yes ( ) No
89. Provide any additional comments regarding the site review (e.g., access to areas in the facility, observations, tests of critical functions, or informal conversations).	No text provided.

Documentation Sampling

Where there is a collection of records to review-such as staff, contractor, and volunteer training records; background check records; supervisory rounds logs; risk screening and intake processing records; inmate education records; medical files; and investigative files-auditors must self-select for review a representative sample of each type of record.

90. In addition to the proof documentation selected by the agency or facility and provided to you, did you also conduct an auditor-selected sampling of documentation?	(●) Yes ( ) No
91. Provide any additional comments regarding selecting additional documentation (e.g., any documentation you oversampled, barriers to selecting additional documentation, etc.).	No text provided.

SEXUAL ABUSE AND SEXUAL HARASSMENT ALLEGATIONS AND INVESTIGATIONS IN THIS FACILITY

Sexual Abuse and Sexual Harassment Allegations and Investigations Overview

Remember the number of allegations should be based on a review of all sources of allegations (e.g., hotline, third-party, grievances) and should not be based solely on the number of investigations conducted. Note: For question brevity, we use the term “inmate” in the following questions. Auditors should provide information on inmate, resident, or detainee sexual abuse allegations and investigations, as applicable to the facility type being audited.

92. Total number of SEXUAL ABUSE allegations and investigations overview during the 12 months preceding the audit, by incident type:

	# of sexual abuse allegations	# of criminal investigations	# of administrative investigations	# of allegations that had both criminal and administrative investigations
Inmate-on-inmate sexual abuse	0	0	0	0
Staff-on-inmate sexual abuse	1	0	1	0
Total	1	0	1	0

93. Total number of SEXUAL HARASSMENT allegations and investigations overview during the 12 months preceding the audit, by incident type:

	# of sexual harassment allegations	# of criminal investigations	# of administrative investigations	# of allegations that had both criminal and administrative investigations
Inmate-on-inmate sexual harassment	0	0	0	0
Staff-on-inmate sexual harassment	0	0	0	0
Total	0	0	0	0

Sexual Abuse and Sexual Harassment Investigation Outcomes

Sexual Abuse Investigation Outcomes

Note: these counts should reflect where the investigation is currently (i.e., if a criminal investigation was referred for prosecution and resulted in a conviction, that investigation outcome should only appear in the count for “convicted.”) Do not double count. Additionally, for question brevity, we use the term “inmate” in the following questions. Auditors should provide information on inmate, resident, and detainee sexual abuse investigation files, as applicable to the facility type being audited.

94. Criminal SEXUAL ABUSE investigation outcomes during the 12 months preceding the audit:

	Ongoing	Referred for Prosecution	Indicted/ Court Case Filed	Convicted/ Adjudicated	Acquitted
Inmate-on-inmate sexual abuse	0	0	0	0	0
Staff-on-inmate sexual abuse	0	0	0	0	0
Total	0	0	0	0	0

95. Administrative SEXUAL ABUSE investigation outcomes during the 12 months preceding the audit:

	Ongoing	Unfounded	Unsubstantiated	Substantiated
Inmate-on-inmate sexual abuse	0	0	0	0
Staff-on-inmate sexual abuse	0	0	0	0
Total	0	0	0	0

Sexual Harassment Investigation Outcomes

Note: these counts should reflect where the investigation is currently. Do not double count. Additionally, for question brevity, we use the term “inmate” in the following questions. Auditors should provide information on inmate, resident, and detainee sexual harassment investigation files, as applicable to the facility type being audited.

96. Criminal SEXUAL HARASSMENT investigation outcomes during the 12 months preceding the audit:

	Ongoing	Referred for Prosecution	Indicted/ Court Case Filed	Convicted/ Adjudicated	Acquitted
Inmate-on-inmate sexual harassment	0	0	0	0	0
Staff-on-inmate sexual harassment	0	0	0	0	0
Total	0	0	0	0	0

97. Administrative SEXUAL HARASSMENT investigation outcomes during the 12 months preceding the audit:

	Ongoing	Unfounded	Unsubstantiated	Substantiated
Inmate-on-inmate sexual harassment	0	0	0	0
Staff-on-inmate sexual harassment	0	0	1	0
Total	0	0	1	0

Sexual Abuse and Sexual Harassment Investigation Files Selected for Review

Sexual Abuse Investigation Files Selected for Review

98. Enter the total number of SEXUAL ABUSE investigation files reviewed/ sampled:	1

99. Did your selection of SEXUAL ABUSE investigation files include a cross-section of criminal and/or administrative investigations by findings/outcomes?	○ Yes ○ No ◉ NA (NA if you were unable to review any sexual abuse investigation files)
Inmate-on-inmate sexual abuse investigation files	
100. Enter the total number of INMATE-ON-INMATE SEXUAL ABUSE investigation files reviewed/sampled:	0
101. Did your sample of INMATE-ON-INMATE SEXUAL ABUSE investigation files include criminal investigations?	○ Yes ○ No ◉ NA (NA if you were unable to review any inmate-on-inmate sexual abuse investigation files)
102. Did your sample of INMATE-ON-INMATE SEXUAL ABUSE investigation files include administrative investigations?	○ Yes ○ No ◉ NA (NA if you were unable to review any inmate-on-inmate sexual abuse investigation files)
Staff-on-inmate sexual abuse investigation files	
103. Enter the total number of STAFF-ON-INMATE SEXUAL ABUSE investigation files reviewed/sampled:	0
104. Did your sample of STAFF-ON-INMATE SEXUAL ABUSE investigation files include criminal investigations?	○ Yes ○ No ◉ NA (NA if you were unable to review any staff-on-inmate sexual abuse investigation files)

105. Did your sample of STAFF-ON-INMATE SEXUAL ABUSE investigation files include administrative investigations?	○ Yes ○ No ◉ NA (NA if you were unable to review any staff-on-inmate sexual abuse investigation files)
Sexual Harassment Investigation Files Selected for Review	
106. Enter the total number of SEXUAL HARASSMENT investigation files reviewed/sampled:	1
107. Did your selection of SEXUAL HARASSMENT investigation files include a cross-section of criminal and/or administrative investigations by findings/outcomes?	◉ Yes ○ No ○ NA (NA if you were unable to review any sexual harassment investigation files)
Inmate-on-inmate sexual harassment investigation files	
108. Enter the total number of INMATE-ON-INMATE SEXUAL HARASSMENT investigation files reviewed/sampled:	0
109. Did your sample of INMATE-ON-INMATE SEXUAL HARASSMENT files include criminal investigations?	○ Yes ○ No ◉ NA (NA if you were unable to review any inmate-on-inmate sexual harassment investigation files)
110. Did your sample of INMATE-ON-INMATE SEXUAL HARASSMENT investigation files include administrative investigations?	○ Yes ○ No ◉ NA (NA if you were unable to review any inmate-on-inmate sexual harassment investigation files)

Staff-on-inmate sexual harassment investigation files	
111. Enter the total number of STAFF-ON-INMATE SEXUAL HARASSMENT investigation files reviewed/sampled:	1
112. Did your sample of STAFF-ON-INMATE SEXUAL HARASSMENT investigation files include criminal investigations?	(●) Yes ( ) No ( ) NA (NA if you were unable to review any staff-on-inmate sexual harassment investigation files)
113. Did your sample of STAFF-ON-INMATE SEXUAL HARASSMENT investigation files include administrative investigations?	(●) Yes ( ) No ( ) NA (NA if you were unable to review any staff-on-inmate sexual harassment investigation files)
114. Provide any additional comments regarding selecting and reviewing sexual abuse and sexual harassment investigation files.	No text provided.

SUPPORT STAFF INFORMATION

DOJ-certified PREA Auditors Support Staff

115. Did you receive assistance from any DOJ-CERTIFIED PREA AUDITORS at any point during this audit? REMEMBER: the audit includes all activities from the pre-onsite through the post-onsite phases to the submission of the final report. Make sure you respond accordingly.	( ) Yes (●) No

Non-certified Support Staff	
116. Did you receive assistance from any NON-CERTIFIED SUPPORT STAFF at any point during this audit? REMEMBER: the audit includes all activities from the pre-onsite through the post-onsite phases to the submission of the final report. Make sure you respond accordingly.	○ Yes ◉ No

AUDITING ARRANGEMENTS AND COMPENSATION	
121. Who paid you to conduct this audit?	○ The audited facility or its parent agency ○ My state/territory or county government employer (if you audit as part of a consortium or circular auditing arrangement, select this option) ◉ A third-party auditing entity (e.g., accreditation body, consulting firm) ○ Other
Identify the name of the third-party auditing entity	Diversified Correctional Services, LLC

Standards
Auditor Overall Determination Definitions
• Exceeds Standard (Substantially exceeds requirement of standard) • Meets Standard (substantial compliance; complies in all material ways with the stand for the relevant review period) • Does Not Meet Standard (requires corrective actions)
Auditor Discussion Instructions
Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

115.211	Zero tolerance of sexual abuse and sexual harassment; PREA coordinator
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Evidence Relied Upon in Making the Compliance Determination: **Documentation:** • Project MORE, INC. Policy – Zero tolerance policy of sexual abuse and sexual harassment; PREA Coordinator • Agency Org • Facility Org • Letter Designating Agency PREA Coordinator • Online PREA Audit: Pre-Audit Questionnaire Community Confinement **Interviews:** • PREA Coordinator **Compliance Determination by Provisions and Corrective Actions:**

115.211 (a)

Compliance Determination:
The facility has demonstrated compliance with this provision of the standard because:

The provision requires that an agency to have a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment and outlining the agency's approach to preventing, detecting, and responding to such conduct.

Project MORE, INC. Policy – Zero tolerance policy of sexual abuse and sexual harassment; PREA Coordinator section I. 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. Project MORE, Inc. (PMI) shall designate an agency-wide PREA coordinator. Section II. Procedures:

A. The agency PREA coordinator shall be a person of Program Manager level of higher.
B. The coordinator shall work with Program staff to develop, implement, and oversee PMI's effort to prevent, detect, and respond to such contact.

Documentation review confirmed that the agency has a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment in facilities it operates directly or under contract. The facility included an outlining how it will implement the agency's approach to preventing, detecting, and responding to sexual abuse and sexual harassment. The policy also includes definitions of prohibited behaviors regarding sexual abuse and sexual harassment. The policy includes sanctions for those found to have participated in prohibited behaviors.

A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted.

115.211 (b)

Compliance Determination:
The facility has demonstrated compliance with this provision of the standard because:

The provision requires that an agency employ or designate an upper-level, agency-wide PREA coordinator with sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards in all its facilities.

Informal conversations with the agency Head indicated that the agency has a PREA coordinator.

Project MORE, INC. Policy – Zero tolerance policy of sexual abuse and sexual harassment; PREA Coordinator section I. 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. Project MORE, Inc. (PMI) shall

	designate an agency wide PREA coordinator. Interviewed agency PREA coordinator confirmed that he feels that he has enough time to manage all their PREA related responsibilities. The PREA coordinator also confirmed that they coordinate the agency's efforts to comply with the PREA standards by: • All staff complete the PREA training at orientation online and must pass the final exam. He completes a refresher training course with all current staff annually in-person that also dives mor into resident manipulation and boundaries. Staff also complete the entire PREA training online annually. • The agency has a PREA on-call phone number that staff or clients can call to report an allegation. • He is in close contact with all Program Managers, Program Managers, and investigators to ensure that the agency is preventing sexual harassment or sexual abuse and responding to it in a timely fashion if it does occur. A review of the organization of the agency includes the PREA Coordinator. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **Overall Findings:** The auditor uses a triangulation approach, by connecting the PREA documentation, policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local advocates, and online PREA Audit: Pre-Audit Questionnaire to collaborate findings determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.212	**Contracting with other entities for the confinement of residents**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Evidence Relied Upon in Making the Compliance Determination: **Documentation:** • Project MORE, INC. Policy – Contracting with other entities for the confinement of residents. • Subcontracting Beds • Letter confirming Project MORE • Online PREA Audit: Pre-Audit Questionnaire Community Confinement **Interviews:**

	• Agency Administrator **Compliance Determination by Provisions and Corrective Actions:** **115.212 (a)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires that a public agency that contracts for the confinement of its residents with private agencies or other entities, including other government agencies, shall include in any new contract or contract renewal the entity's obligation to adopt and comply with the PREA standards. The PREA Coordinator and documentation review concluded that the agency has not entered or renewed a contract for the confinement of Walter Brooks residents. Based on a review of information the facility provided in the PAQ, the number of contracts for the confinement of residents that the agency entered or renewed with private entities or other government agency on or after August 20, 2012, or since the last PREA audit, whichever is later was zero. The number of above contracts that did not require contractors to adopt and comply with PREA standards was zero. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **115.212 (b)** Compliance Determinations: The facility has demonstrated substantial compliance with this provision of the standard because: The provision requires that any new contract or contract renewal provide for agency contract monitoring to ensure that the contractor is complying with the PREA standards. Informal conversation with the agency PREA Coordinator and documentation review confirmed that the agency has not entered and contract for the confinement of residents Walter Brooks. Based on a review of information the facility provided in the PAQ, the number of contracts referenced in 115.212 (a)-3 that do not require the agency to monitor contractor's compliance with PREA standards was zero. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **115.212 (c)**

	Compliance Determination: The facility has demonstrated compliance with this provision of the standards because: The provision requires that only in emergency circumstances in which all reasonable attempts to find a private agency or other entity in compliance with the PREA standards have failed, may the agency enter a contract with an entity that fails to comply with these standards. In such a case, the public agency shall document its unsuccessful attempts to find an entity in compliance with the standards. Informal conversation with the agency administrator/PREA Coordinator confirmed that the facility has not had any emergency circumstances in which all reasonable attempts to find a private agency or other entity in compliance with the PREA standards have failed because the facility does not contract with other entities to house their residents. Informal conversations with the agency PREA Coordinator and a review of documentation confirmed that since August 20, 2012, the agency has not entered into contracts with other private agency into contracts for housing residents for Walter Brooks. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **Overall Findings:** The auditor uses a triangulation approach, by connecting the PREA documentation, policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local advocates, and online PREA Audit: Pre-Audit Questionnaire to collaborate findings determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.213	**Supervision and monitoring**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Evidence Relied Upon in Making the Compliance Determination: **Documentation:** • Project MORE, INC. Policy – Supervision and Monitoring • Article III. Residence Districts • Facility Layout (Third Floor, Second Floor, Basement Storage Room, First Floor Offices, Kitchen) • Camera Reviews

	• Staff Schedule (1st, 2nd, and 3rd shifts) • Unannounced Rounds • Zoning • Staffing Requirements Plan • Staffing Plan Assessment • Staff Plan Development for the Walter Brooks House • Facility Tour/Observations • Online PREA Audit: Pre-Audit Questionnaire Community Confinement **Interviews:** • Manager or Designee • PREA Coordinator **Compliance Determination by Provisions and Corrective Actions:** **115.213 (a)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires that for each facility, the agency develop and document a staffing plan that provides for adequate levels of staffing, and, where applicable, video monitoring, to protect residents against sexual abuse. In calculating adequate staffing levels and determining the need for video monitoring, agencies shall take into consideration: The physical layout of each facility. The composition of the resident population. The prevalence of substantiated and unsubstantiated incidents of sexual abuse; and any other relevant factors. Project MORE, INC. Policy – Supervision and Monitoring Section I. PMI shall have staff coverage 24 hours per day seven days a week. Staff will be alert and awake at all times. There shall be adequate staff on site to ensure the safety of the residents. Section II. Procedure: A. The PMI residential staff works three shifts, Monday through Sunday: a. 8:00am to 4:00pm b. 4:00pm to 12:00pm c. 12:00am to 8:00am B. Staff shall conduct hourly rounds to locate and observe clients. Hourly rounds are staggered. C. The facilities have numerous security cameras located inside and outside the facility. Staff monitors the cameras and has the ability to review the tape in necessary. Cameras are located in common areas. D. Agency PREA coordinator along with agency Administration and Program Managers will conduct camera reviews. E. PREA coordinator will conduct unannounced visits to observe the facility. F. All residents are required to sign out and into the facility. G. The PREA coordinator along with Program Manager will complete an annual

	Staffing Plan to ensure facility residents are protected from sexual harassment or abuse. Documentation review confirmed that this facility has a staffing plan that provides for adequate levels of staffing and has video monitoring to protect residents against sexual abuse. Based on a review of information the facility provided in the PAQ, since August 20, 2012, or last PREA audit, whichever is later, the average daily number of residents was 60. Since August 20, 2012, or last PREA audit, whichever is later, the average daily number of residents on which the staffing plan was predicated was 67. The staffing plan minimum requirements are determined by the funder, CT Department of Corrections. The number of Residents in the program determines the minimum number of staff that should always remain on the floor. The minimum staff requirements can never be deviated from so the staff will always ensure that the minimum staffing is present on the floor. The facility has video monitoring in blind spots throughout the facility and continues to add cameras as money becomes available. Staff complete hourly headcounts/rounds as an additional means of supervision. The Staffing Matrices are established by the funding source however the funding source is open to suggestions based on the agency's on-going assessments of their needs. The staffing matrix is submitted every year. If the agency/facility has changes to recommend, the funding agency does consider the justifications for the requests. The facility has cameras to supplement supervision of residents. They are in and out of the facility to help eliminate blind spots and to assist in monitoring residents. Interviewed agency PREA coordinator confirmed that when assessing adequate staffing levels and the need for video monitoring, the agency considers the following: the staffing plan's minimum requirements are determined by the contract set out by the funder, Department of Corrections. The number of clients in the program will determine the minimum number of staff that should always remain on the floor. The minimum staffing requirements can never be deviated from so the Program Manager/Manager will always ensure that the minimum staff are present on the program floor. The facility has video monitoring in blind spots throughout the program and continues to add cameras as money becomes available. Staff complete hourly headcounts/rounds as an additional means of supervision. The interviewed Program Manager confirmed that the facility has a staffing plan. The staffing plan is based on the contract with the funding agency (DOC) and the facility size. The facility also has video monitoring cameras in the most vulnerable spots. The program manager ensures that the facility has monthly schedules to ensure coverage. Interviewed Program Manager confirmed that when the facility assess adequate staffing levels and the need for video monitoring the facility considers the physical

	layout looking for the most vulnerable spots in the program and ensure those spots have camera and/or staff checks are done more frequently in these areas; The composition of the resident population is always changing, and has a very complex population so staff ensuring that they always monitoring and staffing appropriately; The prevalence of substantiated and unsubstantiated incidents of sexual abuse, when trends are detected the facility will add staff, that may be adding an hourly staff or adding a manager/Manager. However, if the facility feels at certain times extra support is needed, they will do so. To check for compliance with the staffing plan, staff check random sites, and check the payroll system. According to the Program Manager the facility documents all instances of non-compliance with the staffing plan via email with funders as they must give the ok. During the facility tour it was observed four staff were on duty. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **115.213 (b)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires that in circumstances where the staffing plan is not complied with, the facility shall document and justify all deviations from the plan. The facility staffing plan is based on the contract with CT DOC. In circumstances where the staffing plan is not complied with, the facility document and notified CT DOC of deviations. Based on a review of information about the facility provided in the PAQ, each time the staffing plan is not complied with, the facility documents and justifies all deviations from the staffing plan. In situations in which a deviation is made from the staffing plan, written justification for such deviation is documented and sent to the PREA coordinator by the facility supervisors. The interviewed Program Manager confirmed that if there was an instance of non-compliance with the staffing plan it would be documented. However, the program manager ensures that the facility is always in compliance. Documentation confirmed that the facility has not deviated from the staffing plan, the plan is based on DOC contract requirements and funding. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted.

115.213 (C)

Compliance Determination:
The facility has demonstrated compliance with this provision of the standard because:

The provision requires that whenever necessary, but no less frequently than once each year, each facility shall assess, determine, and document whether adjustments are needed to: The staffing plan was established pursuant to paragraph (a) of this section. Prevailing staffing patterns. The facility's deployment of video monitoring systems and other monitoring technologies; and the resources the facility has available to ensure adherence to the staffing plan.

Project MORE, INC. Policy – Supervision and Monitoring Section I. PMI shall have staff coverage 24 hours per day seven days a week. Staff will be alert and awake at all times. There shall be adequate staff on site to ensure the safety of the residents. Section II. Procedure:

A. The PMI residential staff works three shifts, Monday through Sunday:
a. 8:00am to 4:00pm
b. 4:00pm to 12:00pm
c. 12:00am to 8:00am
B. Staff shall conduct hourly rounds to locate and observe clients. Hourly rounds are staggered.
C. The facilities have numerous security cameras located inside and outside the facility. Staff monitors the cameras and has the ability to review the tape in necessary. Cameras are located in common areas.
D. Agency PREA coordinator along with agency Administration and Program Managers will conduct camera reviews.
E. PREA coordinator will conduct unannounced visits to observe the facility.
F. All residents are required to sign out and into the facility.
G. The PREA coordinator along with Program Manager will complete an annual Staffing Plan to ensure facility residents are protected from sexual harassment or abuse.

Based on the documentation at least once every year the facility reviews the staffing plan to see whether adjustments are needed in the staffing plan; prevailing staffing patterns, the deployment of video monitoring systems and other monitoring technologies, or the allocation of facility resources to commit to the staffing plan to ensure compliance with the staffing plan

The staffing plan is reviewed annually. Per protocol, the PREA coordinator would be notified in advance if there were any adjustments made to the plan. The facility documents their annual review.

Interviewed agency PREA coordinator confirmed if the staffing plan is reviewed annually and if there was a question or adjustment regarding the PREA standards and staffing then she will be consulted.

	Informal conversation with the PREA coordinator/ HR Manager confirmed that the staffing plan has the number and placement of staff and some video technology that is necessary to ensure the sexual safety of the resident population given the facility layout and characteristics, classifications of residents, and security needs and programming. The staffing plan considers sick leave, vacation, FMLA, callouts, training days, military leave, etc... During the facility tour the auditor observed that the facility has cameras located in and around the facility that are always monitored. The cameras in the facility cover the inside of the visiting room, rear, front, inside front lobby, and recreation areas. There are no cameras in residents' rooms. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **Overall Findings:** The auditor uses a triangulation approach, by connecting the PREA documentation, policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local advocates, and online PREA Audit: Pre-Audit Questionnaire to collaborate findings determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.215	**Limits to cross-gender viewing and searches**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Evidence Relied Upon in Making the Compliance Determination: **Documentation:** • Project MORE, INC. Policy – Limits to cross-gender viewing and searches. • Cross Gender Supervision • Transgender and Intersex Clients • Project MORE Search Procedures • Online PREA Audit: Pre-Audit Questionnaire Community Confinement **Interviews:** • Non-medical Staff (involved in cross-gender strip or visual searches) - 0. • Random Sample of Staff - • Resident Interview Questionnaire (Female Residents) - 0 • Random Resident Interview Questionnaire - • Transgender/Intersex Residents - 0

Compliance Determination by Provisions and Corrective Actions:

115.215 (a)

Compliance Determination:
The facility has demonstrated compliance with this provision of the standard because:

The provision requires that the facility not conduct cross-gender strip searches or cross-gender visual body cavity searches (meaning a search of the anal or genital opening) except in exigent circumstances or when performed by medical practitioners.

Project MORE, INC. Policy – Limits to Cross-Gender Viewing and Searches section I. PMI shall not allow staff to conduct cross-gender strip searches, cross-gender body cavity searches or cross-gender pat down searches. Medical practitioners entering the facility are exempt from this ban. Section II. Procedures:

A. PMI staff shall not conduct strip or body cavity searches. Facility staff will conduct either male or female on female pat down searches.
B. Medical practitioners who enter the facility to examine a resident, must present proper ID and have a verifiable appointment. Staff will make a copy of the ID and place it in the client's file.
C. If a resident's genital status is unknow, it may be determined during conversation with the resident, or by reviewing referral information.
D. Staff of the opposite gender will announce their presence when entering an area where residents are likely showering, performing bodily functions, or changing clothing.
E. Transgender and intersex residents will be given the opportunity to shower, dress, and use the bathroom separately from other residents.
F. The PREA coordinator, along with the Program Manager and Case Manager will meet with the transgender client as soon as possible topics of discussion will include but not be limited to accommodations, privacy in bathrooms and showers, proper hygiene products, garments, searches and urines.

The facility does not conduct cross-gender strip or cross-gender visual body cavity searches of residents.

Based on a review of information the facility provided in the PAQ, in the past 12 months, the number of cross-gender strip or cross-gender visual body cavity searches of residents were zero.

Based on informal conversation with the Program Manager the facility does not conduct strip searches or body cavity searches at all. Staff are also prohibited from conducting any form of search that involves "touching" by either gender staff. Residents are afforded the utmost privacy in restroom/shower areas where the restroom has stalls and doors, and the showers have stalls and curtains and the doors to the restroom/shower areas may be closed as well. Staff are respectful of residents living areas and their privacy.

	During the onsite audit period there were no non-medical staff that were involved in the strip searches to interview. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **115.215 (b)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires that as of August 20, 2015, or August 20, 2017, for a facility whose rated capacity does not exceed 50 residents, the facility shall not permit cross-gender pat-down searches of female residents, absent exigent circumstances. Facilities shall not restrict female residents' access to regularly available programming or other out-of-cell opportunities to comply with this provision. The facility does not permit cross-gender pat-down searches of female residents, absent exigent circumstances. Based on a review of information the facility provided in the PAQ, the number of pat-down searches of female residents that were conducted by male staff was zero. The number of pat-down searches of female residents conducted by male staff that did not involve exigent circumstance (s) was zero. During the onsite period of the audit there were no female residents to interview. The facility only house male residents. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **115.215 (c)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires that the facility document all cross-gender strip searches and cross-gender visual body cavity searches and shall document all cross-gender pat-down searches of female Residents. Based on facility policy staff are required to ensure that all cross-gender strip searches and cross-gender visual body cavity searches are documented. The facility does not conduct cross-gender strip searches and cross-gender visual body cavity searches and has a policy against these practices. This facility is males only.

	A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **115.215 (d)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires that the facility implement policies and procedures that enable residents to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks. Such policies and procedures shall 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. The facility has implemented policies and procedures that enable residents to shower, perform bodily functions, and change clothing without non-medical 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. A total of nine random staff were interviewed by the auditor from different shifts. Eight Black and One Hispanic, Nine males and zero females. Nine confirmed that they and other staff announce their presence when entering a resident room of the opposite gender. Nine confirmed that residents can dress, shower, and use the toilet without being viewed by staff of the opposite gender. It is noted that female staff do not enter the residents' rooms. A total of 14 random residents were interviewed by the auditor. Nine Black, two White and two Hispanic. These residents came to the facility within the past 12 months. They collaborated that staff announce their presence when entering their rooms. All reported that female staff is not allowed to enter their rooms. They also reported that they are never naked in full view of female staff, this including when using the toilet, showering, or changing clothing. **Onsite Review/Observations:** During the site review, 1. The auditor observes areas where residents may be in a state of undress, showers, toilet, and changing of clothing. The areas observed were housing, intake, showers, bathrooms, and recreation areas. 2. The auditor observed the facility critical function of cross-gender announcements. The auditor observes staff announcing their present when entering housing unit/living areas of the opposite gender. 3. The cameras do not show residents naked, using the showers or toilets on camera monitors 4. The auditor observed the facility's physical storage area of any information/documentation collected and maintained as hard copy. The hard copies of the PREA Screening are kept in the residents' files and maintained in lock file cabinets. There was no confidential resident information located in places

	where other residents or staff can review. 5. The auditor informally interviewed residents regarding staff of the opposite gender announcing the present when entering their bedrooms. All residents indicated female staff does not come in their rooms. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **115.215 (e)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires that the facility not search or physically examine a transgender or intersex resident for the sole purpose of determining the resident's genital status. If the resident's genital status is unknown, it may be determined during conversations with the resident, by reviewing medical records, or inf necessary, by learning that information as part of a broader medical examination conducted in private by a medical practitioner. Informal conversations with the Program Manager confirmed that 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. The facility has a practice that no staff will search or physically examine a transgender or intersex resident for the sole purpose of determining the resident's genital status. A total of nine random staff were interviewed by the auditor from different shifts. Eight Black and One Hispanic, Nine males and zero females. Nine confirmed that they are aware of the policy prohibiting staff from searching or physically examining a transgender or intersex resident for the purpose of determining that resident's genital status. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **115.215 (f)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires that the agency train security staff in how to conduct cross-gender pat down searches, and searches of transgender and intersex residents, in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs.

	Informal conversations and documentation review confirmed that staff is trained to conduct cross-gender pat down searches of transgender and intersex residents. The auditor reviews the “Pat Searching of DOC Clients” power point curricula for staff training. Based on a review of information the facility provided in the PAQ, the percent of all security staff who received training on conducting cross-gender pat-down searches and searches of transgender and intersex residents in a professional and respectful manner, consistent with security needs is 0. The auditor develops an Employee Data Sheet to capture the following information: Employee Name, Hire Date, Initial Background Check Date, Five Year Check Date, Clearance Status, Initial PREA Training Date, PREA Refresher Date and Verification of the 3 required questions. Documentation review confirmed the following: 34 Hire Dates; 34 Initial Background Checks; 14 five Year Background Checks; 34 Clearance. A total of nine random staff were interviewed by the auditor from different shifts. Eight Black and One Hispanic, Nine males and zero females. Nine confirmed that they have received training on how to conduct cross-gender pat-down searches and searches of transgender and intersex residents in a professional and respectful manner, consistent with security needs. They received this training during orientation and online PowerPoint. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **Overall Findings:** The auditor uses a triangulation approach, by connecting the PREA documentation, policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local advocates, and online PREA Audit: Pre-Audit Questionnaire to collaborate findings determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.216	**Residents with disabilities and residents who are limited English proficient**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Evidence Relied Upon in Making the Compliance Determination: **Documentation:** • Project MORE, INC. Policy – Residents with Disabilities and Residents who are Limited English Proficient

	• Letter from Manager of Human Resources • Yale Interpretation Network • Client Handbook in English and Spanish • Interpreters and Translators, Inc. • Instructions for Utilizing an Interpreter • Letters and Invoices for Interpreter Services • Language Services Contract • Online PREA Audit: Pre-Audit Questionnaire Community Confinement **Interviews:** • Agency Head • Residents (with disabilities or who are limited English proficient) • Random Sample of Staff **Compliance Determination by Provisions and Corrective Actions:** **115.216 (a)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires that the agency take appropriate steps to ensure that residents with disabilities (including, for example, residents who are deaf or hard of hearing, those who are blind or have low vision, or those who have intellectual, psychiatric, or speech disabilities), have an equal opportunity to participate in or benefit from all aspects of the agency's effort to prevent, detect, and respond to sexual abuse and sexual harassment. Such steps shall include, when necessary to ensure effective communication with residents who are deaf or hard of hearing, providing access to interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary. Project MORE, INC. Policy – Residents with Disabilities and Residents who are Limited English Proficient Section I. 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 shall not rely on resident interpreters, readers or other types of client assistance except in limited circumstances where an extended delay could compromise a residents' safety. Section II. Procedures: A. CSSD/CT DOC will send a referral packet to the PMI residential program that will state client limitations. These limitations will include but not be limited to the following: medical and/or mental health issues, alcohol and/or drug use, and special conditions. B. Upon entry, staff will complete a client intake. Staff shall determine what limitations and/or handicaps the client has. C. Staff will also complete an LSI-r, if not provided, that will also indicate what

limitations and/or handicaps the client has.
D. Should the client have issues that would affect his understanding of PREA, staff will have a plan-of-action in place. This can include but not be limited to the following: a foreign language and sign language interpreter, large print program handbooks.
E. The PMI facility will also contact CSSD/CT DOC and other facilities to tap into their resources.

A review of documentation that the agency has established procedures to provide disabled residents equal opportunity to participated in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment.

Interviewed Agency Head confirmed that the agency has established procedures to provide residents with disabilities and residents who are limited English proficient equal opportunity to participate in and benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment. The agency has all documents in Spanish, signs in the program are in Spanish, Spanish speaking staff in some of the programs, and would use a translating service if needed. If residents are unable to read, the facility has staff read and review all PREA information with resident in person.

115.216 (b)

Compliance Determination:
The facility has demonstrated compliance with this provision of the standard because:

The provision requires that 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, including steps to provide interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary.

Based on documentation the agency has established procedures to provide residents with limited English proficiency equal opportunity to participate in and benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment.

Project MORE, INC. Policy – Residents with Disabilities and Residents who are Limited English Proficient Section I. 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 shall not rely on resident interpreters, readers or other types of client assistance except in limited circumstances where an extended delay could compromise a residents' safety. Section II. Procedures: Should the client have issues that would affect his understanding of PREA, staff will have a plan-of-action in place. This can include but not be limited to the following: a foreign language and sign language

	interpreter, large print program handbooks. The PMI facility will also contact CSSD/ CT DOC and other facilities to tap into their resources. The auditor reviews the Zero-Tolerance Policy for Sexual Harassment and Sexual Abuse Acknowledgement in Spanish and English. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **115.216 (c)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires that the agency not rely on resident interpreters, resident readers, or other types of resident assistants except in limited circumstances where an extended delay is 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. Based on conversations with the Program Manager the facility prohibits the use of resident interpreters, resident reader and other types of resident assistants regarding PREA. Based on a review of information the facility provided in the PAQ, in the past 12 months, the number of instance where resident interpreters, readers, or other types of resident assistants have been used and it was not the case that an extended delay in obtaining another interpreter could compromise the residents' safety, the performance of first-response duties under 115.264, or the investigation of the resident's allegations was 0. A total of nine random staff were interviewed by the auditor from different shifts. Eight Black and One Hispanic, Nine males and zero females. Nine confirmed that the agency never allows the use of resident interpreters, resident readers, or other types of resident assistants to assist with limited English proficiency when making an allegation of sexual abuse or sexual harassment. All staff refer to the agency interpreter contract and some report that the interpreter comes to the facility. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **Overall Findings:** The auditor uses a triangulation approach, by connecting the PREA documentation, policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local advocates, and online PREA Audit: Pre-Audit Questionnaire to collaborate findings determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.217	Hiring and promotion decisions
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Evidence Relied Upon in Making the Compliance Determination: **Documentation:** • Project MORE, INC. Policy – Hiring and Promotion Decisions • Project MORE, INC. Policy - Discipline Guidelines • Project MORE, INC, Policy – Recruitment Practices • Coeus Global Background Report (Samples) • Letter to Other Agency New Hire Applicant • Release of Information PREA • Three Required Questions Ask of New Hires • Online PREA Audit: Pre-Audit Questionnaire Community Confinement **Interviews:** • Administrative (Human Resources) Staff **Compliance Determination by Provisions and Corrective Actions:** **115.217 (a)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires that the agency not hire or promote anyone who may have contact with residents, and shall not enlist the 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) 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 Has been civilly or administratively adjudicated to have engaged in the activity described in paragraph a-2 of this section. Project MORE, INC. Policy – Hiring and Promotion Decisions section I. PMI shall not hire or promote anyone nor enlist the services of a contractor who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility or other institution. Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refused. Has been civilly or administratively adjudicated to have engaged in engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent

	or was unable to consent or refused. Section II. Procedures: A. Before hiring new staff, PMI will conduct a criminal background investigation. B. PMI will make its best effort to contact all prior employers for information on substantial allegations of sexual abuse or any resignation during a pending investigation of an alleged sexual abuse. This will be consistent with Federal, state and local laws. C. PMI shall perform a criminal background record check before enlisting the services of any contractor who may have contact with residents. D. PMI shall wither conduct criminal background records check at least every five years on current employees and contractors. E. PMI shall ask all applicants and current employees about previous misconducts of a sexual nature. This will be done in writing and on an application or during an interview for hiring or promotion. F. PMI shall impose upon employees a continuing affirmative duty to disclose any such misconduct. G. Omission regarding such misconduct or the provision of materially false information shall be grounds for termination. Informal conversation with the PREA coordinator confirmed the agency policy prohibits hiring or promoting anyone who may have contact with residents and prohibits enlisting the services of any contractor who has contact with residents. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **115.217 (b)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires that the agency consider any incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any contractor, who may have contact with Residents. Interviewed Human Resources Staff confirmed that the facility considers prior incidents of sexual harassment when determining whether to hire or promote anyone, or to enlist the services of any contractor, who may have contact with residents. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **115.217 (c)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard

	because: The provision requires that before hiring new employees, who may have contact with residents, the agency shall: Perform a criminal background records check; and 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. Documentation review requires that before it hires any new employees who may have contact with residents, conducts criminal background record checks, consistent with federal, state, and local law, makes its best efforts to contact all prior institutional employes for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse. The auditor develops an Employee Data Sheet to capture the following information: Employee Name, Hire Date, Initial Background Check Date, Five Year Check Date, Clearance Status, Initial PREA Training Date, PREA Refresher Date and Verification of the 3 required questions. Documentation review confirmed the following: 37 Hire Dates; 37 Initial Background Checks; 10 five Year Background Checks; 37 Clearance; 37 Initial PREA Training; 19 No Longer with the Agency that received Refresher Training; 37 had Verification Questions. Based on a review of information the facility provided in the PAQ, in the past 12 months, the number of persons hired who may have contact with residents who have had criminal background record checks was 9. Interviewed Human Resources Staff confirmed that the facility performs criminal record background checks and consider pertinent civil or administrative adjudications for all newly hired employees. Background checks are performed for all new hires to include FT, PT, and per diem via Paycom. Periodic criminal and driving checks are done for existing staff. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. 1**15.217 (d)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires that the agency also perform a criminal background record check before enlisting the services of any contractor who may have contact with residents. A review of documentation requires that a criminal background record check be completed before enlisting the services of any contractor who may have contact

with residents.

Based on a review of information the facility provided in the PAQ, in the past 12 months, the number of contracts for services where criminal background record checks were conducted on all staff covered in the contract who might have contact with residents was 14.

A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted.

115.217 (e)

Compliance Determination:
The facility has demonstrated compliance with this provision of the standard because:

The provision requires that 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.

A review of documentation indicates 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 that a system is in place for otherwise capturing such information for current employees.

A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted.

115.217 (f)

Compliance Determinations:
The facility has demonstrated compliance with this provision of the standard because:

The provision requires that 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 and in any interviews or written self-evaluations conducted as part of reviews of current employees. The agency shall also impose upon employees a continuing affirmative duty to disclose any such misconduct.

Documentation review of the Applicant Authorization and Consent for Release included staff affirmative duty to disclose misconduct.

Interviewed Human Resources Staff confirmed the agency asks all applicants and employees about previous misconduct for applications for hiring and promotions and as part of the staff current review. Staff also confirm that the agency imposes

upon employees a continuing affirmative duty to disclose any misconduct. This is captured in the agency's Personal Conduct Policy.

A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted.

115.217 (g)

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

The provision requires that material omissions regarding such misconduct, or the provision of materially false information, shall be grounds for termination.

Documentation review indicates that material omissions regarding such misconduct, of the provision of materially false information, are grounds for termination.

A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted.

115.217 (h)

Compliance Determination:
The facility has demonstrated compliance with this provision of the standard because:

The provision requires that unless prohibited by law, the agency shall provide information on substantiated allegations of sexual abuse or sexual harassment involving a former employee upon receiving a request from an institutional employer for whom such employee has applied to work.

Documentation review confirmed that the agency sends a letter to perspective employees requesting information of the former employee. The document states, "Has the applicant named above been terminated from your company/agency for substantiated allegations of sexual abuse or resigned during a pending investigation of an allegation of sexual abuse?

Interviewed Human Resources Staff confirmed when a former employee applies for work at another institution, upon request from that institution, the agency provide information on substantiated allegations of sexual abuse and sexual harassment involving the former employee.

A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted.

Overall Findings:

	The auditor uses a triangulation approach, by connecting the PREA documentation, policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local advocates, and online PREA Audit: Pre-Audit Questionnaire to collaborate findings determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.218	Upgrades to facilities and technology
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Evidence Relied Upon in Making the Compliance Determination: **Documentation:** • Project MORE, INC. Policy – Upgrade to Facilities and Technology • Letter Security Cameras • Online PREA Audit: Pre-Audit Questionnaire Community Confinement **Interviews:** • Agency Head • Program Manager **Compliance Determination by Provisions and Corrective Actions:** **115.218 (a)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires that when designing or acquiring any new facility and in planning any substantial expansion or modification of existing facilities, the agency shall consider the effect of the design, acquisition, expansion, or modification upon the agency's ability to protect residents from sexual abuse. Project MORE, INC. Policy – Upgrades to Facilities and Technologies section I. When installing a new or updating 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. Section II. Procedures: When designing or acquiring any new facility and in planning any substantial expansion or modification to a facility, PMI shall consider the effect of the design, acquisition, expansion, or modification upon the programs ability to protect residents from sexual abuse. When installing a new or updating 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 agency has not acquired a new facility or made substantial expansions or modification to existing facilities.

The interviewed Agency Head confirmed that when designing, acquiring, or planning substantial modifications, or designing any space to be occupied by clients, PREA is taken into consideration. All spaces are evaluated for blind spots that cannot be seen through traditional video monitoring. Any blind spots are given a plan of physical monitoring to include documentation of when those areas are toured and inspected. In addition, substantial modifications to program space would be reviewed by facilities Manager, PREA coordinator and would be submitted to DOC prior to modification.

The interviewed Program Manager confirmed that the facility has not made any major expansions or modifications within the past years.
A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted.

115.218 (b)

Compliance Determination:
The facility has demonstrated compliance with this provision of the standard because:

The provision requires that when installing or updating a video monitoring system, electronic surveillance system, or other monitoring technology, the agency shall consider how such technology may enhance the agency’s ability to protect Residents from sexual abuse.

The agency has not made any major installation or updated a video monitoring system, electronic surveillance system, or other monitoring technology since the last audit.

Interviewed Agency Head confirmed that the agency uses monitoring technology to enhance the protection of residents from resident from incidents of sexual abuse by using video monitoring in spaces occupied by residents. When opportunities for upgrading arise, the agency consistently takes advantage of those times by making upgrades and adding cameras to spaces that may not be monitored by a camera.

The interviewed Program Manager confirmed that when putting any new cameras in the most vulnerable spots. Any blind spots the facility has, they conducted extra rounds, and the facility is first on the list for new cameras based on funding.

A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted.

Overall Findings:

	The auditor uses a triangulation approach, by connecting the PREA documentation, policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local advocates, and online PREA Audit: Pre-Audit Questionnaire to collaborate findings determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.221	Evidence protocol and forensic medical examinations
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Evidence Relied Upon in Making the Compliance Determination: **Documentation:** • Project MORE, INC. Policy – Evidence Protocol and Forensic Medical Examinations • Memorandum of Understanding with Women and Families Center (WFC) • Sexual Assault Forensic Examiners Program • Sexual Harassment an Assault Response • Sexual Harassment and Assault Response & Education (SHARE) **Interviews:** • Random Sample of Staff – 9 • SAFE’s/SANEs Staff – 0 • PREA Coordinator • Residents who Reported a Sexual Abuse - 0 **Compliance Determination by Provisions and Corrective Actions:** **115.221 (a)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires that to the extent the agency is responsible for investigating allegations of sexual abuse, the agency shall follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions. Project MORE, INC. Policy – Evidence Protocol and Forensic Medical Examinations Section I. PMI facilities shall contract local authorities to investigate allegations of sexual abuse. PMI shall offer victims of sexual abuse access to a forensic medical examination. This will be of no cost to the resident. PMI shall also make available to the resident a victim advocate. Section II.

	A. Access to forensic medical examinations: PMI shall offer victims of sexual abuse access to a forensic medical examination vis Yale New Hospital. Such examinations shall be performed by Sexual Assault Forensic Examiners (SAFE's) or Sexual Assault Nurse Examiner (SANE's) where possible. If SAFE or SANE cannot be made available, the examination will be performed by other qualified medical practitioners. The PMI shall document its efforts. B. Victim advocate: PMI has an MOU with the Women and Family Center to provide advocate services. C. State Support: 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 an investigatory review and shall provide emotional support, crisis intervention, information and referrals. D. Qualifications of investigating agency: PMI shall request that the investigating agency abide by all PREA requirements and/or standards. Documentation review confirmed that the agency is responsible for conducting administrative sexual abuse investigations including resident-on-resident sexual abuse or staff sexual misconduct. The agency PREA coordinator is responsible for conducting administrative sexual abuse. The agency is not responsible for conducting criminal sexual abuse investigations including resident-on-resident sexual abuse or staff sexual misconduct. The Connecticut State Police or DOC is responsible for conducting criminal investigations. Each agency follows a uniform evidence protocol. A total of nine random staff were interviewed by the auditor from different shifts. Eight Black and One Hispanic, Nine males and zero females. Eight confirmed that they know and understand the agency's protocol for obtaining usable physical evidence if a resident alleges sexual abuse. They report that if they are the first person to be alerted that a resident has allegedly been the victim of sexual abuse, their responsibility in this situation would be to separate the victim from the abuser, close off the area where it takes place, do not let the victim and abuser brush their teeth, drink, use the bathroom, and change clothing. Staff would call 911 if medical is needed and their supervisor. Staff also reported to the State Police, DOC PREA Investigation Unit or the Agency PREA Coordinator conducts PREA investigations. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **115.221 (b)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires that the protocol be developmentally appropriate for youth where applicable, and as appropriate, shall be 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. Informal conversation with the administrative investigator confirmed that they use the same protocol that the DOC and the Connecticut State Police Department use. A review of the State of Connecticut Technical Guidelines for Health Care Response to Victims of sexual Assault, in accordance with Connecticut General Statute’s section 19a – 112a. Give guidance of Child & Adolescent victims, to include General Information; Initial Response – Triage and Intake; Counseling and Support; Consent for Police Notification – Mandatory Reporting Requirements; Consent for Examination; Medical Report forms and Interviews; Presence of Parent or Guardian; Medical/Evidence Collection Examination and Testing for Sexually Transmitted Infections (STI’s). A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **115.221 (c)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires that the agency offer all victims of sexual abuse access to forensic medical examinations, whether on-site or at an outside facility, without financial cost, where evidentiarily or medically appropriate. Such examinations shall be performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) where possible. The agency shall document its efforts to provide SAFEs or SANEs. The facility does offer residents who experience sexual abuse access to forensic medical examinations through the local hospital or rape crisis center. Forensic medical examinations are offered to residents without financial cost to the victim. When SANEs or SAFE are not available, a qualified medical doctor performs forensic medical examinations at the local hospital. Based on a review of information the facility provided in the PAQ, the number of forensic medical exams conducted during the past 12 months was zero. The number of exams performed by SANEs/SAFEs during the past 12 months was zero. The number of exams performed by a qualified medical practitioner during the past 12 months was zero. A review of the State of Connecticut Technical Guidelines for Health Care Response to Victims of sexual Assault, in accordance with Connecticut General Statute’s section 19a – 112a. CT 100 Sexual Assault Evidence Collection Kit: Preparation for the Examination; The Evidence Collection Examination and Evidence Integrity –

repacking, labeling, and sealing evidence containers. The examinations performed by the SAFE or SANE staff are guided by the State of Connecticut Statute.

A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted.

115.221 (d)

Compliance Determination:
The facility has demonstrated compliance with this provision of the standard because:

The provision requires that the agency attempt to make available to the victim advocate from a rape crisis center. If a rape crisis center is not available to provided victim advocates services, the agency shall make available to provide these services a qualified staff member from a community-based organization, or a qualified agency staff member. Agencies shall document efforts to secure services from rape crisis centers. To this standard, a rape crisis center refers to an entity that provides intervention and related assistance, such as the services specified in 42 U.S.C. 1400043, to victims of sexual assault of all ages. The agency may utilize a rape crisis center that is part of a governmental unit if the center is not part of the criminal justice system and offers a comparable level of confidentiality as a nongovernmental entity that provides similar victim services.

The facility attempts to make available to the victim a victim advocate from a rape crisis center. The agency has a Memorandum of Agreement (MOA) between Connection, Inc., and The Connecticut Alliance to End Sexual Violence. As documentation the agency provided a copy of the MOA. A review of the MOA confirmed that the Connecticut Alliance to End sexual Violence local facility will provide a victim advocate if requested by the victim.

The auditor confirmed this through the documentation review of the Connecticut Alliance to End Sexual Violence MOA.

A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted.

115.221 (e)

Compliance Determination:
The facility has demonstrated compliance with this provision of the standard because:

The provision requires that as requested by the victim, the victim advocate, qualified agency staff member, or qualified community-based organization staff member shall accompany and support the victim through the forensic medical examination process and investigatory interviews and shall provide emotional support, crisis intervention, information, and referrals.

A review of the MOA confirmed that Connecticut Alliance to End Sexual Violence at the residents' request, allow for a sexual assault crisis counselor to accompany and support the victim throughout the forensic medical exam process and investigatory interviews, and provide emotional support, crisis intervention, information, and referrals, as requested by the victim throughout the client's placement in the TCI facility.

Interviewed PREA coordinator collaborated that if requested by the victim, a victim advocate, qualified agency staff member, or qualified community-based organization staff member will accompany and provide emotional support, crisis intervention, information, and referrals during the forensic medical examination process and investigatory interviews. If requested by the client, a qualified agency staff member will accompany the client to the hospital, however, in most cases staff will assist the client in requesting a victim advocate by providing information and phone number for The Alliance to End Sexual Violence. The State of Connecticut provides guidelines for the health care response to victims of sexual assault based on State Statues and Senate Bills which includes providing a victim advocate at the hospital.

A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted.

115.221 (f)

Compliance Determinations:
The facility has demonstrated compliance with this provision of the standard because:

The provision requires that to the extent the agency itself is not responsible for investigating allegations of sexual abuse, the agency shall request that the investigating agency follow the requirements of paragraphs (a) through (e) of this section.

The State Police Department is responsible for investigating allegations of sexual abuse. The agency has requested that the State Police Department follow the requirements of PREA. The agency has provided the auditor with a copy of the PREA letter to the State Police with the request.

Documentation review of the letter to the State Police Department confirmed that the agency has requested that all PREA investigations be conducted in compliance under standard 115.221 and give the detailed requirements.

A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted.

1**15.221 (g)**

Compliance Determination:

	The facility has demonstrated compliance with this provision of the standard because: The provision requires that the requirements of paragraphs (a) through (f) of this section shall also apply to: Any State entity outside of the agency that is responsible for investigating allegations of sexual abuse in prisons or jails; and Any Department of Justice component that is responsible for investigating allegations of sexual abuse in prisons or jails. Auditor is not required to audit this provision. **115.221 (h)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires that for the purposes of this section, a qualified agency staff member or a qualified community-based staff member shall be an individual who has been screened for appropriateness to serve in this role and has received education concerning sexual assault and forensic examination issues in general. The agency uses a qualified community-based staff member with the required education concerning sexual assault and forensic examination issues in general. The agency has an MOA with the Connecticut Alliance to End Sexual Violence to provide qualified community staff members if requested by the resident. A review of the State of Connecticut Technical Guidelines for Health Care Response to Victims of sexual Assault, in accordance with Connecticut General Statute's section 19a – 112a. The examinations performed by the SAFE or SANE staff are guided by the State of Connecticut Statute. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted.

115.222	**Policies to ensure referrals of allegations for investigations**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Evidence Relied Upon in Making the Compliance Determination: **Documentation:** • Project MORE, INC. Policy – Policies to ensure of Allegations for Investigations • Letter Chief, New Haven Police Department

	• PREA Allegation • PREA Incident Report (1) • NIC Online Specialized Investigation Training • Online PREA Audit: Pre-Audit Questionnaire Community Confinement **Interviews:** • Agency Head • Investigative Staff **Compliance Determination by Provisions and Corrective Actions:** **115.222 (a)** Compliance Determinations: The facility has demonstrated compliance with this provision of the standard because: The provision requires that the agency ensure that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment. Project MORE, INC. Policy – Policies to ensure Referrals of Allegations for Investigations section I. PMI shall ensure that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment. Section II. Procedures: A. PMI shall maintain a policy to ensure that all allegations of sexual assault are referred for investigation to local authorities to conduct criminal investigations, unless the allegation does not involve potentially criminal behavior. All referrals shall be documented. B. Local authorities shall be responsible for conducting criminal investigations, not PMI. The agency ensures that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment. The administrative investigations are conducted by the agency PREA coordinator and criminal investigations are conducted by the State Police Department. Documentation review of the Connection Inc. PREA Administration Review Reports confirmed that the agency is conducting the required investigations. There were no criminal investigations to review. Based on a review of information the facility provided in the PAQ, in the past 12 months, the number of allegations of sexual abuse and sexual harassment that were received was 1. In the past 12 months, the number of allegations resulting in an administrative investigation was 1. In the past 12 months, the number of allegations referred to for criminal investigation was zero. Interviewed Agency Head confirmed that the agency does ensure that an

	administrative or criminal investigation is completed for all allegations of sexual abuse or sexual harassment. The agency has a designated PREA coordinator who monitors all administrative and criminal investigations into sexual abuse. At the end of all investigations the PREA coordinator submits a detailed report of the entire incident including the investigation portion. Criminal investigations are handed off to the State Police or controlling police department of the area where the incident occurs. Administrative investigations are done as an internal collaborative effort. These investigations include the Human Resource Department, The agency leadership and the PREA coordinator. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **115.222 (b)** Compliance Determinations: The facility has demonstrated compliance with this provision of the standard because: The provision requires that the agency have in place a policy 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. The agency shall publish such a policy on its website or, if it does not have one, make the policy available through other means. The agency shall document all such referrals. The agency has a policy that requires that allegations of sexual abuse or sexual harassment be referred for investigation to an agency with the legal authority to conduct criminal investigations. The agency requires that the State Police Department has the legal authority to conduct criminal investigations. The agency requires that the PREA coordinator work with the State Police and share information with the facility. Interviewed Investigator confirmed that the agency policy requires that allegations of sexual abuse or sexual harassment be referred for investigation to an agency with the legal authority to conduct criminal investigations. The agency refers criminal allegations to the Connecticut State Police. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **115.222 (c)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires that if a separate entity is responsible for conducting criminal

	investigations, such a publication shall describe the responsibilities of both the agency and the investigating entity. The agency PREA coordinator provided the auditor with a copy of the PREA letter sent to the State Police. This letter describes the responsibilities of the investigating entity. The State Police Department is responsible for investigating allegations of sexual abuse. The agency has requested that the State Police Department follow the requirements of PREA. The agency has provided the auditor with a copy of the PREA letter to the State Police with the request. Documentation review of the letter to the State Police Department confirmed that the agency has requested that all PREA investigations be conducted in compliance under standard 115.221 and give the detailed requirements. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **115.222 (d)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires that any State entity responsible for conducting administrative or criminal investigations of sexual abuse or sexual harassment in prisons or jails shall have in place a policy governing the conduct of such investigations. The auditor is not required to audit this provision. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **115.222 (e)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires that any department of Justice component responsible for conducting administrative or criminal investigations of sexual abuse or sexual harassment in prisons or jails shall have in place a policy governing the conduct of such investigations. The auditor is not required to audit this provision. **Overall Findings:**

	The auditor uses a triangulation approach, by connecting the PREA documentation, policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local advocates, and online PREA Audit: Pre-Audit Questionnaire to collaborate findings determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.231	Employee training
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Evidence Relied Upon in Making the Compliance Determination: **Documentation:** • Project MORE, INC. Policy – Employee Training • Project MORE, INC. Policy 111 – Prison Rape Elimination Act (PREA) Compliance Policies • Staff Prison Rape Elimination Act Training Manual • Employee PREA Training Acknowledgments • Online PREA Audit: Pre-Audit Questionnaire Community Confinement **Interviews:** • Random Sample of Staff - **Compliance Determination by Provisions and Corrective Actions:** **115.231 (a)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires that the agency train all employees who may have contact with residents on: Its zero-tolerance policy for sexual abuse and sexual harassment. How to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures. Residents' right 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 threatened and actual sexual abuse. 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. The agency trains all employees who may have contact with residents regarding the agency's zero-tolerance policy for sexual abuse and sexual harassment. Project MORE, INC. Policy – Employee Training Section I. PMI shall train all employees who may have contact with residents on the following: A. It’s zero tolerance policy for sexual abuse and sexual harassment. B. How to fulfill their responsibilities under PMI sexual abuse and sexual harassment prevention, detection, reporting and response policies and procedures. C. The residents’ and employees to be free from sexual abuse and sexual harassment. D. The right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment. E. The dynamics of sexual abuse and sexual harassment in confinement. F. The common reactions of sexual abuse and sexual harassment victims. G. How to detect and respond to signs of threatened and actual sexual abuse. H. How to avoid inappropriate relationships with residents. I. How to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex or gender non-conforming residents. J. How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities. Training will be tailored to the gender of the facility residents. Employees hall receive additional training if transferred from a male only facility to a female only facility and vice versa. Section II. Procedures. A. PMI shall provide training quarterly for all new facility employees. B. 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. C. In years in which an employee does not receive refresher training, PMI shall also provide refresher information on current sexual abuse and sexual harassment policies. D. PMI shall document all training through employee signature or electronic verification that the employee understands the training received. A total of nine random staff were interviewed by the auditor from different shifts. Eight Black and One Hispanic, Nine males and zero females. Nine confirmed that they received their PREA training during orientation, in-person, and online training. Staff talked about agency zero tolerance, resident rights, retaliation, detection, communication with LGBTI population, and inappropriate relationships with residents. The auditor develops an Employee Data Sheet to capture the following information: Employee Name, Hire Date, Initial Background Check Date, Five Year Check Date,

	Clearance Status, Initial PREA Training Date, PREA Refresher Date and Verification of the 3 required questions. Documentation review confirmed the following: 37 Hire Dates; 37 Initial Background Checks; 10 five Year Background Checks; 37 Clearance; 37 Initial PREA Training; 19 No Longer with the Agency that received Refresher Training; 37 had Verification Questions. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **115.231 (b)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires that such training be tailored to the gender of the residents at the employee's facility. The employee shall receive additional training if the employee is reassigned from a facility that house only male residents to a facility that houses only female residents, or vice versa. The agency PREA training is tailored to the gender of the residents at the facility. Project MORE, INC. Policy – Employee Training Section II. Training will be tailored to the gender of the facility residents. Employees hall receive additional training if transferred from a male only facility to a female only facility and vice versa. A review of the appropriate documentations, interviews and conversations with staff and confined persons, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **115.231 (C** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires that all current employees who have not received such training shall be trained within one year of the effective date of the PREA standards, and the agency shall 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. In years in which an employee does not receive refresher training, the agency shall provide refresher information on current sexual abuse and sexual harassment policies. Between trainings, the agency provides employees who may have contact with residents with refresher information about current policies regarding sexual abuse and sexual harassment. This information is provided through online training, shift briefing notes and staff meetings.

	Project MORE, INC. Policy – Employee Training Section II. Procedures. 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. In years in which an employee does not receive refresher training, PMI shall also provide refresher information on current sexual abuse and sexual harassment policies. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **115.231 (d)** Compliance Determinations: The facility has demonstrated compliance with this provision of the standard because: The provision requires that the agency document, through employee signature or electronic verification, that employees understand the training they have received. The agency documents that employees who may have contact with residents understand the training they have received through employment signatures. Project MORE, INC. Policy – Employee Training Section II. Procedure: PMI shall document all training through employee signature or electronic verification that the employee understands the training received. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **Overall Findings:** The auditor uses a triangulation approach, by connecting the PREA documentation, policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local advocates, and online PREA Audit: Pre-Audit Questionnaire to collaborate findings determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.232	**Volunteer and contractor training**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Evidence Relied Upon in Making the Compliance Determination: **Documentation:**

	• Project MORE, INC. Policy – Volunteer and Contractor Training • Contractors and Volunteers PREA Agreement (Example) • Employee PREA Training Acknowledgement (Samples) • Online PREA Audit: Pre-Audit Questionnaire Community Confinement **Interviews:** • Volunteer (s) or Contractors (s) who may have Contact with Residents - 0 **Compliance Determination by Provisions and Corrective Actions:** **115.232 (a)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires that the agency ensure 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. Project MORE, INC. Policy – Volunteer and Contractor Training section I. All program volunteers/interns shall receive the same training outlined in Standard 115.231. Contractor shall be trained on their responsibilities under PMI's sexual abuse and sexual harassment prevention, detection, and response policies and procedures. Section II: Procedures: A. Volunteers/Interns – See Standard 115.231. B. Contractors shall be informed of their responsibilities under PMI's sexual abuse and sexual harassment prevention, detection, and response policies and procedures. They shall be informed in writing and will sign off upon receipt. Contractors will receive a copy. Volunteers and contractors who have contact with residents have been trained on their responsibilities under the agency's policies and procedures regarding sexual abuse and sexual harassment prevention, detection, and response. Based on a review of information the facility provided in the PAQ, the number of volunteers and individual contractors who have contact with residents who have been trained in agency policies and procedures regarding sexual abuse and sexual harassment prevention, detection, and response was 1. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **115.232 (b)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard

	because: The provision requires that the level and type of training provided to volunteers and contractors shall be based on the services they provided and level of contact they have with residents, but all volunteer and contractors who have contact with residents shall be 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 is based on the services they provide and the level of contract they have with residents. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **115.232 (c)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires that the agency maintain documentation confirming that volunteers and contractors understand the training they have received. The agency maintains documentation confirming that volunteers and contractors who have contact with residents understand the training they have received if they were to have any. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **Overall Findings:** The auditor uses a triangulation approach, by connecting the PREA documentation, policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local advocates, and online PREA Audit: Pre-Audit Questionnaire to collaborate findings determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.233	**Resident education**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Evidence Relied Upon in Making the Compliance Determination: **Documentation:**

	• Project MORE, INC. Policy – Resident Education • Client Handbook • Posters English • PREA Education Acknowledgements • PREA Education Acknowledgements • Sexual Assault Crisis Services Brochure Spanish and English (WFC) • Sexual Assault and Custodial Misconduct Acknowledgments • Treatment Plan (Informed Residents regarding PREA) Statements • Prison Rape Elimination Act of 2023 Statements • Handbook Acknowledgments • Interpreters and Translators, Inc. • Online PREA Audit: Pre-Audit Questionnaire Community Confinement **Interviews:** • Intake Staff • Random Residents **Compliance Determination by Provisions and Corrective Actions:** **115.233 (a)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires during the intake process, residents receive information explaining the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and how to report incidents or suspicions of sexual abuse or sexual harassment, their rights to be free from sexual abuse and sexual harassment and to be free from retaliation for reporting such incidents, and regarding agency policies and procedures for responding to such incidents. Residents receive information at the time of intake regarding the zero-tolerance policy as required by the standard. Project MORE, INC. Policy – Resident Education Section I – During the intake process, residents shall receive information explaining PMI's zero tolerance policy regarding sexual abuse and sexual harassment. Residents will be informed how to report incidents or suspicions of sexual abuse or sexual harassment, their right to be free from sexual abuse and sexual harassment and to be free from retaliation for reporting such incidents and regarding PMI's policies and procedures for responding to such incidents. Based on a review of information the facility provided in the PAQ, the number of residents admitted during past 12 months who were given this information at intake was 140. The residents received the intake information through brochures and Intake package. The facility has the following brochures in English and Spanish title "WFC –

	Your Life Your Goals, Our Purpose, Sexual Asssault Crisis Services". The auditor has reviewed the above brochure and has a copy to upload in the PREA system. The PREA brochures are given the same day of arrival. Based on documentation review of resident's signature and date on the Zero-Tolerance Policy for Sexual Harassment & Sexual Abuse Acknowledgement statements collaborated that the residents are receiving the PREA information. The following are notes from the auditor's intake package review. Sexual Assault and Custodial Misconduct: • What do you do if you have been sexually assaulted. • You can call the Sexual Abuse Crisis Services Hotline at 1-888-999-5545. This line can be used by anyone who wishes to report a sexual assault. • What is Sexual Assault. • Examples of Sexual Assault. • How to prevent sexual Assault. • How to report Sexual Assault. Treatment Plan: • Resident will be made aware of the PREA and the Walter Brooks House zero tolerance policy towards sexual assault and sexual harassment. • Informing residents of the 2023 PREA – residents will be required to sign off on the form. Prison Rape Elimination Act of 2023: • Project MORE, Inc. zero tolerance policy • Sexual Abuse (Definitions) • Sexual Harassment (Definitions) Handbook Acknowledgment: • All residents received a copy of the facility handbook upon entry. The Connecticut Alliance to End Sexual Violence Flyer (Top) • How to Access Emotional Support Services for Survivors of Sexual Abuse • 24 Hours Toll Free Hotline (English and Spanish) • No Personal Identification Number Needed • Local Center: Women and Families Center Number • All PREA mail will be treated as legal mail. Reporting Sexual Abuse or sexual Harassment (Bottom) • How to Report Sexual Abuse or Sexual Harassment • PREA Coordinator Information • State of Connecticut Department of Correction PREA Investigation Unit • New Haven Police Department – 203-946-6316

	• CT State Police, Troop I – 203- 393-4200 Informal conversations with the Program Manager confirmed that the case managers conduct the intake orientation. This was confirmed during the facility tour of the case manager while visiting the office. Based on interviewed intake staff (case manager), when conducting the PREA orientation staff go over the zero-tolerance policy with the residents. The information is in English and Spanish. Documentation review of resident's signature and date on the Zero-Tolerance Policy for Sexual Harassment & Sexual Abuse Acknowledgement statements corroborated that these residents received the PREA information. During the facility tour the case manager was asked to demonstrate the intake process by walking the auditor through the process. Staff was in the office, the PREA information was on the desk in English and Spanish. The brochure titled "WFC – Your Life Your Goals, Our Purpose, Sexual Asssault Crisis Services" have the right to a safe environment, free from sexual abuse and harassment. The were other PREA information that was share with the auditor as listed above. A documentation review from 30 resident's intake file information was selected by the PREA Auditor using the facility residents' roster with Resident Name, ID Number, Admission Date, Commitment, Supervising Officer, Home Community and Offense (s). The selected information was placed on a spreadsheet that included race, arrival date and year, intake orientation date, PREA Education date. Copies of the individual documentation for each resident were copied for uploading into the PREA system. The resident's documentation review corroborated that the resident received the required PREA intake materials. Thirty residents did have the facility Zero-Tolerance Policy for Sexual Harassment and Sexual Abuse Acknowledgement signed and dated by the residents. A total of 14 random residents were interviewed by the auditor. Nine Black, two White and two Hispanic. These residents came to the facility within the past 12 months. They collaborated so that they could recall the facility's going over the rules against sexual abuse and harassment when they first came to the facility. They reported that they received intake paperwork or PREA brochure. All the residents recall that they received the PREA information on the same day of arrival or 72 hours. Documentation review of resident's signature and date on the Zero-Tolerance Policy for Sexual Harassment and Sexual Abuse Acknowledgement corroborated that residents did have a signature and date of receiving the PREA information. All random residents reported that when they came to the facility, they did received information on their rights did to be sexually abused or sexually harassed. How to report sexual abuse or sexual harassment. Your right no to be punished for reporting sexual abuse or sexual harassment. This information was confirmed by reviewing the residents' brochure given to them on their arrival date at the facility.

	A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies corroborated that the facility is following the provisions of this standard. No corrective action is warranted. **115.233 (b)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires that the agency provide refresher information whenever a resident is transferred to a different facility. Project MORE, INC. Policy – Resident Education Section II – Procedures: PMI shall provide refresher information whenever a resident is transferred to another facility. The facility provides residents who are transferred from a different community confinement facility with refresher information. Based on a review of information on the facility provided in the PAQ, the number of residents transferred from a different community confinement facility during the past 12 months was 3. The number of residents transferred from a different community confinement facility, during the past 12 months, who received refresher information was 3. Based on interviewed intake staff confirmed that all residents are educated through PREA brochures and Posters on their rights to be free from sexual abuse, sexual harassment and to be free from retaliation for reporting incidents regarding policies, procedures for responding to retaliation. Intake staff confirmed through informal conversations that they will read PREA materials with the residents and have them sign an acknowledgement form. Usually, the resident receives the information the same day, however no more than 72 hours from arrival to the facility. A total of 14 random residents were interviewed by the auditor. Nine Black, two White and two Hispanic. These residents came to the facility within the past 12 months. They collaborated during the interviews. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **115.233 (c)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires that the agency provide resident education in formats accessible to all residents, including those who are limited English proficient, deaf, visually impaired, or otherwise disabled, as well as to residents who have limited

reading skills.

Project MORE, INC. Policy – Resident Education Section I – During the intake process, residents shall receive information explaining PMI's zero tolerance policy regarding sexual abuse and sexual harassment. Residents will be informed how to report incidents or suspicions of sexual abuse or sexual harassment, their right to be free from sexual abuse and sexual harassment and to be free from retaliation for reporting such incidents and regarding PMI's policies and procedures for responding to such incidents. This information will be 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 facility has resident PREA education available in formats accessible to all residents, including those who are limited English proficient.

The auditor reviewed the PREA Posters and Brochures that were on the intake staff desk, they are written on the 5th – 6th grade level. The brochure is written in everyday street language, uses short sentences that are understandable, and does not use language that requires a high-level of education to read and comprehend. This was confirmed with a phone conversation with the Agency PREA Coordinator. The PREA coordinator confirmed that the PREA Posters and Brochures were created with the intent of clients reading on the 5th – 6th grade levels.

This was also corroborated by the auditor running the PREA Brochures through a grammar program that tells the reading level of the educational materials which rated the reading grade levels as 5th. If the residents have a cognitive or intelligence disability the Intake staff would read the PREA materials to the residents or request assistance from a mental health staff. During the site review the auditor had an informal conversation with the case manager.

The auditor establishes the required number of interviews with residents who are Limited English Proficient (LEP) and determine there was zero.

May 9, 2024, the auditor calls the Interpreters and Translators, Inc. to verify the services. The auditor call from his cell phone. During the residents interviews they all confirmed that they have person cell phones.

During the facility tour, all the residents had access to a facility phone, however, residents interviewed confirmed that all but one resident had a personal cell phone.

A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted.

115.233 (d)

Compliance Determination:
The facility has demonstrated compliance with this provision of the standard because:

	The provision requires that the agency maintain documentation of resident participation in these education sessions. The agency has maintained documentation of resident participation in PREA education sessions. The resident's documentation review collaborated that the residents received the required PREA materials. Thirty residents were selected by the PREA auditor for documentation review of Zero-Tolerance Policy for Sexual Harassment and Sexual Abuse Acknowledgment within the 72 hours timeframe. Thirty of the residents did sign and date the acknowledgement statement affirming they understand the agency/facility zero tolerance policy of sexual abuse and sexual harassment. Documentation of the individual Zero-Tolerance Policy for Sexual Harassment and Sexual Abuse Acknowledgment was reviewed and confirmed that the residents received the education sessions. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **115.233 (e)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires in addition to providing such education, the agency ensure that key information is continuously and readily available or visible to residents through poster, resident handbooks, or other written formats. Project MORE, INC. Policy – Resident Education Section II – Procedures: PMI shall provide refresher information whenever a resident is transferred to another facility. Key information will be readily available to residents. This can be through a combination of posters, client's handbook, handout or another written format. The facility ensures that key information regarding PREA is continuously and readily available and visible through posters, brochures, and flyers. The Auditor confirmed the following key information during the facility tour by observing PREA posters on the wall. The posters observed were Auditor PREA Notice of the upcoming PREA audit. "WFC – Your Life Your Goals, Our Purpose, Sexual Asssault Crisis Services" have the right to a safe environment, free from sexual abuse and harassment. Connecticut State Police Hotline Number. The Connecticut Alliance to End Sexual Violence – how to access emotional support services for survivors of sexual abuse hotline numbers. This information was continuous throughout the facility to include the posted near the phones in the dining/common areas. The posters and brochures are eligible has the outside toll-free numbers and are in English and Spanish.

	A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **Overall Findings:** The auditor uses a triangulation approach, by connecting the PREA documentation, policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local advocates, and online PREA Audit: Pre-Audit Questionnaire to collaborate findings determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.234	**Specialized training: Investigations**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Evidence Relied Upon in Making the Compliance Determination: **Documentation:** • Project MORE, INC. Policy – Specialized Training Investigation • NIC PREA: Investigating Sexual Abuse in a Confinement Setting (2) • PREA Investigator Training Certificates • NIC Online Specialized Investigation Training • Online PREA Audit: Pre-Audit Questionnaire Community Confinement **Interviews:** • Investigative Staff **Compliance Determination by Provisions and Corrective Actions:** **115.234 (a)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires that in addition to the general training provided to all employees pursuant to standard 115.31, the agency shall ensure that, to the extent the agency itself conducts sexual abuse investigations, its investigators have received training in conducting such investigations in confinement settings. Project MORE, INC. Policy – Specialized Training – Investigation section I: 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. Section II: Procedures:

	A. Specialized training shall include techniques for interviewing sexual assault victims, proper use of Miranda and Garrity warnings, sexual abuse evident collection in confinement settings, and the criteria and evidence required to substantiate a case for administrative action or prosecution referral. B. All specialized training in conducting sexual abuse investigation shall be properly documented. C. Any state or local entity component that investigates sexual abuse in confinement setting shall provide such training to investigators who conduct such investigations. The agency does require that investigators are trained in conducting sexual abuse investigations in confinement settings. Interviewed Investigator confirmed that she receives training specific to conducting sexual abuse investigations in confinement settings. Documentation review of the National Institute of Corrections certification of completion of the PREA: Investigating Sexual Abuse in a Confinement Settings. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **115.234 (b)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires that specialized training include techniques for interviewing sexual abuse victims, proper use of Miranda and Garrity warnings, sexual abuse evidence collection in confinement settings, and the criteria and evidence required to substantiate a case for administrative action or prosecution referral. A review of the National Institute of Corrections (NIC) online training “PREA: Investigating Sexual Abuse in a Confinement Setting” includes the following topics: Initial Response, Investigation, Determination of the findings, A Coordinated Response, Sexual Assault Response Team, A Systemic Approach, How Sexual Abuse Investigations Are Different, How Investigations in Confinement Settings Are Different, Criteria for Administrative Action, Criteria for Criminal Prosecution, Report Writing Requirements of an Administrative Report, Requirements for an Administrative Report, Requirements for a Criminal Report, The Importance of Accurate Reporting, Miranda and Garrity Requirement, Miranda Warning Considerations, Garrity Warning Considerations, The Importance of Miranda and Garrity Warnings, Medical and Mental Health Practitioner’s Role in Investigations, PREA Standards for Forensic Medical Examinations. Interviewed Investigator confirmed that they did complete the training topics that included Techniques for interviewing sexual abuse victims: Proper use of Miranda

	and Garrity warnings; Sexual abuse evidence collection in confinement settings; and the criteria and evidence required to substantiate a case for administrative or prosecution referral. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **115.234 (c)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires that the agency maintain documentation that agency investigators have completed the required specialized training in conducting sexual abuse investigations. The agency maintains documentation showing that investigators have completed the required specialized training. Based on a review of information about the facility provided in the PAQ, the number of investigators currently employed who have completed the required training was 2. Documentation review of the National Institute of Corrections certification of completion of the PREA: Investigating Sexual Abuse in a Confinement Settings. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **115.234 (d)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires that any State entity or Department of Justice component that investigates sexual abuse in confinement settings shall provide such training to its agents and investigators who conduct such investigations. The auditor is not required to audit this provision. **Overall Findings:** The auditor uses a triangulation approach, by connecting the PREA documentation, policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local advocates, and online PREA Audit: Pre-Audit Questionnaire to collaborate findings determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.235	Specialized training: Medical and mental health care
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Evidence Relied Upon in Making the Compliance Determination: **Documentation:** • Project MORE, INC. Policy – Specialized Training Medical and Mental Health Care • Letter Medical • Online PREA Audit: Pre-Audit Questionnaire Community Confinement **Interviews:** • Medical and Mental health Staff - 0 **Compliance Determination by Provisions and Corrective Actions:** **115.235 (a)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires that 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. How to preserve physical evidence of sexual abuse. How to respond effectively and professionally to victims of sexual abuse and sexual harassment; and how and to whom to report allegations or suspicions of sexual abuse and sexual harassment. Project MORE, INC. Policy – Specialized Training: Medical and Mental Health Care Section I. PMI has no full or part-time medical and/or mental health care practitioners who work regularly in its facilities. The agency does not hire part-time or full-time medical staff. During the facility tour there was no medical staff. Based on a review of information that the facility provided in the PAQ, the number of all medical and mental health care practitioners who work regularly at this facility and have received the training required by agency policy was zero. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **115.235 (b)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard

	because: The provision requires that if medical staff employed by the agency conduct forensic examinations, such medical staff shall receive the appropriate training to conduct such examinations. The agency does not hire part-time or full-time medical staff. During the facility tour there was no medical staff. Informal conversations with the Program Manager confirmed that if residents need medical services they would be sent to the local hospital. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **115.235 (C)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires that the agency maintain documentation that medical and mental health practitioners have received the training referenced in this standard either from the agency or elsewhere. The agency does not hire part-time or full-time medical staff. During the facility tour there was no medical staff. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **115.235 (d)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires that medical and mental health care practitioners shall also receive the training mandated for employees under standard 115.31 or for contractors and volunteers under standard 115.32, depending upon the practitioner’s status at the agency. The agency does not hire part-time or full-time medical staff. During the facility tour there was no medical staff. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted.

	Overall Findings: The auditor uses a triangulation approach, by connecting the PREA documentation, policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local advocates, and online PREA Audit: Pre-Audit Questionnaire to collaborate findings determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.241	Screening for risk of victimization and abusiveness
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Evidence Relied Upon in Making the Compliance Determination: **Documentation:** • Project MORE, INC. Policy – Screening for Risk of Sexual Victimization and Abusiveness • Additional Information for Assessments • Initial Assessments 34 • Initial Assessments 48 • Initial Assessments 45 • PREA Risk Reassessments • Online PREA Audit: Pre-Audit Questionnaire Community Confinement **Interviews:** • Staff Responsible for Risk Screening (1) • Random Residents • Agency PREA Coordinator **Compliance Determination by Provisions and Corrective Actions:** **115.241 (a)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires that all residents be assessed during an intake screening and upon transfer to another facility for their risk of being sexually abused by other residents or sexually abusive toward other residents. The agency has a policy that requires screening upon admission to a facility or transfer to another facility for the risk of sexual abuse victimization or sexual abuse towards other residents.

	Project MORE, INC. Policy – Screening for Risk of Sexual Victimization and Abusiveness section I. All residents shall be assessed during intake and upon transfer to another facility for their risk of being sexually abused by other resident or sexually abusive toward other residents. The agency PREA Coordinator confirmed that the case managers are responsible for conducting the initial risk screening during intake orientation. This was further collaborated by the auditor reviewing the case manager signature and date on the Intake Orientation and PREA Risk Assessment Tool. Interviewed staff responsible for the initial PREA screening collaborated that residents are screened upon admission to the facility or transfer from another facility for risk of sexual abuse victimization or sexual abusiveness toward other residents using the PREA screening tool. Staff reported that the initial assessment is completed as a part of the intake process. During the facility tour of the case manager office, the auditor had informal conversations with the case manager that confirmed the initial risk screening is conducted by case managers. The auditor requested that the case manager conducts an initial risk screening to demonstrate the PREA screening process. Staff started by giving the auditor a copy of the PREA Risk Assessment Tool and walk the auditor through the process. The screening process occurred in the case manager's office with the door closed. The auditor determined that the location of the screening ensured that as much privacy as possible is given to the resident in discussing potential sensitive information. To ensure that the screening staff ask residents questions in a manner that fosters and sets the residents at easy, the auditor requested that the case manager demo asking questions to the auditor as if the auditor was a new intake. The case manager asks a gender and sexual orientation question. This confirmed that the screening staff ask residents about their sexual orientation and gender identity directly. During the risk screening demonstration, staff explained that the PREA screening information is collected by the agency assessment instrument called PREA Risk Assessment Form. The auditor reviewed a completed PREA screening tool each category had a rating/score that determined the risk of a resident's being sexually abused or being sexually abusive. There are additional sources of information that the case manager may use to help determine risk levels that includes the Connecticut Department of Correction Inmate Overview Sheet, and Statement of Understanding and Agreement Conditions of Parole. The case manager confirmed and explained that they completed the PREA Assessment on paper they calculate the outcome of the assessment, and it is place at the top of the page: Vulnerable for Victimization or Sexually Aggressive. Informal conversation with residents during the tour reported that they were asked questions dealing with their sexual identity and it was not offensive.

	A total of 14 random residents were interviewed by the auditor. Nine Black, two White and two Hispanic. These residents came to the facility within the past 12 months. They collaborated that when they first came to the facility, they were asked about whether they had been in jail or prison before, have ever been sexually abused, identify as being gay, lesbian, or bisexual, and if they think they might be in danger of sexual abuse at this facility. All reported yes, they recall being asked these questions again. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **115.241 (b)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires intake screening ordinarily take place within 72 hours of arrival at the facility. The agency does require that residents be screened for risk of sexual victimization or risk of sexually abusing other residents within 72 hours or their intake. Project MORE, INC. Policy – Screening for Risk of Sexual Victimization and Abusiveness section I. All residents shall be assessed during intake and upon transfer to another facility for their risk of being sexually abused by other resident or sexually abusive toward other residents. Section II: Procedures: A - Intake screening shall take place within 72 hours of arrival. Based on a review of information the facility provided in the PAQ, the number of residents entering the facility (either through intake or transfer) within the past 12 months (whose length of stay in the facility was for 72 hours or more) who were screened for risk of sexual victimization or risk of sexual abusing other residents within 72 hours of their entry into the facility as 140. A documentation review of 30 residents was selected by the PREA Auditor from the resident’s roster with Resident Name, ID, Room Bed Assignments, and Admission Date, the selected information was placed on a spreadsheet that included race, arrival date year, initial PREA screening date and reassessment date. Copies of the individual documentation for each resident assessment were reviewed and uploaded into the PREA system. The documentation confirmed that all residents received the initial PREA screening within the required timeframe. Most of the initial assessments were completed within the same day the resident arrived. Residents’ documentation corroborated that these residents received the initial PREA screenings. Of the 30 residents, 30 completed the initial PREA assessments with the 72 hours timeframe or earlier. The facility maintains and confirms documentation of resident’s participation in PREA orientation and PREA education

	by the resident signature and date on the Handbook Acknowledgement, Prison Rape Elimination Act of 2023 Acknowledgement, and Treatment Plan signature form. Interviewed staff responsible for the initial PREA screening collaborated that PREA screenings are completed within 24 hours of the resident's arriving at the facility. The screening is always conducted within 72 hours as required by policy. A total of 14 random residents were interviewed by the auditor. Nine Black, two White and two Hispanic. These residents came to the facility within the past 12 months. They collaborated that when they first came to the facility, they were asked about whether they had been in jail or prison before, have ever been sexually abused, identify as being gay, lesbian, or bisexual, and if they think they might be in danger of sexual abuse at this facility. All reported yes, they remember being asked these questions. Three reported these questions were asked in orientation and two reported at intake. The residents received orientation on the same day of arrival, but always within 72 hours period. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **115.241 (c)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires such assessments to be conducted using an objective screening instrument. The agency risk assessment is conducted using an objective screening instrument. Project MORE, INC. Policy – Screening for Risk of Sexual Victimization and Abusiveness section I. All residents shall be assessed during intake and upon transfer to another facility for their risk of being sexually abused by other resident or sexually abusive toward other residents. Section II: Procedures: B - Such assessment shall be conducted using an objective screening instrument. A review of the PREA Risk for Sexual Victimization or Abusiveness Tool indicated that it is an objective screening instrument used to screen all residents. Each section is rated and scored. The tool asks open and closed ended questions, along with a variety of questions that address victimizations and abusiveness. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **115.241 (d)** Compliance Determination:

	The facility has demonstrated compliance with this provision of the standard because: The provision requires the intake screening to 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. The age of the residents. 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 offenses against an adult or child. Whether the resident is or is perceived to be gay, lesbian, bisexual, transgender, intersex, or gender nonconforming. Whether the resident has previously experienced sexual victimization. The residents have their own perception of vulnerability. The agency requires the intake screening to consider all the requirements of this provision. Project MORE, INC. Policy – Screening for Risk of Sexual Victimization and Abusiveness section I. All residents shall be assessed during intake and upon transfer to another facility for their risk of being sexually abused by other resident or sexually abusive toward other residents. Section II: Procedures: A. Such assessment shall be conducted using an objective screening instrument. It shall include, at a minimum the following criteria to assess risk of sexual victimization: 1. Whether the resident has a mental, physical, or developmental disability. 2. The age of the resident. 3. The physical build of the resident. 4. Whether the resident has previously been incarcerated. 5. Whether the resident's criminal history is exclusively nonviolent. 6. Whether the resident has prior convictions for sexual offense. 7. Whether the resident perceived to be gay, bisexual, transgender, intersex, or gender nonconforming. 8. Whether the resident has previously experienced sexual victimization. 9. The residents' own perception of vulnerability. B. The intake shall consider prior acts of sexual abuse, prior convictions for violent offenses and history of prior institutional violence or sexual abuse, as known to the agency, in resident for risk of being sexually abusive. C. Within 30 days from the residents' arrival, facility staff shall reassess the residents' risk of victimization or abusiveness. This will be based upon any additional, relevant information. The reassessment will be done with the client present. D. A residents' risk level shall be reassessed when warranted due to a referral, request, incident of sexual abuse, or receipt of added information on the residents' risk of sexual victimization or abusiveness. E. 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.

F. The agency shall have appropriate controls regarding the dissemination of sensitive information on any resident.

An analysis of the Risk for Sexual Victimization or Abusiveness Tool determined all factors required by this provision of the standard are included. Informal staff conversations and documentation confirmed they are aware of the elements of the risk screening instrument.

The auditor reviews the PREA screening tool. The tool has a total of 31 open and closed ended questions. The questions that meet the criteria for assessment are as follows:

1. Social Skills
2. Perception of Risk
3. Gender and Sexual Orientation
4. History of Victimization
5. Age of the Resident
6. Intellectual Impairment
7. Mental Health Issues
8. Lack of fit with a Community Confinement Facility
9. Physical Appearance
10. Client Behavior
11. History of Institutional Predatory Sexual Behavior
12. Any History of Physical Abuse/Domestic Violence
13. History of Assault in Prison
14. Openly Hostile to Gays, Lesbian, Transgender, etc.
15. Arrest or Conviction of a Sexual Offense
16. Intimidating or Aggressive

Interviewed staff responsible for the initial PREA screening corroborated that the above-mentioned areas are considered when conducting the screening. The process for conducting the initial screening involves asking a series of questions and completing a computerized screening. All the above-mentioned questions areas were covered in the screening tool which is conducted in the intake staff office. The process for conducting the initial screening is a set format that asks for data.

A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted.

115.241 (e)

Compliance Determination:
The facility has demonstrated compliance with this provision of the standard because:

The provision requires that the intake screening consider prior acts of sexual abuse, prior convictions for violent offenses, and history of prior institutional violence or sexual abuse, as known to the agency, in assessing Residents for risk of being

	sexually abusive. The intake screening does consider prior acts of sexual abuse. Project MORE, INC. Policy – Screening for Risk of Sexual Victimization and Abusiveness section I. All residents shall be assessed during intake and upon transfer to another facility for their risk of being sexually abused by other resident or sexually abusive toward other residents. Section II: Procedures: G - Such assessment shall be conducted using an objective screening instrument. It shall include, at a minimum, the following criteria to assess risk of sexual victimization: 1 - Whether the resident has prior convictions for sexual offense. An analysis of the Risk for Sexual Victimization or Abusiveness Tool determined all factors required by this provision of the standard are included. The PREA screening instrument considers prior acts of sexual abuse, prior convictions for violent offenses, and history of prior institutional violence or sexual abuse if known to the facility or agency. The auditor analyzed the PREA screening instrument and determined that the additional screening questions meet this provision's requirements. 1. History of Institutional Predatory Sexual Behavior 2. Any History of Physical Abuse/Domestic Violence 3. History of Assault in Prison 4. Openly Hostile to Gays, Lesbian, Transgender, etc. 5. Arrest or Conviction of a Sexual Offense 6. Intimidating or Aggressive Interviewed staff responsible for the initial PREA screening collaborated that the above-mentioned areas are considered when conducting the screening. The auditor analysis of the PREA screening instrument, and it was confirmed that the above-mentioned questions were covered in the screening tool. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **115.241 (f)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires within a set time, not to exceed 30 days from the resident's arrival at the facility, the facility will reassess the resident's risk of victimization or abusiveness based upon any additional, relevant information received by the facility since the intake screening. The agency requires that the facility reassess each resident's risk of victimization or abusiveness within a set time, not to exceed 30 days after the resident's arrival at the facility.

	Project MORE, INC. Policy – Screening for Risk of Sexual Victimization and Abusiveness section I. All residents shall be assessed during intake and upon transfer to another facility for their risk of being sexually abused by other resident or sexually abusive toward other residents. Section II: Procedures: H - Within 30 days from the residents' arrival, facility staff shall reassess the residents' risk of victimization or abusiveness. This will be based upon any additional, relevant information. The reassessment will be done with the client present. Based on a review of information that the facility provided in the PAQ, the number of residents entering the facility (either through intake or transfer) within the past 12 months whose length of stay in the facility was for 30 days or more who were reassessed for their risk of sexual victimization or of being sexually abusive within 30 days after their arrival at the facility based upon any additional, relevant information received since intake was 126. A documentation review of 30 residents was selected by the PREA Auditor from the resident's roster with Resident Name, ID, Room Bed Assignments, and Admission Date. The selected information was placed on a spreadsheet that included race, arrival date year, initial PREA screening date and reassessment date. Of the 30, 30 reassessments were completed within the 30-day timeframe. A total of 14 random residents were interviewed by the auditor. Nine Black, two White and two Hispanic. These residents came to the facility within the past 12 months. Thirteen collaborated that staff asked them the reassessments questions again, after the initial assessment questions. The case managers used the PREA initial assessment to conduct the PREA reassessments. Three have not been at the facility for over 30 days. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies and the required corrective actions collaborated that the facility is following the provisions of this standard. No additional corrective action is warranted. **115.41 (g)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires a resident's risk level be reassessed when warranted due to referral, request, incident of sexual abuse, or receipt of additional information that bears on the resident's risk of sexual victimization or abusiveness. The agency does require that a resident's risk level be reassessed when warranted due to any changes that may have bearing on the resident's risk of sexual victimization or abusiveness. Project MORE, INC. Policy – Screening for Risk of Sexual Victimization and Abusiveness section I. All residents shall be assessed during intake and upon

transfer to another facility for their risk of being sexually abused by other resident or sexually abusive toward other residents. Section II: Procedures: A residents' risk level shall be reassessed when warranted due to a referral, request, incident of sexual abuse, or receipt of added information on the residents' risk of sexual victimization or abusiveness.

Informal conversation with the agency PREA coordinator confirmed that the facility requires 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 risk of sexual victimization or abusiveness. Staff use the same initial PREA Screening questions to conduct the reassessments.

Interviewed staff responsible for the initial PREA screening collaborated that they reassess a resident's risk level as needed due to a referral, request, incident of sexual abuse, or receipt of additional information that bears on the resident's sexual victimization or abusiveness. This may be done before the 30 days, after the 30 days or whenever according to staff. A review of the reassessments included residents who have been victims or perpetrators of sexual abuse upon receipt of additional information.

A review of the appropriate documentations, interviews with staff and residents, and review of relevant policies indicates that the facility is following the provisions of this standard. No corrective action is warranted.

115.241 (h)

Compliance Determination:
The facility has demonstrated compliance with this provision of the standard because:

The provision requires residents may not be disciplined for refusing to answer, or for not disclosing complete information in response to, questions asked pursuant to paragraphs (d-1, 7, 8, 9) of this section.

The agency prohibits disciplining residents for refusing to answer or for not disclosing complete information related to questions in the PREA instrument or screenings.

Project MORE, INC. Policy – Screening for Risk of Sexual Victimization and Abusiveness section I. All residents shall be assessed during intake and upon transfer to another facility for their risk of being sexually abused by other resident or sexually abusive toward other residents. Section II: Procedures: 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.

Informal conversation with the agency PREA Coordinator confined that the facility prohibits disciplining residents for refusing to answer the questions regarding: Whether the resident has a mental, physical, or developmental 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 residents' own perception of vulnerability. The auditor documentation search of investigations, incident reports, grievances for and form of residents receiving disciplined actions for refusing to answer or for not disclosing PREA information was not found. Information conversations with residents doing the facility tour collaborated that they have not been disciplined for refusing to answer or disclosing complete information for PREA related questions during the initial and reassessments. Interviewed staff responsible for the initial PREA screening collaborated that no resident is disciplined in any way for refusing to disclose or answering questions. They may place a note in a resident's file or may reassess and enter the data into the computer system. This was also confirmed by the warden during the facility tour that residents are not disciplined for refusing to disclose information. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **115.241 (I)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires the agency to implement appropriate controls on the dissemination within the facility of responses to questions asked pursuant to this standard to ensure that sensitive information in not exploited to the resident's detriment by staff or other residents. The agency has implemented appropriate controls regarding dissemination of sensitive information. Project MORE, INC. Policy – Screening for Risk of Sexual Victimization and Abusiveness section I. All residents shall be assessed during intake and upon transfer to another facility for their risk of being sexually abused by other resident or sexually abusive toward other residents. Section II: Procedures: The agency shall have appropriate controls regarding the dissemination of sensitive information to any resident. The facility protects sensitive information through the lock office of the case manager. The only persons to have access to the key are the Facility Manager, Case Managers, and the Assistant Manager at the facility. The information is controlled and is disseminated to key staff and any additional staff on a case-by-case basis. Informal conversation with staff during the tour confirmed that PREA sensitive information is protected, and only key staff have access to the case manager's office. This was confirmed by the manager that conducts the initial PREA screening.

	During the facility site visit the auditor observed the physical storage area of any information/documentation collected and maintained as hard copy. The hard copies of the intake, PREA screening and other residents' documentation are kept in the residents' files and maintained in the case manager's office. The PREA investigations files were stored in the Agency PREA Coordinator's office at the agency headquarters under lock and key. There was no confidential resident's information located in places where other residents or staff can review. Interviewed PREA coordinator collaborated that the facility has outlined who should have access to a resident risk assessment within the facility to protect sensitive information from exploitation. Intake, Case Managers, Program Manager, investigators, the PREA Coordinator have access to the PREA information. Staff are instructed through PREA training that any information obtained is limited to a need-to-know basis for staff, and only for the purpose of treatment, security, and management decisions, information as housing, work, education, and programming assignments. Information is not to be indiscriminately discussed. The administration monitor and takes immediate action if any sensitive information is exploited. Interviewed staff responsible for the initial PREA screening collaborated that the facility outlined who can have access to a resident's risk assessment within the facility to protect sensitive information from exploitations. This includes the Investigators, Program Manager, Case manager, and a need-to-know bases. Interviewed agency PREA coordinator confirmed that the facility outlined who can have access to a resident's sensitive information. The facility Upper Management, Investigators, Program Manager, Case Manager, and need-to-know cases. A review of the appropriate documentations, interviews and conversations with staff and review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **Overall Findings:** The auditor uses a triangulation approach, by connecting the PREA documentation, policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local advocates, and online PREA Audit: Pre-Audit Questionnaire to collaborate findings determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.242	**Use of screening information**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion

Evidence Relied Upon in Making the Compliance Determination:

Documentation:

• Project MORE, INC. Policy – Use of Screening Information
• Online PREA Audit: Pre-Audit Questionnaire Community Confinement

Interviews:

• Agency PREA Coordinator
• Staff Responsible for Risk Screening (1)
• Residents Who Identify as Transgender and Intersex (0)
• Residents Who Identify as Lesbian, Gay, or Bisexual (2)
• Residents Who are LEP (0)

Compliance Determination by Provisions and Corrective Actions:

115.242 (a)

Compliance Determination:
The facility has demonstrated compliance with this provision of the standard because:

The provision requires the agency use information from the risk screening required by standard 115.241 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.

Project MORE, INC. Policy – Use of Screening Information section I – PMI shall utilize information from the risk screening from standard 115.241 in determining client housing and bed assignments, work sites, education, and program assignments. This will be utilized with the goal of ensuring the safety of all facility residents.

The agency uses information from the risk screening to inform housing, bed, work, education, with the goal of keeping those residents at high risk of being sexually victimized separate from those at high risk of being sexually abusive.

The facility uses PREA information to make determinations for all resident regarding housing, bed, work, education, and program assignments. The information is used to maintain separation between residents at risk of being sexually victimized and residents likely to commit sexual abuse. The facility’s physical layout is also considered in the determinations of housing. The auditor confirmed the physical layout during the facility tour and reviewed the facility layout.

The auditor assessed the facility's physical layout and examined the scoring rates of initial assessments to ensure alignment with identified sexual safety concerns, documenting risk-based housing decisions accordingly."

Interviewed PREA coordinator collaborated that the facility uses information from the risk screening during intake to keep residents from being sexually victimized or being sexually abusive. The PREA risk screening application uses a scoring system

depending on how a resident answers the questions and it will provide an automatic score representing risk levels of victims and abusers. This information is used to keep the victims away from the abusers. A review of the PREA Risk Screening has the results of the assessment at the top of the page: Vulnerable for Victimization or Sexually Aggressive.

Interviewed staff responsible for the initial PREA screening collaborated that the initial PREA screening during intake is to keep residents safe from being sexually victimized or from being sexually abusive. Staff confirmed that it is up to the management team to place residents in programs, work, and housing assignments. However, they do have input on assignments.

A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted.

115.242 (b)

Compliance Determination:
The facility has demonstrated compliance with this provision of the standard because:

The provision requires the agency to make individualized determinations about how to ensure the safety of each resident.

The agency makes individualized determinations about how to ensure the safety of each resident.

Interviewed PREA coordinator collaborated that the agency considers whether the placement would present management or security concerns. The agency utilizes the PREA Risk Assessment as well as other Assessments conducted to determine the best placement for the client and the program. Sometimes, clients may be placed closer to the main office if there is a concern about security issues.

Interviewed staff who perform PREA screenings confirmed that the facility uses information from the risk screening during intake to keep residents safe from being sexually victimized or from being sexually abusive. This tool processes the ratings which help to determine individual housing that residents will be assigned or programming, education, and work area.

A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted.

115.242 (c)

Compliance Determination:
The facility has demonstrated compliance with this provision of the standard because:

	The provision requires in deciding whether to assign a transgender or intersex resident to a facility for male or female residents, and in making other housing and programming assignments, the agency shall consider on a case-by-case basis whether a placement would ensure the residents health and safety, and whether the placement would present management or security problems. Project MORE, INC. Policy – Use of Screening Information Section II – Procedures: 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. Staff will have the ability to monitor them closely. In deciding whether to assign a transgender or intersex resident to a facility for male or female resident, the agency consider on a case-by-case basis along with the funding agency whether the placement would ensure the residents' health and safety. Informal conversations with the Program Manager indicated that prior to a resident to include transgender or intersex residents arriving at the program, program leadership and the funding agency (DOC) have a discussion to confirm that this is the best fit regarding health and safest location for the resident. When the resident arrives, the program can accommodate the resident so that the resident is and feels safe. If the accommodation is possible then the program will comply and if the accommodation is not possible then the program leadership will discuss with DOC a solution or transfer to another program for the resident. Abusive residents are not housed with a known victim or a vulnerable resident. Interviewed agency PREA coordinator confirmed that prior to a resident arriving at the program, program leadership and the funding agency have a discussion to confirm that this is the best fit and safest location for the resident. When the resident arrives, program staff have a conversation with the resident to find out how the program can accommodate the resident so that the resident is and feels safe. If the accommodation is not possible then program leadership will discuss with DOC a solution or transfer to another program for the resident. During the onsite visit there were no Transgenders or Intersex resident at the facility to confirmed if they felt safe at this facility and whether their views concerning safety are given serious consideration. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **115.242 (d)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires a transgender or intersex resident's own view with respect to

	his or her own safety be given serious consideration. The agency considers transgender or intersex resident's own view with respect to his or her own safety. The auditor reviews the PREA Risk Assessment Questions. The questions that meet this provision of the standard that are ask of each resident are as follows: • Do you feel at risk from attack or abuse from others? • Do you identify yourself as lesbian, gay, bisexual, transgender, or questioning? • Are you perceived by others as being lesbian, gay, bisexual, transgender, or questioning? • Have you ever been attacked, bullied, or abused? • Have you ever been sexually victimized or abused? Informal conversations with the Program Manager confirmed that transgender or intersex residents' views concerning his or her safety are given serious consideration. The resident input is confirmed by his or her signature and date on the initial PREA screening. Interviewed PREA coordinator collaborated that transgender and intersex resident views with respect to his or her own safety are given serious consideration in placement and programming assignments. When the facility receives a transgender or intersex residents, the facility would meet with each transgender or intersex coming into the facility and the resident would be asked if they felt vulnerable and if so, what the facility might do to make them feel safer. Interviewed staff responsible for the initial PREA screening collaborated that residents' views for their own safety are consider specially when it comes to showering, using the toilet or housing. During the onsite visit there were no Transgenders or Intersex resident at the facility to confirmed if they felt safe at this facility and whether their views concerning safety are given serious consideration. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **115.242 (e)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires transgender and intersex residents be given the opportunity to shower separately from other residents. The agency allows the transgender and intersex resident and opportunity to shower separately from other residents.

	The facility has a practice in place that ensures transgenders and intersex residents are given the opportunity to shower separately. During the onsite tour, the auditor observed the residents shower area. Each room has an individual shower with a door and a toilet. There were no transgender or intersex residents located at the facility during the audit period. However, the auditor did have informal conversation with other residents regarding showering separately, and both residents indicate that they do shower separately, and the door is closed. Interviewed staff responsible for the initial PREA screening collaborated that the residents' views for their own safety would be given serious consideration. They also stated if the residents requested to shower separately because of safety and personal issues, the facility would strive to arrange that. Housing assignments for each transgender and intersex residents would be made, according to staff, based on the PREA assessment and the residents' feelings regarding safety. Interviewed PREA coordinator collaborated that Transgender or Intersex residents are given an opportunity to shower separately from other residents, they are allowed to shower individual when other residents are in their rooms. During the onsite tour, the auditor observed the facility areas where residents may be in a state of undress, showers, toilet, urine collection and changing of clothing. The areas observed were housing units, showers, and bathrooms. The showers are in a community area with individual stalls with PREA friendly shower curtains. The toilets are in residents' rooms. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **115.242 (f)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires the agency not to place lesbian, gay, bisexual, transgender, or intersex residents in dedicated facilities, units, or wings solely based on such identification or status, unless such 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 such residents. The agency does not place lesbian, gay, bisexual, transgender, or intersex residents in dedicated housing. Interviewed Agency PREA coordinator confirmed that the policy and agency practice does not have dedicated facilities, units, or wings solely for LGBTI residents. The auditor requested any consent decree, legal settlement, or legal judgement

	requiring the facility to establish a dedicated facility, unit, or wing for LGBTI residents, and any documentation of housing if there were a consent decree, legal settlement, or legal judgement. The Program Manager confirmed none. The auditor further confirmed by conducting an internet search for consent decrees, legal settlements, and legal judgements for this facility. The search results were none founded. During the facility documentation review of the LGBTI residents housing assignments indicated that this population is not house in designated areas. Informal conversations with staff and residents collaborated that there was no evidence that any of the LGBTI population was placed in a designated housing solely based on identification or status. Interviewed PREA coordinator collaborated that the agency ensures against placing lesbian, gay, bisexual, transgender, or intersex residents in dedicated units, or wings solely based on their sexual orientation, genital status, or gender identity. Resident are housed based on their PREA assessment and other assessments conducted at intake. The safety of residents and determining who they are roomed with is always taken into consideration and especially with more targeted populations. There are rooms on the first floor that if requested by LGBTI residents for safety reasons or concerns they may be place in one of those rooms near central control. During the onsite visit there were no Transgenders or Intersex resident at the facility to confirm that they are not placed in designated housing for the sole based on identification or status. Two gay residents were interviewed by the auditors. Two reported that they have not been put in a housing area only for gay, lesbian, bisexual, transgender, or intersex residents. One reported he is housed in the same hall with everyone else and the second reported he is housed with residents. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **Overall Findings:** The auditor uses a triangulation approach, by connecting the PREA documentation, policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local advocates, and online PREA Audit: Pre-Audit Questionnaire to collaborate findings determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.251	**Resident reporting**
	Auditor Overall Determination: Meets Standard

Auditor Discussion

Evidence Relied Upon in Making the Compliance Determination:

Documentation:

• Project MORE, INC. Policy – Resident Reporting
• Project MORE, INC. Policy Prison Rape Elimination Act (PREA) Compliance Policies
• Sexual Assault Crisis Services Brochure Spanish and English
• Sexual Assault and Custodial Misconduct Acknowledgments
• Treatment Plan (Informed Residents regarding PREA) Statements
• Prison Rape Elimination Act of 2023 Statements
• Handbook Acknowledgments
• Online PREA Audit: Pre-Audit Questionnaire Community Confinement

Interviews:

• Random Sample of Staff –
• Random Residents –
• PREA Coordinator

Compliance Determination by Provisions and Corrective Actions:

115.251 (a)

Compliance Determination:
The facility has demonstrated compliance with this provision of the standard because:

The provision requires that the agency provide multiple internal 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.

Project MORE, INC. Policy – Resident Reporting section I. 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. 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. Staff shall accept reports made verbally, in writing, anonymously, and from third parties. All reports will be promptly documented. Section II. Procedures: Residents may report sexual abuse and sexual harassment as follows:

A. Verbally to any facility staff or other PMI staff.
B. In writing to any facility staff or other PMI staff.
C. Submit a grievance in the grievance box. The resident may sign his name or make the grievance anonymous. There is no time limit in filing a PREA grievance.
D. Having a family member of friend contact facility staff or other PMI staff. This can also be done anonymously.

E. Contacting the CT DOC and CSSD verbally or in writing.
F. Contract the Sexual Abuse Crisis Services at 1-888-999-5545 English and 888-568-8332 – Spanish.
G. Contact the Greater New Haven Sexual Assault Crisis Services, 911 State Street, New Haven, CT, 203-624-2273.

The agency has established procedures allowing for multiple internal ways for residents to report privately to agency officials.

Documentation review of the TCT brochure confirmed the following information: The PREA Coordinator mail address and toll-free number; State of Connecticut Department of Correction PREA Investigation Unit and Connecticut Alliance to End Sexual Violence toll free numbers.

Documentation review of the Zero-tolerance Policy for Sexual Harassment & Sexual Abuse Acknowledgement confirmed the PREA Coordinator information and the Connecticut Alliance to End to Sexual Violence by their signature and date on the form.

A total of nine random staff were interviewed by the auditor from different shifts. Eight Black and One Hispanic, Nine males and zero females. Nine confirmed that residents can privately report sexual abuse and sexual harassment, retaliation by other residents or staff for reporting sexual abuse and sexual harassment. The residents have a toll-free hotline, they could call State Police (911) or DOC, Parole Officer, PREA coordinator, or they can report to family member.

A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted.

115.251 (b)

Compliance Determination:
The facility has demonstrated compliance with this provision of the standard because:

The provision requires that the agency also provide 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, and that is able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials, allowing the resident to remain anonymous upon request.

The agency has provided 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.

Documentation review of the Connection brochure, The Client Guide to PREA confirmed the following information: The PREA Coordinator mail address and toll-free number; State of Connecticut Department of Correction PREA Investigation Unit and Connecticut Alliance to End Sexual Violence toll free numbers.

	Informal conversation with the Program Manager reported that residents can call 911 and report to the State Police Department. Interviewed PREA coordinator collaborated that the agency provides at least one way for residents to report abuse or harassment to a public or private office that is not a part of the agency. Residents can be reported by calling the State Police Department by dialing 911 or call the Department of Corrections PREA Investigation Unit. The process will enable receipt and immediate transmission of resident reports of sexual abuse and sexual harassment to agency official that allow the resident to remain anonymous upon request. A total of 14 random residents were interviewed by the auditor. Nine Black, two White and two Hispanic. These residents came to the facility within the past 12 months. They collaborated that they would report sexual abuse or sexual harassment that happened to them or someone else by telling trusted staff, PREA coordinator, call 911, or they would tell a family member, friend, or their parole officer. They are aware that they do not have to give their name. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **115.251 (c)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires that staff accept reports made verbally, in writing, anonymously, and from third parties and shall promptly document any verbal reports. The agency has a policy mandating that staff accept reports of sexual abuse and sexual harassment made verbally in writing, anonymously and for third parties. A total of nine random staff were interviewed by the auditor from different shifts. Eight Black and One Hispanic, Nine males and zero females. Nine confirmed that when a resident alleges sexual abuse, they can report it verbally, in writing, anonymously and from third parties and they can report it immediately. A total of 14 random residents were interviewed by the auditor. Nine Black, two White and two Hispanic. These residents came to the facility within the past 12 months. They collaborated that they can report sexual abuse or sexual harassment either in person or in writing or their family member can report. None of the interviewed residents have reported to the facility that they were sexually abused. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **115.251 (d)**

	Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires that the agency provide a method for staff to privately report sexual abuse and sexual harassment of residents. The agency has established procedures for staff to privately report sexual abuse and sexual harassment or residents. A total of nine random staff were interviewed by the auditor from different shifts. Eight Black and One Hispanic, Nine males and zero females. Nine confirmed that staff can privately report sexual abuse and sexual harassment of resident by using the numbers to call DOC PREA Investigation Units, call 911or the State Police, and report to the Agency PREA coordinator. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **Overall Findings:** The auditor uses a triangulation approach, by connecting the PREA documentation, policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local advocates, and online PREA Audit: Pre-Audit Questionnaire to collaborate findings determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.252	**Exhaustion of administrative remedies**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Evidence Relied Upon in Making the Compliance Determination: **Documentation:** • Project MORE, INC. Policy – Exhaustion of Administrative Remedies • Project MORE, INC. Policy – Resident Grievance Policy • Online PREA Audit: Pre-Audit Questionnaire Community Confinement **Interviews:** • Residents who Reported a Sexual Abuse - 0 **Compliance Determination by Provisions and Corrective Actions:** **115.252 (a)**

	Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires that an agency be exempt from this standard if it does not have administrative procedures to address resident grievances regarding sexual abuse. The agency has an administrative procedure for addressing resident grievances regarding sexual abuse. Project MORE, INC. Policy – Exhaustion of Administrative Remedies Section I. 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. Section II. Procedures: A. PMI shall allow resident to submit a grievance regarding allegations of sexual harassment and abuse. B. There will be no time limit regarding the submission of the grievance. C. The resident may submit a grievance in a locked grievance box, handing it to a program staff member, handing it to any PMI staff member, or to a third party. D. A resident submitting a grievance is not required to submit it to a staff member who would be the subject of the complaint. The resident may submit the grievance to the Program Manager, unless that person is the subject of the grievance. In that case the grievance may be submitted to a PMI administrative staff. E. Once a grievance is submitted, the PREA coordinator will immediately begin the investigation. F. The final decision will be based on the merits of the grievance. The final decision should be made within 30 days of the submission of the grievance. The time period can be extended for a period of up to 70 days, if more time is required. G. The resident who submitted the grievance will be notified in writing of any decision or extension. H. Should the resident not receive a written response within the allotted time, this does not mean the grievance is denied. I. Third Parties: A third party may assist a resident in submitting a grievance. A third-party grievance may be given to any PMI staff member. Should a resident decline to have a grievance processed, PMI will document that decision. J. Emergency Grievance. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **115.252 (b)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because:

	The provision requires that the agency not impose a time limit on when a resident may submit a grievance regarding an allegation of sexual abuse. The agency may apply otherwise-applicable time limits to any portion of a grievance that does not allege an incident of sexual abuse. The agency shall not require a resident to use any informal grievance process, or to otherwise attempt to resolve with staff an alleged incident of sexual abuse. Nothing in this section should restrict the agency's ability to defend against a resident lawsuit on the ground that the applicable status of limitations has expired. Informal conversation with the agency PREA coordinator confirmed that if a grievance involving sexual abuse or sexual harassment is immediately send to the PREA investigator. This process stops the grievance process and begins the PREA investigation process. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **115.252 (c)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires that the agency ensure that: A Resident who alleges sexual abuse may submit a grievance with without submitting it to a staff member who is the subject of the compliant, and Such grievance is not referred to a staff member who is the subject of the complaint. The agency allows a resident to submit a grievance alleging sexual abuse without submitting it to the staff member who is the subject of the complaint. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **115.252 (d)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires that 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 shall not include time consumed by residents in preparing any administrative appeal. The agency may claim an extension of time to respond, of up to 70 days, if the normal time for response is insufficient to make an appropriate decision. The agency shall notify the resident in writing of any such extension and provide a date by which a decision will be made. 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, the resident may consider the absence of a response to be a denial at that level. The agency 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. Informal conversation with the agency PREA coordinator confirmed that if a grievance involving sexual abuse or sexual harassment, it is immediately sent to the PREA investigator. This process stops the grievance process and begins the PREA investigation process. Based on a review of information that the facility provided in the PAQ, in the past 12 months, the number of grievances filed that alleged sexual abuse was zero. In the past 12 months, the number of grievances alleging sexual abuse that reached final decision within 90 days after being filed was zero. In the past 12 months, the number of grievances alleging sexual abuse that involved extensions because final decision was not reached within 90 days was zero. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **115.252 (e)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires that third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, shall be permitted to assist residents in filing request for administrative remedies relating to allegations of sexual abuse, and shall also be permitted to file such requests on behalf of residents. If a third-party file such a request on behalf on 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. If the resident declines to have the request processed on his or her behalf, the agency shall document the resident decision. They will permit third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, to assist residents in filling requests for administrative remedies relating to allegations of sexual abuse and to file request on behalf of the residents. Based on a review of information that the facility provided in the PAQ, the number of grievances alleging sexual abuse filed by residents in the past 12 months in which the resident declined third-party assistance, containing documentation of the

residents' decision to decline was zero.

A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted.

115.252 (f)

Compliance Determination:
The facility has demonstrated compliance with this provision of the standard because:

The provision requires that the agency establish procedures for the filing of an emergency grievance alleging that a resident is subject to a substantial risk of imminent sexual abuse. After receiving an emergency grievance alleging a resident is subject to a substantial risk of imminent sexual abuse, the agency shall 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, shall provide an initial response within 48 hours, and shall issue a final agency decision within 5 calendar days. The initial response and final agency decision shall document the agency's determination whether the resident is at substantial risk of imminent sexual abuse and the action taken in response to the emergency grievance.

The agency has established procedures for filing an emergency grievance alleging that a resident is subject to substantial risk of imminent sexual abuse.

Informal conversation with the agency PREA coordinator confirmed that if a grievance involving sexual abuse or sexual harassment, it is immediately sent to the PREA investigator. This process stops the grievance process and begins the PREA investigation process.

Based on a review of information that the facility provided in the PAQ, the number of emergency grievances alleging substantial risk of imminent sexual abuse that were filed in the past 12 months was zero. The number of those grievances in 115.252 (e)-3 that had an initial response within 48 hours was zero. The number of grievances alleging substantial risk of imminent sexual abuse filed in the past 12 months that reached final decisions within 5 days was zero.

A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted.

115.252 (g)

Compliance Determination:
The facility has demonstrated compliance with this provision of the standard because:

The provision requires that the agency may discipline a resident for filing a

	grievance related to alleged sexual abuse only where the agency demonstrates that the Residents filed the grievance in bad faith. The agency has a 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. Based on a review of information that the facility provided in the PAQ, in the past 12 months, the number of resident grievances alleging sexual abuse that resulted in disciplinary action by the agency against the resident for having filed the grievance in bad faith was zero. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **Overall Findings:** The auditor uses a triangulation approach, by connecting the PREA documentation, policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local advocates, and online PREA Audit: Pre-Audit Questionnaire to collaborate findings determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.253	**Resident access to outside confidential support services**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Evidence Relied Upon in Making the Compliance Determination: **Documentation:** • Project MORE, INC. Policy – Residents Access to Outside Confidential Support Services • CAESV Emotional Support Flyers • MOU Women and Families Center (WFC) • Sexual Assault Crisis Services Brochure English and Spanish • PREA Flyers • No Matter Where You Live Sexual Abuse is a Crime • Letter for the CEO • Online PREA Audit: Pre-Audit Questionnaire Community Confinement **Interviews:** • Random Residents (5) • Resident Who Reported Sexual Abuse (0)

	• MOU Contact (1) **Compliance Determination by Provisions and Corrective Actions:** **115.253 (a)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires the facility to 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, and by enabling reasonable communication between residents and these organizations, in as confidential a manner as possible. The facility provides residents with access to outside victim advocates for emotional support services related to sexual assault. Project MORE, INC. Policy – Residents Access to Outside Confidential Support Services Section I. PMI shall provide residents with access to outside victim advocates for confidential emotional support services related to sexual abuse. Residents will have mailing address, telephone numbers, hotline telephone numbers available of local, State, or national advocacy organizations. This is to enable reasonable communications between residents and these organizations. Section II. Procedures: A. Residents who contact an outside advocate may do so at any time. Contact may be made without staff knowledge. If staff is aware, then the communications will be monitored and the extent to which report of sexual abuse will be forwarded to authorities will be in accordance with mandatory reporting laws. B. 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 agreement or documentation showing attempts to enter into such agreements will be kept on file. The agency/facility provides residents with access to outside victim advocates or counselors for emotional support services. The emotional support services include sexual abuse and sexual harassment. Access is provided by giving residents the mailing address to the local rape crisis center, posting the outside phone numbers in areas where the resident is and by giving them a PREA brochure with the information during intake. During the facility tour the auditor observed PREA posters and flyers on the wall. The posters and flyers observed were Auditor PREA Notice of the upcoming PREA audit; The Women and Families Center (WFC) English and Spanish; No Matter Where You Live Sexual Abuse is a Crime; No Body Deserves to Be a Victim of Sexual Violence; and The Connecticut Alliance to End Sexual Violence/ WFC Flyer English

	and Spanish. The outside emotional support services are on the Connecticut Alliance to End Sexual Violence – How to Access Emotional Support Services for Survivors of Sexual Abuse with Dial: 1-888-999-5545 (24 hours Toll Free Hotline – English). Dial: 1-888-568-8332 (24 hours Toll Free Hotline – Spanish) on the phone to reach a trained counselor. The local mailing address is to The Women and Families Center (WFC) Offices. The local mailing addresses are on the flyer and phone number. The flyer also stated that the calls are free and confidential. PREA mail will be treated as legal mail. The flyer clearly states that “In accordance with state mandatory reporting laws agency/organizations may forward report to proper authorities”. This information was continuous throughout the facility. The posters and brochures are eligible, has the outside toll-free numbers and are in English and Spanish. During the Pre-Audit phase, the auditor calls the Connecticut Alliance to End Sexual Violence the statewide emotional support services number to test it functions. The auditor uses his cell phone and dials the toll-free number. The call went to the statewide office. The person that answered the phone asked for the auditor’s reason for calling. The auditor informed the person that he was a PREA auditor and was testing the statewide toll-free number. The auditor asked the staff to explain the process when a resident calls this number how do they receive emotional support services? The staff indicated that they would talk to the residents and forward the call to the zip code where the facility is located. Connecticut Alliance to End Sexual violence is a statewide coalition of individual sexual assault crisis programs. There are nine local rape crisis centers that provide emotional support services statewide. The On-Site phase, during the tour the PREA auditor informally ask staff how the resident access would the emotional support services. Staff indicated that the residents have cell phones and can call the number posted on the walls. The auditor use tested the outside numbers by using his cell phone to call the outside emotional support services. On May 7, 2024, at 12:57pm, the auditor contacts the local crisis center (Women and Families Center). There was a recording and then the counselor answers the phone stated that they work with all facilities in the region because they are a rape crisis center that provides emotional supports to residents or just individual in the community. On March 11, 2024, the auditor reaches out to Connecticut Alliance to End Sexual Violence (statewide) through email regarding this facility. The email requested to set up a phone interview with the agency. There was no response back from the email. Staff and residents’ informal conversations during the tour indicated that residents confirmed having access to writing instruments, paper, and forms to report. They use them during their free time in the living units. Staff indicated that residents could request them from staff. Informal conversations with residents during the tour also collaborated that they are aware of the outside emotional support services on the flyers and posters, however, they never used it. The auditor observed how mail moves from resident to the facility mailroom (office).

	The resident can use medical or grievance forms, put the letter into an envelope and take it to the front office. The US mail is picked up every day. A total of 14 random residents were interviewed by the auditor. Nine Black, two White and two Hispanic. These residents came to the facility within the past 12 months. Thirteen reported that they were aware of services available outside of the facility for dealing with sexual abuse if they needed it. The kind of services reported ranges from victim advocate, counseling, PREA for advocate. Three said that mailing addresses and phone numbers were given to them by brochures, flyers or on poster. The residents reported that the kind of services provided was victim services, rape counseling crisis, some said they were not sure because they never call or did not read the information. Four said the outside services numbers were free, and some said they did not know because they never used it. Most of the residents reported that they think they can talk with outside service at any time when they are out of their rooms. During the onsite visit, there were no residents who reported sexual abuse at the facility. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **115.253 (b)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires 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. The facility does inform residents, prior to providing them with access to outside support services, of the extent to which such communications will be monitored. Project MORE, INC. Policy – Residents Access to Outside Confidential Support Services Section I. PMI shall provide residents with access to outside victim advocates for confidential emotional support services related to sexual abuse. Residents will have mailing address, telephone numbers, hotline telephone numbers available of local, State, or national advocacy organizations. This is to enable reasonable communications between residents and these organizations. Section II. Procedures: 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 agreement or documentation showing attempts to enter into such agreements will be kept on file. The facility informs residents through the Connecticut Alliance to End Sexual

	Violence flyer prior to giving them access communications that will be monitored and forwarded to authorities in accordance with mandatory reporting laws. The following was reviewed on the flyer: How to Access Emotional Support Services for Survivors of Sexual Abuse. Hotline numbers (English and Spanish) to reach a trained counselor. All calls will be forward to your local centers. The call is not recorded, and you do not have to use and Personal Identification Number (PIN) to make a call. Calls are free and confidential. Local Centers and numbers. All PREA mail will be treated as legal mail. In accordance with state mandatory reporting laws agency/ organizations may forward report to proper authorities. A total of 14 random residents were interviewed by the auditor. Nine Black, two White and two Hispanic. These residents came to the facility within the past 12 months. The random interviewed resident reported that they think the conversation would remain private. However, they did not know if their conversation would remain private because they never use outside services. Some say that they think their conversation would remain private unless they reported a crime. Interviewed Program Manager collaborated that the residents are informed at orientation by case manager when completing the PREA Screening Application the extent to which reports of abuse will be forwarded to authorities as mandated reporters. A total of 14 random residents were interviewed by the auditor. Nine Black, two White and two Hispanic. These residents came to the facility within the past 12 months. They do not know what they say to outside people from these services remains private because they never use the services. However, some did say they think if what they said is a crime it will be reported. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **115.253 (c)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires the agency to 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. The agency maintains copies of agreements or documentation showing attempts to enter into such agreements. The agency maintains memorandum of understanding (MOU) or other agreements with community service provide residents with emotional support services related to sexual abuse. Documentation review of the Memorandum Agreement between Connection, Inc.,

and The Connecticut Alliance to End Sexual Violence. The Alliance to End Sexual Violence (The Alliance) is a coalition of Connecticut's nine (9) community based sexual assault crisis and advocacy services including a 24-hour hotline, individual counseling, medical and legal accompaniment and support, and community education and training programs.

MOU with Women and Families Center (WFC) agree to the following:

• Provide referrals to WFC, for their residential clients who have experienced sexual violence.
• Will offer training as needed to staff members in an effort to provide a trauma informed environment for residential clients.
• Will provide private space for individual counseling and support groups.
• Will provide training to Project MORE staff as requested.
• Provide individual counseling and support groups at Project MORE.
• Accompaniment of Systems support through medical, police and legal proceedings.

During the Pre-Audit phase: March 18, 2024, at 2:03pm, the auditor calls the Connecticut Alliance to End Sexual Violence the statewide emotional support services number to test it functions. The auditor uses his cell phone and dials the toll-free number. The call went to the statewide office. The person that answered the phone asked for the auditor's reason for calling. The auditor informed the person that he was a PREA auditor and was testing the toll-free number. The auditor asked staff to explain the process when a resident calls this number how do they receive emotional support services? Staff indicated that they would talk to the residents and forward the call to the zip code where the facility is located. Connecticut Alliance to End Sexual violence is a statewide coalition of individual sexual assault crisis programs. The auditor asked about the statewide agreement, staff indicated that they service any victim anywhere in Connecticut regardless of whether they are in a facility or in the community. There are nine local rape crisis centers that provide emotional support services throughout the state.

On May 7, 2024, at 12:57pm, the auditor contacts the local crisis center (Women and Families Center). There was a recording and then the counselor answers the phone stated that they work with all facilities in the region because they are a rape crisis center that provides emotional supports to residents or just individual in the community.

The agency PREA coordinator maintains a copy of the agreement in his office.

The auditor reviews the MOU, and the Duration section states, "This Memorandum of Understanding may be modified by mutual consent of authorized officials. This memorandum of Understanding shall become effective upon signature by the authorized officials from both agencies and will remain in effect until modified or terminated by mutual consent." The CEO that signed this agreement is still the current Project MORE CEO.

A review of the appropriate documentations, interviews and conversations with staff

	and review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **Overall Findings:** The auditor uses a triangulation approach, by connecting the PREA documentation, policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local advocates, and online PREA Audit: Pre-Audit Questionnaire to collaborate findings determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.254	**Third party reporting**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Evidence Relied Upon in Making the Compliance Determination: **Documentation:** • Project MORE, INC. Policy – Third Party Reporting • Project MORE Website Information • Training Manual • Online PREA Audit: Pre-Audit Questionnaire Community Confinement **Interviews:** **Compliance Determination by Provisions and Corrective Actions:** **115.254 (a)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires that the agency establish a method to receive third party reports of sexual abuse and sexual harassment and shall distribute publicly information on how to report sexual abuse and sexual harassment on behalf of a resident. The agency provides a method to receive third-party reports of resident sexual abuse or sexual harassment. Project MORE, INC. Policy – Third Party Reporting Section I. PMI shall establish a method to received third party reports of sexual abuse and sexual harassment. PMI shall distribute information on how to report sexual abuse and sexual harassment on behalf of a residents. Section II. Procedures: PMI shall accept third party repots of sexual abuse and sexual harassment as follows:

	A. By mail to the facility or main office. B. By telephone call to the facility, other facility or main office. C. In person – coming directly to the facility and speaking directly to any staff person or going to another facility or main office and speak to any agency staff member. D. By e-mail to any agency staff person. E. By having any other agency contact the facility, other facility or main office by mail, telephone, e-mail or in person. A review of the agency website regarding third-party reporting confirmed that to report a PREA allegation through a third party, please utilize one of the following options: (1) State Connecticut Department of Correction PREA Investigation Unit Hotline, A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **Overall Findings:** The auditor uses a triangulation approach, by connecting the PREA documentation, policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local advocates, and online PREA Audit: Pre-Audit Questionnaire to collaborate findings determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.261	**Staff and agency reporting duties**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Evidence Relied Upon in Making the Compliance Determination: **Documentation:** • Project MORE, INC. Policy – Staff and Agency Reporting Duties • Project MORE PREA Training Manual • PREA Incident Report (1) • Online PREA Audit: Pre-Audit Questionnaire Community Confinement **Interviews:** • Random Sample Staff • Medical and Mental Health Staff - 0 • Manager Program Manager • PREA Coordinator

Compliance Determination by Provisions and Corrective Actions:

115.261 (a)

Compliance Determination:
The facility has demonstrated compliance with this provision of the standard because:

The provision requires that the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether it is part of the agency; retaliation against residents or staff who reported such an incident; and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation.

The agency policy requires all staff to report immediately of any knowledge, suspicion, or information they receive regarding incident of sexual abuse or sexual harassment that occurred in the facility whether or not it is part of the agency.

Project MORE, INC. Policy – Staff and Agency Reporting Duties Section I. PMI shall require all staff to report immediately and according to agency policy and knowledge, suspicion or information regarding, and incident of sexual abuse or sexual harassment that occurred in a facility, whether or mot it is part of the agency; retaliation against clients/residents or staff who reported such an incident; and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation.

Project MORE, INC. Policy – Staff and Agency Reporting Duties Section I. Apart from reporting to designated supervisors or officials, 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.

Project MORE, INC. Policy – Staff and Agency Reporting Duties Section I. unless otherwise precluded by Federal, State or local law, medical and mental health practitioner shall be required to report sexual abuse and to inform resident of a practitioner’s duty to report, and the limits of confidentiality, at the initiation of services.

Project MORE, INC. Policy – Staff and Agency Reporting Duties Section I. 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 the applicable mandatory reporting laws.

Project MORE, INC. Policy – Staff and Agency Reporting Duties Section II. Procedures:

A. The Program Manager or designee shall report all allegations of sexual abuse and sexual harassment to the PREA Coordinator.
B. Upon receiving an allegation that a resident was sexually abused or harassed while confirmed at another facility, the agency PREA Coordinator shall notify the

	head of the facility or appropriate office of the facility where the allegation occurred. Such notification shall be provided as soon as possible, but not later than 72 hours after receiving the allegation. C. PMI shall document all allegations and notifications. All allegations shall be investigated in accordance with these standards. A total of nine random staff were interviewed by the auditor from different shifts. Eight Black and One Hispanic, Nine males and zero females. Nine confirmed that the agency requires all staff to report any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in the facility; retaliation against residents or staff who reported an incident; and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **115.261 (b)** Compliance Determination: The facility has demonstrated compliance with provision of the standard because: The provision requires that apart from reporting to designated supervisors or officials, staff shall not reveal 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. As apart from reporting to designated supervisors or officials and designated state or local services agencies, policy prohibits staff from revealing any information related to sexual abuse report to anyone other than treatment, investigations, security, or management decisions. A total of nine random staff were interviewed by the auditor from different shifts. Eight Black and One Hispanic, Nine males and zero females. Nine confirmed that when they report they will only share information with other staff as needed. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **115.261 (c)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires that unless otherwise precluded by Federal, State, or local law, medical and mental health practitioners shall be required to report sexual abuse pursuant to paragraph (a) of this section and to inform residents of the

	practitioner’s duty to report, and the limitations of confidentiality, at the initiation of services. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **115.261 (d)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires that if the allege victim is under the age of 18 or considered a vulnerable adult under a state or local vulnerable persons statute, the agency shall report the allegation to the designated State or local services agency under applicable mandatory reporting laws. Interviewed PREA coordinator collaborated that the facility does not house individuals under the age of 18, however, if they received an allegation from another program, they would notify the appropriate authorities or DCF as they are mandated reporters. In addition to the normal PREA response, the staff are also mandated reporters for vulnerable adults and report to either the Office of Protection and Advocacy for Persons with Disabilities or The Department of Social Services. The interviewed Program Manager confirmed that they are mandated reporters, they would report to law enforcement immediately. In the program everyone is 18 years or older. They would also report this to the appropriate agency, either DDS or DSS. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **115.261 (e)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires that the facility report all allegations of sexual abuse and sexual harassment, including third-party and anonymous reports, to the facility’s designated investigators. The agency reports all allegations of sexual abuse and sexual harassment to include third party and anonymous reports, to the facility’s designated investigators. The interviewed Program Manager confirmed that all allegations of sexual abuse and sexual harassment including those from third-party and anonymous sources

	reported immediately and directly to the agency PREA coordinator or facility investigator. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **Overall Findings:** The auditor uses a triangulation approach, by connecting the PREA documentation, policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local advocates, and online PREA Audit: Pre-Audit Questionnaire to collaborate findings determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.262	**Agency protection duties**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Evidence Relied Upon in Making the Compliance Determination: **Documentation:** • Project MORE, INC. Policy – Agency Protection Duties • First Responder Duties • Online PREA Audit: Pre-Audit Questionnaire Community Confinement **Interviews:** • Random Sample of Staff – • Agency Head • Program Manager **Compliance Determination by Provisions and Corrective Actions:** **115.262 (a)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires that when an agency learns that a resident is subject to a substantial risk of imminent sexual abuse, it shall take immediate action to protect the Resident. When the agency learns that a resident is subject to a substantial risk of imminent sexual abuse, it takes immediate action to protect the resident.

	Project MORE, INC. Policy – Agency Protection Duties Section I. When PMI learns that a resident is subject to a substantial risk of imminent sexual abuse, immediate action will be taken to protect the residents. Section II. Procedures: A. Once the facility learns that one of its residents is subject to a substantial risk of sexual abuse staff will do the following: 1. Inform the Supervisor on duty. 2. Bring the resident into the main office. 3. Contact the Program Manager and explain the situation. 4. Contact the agency PREA Coordinator and explain the situation. 5. The PREA Coordinator will contact PMI Administrative staff. 6. Contact the referral source and explain the situation. B. If the sexual assault is to be committed by another facility resident, the potential victim will not be out of sight by staff. C. The alleged assaulter will be confined to his room. D. An investigation will be conducted by the PREA Coordinator who will report his findings to the referral source. E. If the investigation shows that the assault was immanent the PREA Coordinator will request removal of the resident who would have committed the assault. F. If the assault was to occur while the resident was off site, the resident will be placed on lockdown. The referral source and the New Haven Police Department would be contacted. Based on a review of information that the facility provided in the PAQ, in the past 12 months, the number of times the agency or facility determined that a resident was subject to a substantial risk imminent sexual abuse was 0. If the agency or facility made such determinations in the past 12 months, the average amount of time (in hours) that passes before acting is 0. Interviewed Agency Head confirmed that when the agency learns that a resident is subject to a substantial risk of imminent sexual abuse the agency would take protective action. When residents are placed in the program, efforts are made to house them according to PREA assessment, which considers victimization risk. In these instances, or instances where a risk is identified at another time, the agency ensures that the resident is housed in an area that is safe and easily monitored. Staff are also made aware of the situation and these residents have frequent physical checks made on them. The facility may also speak with the funder to see if there are more appropriate housing options for these residents. The interviewed Program Manager confirmed, when they learn that a resident is subject to a substantial risk of imminent sexual abuse, the protective action is to ensure the client is roomed either alone or with someone that based on PREA assessment is of low risk to be an abuser. If there is anyone in the program that is of high risk to offend against a client. A total of nine random staff were interviewed by the auditor from different shifts. Eight Black and One Hispanic, Nine males and zero females. Nine confirmed that the actions they would take when they learn that resident may be at risk of imminent

	sexual abuse. They would immediately remove the residents to another area until the supervisor gives additional instructions and stay with the resident. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **Overall Findings:** The auditor uses a triangulation approach, by connecting the PREA documentation, policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local advocates, and online PREA Audit: Pre-Audit Questionnaire to collaborate findings determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.263	**Reporting to other confinement facilities**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Evidence Relied Upon in Making the Compliance Determination: **Documentation:** • Project MORE, INC. Policy – Reporting to other confinement facilities • Responding to an Incident in Another Facility • Online PREA Audit: Pre-Audit Questionnaire Community Confinement **Interviews:** • Agency Head • Program Manager **Compliance Determination by Provisions and Corrective Actions:** **115.263 (a)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires that upon receiving an allegation that a resident was sexually abused while confined at another facility, the head of the facility that received the allegation shall notify the head of the facility or appropriate office of the agency where the alleged abuse occurred. The agency requires upon receiving an allegation that a resident was sexually abused while confined at another facility, the agency notify the head of the facility

	or appropriate office of the facility where sexual abuse is alleged to have occurred. Project MORE, INC. Policy – Reporting to Other Confinement Facilities section I. Upon receiving an allegation that a resident was sexually abused while confined in another facility, the Program Manager or designee, once notified of the allegation will contact the head of the facility or appropriate office of the agency where the allegation occurred. Section II. Procedures: A. Once an allegation has been received staff will immediately contact the Program Manager or designee along with the PMI's PREA Coordinator. B. Staff receiving the alleged abuse shall complete a detailed incident report to include the following information: 1. Name of the resident 2. Location of the alleged abuse 3. Name of the person (s) involved in the alleged abuse. 4. Date and time the alleged abuse took place. 5. Names of any witnesses. C. The PREA Coordinator will contact the head of the facility, or appropriate office where the alleged abuse took place. This shall be done as soon as possible, but no later than 72 hours after receiving the allegation. Initially contact will be made by telephone. Follow up will be having the incident report faxed or e-mailed to the proper individual. A copy of the fax receipt or e-mail along with the incident report will be placed in the residents' file. D. The PREA Coordinator shall document that the agency has provided notification. Based on a review of information that the facility provided in the PAQ, during the past 12 months, the number of allegations the facility received that a resident was abused while confined at another facility is zero. In the past 12 months, the number of allegations of sexual abuse the facility received from other facilities is zero. Interviewed Agency Head confirmed that if another agency or a facility within another agency refers allegations of sexual abuse or sexual harassment that occurred within one of the facilities the agency has a designated point of contact. TCI agency PREA coordinator is the designated point of contact for all facilities. All allegations go through the PREA coordinator who then makes appropriate collateral contacts with those needing to be informed of the situation. At this time there were no examples from another facility or agency. The interviewed Program Manager confirmed when a facility receives an allegation from another facility or agency that an incident of sexual abuse or sexual harassment occurred in his facility it is handle the same as an allegation directly from the client which would initiate the first responder's response. The PREA coordinator contacted and initiated an investigation, the Police and DOC are notified as well. There are no examples at this facility, if the facility were to receive an allegation, the program staff would notify the PREA coordinator, Parole, and the State Police. The response is the same and is not dependent on who makes the allegations. A review of the appropriate documentations, interviews and conversations with staff

	and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **115.263 (b)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires that such notification be provided as soon as possible, but no later than 72 hours after receiving the allegation. The agency requires the facility PREA coordinator to provide notification as soon as possible, but no later than 72 hours after receiving the allegation. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **115.263 (c)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires that the agency document that it has provided such notification. The agency does document that it has provided notification within 72 hours of receiving the allegation. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **115.263 (d)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires that the facility head or agency office that receives such notification shall ensure that the allegation is investigated in accordance with these standards. The facility requires that allegations received from other facilities are investigated in accordance with the PREA standards. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted.

	Overall Findings: The auditor uses a triangulation approach, by connecting the PREA documentation, policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local advocates, and online PREA Audit: Pre-Audit Questionnaire to collaborate findings determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.264	Staff first responder duties
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Evidence Relied Upon in Making the Compliance Determination: **Documentation:** • Project MORE, INC. Policy – Staff First Responder Duties • First Responder Duties Pages • Detecting and Responding to Actual and Threatened Sexual Abuse (Training) • Sexual Abuse Incident Coordinated Response Plan • Online PREA Audit: Pre-Audit Questionnaire Community Confinement **Interviews:** • Security Staff and Non-Security Staff First Responders • Residents who Reported a Sexual Abuse – 0 **Compliance Determination by Provisions and Corrective Actions:** **115.264 (a)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires that 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 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 If the abuse occurred within a time 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.

The agency has a first responder policy for allegations of sexual abuse.

Project MORE, INC. Policy – Staff First Responder Duties Section I. Upon learning of an allegation that a resident was sexually abused, the first staff member to respond will have requirements he must respond to. Section II. Procedures:

A. Upon learning a resident was sexually abused, the first staff member to respond is required to do the following:
1. Separate the victim from the abuser.
2. The victim will be kept in the staff office under staff supervision.
3. The abuser must remain in his room, also under staff supervision.
4. Staff will then contact the Program Manager and the PMI PREA Coordinator.
5. Preserve and protect the crime scene until appropriate steps can be taken to collect any evidence.
6. 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.
B. Preserving the Crime Scene.

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:

1. Washing
2. Brushing teeth
3. Changing cloths
4. Smoking
5. Urinating or defecating
6. Drinking or eating unless medically indicated

If toileting needs to take place, the resident should be instructed not to wipe.

Based on a review of information that the facility provided in the PAQ, in the past 12 months, the number of allegations that a resident was sexually abused is zero. Of these allegations, the number of times the first security staff member responded to the report separated the alleged victim and abuser is zero. In the past 12 months, the number of allegations where staff were notified within a time that still allowed for the collection of physical evidence is zero.

A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted.

115.264 (b)

Compliance Determination:
The facility has demonstrated compliance with this provision of the standard because:

	The provision requires that if the first staff responder is not a security staff member, the responder shall be required to request that the alleged victim not take any actions that could destroy physical evidence, and then notify security staff. The agency training requires that if the first staff responder is not a security staff, that responder is required to request that the alleged victim not take any actions that could destroy physical evidence just as the security staff. Based on a review of information that the facility provided in the PAQ, of the allegations that a resident was sexually abused made in the past 12 months, the number of times a non-security staff member was the first responder is zero. Of those allegations responded to first by a non-security staff member, the number of times that staff member requested that the alleged victim not take any actions that could destroy physical evidence is zero. Of those allegations responded to first by a non-security staff member, the number of times that staff member notified security staff is zero. A total of nine random staff were interviewed by the auditor from different shifts. Eight Black and One Hispanic, Nine males and zero females. Nine confirmed that they know and understand the agency's protocol for preserving usable physical evidence if a resident alleges sexual abuse. They report that if they are the first person to be alerted that a resident has allegedly been the victim of sexual abuse, their responsibility in this situation would be to separate the victim from the abuser, close off the area where it takes place, do not let the victim and abuser brush their teeth, drink, use the bathroom, and change clothing. Staff would call 911 if medical is needed and their supervisor. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **Overall Findings:** The auditor uses a triangulation approach, by connecting the PREA documentation, policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local advocates, and online PREA Audit: Pre-Audit Questionnaire to collaborate findings determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.265	**Coordinated response**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Evidence Relied Upon in Making the Compliance Determination:

	Documentation: • Project MORE, INC. Policy – Coordinated Response • Sexual Abuse Incident Coordinator Response Plan • Online PREA Audit: Pre-Audit Questionnaire Community Confinement **Interviews:** • Program Manager **Compliance Determination by Provisions and Corrective Actions:** **115.265 (a)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires that the facility develop a written institutional plan to coordinate actions taken in response to an incident of sexual abuse, among staff first responders, medical and mental health practitioners, investigators, and facility leadership. The facility has a written policy to coordinate actions taken in response to an incident of sexual abuse among staff first responders, medical and mental health staff, investigators, and facility leadership. Project MORE, INC. Policy – The PMI shall ensure a coordinated response to any incident of sexual abuse among staff, first responders and Agency leadership. The interviewed Program Manager confirmed that the agency has a policy to coordinate actions among staff first responders, program staff and facility leadership in response to an incident of sexual abuse. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **Overall Findings:** The auditor uses a triangulation approach, by connecting the PREA documentation, policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local advocates, and online PREA Audit: Pre-Audit Questionnaire to collaborate findings determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.266	**Preservation of ability to protect residents from contact with abusers**

	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Evidence Relied Upon in Making the Compliance Determination: **Documentation:** • Project MORE, INC. Policy – Preservation of ability to Protect Residents From Contact with Abusers • Online PREA Audit: Pre-Audit Questionnaire Community Confinement **Interviews:** • Agency Head **Compliance Determination by Provisions and Corrective Actions:** **115.266 (a)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires that neither the agency nor any other governmental entity responsible for collective bargaining on the agency's behalf shall enter or renew 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. The agency is not involved in any governmental entity responsible for collective bargaining on the agency's behalf. Project MORE, INC. Policy – Preservation of ability to Protect Residents from contact with Abusers. PMI is a private not-for-profit agency. The agency staff is not unionized. PMI does not enter into collective bargaining agreements with staff. Interviewed Agency Head confirmed that the agency is not involved in any governmental entity responsible for collective bargaining on the agency's behalf. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **115.266 (b)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because:

	The provision requires that nothing in this standard restrict the entering into or renewal of agreement that govern: The conduct of the disciplinary process, if such agreements are not inconsistent with the provisions of standards 115.72 and 115.76; or Whether a no-contact assignment that is imposed pending the outcome of an investigation shall be expunged from or retained in the staff member's personnel file following a determination that the allegation of sexual abuse is not substantiated. The auditor is not required to audit this provision. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **Overall Findings:** The auditor uses a triangulation approach, by connecting the PREA documentation, policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local advocates, and online PREA Audit: Pre-Audit Questionnaire to collaborate findings determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.267	**Agency protection against retaliation**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Evidence Relied Upon in Making the Compliance Determination: **Documentation:** • Project MORE, INC. Policy – Agency Protection Against Retaliation • Letters 267 • PREA Incident Report • PREA Sexual Harassment Review • Staff Training Page 1 • Online PREA Audit: Pre-Audit Questionnaire Community Confinement **Interviews:** • Agency Head • Program Manager • Designated Staff Member Charged with Monitoring Retaliation • Residents who Reported a Sexual Abuse - 0 **Compliance Determination by Provisions and Corrective Actions:**

115.267 (a)

Compliance Determination:
The facility has demonstrated compliance with this provision of the standard because:

The provision requires that the agency establish 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 and shall designate which staff members or departments are charged with monitoring retaliation.

The agency protects all residents and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other resident or staff.

Project MORE, INC. Policy – Agency Protection Against Retaliation Section I. 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 PREA Coordinator and Program Manager will monitor retaliation. Section II. Procedures: PMI shall employ the following measures to protect residents and staff from retaliation:

A. Transfer of victim and/or abuser to another facility.
B. Transfer staff to another agency residential facility or program, if operationally possible.
C. Removal of alleged staff or resident from contact with victim.
D. Provide emotional support services for resident 9s) and /or staff that fear retaliation for reporting the incident.
E. Segregation during transportation.
F. Consult with the referring source.
G. Actively monitor the conduct and treatment of residents or staff who have reported abuse and of residents who have reported and/or suffered abuse for signs of retaliation.
H. Protect individuals who cooperate in investigations who express fear of retaliation.

The PREA Coordinator, for a period of 90 days following the incident, shall monitor the conduct and treatment of the resident (s) and/or staff who reported the incident. This is done to see if there is anything to suggest possible retaliation by other residents or staff. Items PMI shall monitor include the following:

A. Staff and resident disciplinary reports.
B. Housing or program changes.
C. Negative performance reviews.
D. Resident misconducts.
E. Reassignment of staff

PMI shall continue to be monitored beyond 90 days if the initial monitoring indicates

a continuing need. In the case of residents, such monitoring shall include their Monthly Reports.

PMI’s obligation to monitor shall terminate if the agency determines that the allegation is unfounded.

Interviewed Agency Head confirmed that that the agency protects residents and staff from retaliation for sexual abuse or sexual harassment allegations. The agency has a system in which they follow up with residents who report allegations of abuse. The agency also monitors any residents closely following reports of sexual abuse. The agency has managers closely watch staff overseeing these residents to ensure there is no retaliation taking place. The facility informs the residents of the agency retaliation policy and notifies staff immediately if they feel they are being retaliated against. Staff can report any retaliation to the Human Resources department, the PREA coordinator or agency leadership at any time. When making considerations on program changes, or movement, the facility ensures that the individual perpetrated against is given preference or is included in discussions surrounding any changes to programming. Victims are informed of services and behavioral health support available to him or her.

A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted.

115.267 (b)

Compliance Determination:
The facility has demonstrated compliance with this provision of the standard because:

The provision requires that 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.

Interviewed staff responsible for monitoring retaliation confirmed that the role she plays in preventing retaliation against residents and staff who report sexual abuse or sexual harassment or who cooperate with sexual abuse or sexual harassment investigation by making housing changes or they can transfer to another agency facility, provide emotional support services through the local rape crisis center. The agency works closely with the funder, PREA coordinator, HR and agency leadership team to ensure that individual(s) who cooperate with PREA are protected. In addition, staff initiate contact with residents who have reported sexual abuse when inspecting the facility, or during counseling sessions.

The interviewed Program Manage described the different measures that are taken to protect residents and staff from retaliation are: Clients involved are kept always separated. If it’s against a staff that staff member is sent home until the facility

completes the investigation. Staff keeps a close eye on client and the Program Manager keeps an eye on clients and staff to ensure there are no increases in chores or tickets. The staff notify the client that the facility has zero tolerance for retaliation, and they should notify staff immediately if they feel that they are being retaliated against. If there is an incident of retaliation, then the program would notify the client's supervising officer. If it were a staff member retaliating against clients, they would be reported to Human Resources and be addressed appropriately.

A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted.

115.267 (c)

Compliance Determination:
The facility has demonstrated compliance with this provision of the standard because:

The provision requires that for at least 90 days following a report of sexual abuse, the agency shall monitor the conduct and treatment of residents or staff who reported the sexual abuse and of innates who were reported to have suffered sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff and shall act promptly to remedy any such retaliation. Items the agency should monitor include any resident disciplinary reports, housing, or program changes, or negative performance reviews or reassignments of staff. The agency shall continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need.

The facility does monitor the conduct or treatment of residents or staff who reported sexual abuse and of residents who were reported sexual abuse and of residents who were reported to have suffered sexually abuse to see if there are any changes that may suggest possible retaliation by residents or staff.

Interviewed staff responsible for monitoring retaliation confirmed that a part of the monitoring process they look for residents' rooms changes, disciplinary report regarding residents, program changes, and for staff shift changes for day to night, bad performance reviews and reassignments. Staff monitor the conducts and treatment of residents and staff for 90 days or longer if needed.

Based on a review of information that the facility provided in the PAQ, the number of times an incident of retaliation occurred in the past 12 months is zero.

A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted.

115.267 (d)

Compliance Determination:

	The facility has demonstrated compliance with this provision of the standard because: The provision requires that in the case of residents, such monitoring should also include periodic status checks. The facility conducts periodic status checks. TCI Policy PREA: Protection and Retaliation Policy and Procedure section 7.0, on site staff members will perform periodic status checks on the alleged victim. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **115.267 (e)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires that if any other individual who cooperates with an investigation expresses a fear of retaliation, the agency shall respond appropriately to protect that individual against retaliation. The agency takes appropriate measures to protect the individual against retaliation. Interviewed Agency Head confirmed that if an individual who cooperates with an investigation expresses a fear of retaliation the agency takes measures to protect that individual against retaliation. The agency works closely with the funder, PREA coordinator, HR, and agency leadership team to ensure that individuals who cooperate with PREA investigations are protected from potential retaliation. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **115.267 (f)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires that an agency’s obligation to monitor shall terminate if the agency determines that the allegation is unfounded. Auditor is not required to audit this provision. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted.

	Overall Findings: The auditor uses a triangulation approach, by connecting the PREA documentation, policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local advocates, and online PREA Audit: Pre-Audit Questionnaire to collaborate findings determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.271	Criminal and administrative agency investigations
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Evidence Relied Upon in Making the Compliance Determination: **Documentation:** • Project MORE, INC. Policy – Criminal and Administrative Agency Investigation • Letter Police Department • Online PREA Audit: Pre-Audit Questionnaire Community Confinement **Interviews:** • Investigative Staff • Resident who Reported a Sexual Abuse - 0 • Program Manager • PREA Coordinator **Compliance Determination by Provisions and Corrective Actions:** **115.271 (a)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires that when the agency conducts its own investigations into allegations of sexual abuse and sexual harassment, it shall do so promptly, thoroughly, and objectively for all allegations, including third-party and anonymous reports. Project MORE, INC. Policy – Criminal and Administrative Agency Investigations Section I. PMI shall conduct administrative investigations into allegations of sexual abuse and sexual harassment in a prompt, though, and objective manner, including third-party anonymous reports. When sexual assault is alleged, PMI shall contact the New Haven Police Department who shall conduct a criminal investigation. Section II. Procedures:

	A. 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. B. 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. C. The credibility of an alleged victim, suspect, or witness shall be assessed on an individual basis, and shall not be determined by a persons' 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 devise as a condition for processing the investigation. D. 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. E. Criminal Investigations: 1. Shall be conducted by the New Haven Police Department. 2. The NHPD will interview alleged victim 9s), suspects, witnesses and staff. 3. Evidence will be collected. 4. Conduct that appears to be criminal shall be referred for prosecution. F. PMI shall cooperate with the New Haven Police Department investigators and endeavor to remain informed regarding the progress of the investigation. 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. G. 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. H. Any State entity or Department of Justice component that conducts such investigations shall do so pursuant to PREA Standard 115.271. Interviewed Investigator confirmed that the investigation begins immediately upon receiving an allegation and the funding agency is notified immediately and the CT State Police if evidence shows criminal conduct. The first steps in initiating an investigation are as follows: • Staff immediately notify their supervisor or on-call when they discover something, or an allegation is made. • Staff will determine the safety of the client and, if need be, contact emergency medical services (call 911). • If needed, staff will preserve and protect any crime scene until appropriate steps can be taken to collect evidence. • The investigator will collect all evidence, review cameras, interview staff, interview the victim and abuser, review files.

	Interviewed Investigator confirmed that they handle anonymous or third-party reports of sexual abuse or sexual harassment the same as any other report. They are not investigated differently. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **115.271 (b)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires that where sexual abuse is alleged, the agency use investigators who have received special training in sexual abuse investigations pursuant to standard 115.34. The agency has trained investigators to conduct its investigations. A review of the National Institute of Corrections (NIC) online training “PREA: Investigating Sexual Abuse in a Confinement Setting” includes the following topics: Initial Response, Investigation, Determination of the findings, A Coordinated Response, Sexual Assault Response Team, A Systemic Approach, How Sexual Abuse Investigations Are Different, How Investigations in Confinement Settings Are Different, Criteria for Administrative Action, Criteria for Criminal Prosecution, Report Writing Requirements of an Administrative Report, Requirements for an Administrative Report, Requirements for a Criminal Report, The Importance of Accurate Reporting, Miranda and Garrity Requirement, Miranda Warning Considerations, Garrity Warning Considerations, The Importance of Miranda and Garrity Warnings, Medical and Mental Health Practitioner’s Role in Investigations, PREA Standards for Forensic Medical Examinations. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **115.271 (c)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires that investigators gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data; shall interview alleged victims, suspected perpetrators, and witnesses; and shall review prior complaints and reports of sexual abuse involving the suspected perpetrator. The agency investigators do gather and preserve direct and circumstantial

	evidence, including any available physical and DNA evidence, electronic data, interviews witness statements. In addition, A review of the State of Connecticut Technical Guidelines for Health Care Response to Victims of sexual Assault, in accordance with Connecticut General Statute's section 19a – 112a. CT 100 Sexual Assault Evidence Collection Kit: Preparation for the Examination; The Evidence Collection Examination and Evidence Integrity – repacking, labeling, and sealing evidence containers. The examinations performed by the SAFE or SANE staff are guided by the State of Connecticut Statute. Interviewed Investigator confirmed and described direct and circumstantial evidence the agency would be responsible for gathering in an investigation of an incident of sexual abuse. The program staff are not responsible for collecting or gathering evidence but rather preserving/securing any evidence in a location or on a person for the crime scene unit to collect. The program will request a written statement be started for the supervising officer and/or CT State Police. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **115.271 (d)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires that when the quality of evidence supports criminal prosecution, the agency conduct compelled interviews only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution. Interviewed Investigator confirmed that when they discover evidence that a prosecutable crime may have taken place they will consult with prosecutors before they conduct compelled interviews through the Department of Corrections or CT State Police. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **115.271 (e)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires that the credibility of an alleged victim, suspect, or witness shall be assessed on an individual as is and not be determined by the person's

	status as resident or staff. No agency requires a resident who alleges sexual abuse to submit to a polygraph examination or other truth-telling device as a condition for proceeding with the investigation of such an allegation. The credibility of an alleged victim, suspect, or witness is assessed on an individual basis and is not determined by the person's status as resident or staff. Interviewed Investigator confirmed that they judge the credibility of an alleged victim, suspect, or witness only by collecting the statements and report to the investigating agency whether it is DOC, CSSD, or CT State Police. Staff are always instructed not to determine whether an allegation is true or not and they should always report to their supervisor. Investigator indicated that under no circumstances that they would require a resident who alleges sexual abuse to submit to a polygraph examination. During the onsite review period there were no residents who reported sexual abuse for interview. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **115.271 (f)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires that administrative Investigations: include an effort to determine whether staff actions or failures to act contributed to the abuse; and shall be documented in written reports that include a description of the physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings. The administrative investigations include effort to determine whether staff actions or failures to act contributes to the abuse, and documented in written reports include a description of the physical and testimonia evidence, the reasoning behind credibility assessments, and investigative facts and findings. Interviewed Investigator confirmed the efforts they made during an administrative investigation to determine whether staff actions or failure to act contributed to the sexual abuse. The investigator will review police and procedures to ensure that staff failure to act contributed to the allegations. All administrative investigations are in written reports. A review of the PREA Administrative Review Report confirmed the following information: Administrative Review Team members; Review Timeline; Description to include date, action steps taken; Findings; Recommendations/Summary of Resolution; Information regarding who report was given to.

	A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **115.271 (g)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires that criminal investigations be documented in a written report that contains a thorough description of physical, testimonial, and documentary evidence and attaches copies of all documentary evidence where feasible. Criminal investigations are documented in a written report that contains a thorough description of physical, testimonial, and documentary evidence and attaches copies of all documentary evidence where feasible. Interviewed Investigator confirmed that criminal investigations are documented and contain victim statements, physical evidence, and other documentary evidence. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **115.271 (h)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires that substantiated allegations of conduct that are criminal shall be referred for prosecution. Substantiated allegations of conduct that appear to be criminal are referred for prosecution. Interviewed Investigator confirmed that they refer cases for prosecution through the State Police any time a crime appears to have occurred or if a staff member is involved in the allegation. Staff also includes volunteers, interns, and contractors. Based on a review of information that the facility provided in the PAQ, the number of substantiated allegations of conduct that appear to be criminal that were referred for prosecution since August 20, 2012, or since the last PREA audit, whichever is later is zero. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted.

115.271 (i)

Compliance Determination:
The facility has demonstrated compliance with provision of the standard because:

The provision requires that the agency retain all written reports referenced in paragraphs (f) and (g) of this section for as long as the alleged abuser is incarcerated or employed by the agency, plus five years.

The agency retains all written reports pertaining to the administrative or criminal investigation of alleged sexual abuse or sexual harassment for as long as the alleged abuser is incarcerated or employed by the agency, plus five years.

A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted.

115.271 (j)

Compliance Determination:
The facility has demonstrated compliance with this provision of the standard because:

The provision requires that the departure of the alleged abuser or victim from the employment or control of the facility or agency shall not provide a basis for terminating an investigation.

Interviewed Investigator confirmed that they would proceed when a staff member alleged to have committed sexual abuse terminates employment prior to a completed investigation. The investigation would continue to determine whether the staff terminate their employment or not. The departure of the alleged abuser or victim from employment or control of the facility is not a basis for terminating and investigation.

A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted.

115.271 (k)

Compliance Determination:
The facility has demonstrated compliance with this provision of the standard because:

The provision requires that any State entity or Department of Justice component that conducts such investigations shall do so pursuant to the above requirements.

The auditor is not required to audit this provision.

A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following

	the provisions of this standard. No corrective action is warranted. **115.271 (l)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires that when outside agencies investigate sexual abuse, the facility cooperate with outside investigators and endeavor to remain informed about the progress of the investigation. When outside agencies investigate sexual abuse, the facility cooperates with outside investigators and endeavor to remain informed about the progress of the investigation. Interviewed PREA coordinator collaborated that when an outside agency investigates allegations of sexual abuse the agency remains informed of the progress of a sexual abuse investigations by following up with the CT State Police for any ongoing investigations or the agency will follow up with Parole if they are in contact with the CT State Police. Interviewed Investigator confirmed that when an outside agency investigates an incident of sexual abuse their role is to provide any information requested and assist in any way the facility can as requested. The interviewed Program Manager confirmed that if an outside agency investigates allegations of sexual abuse the facility remains informed of the progress of a sexual abuse investigation through the PREA coordinator. The PREA coordinator would maintain contact with the outside agency via email and telephone. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **Overall Findings:** The auditor uses a triangulation approach, by connecting the PREA documentation, policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local advocates, and online PREA Audit: Pre-Audit Questionnaire to collaborate findings determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.272	**Evidentiary standard for administrative investigations**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion

Evidence Relied Upon in Making the Compliance Determination:

Documentation:

• Project MORE, INC. Policy – Evidentiary Standard for Administrative Investigations
• Letters Police Department
• NIC Certificate of Completion
• NIC Training
• Online PREA Audit: Pre-Audit Questionnaire Community Confinement

Interviews:

• Investigative Staff

Compliance Determination by Provisions and Corrective Actions:

115.272 (a)

Compliance Determination:
The facility has demonstrated compliance with this provision of the standard because:

The provision requires that the agency impose no standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated.

The facility imposes a standard of a preponderance of evidence or a lower standard of proof when determining whether allegations of sexual abuse or sexual harassment can be substantiated.

Project MORE, INC. Policy – Evidentiary Standard for Administrative Investigations Section I. 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 decide as to whether allegations of sexual assault are substantiated. This determination shall be at the discretion of the local authorities conducting the investigation. Section II. Procedures:

A. An investigation may include but not be limited to the following:

1. Review of relevant documents.
2. Review of audio, video, photographic and/or electronic information.
3. Interview of complainants
4. Interview of witnesses
5. Interview of technical experts
6. Observations made by the investigator (s)
7. Examination of evidence

B. A greater weight of the evidence will be utilized to decide who may be at fault. This preponderance is based on the more convincing evidence and its probable truth or accuracy.

	Interviewed Investigator confirmed that the standard of evidence to substantiate allegations of sexual abuse or sexual harassment is the preponderance of evidence. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **Overall Findings:** The auditor uses a triangulation approach, by connecting the PREA documentation, policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local advocates, and online PREA Audit: Pre-Audit Questionnaire to collaborate findings determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.273	**Reporting to residents**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Evidence Relied Upon in Making the Compliance Determination: **Documentation:** • Project MORE, INC. Policy – Reporting to Residents • PREA Incident Reports • Review Notifications • Letter Report to Resident • PREA Incident Report **Interviews:** • Program Manager • Investigative Staff • Residents who Reported a Sexual Abuse - 0 **Compliance Determination by Provisions and Corrective Actions:** **115.273 (a)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires that following an investigation into a resident’s allegation that he or she suffered sexual abuse in an agency facility, the agency shall inform the resident as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded.

	The agency has a policy requiring that any resident who alleges that he or she suffered sexual abuse in a facility informed, verbally or in writing, as to whether the allegation has been determined to substantiate, unsubstantiated, or unfounded following an investigation by the agency. Project MORE, INC. Policy – Reporting to Residents Section I. Following an investigation into a residents' 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. If PMI did not conduct the investigation, it shall request the relevant information from the investigating agency in order to inform the resident. Section II. Procedures: A. Following a residents' allegation and an investigation PMI shall inform the resident the following if the allegation was against staff: 1. The allegation was unfounded. 2. The allegation was substantiated, and the staff member is either no longer posted at the facility or is no longer employed at the agency. 3. Staff may have been indicted on a charge of sexual abuse. 4. Staff may have been convicted of sexual abuse. B. Following a resident's allegation and an investigation PMI shall inform the resident the following if the allegation was against another resident: 1. The allegation was unfounded. 2. The allegation was substantiated, and the alleged abuser has been indicted on a charge of sexual abuse. 3. The alleged abuser has been convicted of sexual abuse. C. Following a resident's allegation that a staff member has committed a sexual abuse against a resident, PMI shall inform the resident whenever: 1. The staff member is no longer posted at the residents' facility. 2. The staff member is no longer employed at the facility. 3. The agency has learned the staff member has been indicted on charges. 4. The agency has learned the staff member has been convicted on a charge of sexual assault. D. All notifications or attempted notifications shall be documented. E. PMI's obligation to report under this standard shall terminate if the resident is released from the agency's custody. Interviewed Investigator confirmed that the agency requires that a resident who makes an allegation of sexual abuse be informed as to the status of the investigation. Based on a review of information that the facility provided in the PAQ, the number of criminal and/or administrative investigations of alleged resident sexual abuse that were completed by the agency/facility in the past 12 months is 1. Of the alleged sexual abuse investigations that were completed in the past 12 months, the number of residents who were notified, verbally or in writing, of the results of the investigation is 2. The auditor review one investigations that were sexual harassments and it was

	determined that they meet the requirements. The interviewed Program Manager confirmed that the agency would 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. Depending on who made the allegations the appropriate staff person will inform them, typically the Program Manager or Program Manager or the PREA Coordinator. If the police investigate, they would be the ones to tell the client and in some cases their parole officer will tell them. During the onsite review period there were no residents who reported sexual abuse for interview. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **115.273 (b)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires that if the agency did not conduct the investigation, it shall request the relevant information from the investigative agency to inform the resident. If the agency did not conduct the investigation the requests the relevant information from the investigative office to inform the resident of the outcome of the investigation. Based on a review of information that the facility provided in the PAQ, the number of investigations of alleged resident sexual abuse in the facility that were completed by an outside agency in the past 12 months was zero. Of the outside agency investigations of alleged sexual abuse that were completed in the past 12 months, the number of residents alleging sexual abuse in the facility who were notified verbally or in writing of the results of the investigations was zero. During the onsite review period there were no residents who reported sexual abuse for interview. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **115.273 (c)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because:

	The provision requires that following a resident's allegation that a staff member has committed sexual abuse against the resident, the agency shall subsequently inform the resident (unless the agency has determined that the allegation is unfounded) whenever: The staff member is no longer posted within the resident's 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. Project MORE, INC. Policy – Reporting to Residents Section I. Following an investigation into a residents' 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. If PMI did not conduct the investigation, it shall request the relevant information from the investigating agency to inform the resident. Section II. Procedures. During the onsite review period there were no residents who reported sexual abuse for interview. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **115.273 (d)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires that following a resident's allegation that he or she has been sexually abused by another resident, the agency shall subsequently inform the alleged victim whenever: 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. During the onsite review period there were no residents who reported sexual abuse for interview. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **115.273 (e)** Compliance Determination: The facility has demonstrated compliance with provision of this standard because: The provision requires that all such notifications or attempted notifications should be documented.

	The agency has a policy that all notifications to residents described under this standard are documented. Based on a review of information that the facility provided in the PAQ, in the past 12 months, the number of notifications to residents that were provided pursuant to this standard is 2. Of those notifications made in the past 12 months, the number that were documented is 2. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **115.273 (f)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: As in the PAQ, an agency's obligation to report under this standard shall terminate if the resident is released from the agency's custody. The auditor is not required to audit this provision. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **Overall Findings:** The auditor uses a triangulation approach, by connecting the PREA documentation, policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local advocates, and online PREA Audit: Pre-Audit Questionnaire to collaborate findings determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.276	**Disciplinary sanctions for staff**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Evidence Relied Upon in Making the Compliance Determination: **Documentation:** • Project MORE, INC. Policy – Disciplinary Sanctions for Staff • Project More Discipline • Training Page Disciplinary • Online PREA Audit: Pre-Audit Questionnaire Community Confinement

Interviews:

Compliance Determination by Provisions and Corrective Actions:

115.276 (a)

Compliance Determination:
The facility has demonstrated compliance with this provision of the standard because:

The provision requires that staff be subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies.

The agency has policy that staff is subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies.

Project MORE, INC. Policy – Disciplinary Sanctions for Staff Section I. Project MORE, INC. Policy –PMI staff shall be subject to disciplinary sanctions up to an including termination for violating agency sexual abuse or sexual harassment policies. Termination shall be the presumptive disciplinary sanction for staff who engage 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. All termination of violations of sexual abuse or sexual harassment policies or resignation, shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and to any relevant licensing bodies. Section II. Procedures:

A. All allegations of sexual abuse and sexual harassment against residents will be forwarded to the agency PREA Coordinator.
B. All complaints should be documented and include, but not be limited to the following:
1. Date and time of the allegation.
2. Name of the alleged abuser.
3. Complaint's name.
4. Name and location of the program.
5. Description of the allegation.
6. Name of any witness.
C. The PREA Coordinator shall conduct the investigation.
D. Disposition of all allegations will be forwarded to the Manager of Human Resources and President/CEO.
E. If it is concluded that the allegation is valid, immediate, and appropriate corrective action will take place.
F. Disciplinary action can range from verbal or written warnings up to termination, depending on the circumstances.
G. If applicable, law enforcement agencies will be contacted.

	A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **115.276 (b)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires that termination be the presumptive disciplinary sanction for who have engaged in sexual abuse. Based on a review of information that the facility provided in the PAQ, in the past 12 months, the number of staff from the facility who have violated agency sexual abuse or sexual harassment policies is zero. In the past 12 months, the number of staff from the facility who have been terminated (or resigned prior to termination) for violating agency sexual abuse or sexual harassment policies is zero. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **115.276 (c)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires that disciplinary sanctions for violations of 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 acts committed, the staff member’s disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories. Based on a review of information that the facility provided in the PAQ, in the past 12 months, the number of staff from the facility who have been disciplined, short of termination, for violation of agency sexual abuse or sexual harassment policies (other than engaging in sexual abuse is zero. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **115.276 (d)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires that 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, shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and to any relevant licensing bodies. Based on a review of information that the facility provided in the PAQ, in the past 12 months, the number of staff from the facility that 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 is zero. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **Overall Findings:** The auditor uses a triangulation approach, by connecting the PREA documentation, policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local advocates, and online PREA Audit: Pre-Audit Questionnaire to collaborate findings determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.277	**Corrective action for contractors and volunteers**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Evidence Relied Upon in Making the Compliance Determination: **Documentation:** • Project MORE, INC. Policy – Corrective Action for Contractors and Volunteers • Online PREA Audit: Pre-Audit Questionnaire Community Confinement **Interviews:** **Compliance Determination by Provisions and Corrective Actions:** **115.277 (a)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires that any contractor or volunteer who engages in sexual abuse be prohibited from contact with residents and be reported to law enforcement agencies, unless the activity was clearly not criminal, and to relevant licensing bodies.

	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. Project MORE, INC. Policy – Corrective Action for Contractors and Volunteers Section I. 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. 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. Section II. Procedures. A. Volunteers 1. Volunteers will be subject to all rules, regulations, and conditions of employment as any PMI employee. This will include an application, background check and disciplinary actions. 2. Volunteers will be under the direct supervision of the Program Manager or designee. B. Contractors 1. The WBH will require all contractors to receive training on PMI policy regarding sexual abuse and sexual harassment. 2. Contractors will sign off on the PMI policy and receive a copy. 3. Staff will monitor all contractors doing business in the facility. C. Project MORE maintenance staff will receive the same training as facility staff. Informal conversation with the Program Manager confirmed that if a contractor or volunteer engage in sexual misconduct be reported to law enforcement agencies and to relevant licensing bodies. Based on a review of information that the facility provided in the PAQ, in the past 12 months, the number of contractors or volunteers reported to law enforcement for engaging in sexual abuse of residents is zero. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **115.277 (b)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires that the facility take appropriate remedial measures and consider whether to prohibit further contact with Residents, in the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer. The 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. Informal conversation with the Program Manager confirmed that if a contractor or volunteer engages in sexual misconduct with a resident, they will be prohibited from further contact with the residents until the investigation is completed. The interviewed Program Manager confirmed that in a case of any violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer the measures the facility will take not allow the person access to the program and prohibit further contact with the resident. The investigation may be occurring, the police would be notified. For the safety of the residents the facility would request a different employee from the contracting company, and if it was a volunteer the facility would no longer utilize them. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **Overall Findings:** The auditor uses a triangulation approach, by connecting the PREA documentation, policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local advocates, and online PREA Audit: Pre-Audit Questionnaire to collaborate findings determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.278	**Disciplinary sanctions for residents**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Evidence Relied Upon in Making the Compliance Determination: **Documentation:** • Project MORE, INC. Policy – Disciplinary Sanctions for Residents • WFC MOU • Online PREA Audit: Pre-Audit Questionnaire Community Confinement **Interviews:** • Program Manager • Medical and Mental Health Staff - 0 **Compliance Determination by Provisions and Corrective Actions:** **115.278 (a)**

	Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires that residents shall be subject to disciplinary sanctions pursuant to a formal disciplinary process following an administrative finding that the resident engaged in resident-on-resident sexual abuse or following a criminal finding of guilt for resident-on-resident sexual abuse. The facility has a policy that 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. Project MORE, INC. Policy – Disciplinary sanctions for Residents Section I. 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. Sanctions shall be commensurate with the nature and circumstances of the abuse committed, that and the resident's disciplinary history, and the sanctions imposed for the comparable offenses by other residents with similar histories. The disciplinary process shall consider whether a residents' mental disabilities or mental illness contributed to his/her behavior when determining what type of sanction, if any should be imposed. PMI shall sanction a resident for sexual contact with staff only upon finding that the staff member did not consent to such contact. Section II. Procedures: A. All incidents shall be investigated by PMI. B. PMI will discipline a resident for sexual contact with staff only upon finding that the staff member did not consent to such contact. C. Should allegations be proved true, the New Haven Police Department will be contacted. D. PMI does not offer in-house therapy. However, should a resident or staff member require therapy or counseling, arrangements with be made with an outside agency to provide services. E. 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. Based on a review of information that the facility provided in the PAQ, in the past 12 months, the number of administrative findings of resident-on-resident sexual abuse that have occurred at that facility is zero. In the past 12 months, the number of criminal findings guilty of resident-on-resident sexual abuse that have occurred at the facility is zero. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **115.278 (b)**

	Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires that sanctions be commensurate with the nature and circumstances of the abuse committed, the resident's disciplinary history, and the sanctions imposed for comparable offenses other residents with similar histories. Informal conversation with the agency PREA coordinator confirmed that the agency resident's sanctions are commensurate with the nature and circumstances of the abuse committed, and the resident's disciplinary history. The interviewed Program Manager confirmed that the disciplinary sanctions residents are subject to following an administrative or criminal finding that the resident engaged in resident-on-resident sexual abuse, the supervising agency would remove the client from the program and determine sanctions. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **115.278 (c)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires that the disciplinary process consider whether a resident's mental disabilities or mental illness contributed to his or her behavior when determining what type of sanction, in any, should be imposed. Informal conversation with the agency PREA coordinator confirmed that the disciplinary process does consider whether a resident mental disabilities or mental illness contributed to the behavior. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **115.278 (d)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires that if the facility offers therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse, the facility shall consider whether to require the offending inmate to participate in such interventions as a condition of access to programming or other benefits.

	Informal conversations with the case manager confirmed that they would offer counseling or other interventions to help to correct underlying reasons or motivation for the abuse. They do have an option to refer the resident to the rape crisis center for emotional support services. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **115.278 (e)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires that the agency may discipline a resident for sexual contact with staff only upon a finding that the staff member did not consent to such contact. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **115.278 (f)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires that to disciplinary action, a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred shall not constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation. 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 that allegation. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **115.278 (g)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires that an agency may, in its discretion, prohibit all sexual activity between residents and may discipline residents for such activity. An agency may not, however, deem such activity to constitute sexual abuse if it determines that the activity is not coerced.

	The agency probits all sexual activity between residents. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **Overall Findings:** The auditor uses a triangulation approach, by connecting the PREA documentation, policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local advocates, and online PREA Audit: Pre-Audit Questionnaire to collaborate findings determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.282	**Access to emergency medical and mental health services**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Evidence Relied Upon in Making the Compliance Determination: **Documentation:** • Project MORE, INC. Policy – Access to Emergency Medical and Mental Health Services • MOU WFC • Hospital Response to Sexual Assault Victim • Online PREA Audit: Pre-Audit Questionnaire Community Confinement **Interviews:** • Medical and Mental Health Staff - 0 • Resident who reported a Sexual Abuse - 0 **Compliance Determination by Provisions and Corrective Actions:** **115.282 (a)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires that resident victims of sexual abuse shall 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. Resident victims of sexual abuse receive timely, unimpeded access to emergency

	medical treatment and crisis intervention service. Project MORE, INC. Policy – Access to Emergency Medical and Mental Health Services Section I. Resident victim of sexual abuse shall 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 judgement. Section II. Procedures: A. PMI does not have qualified medical or mental health practitioners at their facilities. Staff will take steps pursuant to standard 115.262 to protect the victim and notify the appropriate medical and mental health practitioners. B. Treatment will be provided without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising from the incident. C. Residents who may have become pregnant or have a sexually transmitted disease shall be referred to Yale New Haven Hospital. Staff will accompany the resident to the hospital. Informal conversation with the agency PREA coordinator confirmed that the agency's facilities ensure that the residents receive timely, unimpeded access to emergency medical treatment and crisis intervention services through the local hospital. Local hospital is required to follow the State of Connecticut Technical Guidelines for Health Care Response to Victims of Sexual assault. In accordance with Connecticut General Statutes Section 19a-112a. The auditor reviews a copy of the State of Connecticut Technical Guidelines for Health Care Response to Victims of Sexual assault review general medical care and treatment. Informal conversation with the Program manager confirmed that the local hospital or the rape crisis center will provide timely access to emergency services. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **115.282 (b)** Compliance Determination: The facility had demonstrated compliance with this provision of the standard because: The provision requires that if no qualified medical or mental health practitioners are on duty at the time a report of recent abuse is made, security staff first responders shall take preliminary steps to protect the victim pursuant to standard 115.62 and shall immediately notify the appropriate medical and mental health practitioners. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following

	the provisions of this standard. No corrective action is warranted. **115.282 (C)** Compliance Determination: The facility had demonstrated compliance with this provision of the standard because: The provision requires that resident victims of sexual abuse while incarcerated shall be 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. Resident victims of sexual abuse while incarcerated are offered timely information about ant timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate. Informal conversation with the agency PREA coordinator confirmed that the agency's facilities ensure that the residents receive timely, unimpeded access to emergency medical treatment and crisis intervention services through the local hospital. Local hospital is required to follows the State of Connecticut Technical Guidelines for Health Care Response to Victims of Sexual assault. In accordance with Connecticut General Statutes Section 19a-112a. The auditor reviews a copy of the State of Connecticut Technical Guidelines for Health Care Response to Victims of Sexual assault review general medical care and treatment. Informal conversation with the Program manager confirmed that the local hospital or the rape crisis center will provide timely access to emergency services. During the onsite review period there were no residents who reported sexual abuse for interview. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **115.282 (d)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires that treatment services be 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. 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. Informal conversation with the Program manager confirmed that the residents are not charged for sexual abuse services. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **Overall Findings:** The auditor uses a triangulation approach, by connecting the PREA documentation, policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local advocates, and online PREA Audit: Pre-Audit Questionnaire to collaborate findings determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.283	**Ongoing medical and mental health care for sexual abuse victims and abusers**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Evidence Relied Upon in Making the Compliance Determination: **Documentation:** • Project MORE, INC. Policy – Project MORE, INC. Policy – Ongoing Medical and Mental Health Care for Sexual Abuse Victims and Abusers • Hospital Response to Sexual Assault Victim • MOU • Online PREA Audit: Pre-Audit Questionnaire Community Confinement **Interviews:** • Medical and Mental Health Staff - 0 • Resident who reported a Sexual Abuse - 0 **Compliance Determination by Provisions and Corrective Actions:** **115.283 (a)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires that 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.

The facility offers medical and mental health evaluation and, as appropriate, treatment to all residents who have been abused in any prison, jail, lockup, or juvenile facility.

Project MORE, INC. Policy – Ongoing Medical and Mental Health Care for Sexual Abuse Victims and Abusers Section I. The agency shall offer medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse in any prison, jail, lock up or juvenile facility. Section II. Procedures:

A. Once it has been determined that a resident has been victim of sexual abuse PMI staff will make appropriate referrals to medical, mental health evaluation, and treatment to the client.
B. Should the resident agree to the offer PMI staff will contact the appropriate provider.
C. Counseling can be done on site or at any outside location. On-site counseling will be held in a private secure office. Staff will transport the resident to any outside counseling or medical appointment.
D. PMI shall attempt to refer all known resident on resident abusers for a mental health evaluation/treatment within 60 days of learning of such abusive history.
E. Residents who may have become pregnant or have a sexually transmitted disease shall be referred to Yale New Haven Hospital. Staff will transport.
F. All information will be placed in the residents' case file.

Informal conversation with the Program Manager confirmed that mental health services are provided by the local hospital or rape crisis center.

A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted.

115.283 (b)

Compliance Determination:
The facility has demonstrated compliance with this provision of the standard because:

The provision requires that 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 replacement in, other facilities, or their release from custody.

During the onsite review period, there were no individuals who reported sexual abuse for interview.

A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted.

	115.283 (c) Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires that the facility provide such victims with medical and mental health services consistent with the community level of care. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **115.283 (d)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires that resident victims of sexually abusive vaginal penetration while incarcerated shall be offered pregnancy tests. The facility only house male resident. During the onsite review period there were no residents who reported sexual abuse for interview. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **115.283 (e)** Compliance Determination: The facility had demonstrated compliance with this provision of the standard because: The provision requires that if pregnancy results from the conduct described in paragraph (d) of this section, such victims shall receive timely and comprehensive information about and timely access to all lawful pregnancy-related medical services. The facility only house male residents. During the onsite review period there were no residents who reported sexual abuse for interview. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted.

	115.283 (f) Compliance Determination: The facility had demonstrated compliance with this provision of the standard because: The provision requires that resident victims of sexual abuse while incarcerated be offered tests for sexually transmitted infections as medically appropriate. Resident victims of sexual abuse while incarcerated are offered tests for sexually transmitted infections as medically appropriate by the rape crisis center or local hospital. During the onsite review period there were no residents who reported sexual abuse for interview. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **115.283 (g)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires that treatment services be 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. During the onsite review period there were no residents who reported sexual abuse for interview. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **115.283 (h)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires that all 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. During the onsite review period there were no residents who reported sexual abuse for interview.

	A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **Overall Findings:** The auditor uses a triangulation approach, by connecting the PREA documentation, policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local advocates, and online PREA Audit: Pre-Audit Questionnaire to collaborate findings determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.286	**Sexual abuse incident reviews**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Evidence Relied Upon in Making the Compliance Determination: **Documentation:** • Project MORE, INC. Policy – Sexual Abuse Incident Reviews • PREA Sexual Abuse Review • Online PREA Audit: Pre-Audit Questionnaire Community Confinement **Interviews:** • Program Manager • Agency PREA Coordinator • Incident Review Staff Member **Compliance Determination by Provisions and Corrective Actions:** **115.286 (a)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires that 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. The facility conducts a sexual abuse investigation at the conclusion of every criminal or administrative sexual abuse investigation unless the allegations have been determined to be unfounded.

	Project MORE, INC. Policy – Sexual Abuse Incident Review Section I. PMI shall conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation. Section II. Procedures. A. The review will occur within 30 days of the conclusion of the investigation. B. The review team shall include the PREA Coordinator, Program Manager, and any staff that was involved in the investigation, any outside medical and/or mental health practitioners if available and applicable. C. The review team shall consider the following: 1. Consider if the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse. 2. Consider whether the incident or allegations was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; or gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility. 3. Examine the area in the facility where the incident allegedly occurred to access whether physical barriers in the area may enable abuse. 4. Assess the adequacy of staffing levels in that area during different shifts. 5. Assess whether monitoring technology should be deployed or augmented to supplement staff supervision. 6. Prepare a report of its findings and recommendations for improvement and submit such report to PMI's President and PREA Coordinator. D. A report of the team's findings will be prepared. Copies will be given to all PMI staff in attendance. E. All recommendations will be implemented, provided adequate resources are available, or shall document reasons for not doing so. Based on a review of information that the facility provided in the PAQ, in the past 12 months, the number of criminal and/or administrative investigations of alleged sexual abuse completed at the facility, excluding only "unfounded" incidents is 1. Interviewed PREA coordinator collaborated that the agency does conducts sexual abuse incident reviews and prepares a report of its findings form the reviews, including any determinations and any recommendations for improvement. The agency completes sexual abuse incident reviews for all allegations with a substantiated or unsubstantiated outcome. The form includes the specific determinations noted in this standard and documents any recommendations for improvement. These reports are forwarded for review to the management team. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **115.286 (b)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because:

	The provision requires that such a review ordinarily occurs within 30 days of the conclusion of the investigation. The facility ordinarily conducts a sexual abuse incident review within 30 days of the conclusion of the criminal or administrative sexual abuse investigation. Based on a review of information that the facility provided in the PAQ, in the past 12 months, the number of criminal and/or administrative investigations of alleged sexual abuse completed at the facility that were followed by a sexual abuse incident review within 30 days, excluding only “unfounded” incidents is one. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **115.286 (c)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires that the review team include upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners. The sexual abuse incident review team includes upper-level management officials and allows for input from line supervisors, investigators, and medical or mental health practitioners. The interviewed Program Manager confirmed that the agency has a sexual abuse Incident Review Team, the Connection review team discusses the event, and a written report is done. The Incident review Team involves the Chief Operating Officer, the VP of the Service Area, PREA Coordinator, the VP of Quality, Risk and Information, the Program Manager, and the Program Manager. Additional members may be added depending on the incident. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **115.286 (d)** Compliance Determinations: The facility has demonstrated compliance with this provision of the standard because: The provision requires that 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. Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian; gay, bisexual, transgender, or

	intersex identification, status, or perceived status; or gang affiliation; or was motivated or otherwise cause by other group dynamics at the facility. Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse. Assess the adequacy of staffing levels in that area during different shifts. Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff; and prepare a report of its findings, including but not necessarily limited to determinations made pursuant to paragraphs (d) of this section, and any recommendations for improvement and submit such report to the facility head and PREA compliance manager. Interviewed staff that is member of the Incident Review Team confirmed that they consider whether the allegations or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse; whether the incident or allegation was motivated by race, ethnicity, gender identity, or LGBT population. They look at physical barriers and the different shifts. A review of one PREA Administrative Review Report confirmed the following information: • Does the allegation or investigation indicate a need to change policy or practice to better prevent, detect, or respond to sexual abuse? • Was the incident or allegation motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; or gang affiliation; or was motivated or otherwise cause by other group dynamics at the facility? • Does the area in the facility where the incident allegedly occurred have physical barriers that may enable abuse? • Was the staffing level adequate for the time and activities at the time of the incident? • Is monitoring technology sufficient to supplement supervision by staff? The interviewed Program Manager confirmed that the information from the sexual abuse incident review is used to make changes and implement policies and training another related issue from the report. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **115.286 (e)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires that the facility implement the recommendations for improvement or shall document its reasons for not doing so. The facility implements recommendations for improvement or documents its

	reasons for not doing so. A review of the PREA Administrative Review Report confirmed that the findings are listed at the bottom of the page and the recommendations for improvement. There is a statement “will the recommendations of improvement be implemented? Informal conversation with the PREA coordinator confirmed that the Team recommended is approval and implemented because the Team members are the upper level from the central office. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **Overall Findings:** The auditor uses a triangulation approach, by connecting the PREA documentation, policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local advocates, and online PREA Audit: Pre-Audit Questionnaire to collaborate findings determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.287	**Data collection**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Evidence Relied Upon in Making the Compliance Determination: **Documentation:** • Project MORE, INC. Policy – Data Collection • SSV 2023 Report • Policy Review for Correction Action • Online PREA Audit: Pre-Audit Questionnaire Community Confinement **Interview:** **Compliance Determination by Provisions and Corrective Actions:** **115.287 (a)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires that 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.

The agency collects accurate, uniform data for every allegation of sexual abuse at facilities under its direct supervision using a standardized instrument and set of definitions.

Project MORE, INC. Policy – Data Collection Section I. The PREA Coordinator shall collect accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions. All information will be kept in a secure and confidential area. Section II. Procedures:

A. PMI shall utilize the latest Survey of Sexual Victimization questioner conducted by the Department of Justice in collecting data.
B. PMI shall also utilize an in-house data collection tool that will include the following information:
1. Facility census
2. Nonconsensual Instances
3. Staff misconducts
4. New Employees
5. Staff trainings
C. PMI shall maintain, review and collect data as needed from all available incident-based reports, investigation files, and sexual abuse incident reviews. This data will come from PMI's residential facilities along with any private facility the agency contracts with.
D. Upon request, PMI shall provide such data from the previous calendar year to CSSD and, if requested, the Department of Justice.

A review of the Survey of Sexual Victimization, 2023 Adult Residential Facilities confirmed that the agency is collecting the required data in a standardized instrument and set of definitions.

A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted.

115.287 (b)

Compliance Determination:
The facility has demonstrated compliance with this provision of the standard because:

The provision requires that the agency aggregate the incident-based sexual abuse data at least annually.

The agency aggregates the incident-based sexual abuse data at least annual PREA report.

A review of the agency 2023 PREA Annual Report confirmed that the agency has aggregated incident-based sexual abuse data.

	A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **115.287 (c)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires that the incident-based data collected 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. 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 conducted by the Department of Justice. A review of the Survey of Sexual Victimization, 2023 Adult Residential Facilities confirmed that the agency is collecting the required data that answers all questions from the most recent version of the survey for the Department of Justice. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **115.287 (d)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires that the agency maintain, review, and collect data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews. The agency maintains, reviews, and collects data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews. Informal conversation with the PREA coordinator confirmed that the agency maintains, review, and collects data, investigation files and sexual abuse incident reviews. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **115.287 (e)** Compliance Determination:

	The facility has demonstrated compliance with this provision of the standard because: The provision requires that the agency also obtain incident-based and aggregated data from every private facility with which it contracts for the confinement of its residents. The agency does not obtain incident-based and aggregated data from every private facility with which it contracts for the confinement of its residents. Informal conversation with the PREA coordinator confirmed that the agency does not contract with any private facilities to house its contract residents. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **115.287 (f)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires that upon request, the agency provide all such data from the previous calendar year to the Department of Justice no later than June 30. The agency will provide the Department of Justice with data from the previous calendar year upon request. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **Overall Findings:** The auditor uses a triangulation approach, by connecting the PREA documentation, policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local advocates, and online PREA Audit: Pre-Audit Questionnaire to collaborate findings determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.288	**Data review for corrective action**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Evidence Relied Upon in Making the Compliance Determination:

Documentation:

• Project MORE, INC. Policy – Data Review for Corrective Action
• PREA Reports Websit
• Online PREA Audit: Pre-Audit Questionnaire Community Confinement

Interviews:

• Agency Head
• PREA Coordinator

Compliance Determination by Provisions and Corrective Actions:

115.288 (a)

Compliance Determination:
The facility has demonstrated compliance with this provision of the standard because:

The provision requires that the agency review data collected and aggregated pursuant to standard 115.87 to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Identifying problem areas. Taking corrective action on an ongoing basis; and preparing an annual report of its findings and corrective actions for each facility, as well as the agency.

The agency reviews data collected and aggregated to assess and improve the effectiveness of its sexual abuse prevention, detection, response polices, and training.

Project MORE, INC. Policy – Data Review for Corrective Action Section I. PMI shall review data collected and aggregated pursuant to standard 115.287. This will be done in order to access and improve the effectiveness of its sexual abuse prevention, detection and response policies, practices and training. Section II. Procedures.

A. Data collection will identify problem areas which will enable the agency to take corrective action on an ongoing basis.
B. The agency will prepare an annual report of its finding along with corrective action plans for each facility, as well as the agency as a whole.
C. The report will include a comparison of the current years' data and corrective actions with those from prior years and provide an assessment of the agency's progress in addressing sexual abuse.
D. The report shall be approved by the agency President/CEO.
E. The report will be made available to the public through the agency website.
F. Information in the report may be deleted when publication would present a clear and specific threat to the safety and security of the facility. However, the report must indicate the nature of the material redacted.

Interviewed Agency Head confirmed that the agency uses incident-based sexual

	abuse data to assess and improve sexual abuse prevention, detection, and response policies, practices, and training. Incident report data is routinely reviewed to look for trends and opportunities to make early detection of incidents of sexual abuse. By reviewing the incidents on a regular basis, the agency can make preemptive changes to improve overall practice related to prevention, detection and response to abuse. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **115.288 (b)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires that such a report include a comparison of the current year's data and corrective actions with those from prior years and should provide an assessment of the agency's progress in addressing sexual abuse. The annual report includes a comparison of the current year's data and corrective actions with those from prior years. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **115.288 (c)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires that the agency's report be approved by the agency heard and made readily available to the public through its website or, if it does not have one, through other means. Interviewed PREA coordinator collaborated that the agency prepares an annual report of findings from its data review and any corrective actions for each facility, as well as the agency. PREA coordinator completes an annual report that complies finding data, review data, and corrective action plans for every program. The Interview Agency Head confirmed that that she approves annual reports in written format and publishes the report on the agency website. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **115.288 (d)**

	Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires that the agency may redact specific material from the reports when publication would present a clear and specific threat to the safety and security of a facility but must indicate the nature of the material redacted. 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. Interviewed PREA coordinator collaborated the types of material that are typically redacted from the annual report does include any resident and staff personal information. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **Overall Findings:** The auditor uses a triangulation approach, by connecting the PREA documentation, policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local advocates, and online PREA Audit: Pre-Audit Questionnaire to collaborate findings determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.289	**Data storage, publication, and destruction**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Evidence Relied Upon in Making the Compliance Determination: **Documentation:** • Project MORE, INC. Policy – Data Storage, Publication, and Destruction • Online PREA Audit: Pre-Audit Questionnaire Community Confinement **Interviews:** • PREA Coordinator **Compliance Determination by Provisions and Corrective Actions:** **115.289 (a)**

Compliance Determination:
The facility has demonstrated compliance with this provision of the standard because:

The provision requires that the agency ensure that data collected pursuant to standard 115.87 are securely retained.

The agency ensures that the incident based, and aggregate data are securely preserved.

Project MORE, INC. Policy – Data Storage, Publication, and Destruction Section I. PMI shall ensure that collected pursuant to standard 115.287 are securely retained. PMI shall make all arrogated sexual abuse data, from its facilities along with private facilities with which it contracts, available to the public. The information shall be posted on its web page, and the agency will ensure all personal identifiers are removed. The agency shall maintain sexual abuse data for at least 10 years after the date of the initial collection, unless Federal, State, or local law requires otherwise. Section II. Procedures.

A. All data collected pursuant to standard 115.287 shall be stored in a locked secure location.
B. PMI shall make all aggregated sexual abuse data from the WBH readily available to the public at least annually via its website.
1. All personal identifiers shall be removed from the data.
C. The PREA Coordinator will be responsible for destroying these files.
1. Files will be destroyed 10 years after the initial collection date, unless Federal, State, or local law requires otherwise.

A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted.

115.289 (b)

Compliance Determination:
The facility has demonstrated compliance with this provision of the standard because:

The provision requires that the agency to 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.

Informal conversation with the PREA coordinator confirmed that the agency does not contract with any private facilities to house its residents.

A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted.

	115.289 (c) Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires that before making aggregated sexual abuse data publicly available, the agency shall remove all personal identifiers. Before making aggregated sexual abuse data publicly available, the agency removes all personal identifiers. A review of the agency 2023 Annual PREA report confirmed that the agency removes all personal identifiers. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **115.289 (d)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires that the agency maintain sexual abuse data collected pursuant to 115.87 for at least 10 years after the date of the initial collection unless Federal, State, or local law requires otherwise. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **Overall Findings:** The auditor uses a triangulation approach, by connecting the PREA documentation, policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local advocates, and online PREA Audit: Pre-Audit Questionnaire to collaborate findings determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.401	**Frequency and scope of audits**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Evidence Relied Upon in Making the Compliance Determination:

Documentation:

• Facility Past Final Audit Report
• Agency PREA Website
• Facility Posting of PREA Notices
• Agency Annual PREA Report

Interviews:

• Agency PREA Coordinator

Compliance Determination by Provisions and Corrective Actions:

115.401 (a)

Compliance Determination:
The facility has demonstrated compliance with this provision of the standard because:

The provision requires that during the three-year period starting on August 20, 2013, and during each three-year period thereafter, the agency shall ensure that each facility operated by the agency, or a private organization on behalf of the agency, is audited at least once.

A review of the agency's website confirmed PREA audit according to cycles. Each facility is included in the agency's Annual PREA Report. The private facility produces its own annual PREA report.

A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted.

115.401 (b)

Compliance Determination:
The facility has demonstrated compliance with this provision of the standard because:

The provision requires that during each one-year period starting on August 20, 2013, the agency shall ensure that at least one third of each facility type operated by the agency, or by a private organization on behalf of the agency, is audited.

A review of the agency's website confirmed PREA audit according to cycles. The agency has scheduled a third of its facilities to be audited within the required cycle.

A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted.

115.401 (h)

	Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires that the auditor have access to, and shall observe, all areas of the audited facilities. On the first day of the audit after the entrance conference, the auditor conducted a comprehensive tour of the facility. It was requested that when the auditor paused to speak to a resident or staff, that staff on the tour please step away so the conversation might remain private. This request was well respected. During the tour, the auditor reviewed PREA related documentation and materials located on bulletin boards and walls. The auditor observed camera surveillance, physical supervision, and electronic monitoring capabilities. Other areas of focus during the tour included, but were not limited to, levels of staff supervision, and limits to cross-gender viewing. Housing units, visitation, intake area, administrative areas, Kitchen, dining, storage, work areas were toured. A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted. **115.401 (i)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires that the auditor be permitted to request and receive copies of any relevant documents (including electronically stored information). The PREA Coordinator and the facility provided the auditor with all relevant documents to include electronically stored information through the agency system. **115.401 (m)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires that the auditor be permitted to conduct private interviews with residents. During the pre-audit period, the facility received instructions to post the required PREA Audit Notice of the upcoming audit prior to the on-site visit for confidential communications. The facility posted the notices in English and Spanish. The auditor received email and pictures confirming the posted notices and observed the posted notices on-site. During the onsite visit the auditor requested and receive areas to interview

residents in private.

115.401 (n)

Compliance Determination:
The facility has demonstrated compliance with this provision of the standard because:

The provision requires that confined persons be permitted to send confidential information or correspondence to the auditor in the same manner as if they were communicating with legal counsel.

There were no confidential communications from residents and none from staff. Staff interview indicated that resident is permitted to send confidential information or correspondence in the same manner as if they were communicating with legal counsel.

The auditor reviews the MOU for Emotional Support Services for Survivors of Sexual Abuse.

• Documentation review of the Memorandum Agreement between Connection, Inc., and The Connecticut Alliance to End Sexual Violence. The Alliance to End Sexual Violence (The Alliance) is a coalition of Connecticut's nine (9) community based sexual assault crisis and advocacy services including a 24-hour hotline, individual counseling, medical and legal accompaniment and support, and community education and training programs.

• Just Detention International (JDI) – is a health and human rights organization that seeks to end sexual abuse in all forms of detention. Founded in 1980, JDI is the only organization in the U.S. – and the world – dedicated exclusively to ending sexual abuse behind bars. They hold government officials accountable for prisoner rape; challenge the attitudes and misperception that enable sexual abuse to flourish; and make sure that survivors get the help they need. This agency reported that they did not receive reports from the facility.

• National Sexual Violence Resource Center (NSVRC) response: A email was sent to NSVRC, the return email states that they provide information and tools to prevent and respond to sexual violence. While they are happy to have our organization listed as a resource for people who are incarcerated, they do not receive reports or provide services in any capacity. They also are not able to disclose if anyone from the facility reached out for resources.

A review of the appropriate documentations, interviews and conversations with staff and residents, review of relevant policies collaborated that the facility is following the provisions of this standard. No corrective action is warranted.

Overall Findings:

The auditor uses a triangulation approach, by connecting the PREA documentation, policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local advocates, and online PREA Audit: Pre-Audit Questionnaire

	to collaborate findings determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.403	Audit contents and findings
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Evidence Relied Upon in Making the Compliance Determination: **Documentation:** • Facility Past Final Audit Report • Agency PREA Website • Facility Posting of PREA Notices • Agency Annual PREA Report **Interviews:** • Agency PREA Coordinator **Compliance Determination by Provisions and Corrective Actions:** **115.403 (f)** Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The provision requires that the agency ensure that the auditor’s final report is published on the agency’s website if it has one or is otherwise made readily available to the public. The auditor reviewed the agency website and confirmed the facility final PREA reports are published on the agency website. **Overall Findings:** The auditor uses a triangulation approach, by connecting the PREA documentation, policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local advocates, and online PREA Audit: Pre-Audit Questionnaire to collaborate findings determinations. Based on analysis, the facility is compliant with all provisions in this standard.

Appendix: Provision Findings		
115.211 (a)	**Zero tolerance of sexual abuse and sexual harassment; PREA coordinator**	
	Does the agency have a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment?	yes
	Does the written policy outline the agency's approach to preventing, detecting, and responding to sexual abuse and sexual harassment?	yes
115.211 (b)	**Zero tolerance of sexual abuse and sexual harassment; PREA coordinator**	
	Has the agency employed or designated an agency-wide PREA Coordinator?	yes
	Is the PREA Coordinator position in the upper-level of the agency hierarchy?	yes
	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 community confinement facilities?	yes
115.212 (a)	**Contracting with other entities for the confinement of residents**	
	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 adopt and 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.)	na
115.212 (b)	**Contracting with other entities for the confinement of residents**	
	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.)	na
115.212 (c)	**Contracting with other entities for the confinement of residents**	
	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	na

	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.)	
	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.)	na
115.213 (a)	**Supervision and monitoring**	
	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
	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
	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
	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
	In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Any other relevant factors?	yes
115.213 (b)	**Supervision and monitoring**	
	In circumstances where the staffing plan is not complied with, does the facility document and justify all deviations from the plan? (NA if no deviations from staffing plan.)	yes
115.213 (c)	**Supervision and monitoring**	
	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
	In the past 12 months, has the facility assessed, determined, and documented whether adjustments are needed to prevailing	yes

	staffing patterns?	
	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
	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
115.215 (a)	**Limits to cross-gender viewing and searches**	
	Does the facility always refrain from conducting any cross-gender strip searches or cross-gender visual body cavity searches, except in exigent circumstances or by medical practitioners?	yes
115.215 (b)	**Limits to cross-gender viewing and searches**	
	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 inmates.)	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 inmates.)	na
115.215 (c)	**Limits to cross-gender viewing and searches**	
	Does the facility document all cross-gender strip searches and cross-gender visual body cavity searches?	yes
	Does the facility document all cross-gender pat-down searches of female residents?	yes
115.215 (d)	**Limits to cross-gender viewing and searches**	
	Does the facility have policies that enable residents to shower, perform bodily functions, and change clothing without non-medical 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
	Does the facility have procedures that enable residents to shower,	yes

	perform bodily functions, and change clothing without non-medical 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?	
	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
115.215 (e)	**Limits to cross-gender viewing and searches**	
	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
	If the 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
115.215 (f)	**Limits to cross-gender viewing and searches**	
	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
	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
115.216 (a)	**Residents with disabilities and residents who are limited English proficient**	
	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
	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

	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
	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
	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
	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
	Do such steps include, when necessary, ensuring effective communication with residents who are deaf or hard of hearing?	yes
	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
	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
	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
	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: Who are blind or have low vision?	yes
115.216 (b)	**Residents with disabilities and residents who are limited English proficient**	

	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
	Do these steps include providing interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary?	yes
115.216 (c)	**Residents with disabilities and residents who are limited English proficient**	
	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
115.217 (a)	**Hiring and promotion decisions**	
	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
	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
	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 two questions immediately above ?	yes
	Does the agency prohibit the enlistment of the 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
	Does the agency prohibit the enlistment of the 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	yes

	force, or coercion, or if the victim did not consent or was unable to consent or refuse?	
	Does the agency prohibit the enlistment of the 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 two questions immediately above ?	yes
115.217 (b)	**Hiring and promotion decisions**	
	Does the agency consider any incidents of sexual harassment in determining whether to hire or promote anyone who may have contact with residents?	yes
	Does the agency consider any incidents of sexual harassment in determining to enlist the services of any contractor who may have contact with residents?	yes
115.217 (c)	**Hiring and promotion decisions**	
	Before hiring new employees who may have contact with residents, does the agency: Perform a criminal background records check?	yes
	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
115.217 (d)	**Hiring and promotion decisions**	
	Does the agency perform a criminal background records check before enlisting the services of any contractor who may have contact with residents?	yes
115.217 (e)	**Hiring and promotion decisions**	
	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
115.217	**Hiring and promotion decisions**	

(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
	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
	Does the agency impose upon employees a continuing affirmative duty to disclose any such misconduct?	yes
115.217 (g)	**Hiring and promotion decisions**	
	Does the agency consider material omissions regarding such misconduct, or the provision of materially false information, grounds for termination?	yes
115.217 (h)	**Hiring and promotion decisions**	
	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
115.218 (a)	**Upgrades to facilities and technology**	
	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.)	na
115.218 (b)	**Upgrades to facilities and technology**	
	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	na

	agency’s ability to protect residents from sexual abuse? (N/A if agency/facility has not installed or updated any video monitoring system, electronic surveillance system, or other monitoring technology since August 20, 2012 or since the last PREA audit, whichever is later.)	
115.221 (a)	**Evidence protocol and forensic medical examinations**	
	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
115.221 (b)	**Evidence protocol and forensic medical examinations**	
	Is this protocol developmentally appropriate for youth where applicable? (NA if the agency/facility is not responsible for conducting any form of criminal or administrative sexual abuse investigations.)	yes
	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? (NA if the agency/facility is not responsible for conducting any form of criminal or administrative sexual abuse investigations.)	yes
115.221 (c)	**Evidence protocol and forensic medical examinations**	
	Does the agency offer all victims of sexual abuse access to forensic medical examinations, whether on-site or at an outside facility, without financial cost, where evidentiarily or medically appropriate?	yes
	Are such examinations performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) where possible?	yes
	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

	Has the agency documented its efforts to provide SAFEs or SANEs?	yes
115.221 (d)	**Evidence protocol and forensic medical examinations**	
	Does the agency attempt to make available to the victim a victim advocate from a rape crisis center?	yes
	If a rape crisis center is not available to provide victim advocate services, does the agency make available to provide these services a qualified staff member from a community-based organization, or a qualified agency staff member?	yes
	Has the agency documented its efforts to secure services from rape crisis centers?	yes
115.221 (e)	**Evidence protocol and forensic medical examinations**	
	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
	As requested by the victim, does this person provide emotional support, crisis intervention, information, and referrals?	yes
115.221 (f)	**Evidence protocol and forensic medical examinations**	
	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.)	na
115.221 (h)	**Evidence protocol and forensic medical examinations**	
	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 attempts to make a victim advocate from a rape crisis center available to victims per 115.221(d) above).	na

115.222 (a)	**Policies to ensure referrals of allegations for investigations**	
	Does the agency ensure an administrative or criminal investigation is completed for all allegations of sexual abuse?	yes
	Does the agency ensure an administrative or criminal investigation is completed for all allegations of sexual harassment?	yes
115.222 (b)	**Policies to ensure referrals of allegations for investigations**	
	Does the agency have a policy 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
	Has the agency published such policy on its website or, if it does not have one, made the policy available through other means?	yes
	Does the agency document all such referrals?	yes
115.222 (c)	**Policies to ensure referrals of allegations for investigations**	
	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
115.231 (a)	**Employee training**	
	Does the agency train all employees who may have contact with residents on: Its zero-tolerance policy for sexual abuse and sexual harassment?	yes
	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
	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
	Does the agency train all employees who may have contact with	yes

	residents on: The right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment?	
	Does the agency train all employees who may have contact with residents on: The dynamics of sexual abuse and sexual harassment in confinement?	yes
	Does the agency train all employees who may have contact with residents on: The common reactions of sexual abuse and sexual harassment victims?	yes
	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
	Does the agency train all employees who may have contact with residents on: How to avoid inappropriate relationships with residents?	yes
	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
	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
115.231 (b)	**Employee training**	
	Is such training tailored to the gender of the residents at the employee's facility?	yes
	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
115.231 (c)	**Employee training**	
	Have all current employees who may have contact with residents received such training?	yes
	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
	In years in which an employee does not receive refresher training,	yes

	does the agency provide refresher information on current sexual abuse and sexual harassment policies?	
115.231 (d)	**Employee training**	
	Does the agency document, through employee signature or electronic verification, that employees understand the training they have received?	yes
115.232 (a)	**Volunteer and contractor training**	
	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
115.232 (b)	**Volunteer and contractor training**	
	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
115.232 (c)	**Volunteer and contractor training**	
	Does the agency maintain documentation confirming that volunteers and contractors understand the training they have received?	yes
115.233 (a)	**Resident education**	
	During intake, do residents receive information explaining: The agency's zero-tolerance policy regarding sexual abuse and sexual harassment?	yes
	During intake, do residents receive information explaining: How to report incidents or suspicions of sexual abuse or sexual harassment?	yes
	During intake, do residents receive information explaining: Their rights to be free from sexual abuse and sexual harassment?	yes

	During intake, do residents receive information explaining: Their rights to be free from retaliation for reporting such incidents?	yes
	During intake, do residents receive information regarding agency policies and procedures for responding to such incidents?	yes
115.233 (b)	**Resident education**	
	Does the agency provide refresher information whenever a resident is transferred to a different facility?	yes
115.233 (c)	**Resident education**	
	Does the agency provide resident education in formats accessible to all residents, including those who: Are limited English proficient?	yes
	Does the agency provide resident education in formats accessible to all residents, including those who: Are deaf?	yes
	Does the agency provide resident education in formats accessible to all residents, including those who: Are visually impaired?	yes
	Does the agency provide resident education in formats accessible to all residents, including those who: Are otherwise disabled?	yes
	Does the agency provide resident education in formats accessible to all residents, including those who: Have limited reading skills?	yes
115.233 (d)	**Resident education**	
	Does the agency maintain documentation of resident participation in these education sessions?	yes
115.233 (e)	**Resident education**	
	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
115.234 (a)	**Specialized training: Investigations**	
	In addition to the general training provided to all employees pursuant to §115.231, does the agency ensure that, to the extent	yes

	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 criminal or administrative sexual abuse investigations. See 115.221(a)).	
115.234 (b)	**Specialized training: Investigations**	
	Does this specialized training include: Techniques for interviewing sexual abuse victims?(N/A if the agency does not conduct any form of criminal or administrative sexual abuse investigations. See 115.221(a)).	yes
	Does this specialized training include: Proper use of Miranda and Garrity warnings?(N/A if the agency does not conduct any form of criminal or administrative sexual abuse investigations. See 115.221(a)).	yes
	Does this specialized training include: Sexual abuse evidence collection in confinement settings?(N/A if the agency does not conduct any form of criminal or administrative sexual abuse investigations. See 115.221(a)).	yes
	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 criminal or administrative sexual abuse investigations. See 115.221(a)).	yes
115.234 (c)	**Specialized training: Investigations**	
	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 criminal or administrative sexual abuse investigations. See 115.221(a).)	yes
115.235 (a)	**Specialized training: Medical and mental health care**	
	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.)	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.)	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.)	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.)	na
115.235 (b)	**Specialized training: Medical and mental health care**	
	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.)	na
115.235 (c)	**Specialized training: Medical and mental health care**	
	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.)	na
115.235 (d)	**Specialized training: Medical and mental health care**	
	Do medical and mental health care practitioners employed by the agency also receive training mandated for employees by §115.231? (N/A for circumstances in which a particular status (employee or contractor/volunteer) does not apply.)	na
	Do medical and mental health care practitioners contracted by	na

	and volunteering for the agency also receive training mandated for contractors and volunteers by §115.232? (N/A for circumstances in which a particular status (employee or contractor/volunteer) does not apply.)	
115.241 (a)	**Screening for risk of victimization and abusiveness**	
	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
	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
115.241 (b)	**Screening for risk of victimization and abusiveness**	
	Do intake screenings ordinarily take place within 72 hours of arrival at the facility?	yes
115.241 (c)	**Screening for risk of victimization and abusiveness**	
	Are all PREA screening assessments conducted using an objective screening instrument?	yes
115.241 (d)	**Screening for risk of victimization and abusiveness**	
	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
	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
	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
	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
	Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization:	yes

	Whether the resident's criminal history is exclusively nonviolent?	
	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
	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
	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
	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
115.241 (e)	**Screening for risk of victimization and abusiveness**	
	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
	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
	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
115.241 (f)	**Screening for risk of victimization and abusiveness**	
	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

115.241 (g)	**Screening for risk of victimization and abusiveness**	
	Does the facility reassess a resident’s risk level when warranted due to a: Referral?	yes
	Does the facility reassess a resident’s risk level when warranted due to a: Request?	yes
	Does the facility reassess a resident’s risk level when warranted due to a: Incident of sexual abuse?	yes
	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
115.241 (h)	**Screening for risk of victimization and abusiveness**	
	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
115.241 (i)	**Screening for risk of victimization and abusiveness**	
	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
115.242 (a)	**Use of screening information**	
	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
	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
	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

	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
	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
115.242 (b)	**Use of screening information**	
	Does the agency make individualized determinations about how to ensure the safety of each resident?	yes
115.242 (c)	**Use of screening information**	
	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
	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
115.242 (d)	**Use of screening information**	
	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
115.242 (e)	**Use of screening information**	
	Are transgender and intersex residents given the opportunity to shower separately from other residents?	yes
115.242	**Use of screening information**	

(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.)	no
	Unless placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting lesbian, gay, bisexual, transgender, or intersex residents, does the agency always refrain from placing: transgender residents in dedicated facilities, units, or wings solely on the basis of such identification or status? (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.)	no
	Unless placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting lesbian, gay, bisexual, transgender, or intersex residents, does the agency always refrain from placing: intersex residents in dedicated facilities, units, or wings solely on the basis of such identification or status? (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.)	no
115.251 (a)	**Resident reporting**	
	Does the agency provide multiple internal ways for residents to privately report: Sexual abuse and sexual harassment?	yes
	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
	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
115.251 (b)	**Resident reporting**	

	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
	Is that private entity or office able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials?	yes
	Does that private entity or office allow the resident to remain anonymous upon request?	yes
115.251 (c)	**Resident reporting**	
	Do staff members accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously, and from third parties?	yes
	Do staff members promptly document any verbal reports of sexual abuse and sexual harassment?	yes
115.251 (d)	**Resident reporting**	
	Does the agency provide a method for staff to privately report sexual abuse and sexual harassment of residents?	yes
115.252 (a)	**Exhaustion of administrative remedies**	
	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
115.252 (b)	**Exhaustion of administrative remedies**	
	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
	Does the agency always refrain from requiring a resident to use any informal grievance process, or to otherwise attempt to resolve	yes

	with staff, an alleged incident of sexual abuse? (N/A if agency is exempt from this standard.)	
115.252 (c)	**Exhaustion of administrative remedies**	
	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
	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
115.252 (d)	**Exhaustion of administrative remedies**	
	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
	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 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
	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
115.252 (e)	**Exhaustion of administrative remedies**	
	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
	Are those third parties also permitted to file such requests on behalf of residents? (If a third party files such a request on behalf	yes

	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.)	
	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
115.252 (f)	**Exhaustion of administrative remedies**	
	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
	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
	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
	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
	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
	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
	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
115.252 (g)	**Exhaustion of administrative remedies**	
	If the agency disciplines a resident for filing a grievance related to	yes

	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.)	
115.253 (a)	**Resident access to outside confidential support services**	
	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
	Does the facility enable reasonable communication between residents and these organizations, in as confidential a manner as possible?	yes
115.253 (b)	**Resident access to outside confidential support services**	
	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
115.253 (c)	**Resident access to outside confidential support services**	
	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
	Does the agency maintain copies of agreements or documentation showing attempts to enter into such agreements?	yes
115.254 (a)	**Third party reporting**	
	Has the agency established a method to receive third-party reports of sexual abuse and sexual harassment?	yes
	Has the agency distributed publicly information on how to report sexual abuse and sexual harassment on behalf of a resident?	yes
115.261 (a)	**Staff and agency reporting duties**	
	Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or	yes

	information regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency?	
	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
	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
115.261 (b)	**Staff and agency reporting duties**	
	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
115.261 (c)	**Staff and agency reporting duties**	
	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
	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
115.261 (d)	**Staff and agency reporting duties**	
	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
115.261 (e)	**Staff and agency reporting duties**	
	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

115.262 (a)	**Agency protection duties**	
	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
115.263 (a)	**Reporting to other confinement facilities**	
	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
115.263 (b)	**Reporting to other confinement facilities**	
	Is such notification provided as soon as possible, but no later than 72 hours after receiving the allegation?	yes
115.263 (c)	**Reporting to other confinement facilities**	
	Does the agency document that it has provided such notification?	yes
115.263 (d)	**Reporting to other confinement facilities**	
	Does the facility head or agency office that receives such notification ensure that the allegation is investigated in accordance with these standards?	yes
115.264 (a)	**Staff first responder duties**	
	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
	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
	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,	yes

	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?	
	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
115.264 (b)	**Staff first responder duties**	
	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
115.265 (a)	**Coordinated response**	
	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
115.266 (a)	**Preservation of ability to protect residents from contact with abusers**	
	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
115.267 (a)	**Agency protection against retaliation**	
	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

	Has the agency designated which staff members or departments are charged with monitoring retaliation?	yes
115.267 (b)	**Agency protection against retaliation**	
	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
115.267 (c)	**Agency protection against retaliation**	
	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
	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
	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
	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
	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:4. Monitor resident housing changes?	yes
	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

	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
	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 reassignment of staff?	yes
	Does the agency continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need?	yes
115.267 (d)	**Agency protection against retaliation**	
	In the case of residents, does such monitoring also include periodic status checks?	yes
115.267 (e)	**Agency protection against retaliation**	
	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
115.271 (a)	**Criminal and administrative agency investigations**	
	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
	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
115.271 (b)	**Criminal and administrative agency investigations**	
	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
115.271 (c)	**Criminal and administrative agency investigations**	
	Do investigators gather and preserve direct and circumstantial	yes

	evidence, including any available physical and DNA evidence and any available electronic monitoring data?	
	Do investigators interview alleged victims, suspected perpetrators, and witnesses?	yes
	Do investigators review prior reports and complaints of sexual abuse involving the suspected perpetrator?	yes
115.271 (d)	**Criminal and administrative agency investigations**	
	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
115.271 (e)	**Criminal and administrative agency investigations**	
	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
	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
115.271 (f)	**Criminal and administrative agency investigations**	
	Do administrative investigations include an effort to determine whether staff actions or failures to act contributed to the abuse?	yes
	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
115.271 (g)	**Criminal and administrative agency investigations**	
	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
115.271	**Criminal and administrative agency investigations**	

(h)		
	Are all substantiated allegations of conduct that appears to be criminal referred for prosecution?	yes
115.271 (i)	**Criminal and administrative agency investigations**	
	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
115.271 (j)	**Criminal and administrative agency investigations**	
	Does the agency ensure that the departure of an alleged abuser or victim from the employment or control of the facility or agency does not provide a basis for terminating an investigation?	yes
115.271 (l)	**Criminal and administrative agency investigations**	
	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 any form of administrative or criminal sexual abuse investigations. See 115.221(a).)	yes
115.272 (a)	**Evidentiary standard for administrative investigations**	
	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
115.273 (a)	**Reporting to residents**	
	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
115.273 (b)	**Reporting to residents**	
	If the agency did not conduct the investigation into a resident’s allegation of sexual abuse in an agency facility, does the agency	na

	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.)	
115.273 (c)	**Reporting to residents**	
	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
	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
	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
	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
115.273 (d)	**Reporting to residents**	
	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
	Following a resident's allegation that he or she has been sexually abused by another resident, does the agency subsequently inform	yes

	the alleged victim whenever: The agency learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility?	
115.273 (e)	**Reporting to residents**	
	Does the agency document all such notifications or attempted notifications?	yes
115.276 (a)	**Disciplinary sanctions for staff**	
	Are staff subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies?	yes
115.276 (b)	**Disciplinary sanctions for staff**	
	Is termination the presumptive disciplinary sanction for staff who have engaged in sexual abuse?	yes
115.276 (c)	**Disciplinary sanctions for staff**	
	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
115.276 (d)	**Disciplinary sanctions for staff**	
	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
	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
115.277 (a)	**Corrective action for contractors and volunteers**	

	Is any contractor or volunteer who engages in sexual abuse prohibited from contact with residents?	yes
	Is any contractor or volunteer who engages in sexual abuse reported to: Law enforcement agencies (unless the activity was clearly not criminal)?	yes
	Is any contractor or volunteer who engages in sexual abuse reported to: Relevant licensing bodies?	yes
115.277 (b)	**Corrective action for contractors and volunteers**	
	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
115.278 (a)	**Disciplinary sanctions for residents**	
	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
115.278 (b)	**Disciplinary sanctions for residents**	
	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
115.278 (c)	**Disciplinary sanctions for residents**	
	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
115.278 (d)	**Disciplinary sanctions for residents**	
	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	yes

	condition of access to programming and other benefits?	
115.278 (e)	**Disciplinary sanctions for residents**	
	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
115.278 (f)	**Disciplinary sanctions for residents**	
	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
115.278 (g)	**Disciplinary sanctions for 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
115.282 (a)	**Access to emergency medical and mental health services**	
	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
115.282 (b)	**Access to emergency medical and mental health services**	
	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
	Do security staff first responders immediately notify the appropriate medical and mental health practitioners?	yes
115.282 (c)	**Access to emergency medical and mental health services**	
	Are resident victims of sexual abuse offered timely information	yes

	about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate?	
115.282 (d)	**Access to emergency medical and mental health services**	
	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
115.283 (a)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	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
115.283 (b)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	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
115.283 (c)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	Does the facility provide such victims with medical and mental health services consistent with the community level of care?	yes
115.283 (d)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	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.)	na
115.283 (e)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	If pregnancy results from the conduct described in paragraph § 115.283(d), do such victims receive timely and comprehensive	na

	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.)	
115.283 (f)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	Are resident victims of sexual abuse while incarcerated offered tests for sexually transmitted infections as medically appropriate?	yes
115.283 (g)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	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
115.283 (h)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	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
115.286 (a)	**Sexual abuse incident reviews**	
	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
115.286 (b)	**Sexual abuse incident reviews**	
	Does such review ordinarily occur within 30 days of the conclusion of the investigation?	yes
115.286 (c)	**Sexual abuse incident reviews**	
	Does the review team include upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners?	yes

115.286 (d)	**Sexual abuse incident reviews**	
	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
	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
	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
	Does the review team: Assess the adequacy of staffing levels in that area during different shifts?	yes
	Does the review team: Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff?	yes
	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
115.286 (e)	**Sexual abuse incident reviews**	
	Does the facility implement the recommendations for improvement, or document its reasons for not doing so?	yes
115.287 (a)	**Data collection**	
	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
115.287 (b)	**Data collection**	
	Does the agency aggregate the incident-based sexual abuse data at least annually?	yes
115.287	**Data collection**	

(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
115.287 (d)	**Data collection**	
	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
115.287 (e)	**Data collection**	
	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.)	na
115.287 (f)	**Data collection**	
	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
115.288 (a)	**Data review for corrective action**	
	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
	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
	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

115.288 (b)	**Data review for corrective action**	
	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
115.288 (c)	**Data review for corrective action**	
	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
115.288 (d)	**Data review for corrective action**	
	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
115.289 (a)	**Data storage, publication, and destruction**	
	Does the agency ensure that data collected pursuant to § 115.287 are securely retained?	yes
115.289 (b)	**Data storage, publication, and destruction**	
	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
115.289 (c)	**Data storage, publication, and destruction**	
	Does the agency remove all personal identifiers before making aggregated sexual abuse data publicly available?	yes
115.289 (d)	**Data storage, publication, and destruction**	
	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

115.401 (a)	**Frequency and scope of audits**	
	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
115.401 (b)	**Frequency and scope of audits**	
	Is this the first year of the current audit cycle? (Note: a “no” response does not impact overall compliance with this standard.)	yes
	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.)	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.)	na
115.401 (h)	**Frequency and scope of audits**	
	Did the auditor have access to, and the ability to observe, all areas of the audited facility?	yes
115.401 (i)	**Frequency and scope of audits**	
	Was the auditor permitted to request and receive copies of any relevant documents (including electronically stored information)?	yes
115.401 (m)	**Frequency and scope of audits**	
	Was the auditor permitted to conduct private interviews with residents?	yes
115.401 (n)	**Frequency and scope of audits**	
	Were inmates, residents, and detainees permitted to send confidential information or correspondence to the auditor in the	yes

	same manner as if they were communicating with legal counsel?	
115.403 (f)	**Audit contents and findings**	
	The agency has published on its agency website, if it has one, or has otherwise made publicly available, all Final Audit Reports. The review period is for prior audits completed during the past three years PRECEDING THIS 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, there has never been a Final Audit Report issued.)	yes