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

☐ **Interim** ☒ **Final**

Date of Report: March 11, 2018

Auditor Information

Name: Walter J. Krauss, Psy.D.	**Email:** waltjk@aol.com
Company Name: N/A	
Mailing Address: 66 Elaine Drive	**City, State, Zip:** Southbury, CT 06488
Telephone: 860-707-4622	**Date of Facility Visit:** December 18 & 19, 2017

Agency Information

Name of Agency: Wellmore Behavioral Health		**Governing Authority or Parent Agency** *(If Applicable)*: Click or tap here to enter text.	
Physical Address: 141 East Main Street		**City, State, Zip:** Waterbury, CT 06702	
Mailing Address: Click or tap here to enter text.		**City, State, Zip:** Click or tap here to enter text.	
Telephone: 203-574-9000		**Is Agency accredited by any organization?** ☐ Yes ☒ No	
The Agency Is:	☐ Military	☐ Private for Profit	☒ Private not for Profit
☐ Municipal	☐ County	☐ State	☐ Federal

Agency mission: Wellmore Behavioral Health promotes lifetime wellness through essential and innovative treatment and support. Click or tap here to enter text.

Agency Website with PREA Information: http:/wellmore.org/news-info/prea/

Agency Chief Executive Officer

Name: Gary Steck, LMFT	**Title:** Chief Executive Officer
Email: gsteck@wellmore.org	**Telephone:** 203-574-9000 x 1102

Agency-Wide PREA Coordinator

Name: Chris Desroches	**Title:** Program Manager / Morris Recovery House

Email: cdesroches@wellmore.org	**Telephone:** 203-725-5839 (work cell
PREA Coordinator Reports to: Click or tap here to enter text.	**Number of Compliance Managers who report to the PREA Coordinator** Click or tap here to enter text.

Facility Information

Name of Facility: Therapeutic Shelter			
Physical Address: 142 Griggs Street, Waterbury, CT 06702			
Mailing Address (if different than above): Click or tap here to enter text.			
Telephone Number: 203-574-1419			
The Facility Is:	☐ Military	☐ Private for Profit	☒ Private not for Profit
☐ Municipal	☐ County	☐ State	☐ Federal

Facility Type:	☒ Community treatment center	☐ Halfway house	☐ Restitution center
	☐ Mental health facility	☐ Alcohol or drug rehabilitation center	
	☐ Other community correctional facility		

Facility Mission: The Therapeutic Shelter, in accordance with the agency mission, is a safe and supportive residential facility that provides case management and intensive treatment services for adult men age 18 and over.

Facility Website with PREA Information: http:/wellmore.org/news-info/prea/

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

Director

Name: Robert Haswell, LCSW	**Title:** Program Manager
Email: rhaswell@wellmore.org	**Telephone:** 203-753-3274 (work cell)

Facility PREA Compliance Manager

Name: N/A	**Title:**
Email: Click or tap here to enter text.	**Telephone:** Click or tap here to enter text.

Facility Health Service Administrator

Name: Christie Hunnicutt, LCSW	**Title:** Vice President of Adult Services
Email: chunnicutt@wellmore.org	**Telephone:** 203-676-5206

Facility Characteristics			
Designated Facility Capacity: Licensed for 23, but currently allocated for 15 DMHAS, 3 CSSD residents	**Current Population of Facility:** 2 CSSD, 11 DMHAS		
Number of residents admitted to facility during the past 12 months			25 CSSD, 220 DMHAS
Number of residents admitted to facility during the past 12 months who were transferred from a different community confinement facility:			0
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 30 days or more:			14
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 72 hours or more:			15
Number of residents on date of audit who were admitted to facility prior to August 20, 2012:			0
Age Range of Population:	☒ Adults 18 +	☐ Juveniles Click or tap here to enter text.	☐ Youthful residents Click or tap here to enter text.
Average length of stay or time under supervision:			33 days
Facility Security Level:			Community Confinement (locked facility)
Resident Custody Levels:			CSSD (Pre-trial or Probation), DHMAS (None)
Number of staff currently employed by the facility who may have contact with residents:			15
Number of staff hired by the facility during the past 12 months who may have contact with residents:			5
Number of contracts in the past 12 months for services with contractors who may have contact with residents:			1

Physical Plant	
Number of Buildings: 1	**Number of Single Cell Housing Units:** 5 single bedrooms
Number of Multiple Occupancy Cell Housing Units:	6 multiple bedrooms
Number of Open Bay/Dorm Housing Units:	0
Description of any video or electronic monitoring technology (including any relevant information about where cameras are placed, where the control room is, retention of video, etc.): 25 video cameras	

Medical	
Type of Medical Facility:	Non-medical facility
Forensic sexual assault medical exams are conducted at:	St Mary's in Waterbury, CT

Other	
Number of volunteers and individual contractors, who may have contact with residents, currently authorized to enter the facility:	0
Number of investigators the agency currently employs to investigate allegations of sexual abuse:	0

Audit Findings

Audit Narrative

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

Wellmore Behavioral Health's Therapeutic Shelter received an on-site PREA audit on December 18 and December 19, 2017 by Walter J. Krauss, Psy.D.,DOJ Certified PREA Auditor. During the Pre-Audit phase, the auditor reviewed a variety of documentation provided by the agency and facility. These included policies and procedures, plans, protocols, training records, curricula, and other documents related to demonstrating compliance with PREA Standards. Dr. Krauss contacted the agency Vice President of Adult Services, PREA Coordinator, and Therapeutic Shelter's Program Manager prior to the site visit to discuss the agenda and to provide information on how best to facilitate the on-site auditing process. The auditor provided an agenda for the site visit and requested additional information be made available on the first day of the audit. This additional information included resident rosters with housing unit assignments and staff rosters broken down by job title and shift.

The on-site audit began with a meeting between the PREA Auditor, PREA Coordinator, Vice President of Adult Services, and the facility's Program Manager. The discussion briefly focused on the audit process, the interim/final 45-day report, Corrective Action Plan period if required, and the final report. The meeting was followed by a comprehensive tour of the facility.

During the tour, the auditor observed PREA audit notices and Zero Tolerance posters throughout the facility where both residents and staff could readily view or access the information in both English and Spanish. Residents are permitted to use their cell phones or staff phones upon request at any time to access outside victim support services.

The tour included all areas of the facility, which includes a basement, the main, or first floor, where all the facility programming takes place, and the two upper levels where the residents are housed. During the tour, areas identified included, but were not limited to, the basement, an admissions office, medication room, programming and clinician offices, conference/group room, kitchen/food service room, dining area, a client intake bathroom and shower, two housing units each with separate bathroom and shower areas that allow for privacy.

Interviewees were randomly selected for both residents and staff by the auditor. Because the population was only thirteen every third resident on the requested list was selected until ten residents were identified, including the only two CSSD residents. Twelve of fifteen staff were interviewed as well, incorporating all levels of staff and across all three shifts. There were a total of ten random residents, with at least one from each of the rooms on the two housing floors. None of the residents spoke Spanish, or any other language, with English as a second language. There were no residents at the facility at the time of the audit who had reported current PREA allegations, reported prior victimization, were identified as cognitively limited or developmentally disabled, or who had identified themselves as gay, lesbian, bisexual, transgender, or intersex, There were three residents interviewed that reported

extensive mental health histories that were asked additional questions to ensure that the PREA education and information was provided to them appropriately and they could not have been more complimentary of those staff who did so.

Staff interviews at the agency level included Wellmore Behavioral Health's Chief Executive Officer, Director of Systems Operations, Human Resources Director, Vice President of Finance and Administration, PREA Coordinator, as well as multiple extensive conversations with the Vice President of Adult Services during this process. Phone interviews were conducted with the Executive Director of Safe Haven of Greater Waterbury and the Chairman of the Department of Emergency Services of St. Mary's Hospital. At the facility-level, the Program Manager, Senior Clinician, two Counselors, one clinical intern, seven Shift Monitors, and the Transportation Coordinator. Facility-based staff were asked additional questions as well to meet process requirements including those questions from the Medical and Mental Health staff (Senior Clinician), a volunteer (intern) who has contact with inmates, intake and screening staff (Counselor), and a staff member who monitors retaliation (Program Manager). There were no staff who had acted as a first responder to a sexual assault. Although there was no correspondence sent to the auditor's attention, there was one allegation of sexual abuse at a prior facility outside of the agency and a report of sexual harassment at Therapeutic Shelter in the past 12 months. The former was reported immediately to the facility where the alleged abuse had taken place and the latter resulted in an investigation that was unsubstantiated.

Facility Characteristics

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

Therapeutic Shelter is a locked community-based confinement and treatment center that is run by Wellmore Behavioral Health, both which are located in Waterbury, Connecticut. According to the agency brochure, "Wellmore Behavioral Health promotes lifetime wellness through essential and innovative treatment and support." The facility provides case management and intensive treatment services for adult men age 18 and over. It is a short-term program with residents staying generally between ten to fourteen days. The facility is licensed to accommodate twenty three residents, but currently the maximum is set at eighteen residents, three of which are allocated for Court Support Services Division (CSSD) residents and fifteen for Department of Mental Health and Addictions Services (DMHAS) residents. Therapeutic Shelter previously admitted both male and female residents; however, as of September 2016, only male residents are admitted to the program. On the first day of the onsite PREA audit, there were reportedly thirteen residents at the facility, two of which were CSSD residents and the remaining eleven referred by DMHAS.

The facility contains a basement, main or first floor, and two residential housing floors. Although there is no difference in the criteria for assigning residents to either the second or third floor, the residents on each floor are restricted from accessing a floor to which they are not assigned. Residents housed on the second floor can enter from the front stairwell and those on the third floor through the back stairwell. They can only enter and leave through those doors, thereby restricting residents from accessing a housing floor to which they are not assigned. The second and third floors contain a total of five single

and six multi bedrooms between them with each floor containing a room with three separate showers and another bathroom with three toilet stalls, each allowing for resident privacy. On the main floor is a separate “Client Bathroom” that allows new intakes or residents identified as high risk for victimization to use the single combination bathroom and shower in privacy.

There is a total of fifteen staff that cover the three shift per day system: 1st shift is 8:00 AM to 4:00 PM; 2nd shift is 4:00 PM to 12:00 AM; 3rd shift is 12:00 AM to 8:00 AM. There are two Shift Monitors assigned to cover each shift with the exception of Saturday and Sunday’s 3rd shift which has one Shift Monitor during those hours. Shift monitors tour the housing areas every two hours during the 1st and 2nd shifts and hourly during the 3rd shift.

Upon entrance to the locked facility, one will find the lobby and then the “Admissions Office” to the left where staff counselors and the clinical intern share a large open area and office. Resident intake interviews had previously been conducted in this area upon admission, but currently most intakes are conducted in the staff office down the hall since it has a camera in the room for surveillance. Visitors are asked to sign in on a form that specifies that the facility is a zero tolerance facility. Staff report and residents confirm that they are provided PREA education, verbally and in writing, almost immediately by the Program Manager or Counselors. Resident property is inspected and they are asked to change their clothes at least long enough for them to be washed in the laundry room across from the staff office and next to the Client Bathroom where they then shower in privacy.

Throughout the facility, there are PREA audit announcements stating that the audit would take place on December 18th and 19th, zero tolerance posters, as well as signs on “How to Report Suspected or Complaints of Abuse at a Wellmore Facility” in both English and Spanish.

There is a medical office/exam room on the main floor where medical staff conduct evaluations and store resident medications. Residents are responsible for taking their medications as prescribed. Staff supervise residents while they take their medications, but they do not touch the medications. Residents housed at the facility are offered at least six hours of medical coverage. Wellmore’s medical director provides oversight to all clinical programs and is on call 24/7 for medical issues that arise on site.

In the event of a sexual assault, inmates would be transferred to St Mary’s Hospital in Waterbury, CT where there is a Sexual Assault Nurse Examiner (SANE) available on staff. Safe Haven in Waterbury, CT is available to residents for toll free private crisis calls and as victim advocates who can accompany residents when meeting with the SANE, if requested. Additional outside resources available to residents are referenced, including contact information, within the Wellmore PREA pamphlet Sexual Abuse Resource List provided to residents upon admission. These resources include the Connecticut Alliance to End Sexual Violence, the Waterbury Police Department, the State of CT Office of Victim Advocate, the National Sexual Violence Resource Center, and the Rape/Abuse Incest National Network.

Summary of Audit Findings

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

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

Number of Standards Exceeded: **0** Click or tap here to enter text.

Click or tap here to enter text.

Number of Standards Met: **41** Click or tap here to enter text.

Click or tap here to enter text.

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

Click or tap here to enter text.

Summary of Corrective Action (if any)

It is clear that Wellmore Behavioral Health and the Therapeutic Shelter program have a firm commitment to meeting PREA Standard requirements not only in policy, but in practice as well. This auditor left the on-site visit confident that the residents are safe and have an excellent understanding of what they need to do in the event of sexual harassment or sexual abuse at this facility. Throughout the process, the agency and facility staff interviewed were professional and knowledgeable of the PREA requirements as well as most resources available at the facility level. Administration was responsive to concerns, open to suggestions, and encouraged the auditor to provide feedback on how the facility could improve where applicable. Overall, it was a pleasure to work with the Administration and staff during this process, and this auditor was appreciative of the facility's hospitality and ability to facilitate this process efficiently as requested.

Communication and its value in the effective implementation of the PREA requirements were evident throughout this process via documentation and staff interactions with this auditor. Surveillance camera coverage includes the use of 25 Axis M3004-4 Fixed Dome Network Cameras, which are integrated through a network digital recorder. There are no cameras positioned outside the facility or within the basement, which is off limits to the residents unless under direct staff supervision.

Despite the use of the aforementioned technology, a significant number of blind spots remain where surveillance is not readily available. These blind spots present additional security challenges, which

were shared with Administration. Specific concerns related to blind spots/ surveillance camera coverage included those found in the large closet in Bedroom 3-7, side room of the “Admissions Office”, large closet in the Medication Room, Laundry Room, all staff offices, large walk-in closets throughout the facility, and throughout the basement.

While there were multiple written policy and minor issues identified during the process in need of corrective action that are addressed within the appropriate Standard description in the next section, the more salient issues will be described in this one.

All medical and mental health staff are required to receive not only the basic PREA training, but specialized training as well. At the time of the on-site audit, required staff had not received the specialized trainings to date. Staff were asked to provide a roster of all medical (APRN’s) and mental health staff (Program Manager, Counselors, and Senior Clinician) and verify that they have received and understood the specialized training indicated in the standard 115.235(a) for the corrective action. A copy or reference for the specialized training curriculum utilized, medical and mental health, was asked to be included in the corrective action. Administration provided both the specialized training curriculum utilized and verification that the training had been completed for all medical and mental health staff.

No letters were received from residents in advance of the audit nor were there any residents that reported being sexually assaulted while at the facility during the site visit or within documentation reviewed within the past twelve months.

Standards 115.41 and 115.42 require that both residents classified as potential high risk for abuse and/or high risk for victimization are identified in order to provide appropriate protections. The objective screening tool and system utilized at the time of the site visit did not specifically classify them in appropriate categories and a system for tracking them had not been developed. Administration was asked to modify the tool and develop such a system and spreadsheet for logging related information, which they initiated during the interim period, but had not been fully integrated into standard practice during the corrective action phase. Within this new system, residents can now be identified specifically as being in at least one of four categories, not just two, which will be described further in this section. In this way, information will be able to be accessed upon request, high risk residents can be tracked more efficiently, and will assist with future PREA audit processes as well.

Administration’s response to the identified concerns in Standards 115.41 and 115.42 was impressive. Rethinking and modifying their own approach to screening, the process included the development of a new protocol entitled, “PREA Risk Screening”, in which newly admitted residents are now housed in a single room for up to 72 hours until the PREA Screening process can be completed. Furthermore, a new objective screening tool developed by the South Dakota Department of Corrections was adopted, thereby classifying each resident as a Potential Aggressor (PA), Potential Victim (PV), Mix (MX), or NS (not scored). As a result of the screening, the following outcomes result in the following placements:

- Clients identified as PA can be housed with another PA or NS
- Clients identified as a PV can be housed with a PV or NS
- Clients identified with an NS can be housed with any other outcome
- Clients identified as MX can be housed with another MX or PV

- Some clients may receive a single room assignment regardless of score.

At the time of the on-site audit, only CSSD residents would be re-screened for risk within 30 days of the initial risk assessment screening as required or when additional relevant information is obtained. Corrective action required that all residents, not just those from CSSD, are re-screened within 30 days. As indicated above, staff were asked to develop a system and spreadsheet that tracks and logs the names of residents, dates of their initial screening, risk level, date of re-screening, and corresponding risk level. Corrective action included providing this list with evidence that all residents for whom this applies have been re-screened. This system was not completed by the time the interim report was submitted, but has been addressed appropriately in the correction action phase.

Two of ten residents had not received the risk assessment intake screen within 72 hours of arrival to the facility, including one that had not received the screening at the time of this audit ten days after admission. Nine of the ten residents received the basic PREA education within twenty four hours upon admission with the other resident receiving the training five days after admission. Documentation was provided that the screenings had all been completed prior to the end of the on-site visit. Staff were asked to ensure all residents received the appropriate education and screening/re-screening, which would be included on the spreadsheet/data base that was developed. It shall be noted that when residents were asked if they felt safe at this facility, they did not hesitate to indicate that they did. Most residents offered unsolicited compliments of the staff and program.

Three of twelve random staff interviewed were not aware that residents cannot be searched or examined for the sole purpose of identifying genital status, including medical staff. Seven of twelve were either unclear or unaware of the Language Line service staff have available to them for resident interpretation services. Four of twelve random staff were unclear as to their roles in situations where they would have to serve as first responders. Administration was asked to provide refresher training for staff to address the use of the Language Link, protocol for first responder duties as well as preserving physical evidence. Administration was requested to provide the training and training sheets with signatures as verification for each staff to ensure compliance, which they did.

During the on-site visit, it was learned that if residents contact the “PREA Hotline” that it connects to the Program Manager’s phone line at the Morris Recovery House which can be answered by any staff member if the Program Manager is not present. Corrective action required that the system for the “PREA Hotline” be revamped such that only upper level designated administration can answer the phone and that calls are answered immediately rather than being left on a voice mail, if possible. As a result, a direct line to the PREA Coordinator was set up. If he cannot answer, then a voice mail message can be left. The PREA Coordinator will check his messages at least twice per day.

Administration was asked to provide refresher training for residents to address changes to the PREA Hotline, a description of the services available to them including Safe Haven, and make it clear that if phone calls are made for such services they can be made at any time and with facility phones that are not monitored. It was suggested that staff provide key points on a sheet and have residents sign off that the training has been received and is understood. Administration was requested to provide the training sheets with signatures as verification for each staff to ensure compliance. Although the

resident training had not been completed by the date the interim report, all of the issues had been addressed in the corrective action period of the process.

Consistent with 115.233(c), the agency was asked to develop a process on how to provide services for potential visually impaired residents, which was not evident during the on-site audit, such that residents can receive education related to PREA in formats accessible to all residents. This was addressed in policy whereby staff will provide additional support to the resident and read all materials to them throughout the intake process and whenever necessary during their stay at the facility.

Consistent with standards 115.217 (a) and (f), administration needs to ensure all potential new hires are asked the PREA questions in these standards as part of the hiring process and asked again and reviewed prior to staff promotions. The questions need to be specifically included in policy to be provided as part of the corrective action. Corrective action included modification to policy and adding the specified questions on the PREA Interview Form.

In accordance with 115.217 (e), background checks for two staff identified during the on-site audit need to have their National and DCF background checks (Staff 1) and National or State checks completed (Staff 2). Corrective action included evidence that they were completed and cleared of sexual assault/abuse as well as policy added requiring the completion of background checks at least every five years at Wellmore's Therapeutic Shelter.

PREVENTION PLANNING

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

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

115.211 (a)

- Does the agency have a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment? ☒ Yes ☐ No

- Does the written policy outline the agency's approach to preventing, detecting, and responding to sexual abuse and sexual harassment? ☒ Yes ☐ No

115.211 (b)

- Has the agency employed or designated an agency-wide PREA Coordinator? ☒ Yes ☐ No

- Is the PREA Coordinator position in the upper-level of the agency hierarchy? ☒ Yes ☐ No

- Does the PREA Coordinator have sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards in all of its facilities?

☒ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The 'Prison Rape Elimination Act (PREA) Compliance', 'Sexual Harassment, Misconduct, Assault Zero Tolerance', and 'Notification and Reporting' policies were reviewed as were the PREA pamphlet and 'Sexual Assault Prevention for Residents' handout provided to residents upon admission. The Chief Executive Officer, PREA Coordinator, and the Program Manager were interviewed.

Therapeutic Shelter has a policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment. The policies outline the prevention, detecting, reporting, and response to sexual abuse and sexual harassment allegations. All staff are required to immediately report any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency; retaliation against 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. Definitions that mirror the PREA Standards are included in the PREA Compliance policy as well as sanctions for those who violated policy. All interviewed shared their knowledge of the strategies and responses towards PREA allegations. The PREA Coordinator reported sufficient time to attend to PREA duties.

Therapeutic Shelter is committed to maintaining an environment free from sexual abuse and sexual harassment of residents. Zero tolerance regarding resident sexual assault and harassment is mandated. Sexual abuse and sexual harassment of residents is prohibited by State and Federal law. (28 CFR 115.11) All staff will have access to and be familiar with the Prison Rape Elimination Act Standards.

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

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

115.212 (a)

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

115.212 (b)

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

115.212 (c)

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

- In such a case, does the agency document its unsuccessful attempts to find an entity in compliance with the standards? (N/A if the agency has not entered into a contract with an entity that fails to comply with the PREA standards.) ☐ Yes ☐ No ☒ NA

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Therapeutic Shelter is compliant with this standard and does not contract with other agencies for confinement of their residents. Rather, Wellmore Behavioral Health contractually agreed to meet PREA requirements at Therapeutic Shelter so that three beds at the Therapeutic Shelter would be allocated to house the State of Connecticut's Court Support Services Division (CSSD's) residents.

Standard 115.213: Supervision and monitoring

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

115.213 (a)

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

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

- Does the agency ensure that each facility's staffing plan takes into consideration the physical layout of each facility in calculating adequate staffing levels and determining the need for video monitoring? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the composition of the resident population in calculating adequate staffing levels and determining the need for video monitoring? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the prevalence of substantiated and unsubstantiated incidents of sexual abuse in calculating adequate staffing levels and determining the need for video monitoring? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration any other relevant factors in calculating adequate staffing levels and determining the need for video monitoring? ☒ Yes ☐ No

115.213 (b)

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

115.213 (c)

- In the past 12 months, has the facility assessed, determined, and documented whether adjustments are needed to the staffing plan established pursuant to paragraph (a) of this section? ☒ Yes ☐ No

- In the past 12 months, has the facility assessed, determined, and documented whether adjustments are needed to prevailing staffing patterns? ☒ Yes ☐ No

- In the past 12 months, has the facility assessed, determined, and documented whether adjustments are needed to the facility's deployment of video monitoring systems and other monitoring technologies? ☒ Yes ☐ No

- In the past 12 months, has the facility assessed, determined, and documented whether adjustments are needed to the resources the facility has available to commit to ensure adequate staffing levels? ☒ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The 'Therapeutic Shelter Staffing Plan' was reviewed and the Chief Executive Officer, PREA Coordinator, and Program Manager were interviewed to determine compliance.

Whenever necessary but no less frequently than once each year, the Program Manager in consultation with the PREA Coordinator, Vice President of Adult Services, and Chief Executive Officer assess, determine, and document whether adjustments are needed to the staffing plan, video/surveillance monitoring systems or other technologies, and resources the facility has available to commit to ensure adherence to the staffing plan.

Standard 115.215: Limits to cross-gender viewing and searches

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

115.215 (a)

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

115.215 (b)

- Does the facility always refrain from conducting cross-gender pat-down searches of female residents, except in exigent circumstances? (N/A if less than 50 residents)

☐ Yes ☐ No ☒ NA

- Does the facility always refrain from restricting female residents' access to regularly available programming or other outside opportunities in order to comply with this provision? (N/A if less than 50 residents) ☐ Yes ☐ No ☒ NA

115.215 (c)

- Does the facility document all cross-gender strip searches and cross-gender visual body cavity searches? ☐ Yes ☒ No

- Does the facility document all cross-gender pat-down searches of female residents? ☐ Yes ☒ No

115.215 (d)

- Does the facility implement policies and procedures that enable residents to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks? ☒ Yes ☐ No

- Does the facility require staff of the opposite gender to announce their presence when entering an area where residents are likely to be showering, performing bodily functions, or changing clothing? ☒ Yes ☐ No

115.215 (e)

- Does the facility always refrain from searching or physically examining transgender or intersex residents for the sole purpose of determining the resident's genital status? ☒ Yes ☐ No

- If a resident's genital status is unknown, does the facility determine genital status during conversations with the resident, by reviewing medical records, or, if necessary, by learning that information as part of a broader medical examination conducted in private by a medical practitioner? ☒ Yes ☐ No

115.215 (f)

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

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The protocol entitled, 'Searches of Residents, Visitors, and Facility', and search training modules were reviewed and twelve interviews with random staff were conducted to assist with the determination of compliance or non-compliance.

Program staff do not participate in pat-down searches, conduct strip searches or participate in visual body cavity searches. Staff never physically touch residents as part of their search procedures. Instead, residents are directed to empty and turn out their pockets; open and visually assess wallets, book bags, backpacks, or any other accessory of suspicion; removal of jackets, coats, and footwear; and will ask a resident to conduct their own personal search of waistbands.

Staff will not physically search or physically examine a transgender or intersex resident for the sole purpose of determining the detainee's genital status.

Staff of the opposite gender are trained to announce their presence when entering a housing unit when there is not another staff member of opposite gender already assigned to the post. The announcement must be loud enough that detainees can hear the announcement.

Training documents reviewed indicated that staff have completed appropriate training.

During the ten random resident interviews, all ten reported that opposite gender staff announce their presence when entering a housing unit as part of common practice.

Corrective Action:

Although it was already facility practice per staff and all residents interviewed, policy was added to the protocol on 'Searches of Residents, Visitors, and Facility' as part of corrective action so that it states that residents are able to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing them except in exigent circumstances or when incidental to routine room checks.

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

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

115.216 (a)

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

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

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

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

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

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Other? (if "other," please explain in overall determination notes.) ☒ Yes ☐ No

- Do such steps include, when necessary, ensuring effective communication with residents who are deaf or hard of hearing? ☒ Yes ☐ No

- Do such steps include, when necessary, providing access to interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary? ☒ Yes ☐ No

- Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Have intellectual disabilities? ☒ Yes ☐ No

- Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Have limited reading skills? ☒ Yes ☐ No

- Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Are blind or have low vision? ☒ Yes ☐ No

115.216 (b)

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

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

115.216 (c)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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Policy & Procedure 'Providing Meaningful Communication with Persons with Limited English Proficiency' and 'Resident Education', Wellmore Behavioral Health's 'Cultural Competency and Diversity Plan', Language Identification Flashcards, I Speak Cards, and a business associate agreement between Wellmore Behavioral Health and Language Link Corp, were reviewed to determine compliance with this standard. Interviews with twelve random staff were also conducted.

The agency has established policy to provide for educational services for residents with disabilities to be provided information at intake and assistance on PREA allegations, including reporting. Staff

arrange for education in formats for those residents identified as disabled. Agency policy also addresses the provision of interpreters to those residents with a non-English primary language. There is a contract in effect with Language Link Corp to provide language interpreter services for those appropriate residents.

When residents arrive at the facility, residents are immediately provided with a resident handbook and a comprehensive facility-based PREA pamphlet, which clearly states that the facility has zero tolerance for sexual abuse and harassment complete with definitions, immediate steps to take, how to report, and how to get help. The auditor observed PREA audit notices and Zero Tolerance posters throughout the facility where both residents and staff could readily view or access the information in both English and Spanish.

Corrective Action:

Seven of twelve random staff interviewed were either unclear or unaware of the Language Line service staff have available to them for resident interpretation services. Administration was asked to address methods of assisting visually impaired residents in policy, which was completed in the interim between the on-site visit and this report. Evidence of staff training on these changes and the use of "My Language Link" was provided as requested.

Standard 115.217: Hiring and promotion decisions

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

115.217 (a)

- Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997)? ☒ Yes ☐ No

- Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse? ☒ Yes ☐ No

- Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has been civilly or administratively adjudicated to have engaged in the activity described in the question immediately above? ☒ Yes ☐ No

- Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997)? ☒ Yes ☐ No

- Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse? ☒ Yes ☐ No

- Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has been civilly or administratively adjudicated to have engaged in the activity described in the question immediately above? ☒ Yes ☐ No

115.217 (b)

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

115.217 (c)

- Before hiring new employees, who may have contact with residents, does the agency: Perform a criminal background records check? ☒ Yes ☐ No

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

115.217 (d)

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

115.217 (e)

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

115.217 (f)

- Does the agency ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in written applications or interviews for hiring or promotions? ☒ Yes ☐ No

- Does the agency ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in any interviews or written self-evaluations conducted as part of reviews of current employees? ☒ Yes ☐ No

- Does the agency impose upon employees a continuing affirmative duty to disclose any such misconduct? ☒ Yes ☐ No

115.217 (g)

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

115.217 (h)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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Wellmore Behavioral Health's protocol for 'PREA: Hiring and Promotion Decisions' was reviewed and the Director of Human Resources interviewed to assist with determining compliance.

Therapeutic Shelter shall 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 inmates, who has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution. An applicant shall not be considered for hire if they have 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 refuse; or has been civilly or administratively adjudicated to have engaged in the activity.

The agency will ask all applicants and employees who may have contact with residents directly about previous misconduct in the pre-employment background investigation document and during performance evaluation discussions as part of individual job standards ratings.

All staff has an ongoing affirmative duty to disclose any such misconduct to their supervisor who will report to their respective captain. Material omissions regarding such misconduct, or the provision of materially false information, are grounds for termination. Unless prohibited by law the agency will provide information on substantiated allegations of sexual abuse or harassment involving a former employee upon receiving a request and a signed authorization of release from an institutional employer for whom such an employee has applied to work. Criminal history checks are conducted on every employee and contractor every five years. Background checks will be accompanied by a PREA

background consent form and will be kept in a locked area.

Corrective Action:

Corrective action involved adding components to the 'PREA: Hiring and Promotion Decisions' protocol and completing background checks for two employees that were missing. The interview form used specifically for Therapeutic Shelter employee new hires or for those considered for promotion was modified to reflect the PREA requirements with regard to 115.217 (a). All requested corrective actions were completed as requested.

Standard 115.218: Upgrades to facilities and technologies

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

115.218 (a)

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

115.218 (b)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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Surveillance camera coverage includes the use of 25 Axis M3004-4 Fixed Dome Network Cameras, which are integrated through a digital video recorder. This technology has enhanced the facility's ability to protect residents from sexual abuse. According to the staffing plan, the most recent camera was added to the middle and front staff offices in December 2016. There were no modifications in the past twelve months.

RESPONSIVE PLANNING

Standard 115.221: Evidence protocol and forensic medical examinations

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

115.221 (a)

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

115.221 (b)

- Is this protocol developmentally appropriate for youth where applicable? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.) ☐ Yes ☐ No ☒ NA

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

115.221 (c)

- Does the agency offer all residents who experience sexual abuse access to forensic medical examinations, whether on-site or at an outside facility, without financial cost, where evidentiarily or medically appropriate? ☒ Yes ☐ No

- Are such examinations performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) where possible? ☒ Yes ☐ No

- If SAFEs or SANEs cannot be made available, is the examination performed by other qualified medical practitioners (they must have been specifically trained to conduct sexual assault forensic exams)? ☒ Yes ☐ No

- Has the agency documented its efforts to provide SAFEs or SANEs? ☒ Yes ☐ No

115.221 (d)

- Does the agency attempt to make available to the victim a victim advocate from a rape crisis center? ☒ Yes ☐ No

- If a rape crisis center is not available to provide victim advocate services, does the agency make available to provide these services a qualified staff member from a community-based organization, or a qualified agency staff member? ☒ Yes ☐ No

- Has the agency documented its efforts to secure services from rape crisis centers? ☒ Yes ☐ No

115.221 (e)

- As requested by the victim, does the victim advocate, qualified agency staff member, or qualified community-based organization staff member accompany and support the victim through the forensic medical examination process and investigatory interviews? ☒ Yes ☐ No

- As requested by the victim, does this person provide emotional support, crisis intervention, information, and referrals? ☒ Yes ☐ No

115.221 (f)

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

115.221 (g)

- Auditor is not required to audit this provision.

115.221 (h)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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The protocol entitled, 'Evidence, Forensic Medical Examinations, and Administrative Inquiry', a Memorandum of Understanding with Safe Haven of Greater Waterbury for advocacy services, a letter from St Mary's Hospital in Waterbury explaining their protocol were reviewed. Interviews with the PREA Coordinator and Program Manager as well as phone conversations with the Executive Director of Safe Haven of Greater Waterbury and the Chairman of the Department of Emergency Services of St Mary's all provided information in the determination of compliance.

Therapeutic Shelter staff are not be responsible for conducting investigations in the event of a sexual abuse incident, but do assist the Waterbury Police Department with the process at their request, including but not limited to surveillance footage, Incident Accident Reports, etc. The agency follows a uniform evidence protocol when investigating allegations of sexual abuse that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions. The agency conducts only administrative investigations. Both the PREA Coordinator and Vice President of Adult Services have received the National Institute of Correction's 'Investigating Sexual Abuse in a Confinement Setting' training.

The agency offers all victims of sexual abuse a forensic medical examination at St Mary's Hospital without cost where evidentiary or medically appropriate. A letter from St Mary's Hospital in Waterbury explained that a Sexual Assault Nurse Examiner (SANE) is on staff that follows the guidelines outlined by the Commission for Standardization of Collection of Sexual Assault Evidence in Connecticut. Evidence that needs to be obtained from a victim's person will be acquired by the hospital emergency department. A phone interview with the Chairman of the Department of Emergency Services of St Mary's revealed that the hospital currently has three certified SANE's with another three set to take the class. The contracted medical staff at Therapeutic Shelter will not perform any exams in the event of a sexual abuse case.

Phone calls can be made to outside support services twenty four hours per day. Typically residents use their personal cell phones to make calls, but staff phones are always available for use and are not monitored.

Corrective Action:

Four of twelve random staff were unclear as to their roles in situations where they would have to serve as first responders. As a result of these issues, administration was asked to provide refresher training for staff on the protocol for first responder duties as well as preserving physical evidence. It was suggested that staff provide key points on a sheet and have staff sign off that the training has been received and is understood. Administration was requested to provide the training sheets with signatures as verification for each staff to ensure compliance, which was provided.

Administration was asked to provide refresher training to further educate residents on the services available to them through Safe Haven and to make it clear that if phone calls are made for such services they can be made at any time and with facility phones that are not monitored. In addition to other identified areas, it was suggested that staff provide key points on a sheet and have residents sign off that the training has been received and is understood. Administration was requested to provide the training sheets with signatures as verification for each resident to ensure compliance. This issue was not addressed by the date of the interim report, but it was completed as requested in the corrective action phase of this process.

Standard 115.222: Policies to ensure referrals of allegations for investigations

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

115.222 (a)

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

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

115.222 (b)

- Does the agency have a policy and practice in place to ensure that allegations of sexual abuse or sexual harassment are referred for investigation to an agency with the legal authority to conduct criminal investigations, unless the allegation does not involve potentially criminal behavior? ☒ Yes ☐ No

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

- Does the agency document all such referrals? ☒ Yes ☐ No

115.222 (c)

- If a separate entity is responsible for conducting criminal investigations, does such publication describe the responsibilities of both the agency and the investigating entity? [N/A if the

agency/facility is responsible for conducting criminal investigations. See 115.221(a).]
☒ Yes ☐ No ☐ NA

115.222 (d)

- Auditor is not required to audit this provision.

115.222 (e)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

Instructions for Overall Compliance Determination Narrative

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The protocol entitled, 'Evidence, Forensic Medical Examinations, and Administrative Inquiry', was reviewed. Interviews with the PREA Coordinator and Program Manager also provided information in the determination of compliance.

Therapeutic Shelter staff will not be responsible for conducting investigations in the event of a sexual abuse incident, but does assist the Waterbury Police Department with the process at their request, including but not limited to surveillance footage, Incident Accident Reports, etc. The agency follows a uniform evidence protocol when investigating allegations of sexual abuse that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions. The agency conducts only administrative investigations. Both the PREA Coordinator and Vice President of Adult Services have received the National Institute of Correction's 'Investigating Sexual Abuse in a Confinement Setting' training.

The agency offers all victims of sexual abuse a forensic medical examination at St Mary's Hospital without cost where evidentiary or medically appropriate. A letter from St Mary's Hospital in Waterbury explained that a Sexual Assault Nurse Examiner (SANE) is on staff that follows the guidelines outlined by the Commission for Standardization of Collection of Sexual Assault Evidence in Connecticut. Evidence that needs to be obtained from a victim's person will be acquired by the hospital emergency department. The contracted medical staff at the facility will not perform any exams in the event of a sexual abuse case.

The PREA pamphlet is provided to all residents upon admission and is available on the agency website http://wellmore.org/news-info/prea/. It describes what actions staff will take, including contacting the Waterbury Police Department immediately to initiate an investigation in response to any sexual assault.

TRAINING AND EDUCATION

Standard 115.231: Employee training

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

115.231 (a)

- Does the agency train all employees who may have contact with residents on: Its zero-tolerance policy for sexual abuse and sexual harassment? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: How to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: Residents' right to be free from sexual abuse and sexual harassment ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: The right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: The dynamics of sexual abuse and sexual harassment in juvenile facilities? ☐ Yes ☒ No
- Does the agency train all employees who may have contact with residents on: The common reactions of juvenile victims of sexual abuse and sexual harassment? ☐ Yes ☒ No
- Does the agency train all employees who may have contact with residents on: How to detect and respond to signs of threatened and actual sexual abuse? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: How to avoid inappropriate relationships with residents? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: How to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities? ☒ Yes ☐ No

115.231 (b)

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

115.231 (c)

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

115.231 (d)

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

Auditor Overall Compliance Determination

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

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

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The 'PREA Employee Training and Education' protocol was reviewed and various trainings were reviewed including the PREA training curriculum. Interviews with twelve random staff were also conducted.

The agency policy requires annual training for all staff in all areas identified within the standard. Staff receive a refresher training every two years. Interviews with staff confirmed they completed training and

basically understood the material presented. Employee training documentation found that all staff had completed their training. Staff were generally able to articulate the training they had received.

All staff are trained on the Prison Rape Elimination Act (PREA) within the first year of employment and receive a refresher every two years to include the following:

- The zero tolerance policy for sexual abuse and sexual harassment
- How to fulfill their responsibilities under the PREA policies
- Detainee's rights to be free from sexual harassment or sexual abuse
- The rights of detainees and employees to be free of retaliation for reporting sexual abuse or sexual harassment
- The dynamics of sexual abuse and sexual harassment in confinement
- The common reactions of sexual abuse and sexual harassment victims
- How to detect and respond to signs of threatened or actual sexual abuse
- How to avoid inappropriate relationships with inmates
- How to communicate effectively and professionally with detainees, including those that identify as lesbian, gay, bisexual, transgender, intersex, or gender nonconforming
- How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities.

Corrective Action:

Four of twelve random staff were unclear as to their roles in situations where they would have to serve as first responders. As a result of these issues, administration was asked to provide education and refresher training to staff, which they did. Evidence of training was provided as requested.

Standard 115.232: Volunteer and contractor training

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

115.232 (a)

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

115.232 (b)

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

115.232 (c)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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The 'PREA Employee Training and Education' protocol was reviewed and various trainings were reviewed including the PREA training curriculum. Although the facility does not have volunteers per se, they do have an unpaid clinical intern at the facility who was interviewed to assist in determining compliance with this standard.

The agency policy requires annual training for all staff in all areas identified within the standard. The staff receive a refresher training every two years. Volunteers, or in this case the clinical intern, received the same training and orientation as a staff member would receive. The interview confirmed he completed training and understood the material presented. Employee training documentation was provided.

Any volunteers or visitors entering the facility are required to sign a visitor's log which explains the facility maintains a zero tolerance policy. These individuals would also receive the PREA pamphlet as well.

Standard 115.233: Resident education

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

115.233 (a)

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

- During intake, do residents receive information explaining: Their rights to be free from retaliation for reporting such incidents? ☒ Yes ☐ No

- During intake, do residents receive information regarding agency policies and procedures for responding to such incidents? ☒ Yes ☐ No

115.233 (b)

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

115.233 (c)

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

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

- Does the agency provide resident education in formats accessible to all residents, including those who: Are visually impaired? ☒ Yes ☐ No

- Does the agency provide resident education in formats accessible to all residents, including those who: Are otherwise disabled? ☒ Yes ☐ No

- Does the agency provide resident education in formats accessible to all residents, including those who: Have limited reading skills? ☒ Yes ☐ No

115.233 (d)

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

115.233 (e)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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Policy & Procedure 'Providing Meaningful Communication with Persons with Limited English Proficiency' and 'Resident Education', Wellmore Behavioral Health's 'Cultural Competency and Diversity Plan', Language Identification Flashcards, I Speak Cards, and a business associate agreement between Wellmore Behavioral Health and Language Link Corp were reviewed. Interviews with ten random residents were conducted as well to determine compliance with this standard.

The agency provides education in formats accessible to all residents, including those who are limited in English proficiency, deaf, or otherwise disabled, as well as to residents who have limited reading skills. The agency has established policy to provide for educational services for residents with disabilities to be provided information at intake and assistance on PREA allegations, including reporting. Staff arrange for education in formats for those residents identified as disabled. Agency policy also addresses the provision of interpreters to those residents with a non-English primary language. There is a contract in effect with Language Link Corp to provide language interpreter services for those appropriate residents.

When residents arrive at the facility, residents are immediately provided with a resident handbook, A Sexual Assault Prevention for Residents' handout, and a comprehensive facility-based PREA pamphlet, which clearly states that the facility has zero tolerance for sexual abuse and harassment complete with definitions, immediate steps to take, how to report, and how to get help. The auditor observed PREA audit notices and Zero Tolerance posters throughout the facility where both residents and staff could readily view or access the information in both English and Spanish.

Nine of the ten residents received the basic PREA education within twenty four hours upon admission with the other resident receiving the training five days after admission.

Corrective Action:

Corrective action involved adding how visually impaired residents would be educated on PREA within the Policy & Procedure 'Providing Meaningful Communication with Persons with Limited English Proficiency' and 'Resident Education'. This was addressed in policy whereby staff will provide additional support to the resident and read all materials to them throughout the intake process and whenever necessary during their stay at the facility.

Standard 115.234: Specialized training: Investigations

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

115.234 (a)

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

115.234 (b)

- Does this specialized training include: Techniques for interviewing sexual abuse victims? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).] ☒ Yes ☐ No ☐ NA

- Does this specialized training include: Proper use of Miranda and Garrity warnings? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).] ☒ Yes ☐ No ☐ NA

- Does this specialized training include: Sexual abuse evidence collection in confinement settings? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).] ☒ Yes ☐ No ☐ NA

- Does this specialized training include: The criteria and evidence required to substantiate a case for administrative action or prosecution referral? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).] ☒ Yes ☐ No ☐ NA

115.234 (c)

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

115.234 (d)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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The protocol entitled, 'Evidence, Forensic Medical Examinations, and Administrative Inquiry', was reviewed as well as completed training documentation. An interview with the PREA Coordinator also provided information in the determination of compliance.

Both the PREA Coordinator and Vice President of Adult Services have received the National Institute of Correction's 'Investigating Sexual Abuse in a Confinement Setting' training. Therapeutic Shelter staff, however, will not be responsible for conducting investigations in the event of a sexual abuse incident, but does assist the Waterbury Police Department with the process at their request, including but not limited to surveillance footage, Incident Accident Reporting (IAR) documentation, etc. The agency follows a uniform evidence protocol when investigating allegations of sexual abuse that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions. The agency conducts only administrative investigations.

Standard 115.235: Specialized training: Medical and mental health care

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

115.235 (a)

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to detect and assess signs of sexual abuse and sexual harassment? ☒ Yes ☐ No

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

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How and to whom to report allegations or suspicions of sexual abuse and sexual harassment? ☒ Yes ☐ No

115.235 (b)

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

115.235 (c)

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

115.235 (d)

- Do medical and mental health care practitioners employed by the agency also receive training mandated for employees by §115.231? ☒ Yes ☐ No

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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Corrective Action:

At the time of the on-site audit, required staff had not received the specialized trainings to date. In response, administration was asked to provide a roster of all medical (APRN's) and mental health staff (Program Manager, Counselors, and Senior Clinician) and verify that they have received and understood the specialized training indicated in the standard for corrective action. A copy or reference for the specialized training curriculum utilized, medical and mental health, was asked to be included in the corrective action as well. Administration provided both the specialized training curriculum utilized and verification that the training had been completed for all medical and mental health staff. In addition, the 'PREA Employee Training and Education' protocol was updated to reflect the requirements of this standard.

SCREENING FOR RISK OF SEXUAL VICTIMIZATION AND ABUSIVENESS

Standard 115.241: Screening for risk of victimization and abusiveness

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

115.241 (a)

- Are all residents assessed during an intake screening for their risk of being sexually abused by other residents or sexually abusive toward other residents? ☒ Yes ☐ No

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

115.241 (b)

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

115.241 (c)

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

115.241 (d)

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has a mental, physical, or developmental disability? ☒ Yes ☐ No

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: The age of the resident? ☒ Yes ☐ No

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: The physical build of the resident? ☒ Yes ☐ No

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has previously been incarcerated? ☒ Yes ☐ No

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident's criminal history is exclusively nonviolent? ☒ Yes ☐ No

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has prior convictions for sex offenses against an adult or child? ☒ Yes ☐ No

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident is or is perceived to be gay, lesbian, bisexual,

transgender, intersex, or gender nonconforming (the facility affirmatively asks the resident about his/her sexual orientation and gender identity AND makes a subjective determination based on the screener's perception whether the resident is gender non-conforming or otherwise may be perceived to be LGBTI)? ☒ Yes ☐ No

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has previously experienced sexual victimization? ☒ Yes ☐ No

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

115.241 (e)

- In assessing residents for risk of being sexually abusive, does the initial PREA risk screening consider, when known to the agency: prior acts of sexual abuse? ☒ Yes ☐ No

- In assessing residents for risk of being sexually abusive, does the initial PREA risk screening consider, when known to the agency: prior convictions for violent offenses? ☒ Yes ☐ No

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

115.241 (f)

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

115.241 (g)

- Does the facility reassess a resident's risk level when warranted due to a: Referral? ☒ Yes ☐ No

- Does the facility reassess a resident's risk level when warranted due to a: Request? ☒ Yes ☐ No

- Does the facility reassess a resident's risk level when warranted due to a: Incident of sexual abuse? ☒ Yes ☐ No

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

115.241 (h)

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

115.241 (i)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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In order to determine compliance or noncompliance with this standard, the 'Screening / Re-Assessment for Risk of Sexual Victimization and Abusiveness' protocol, the Intake PREA Screening tool, and ten risk screening samples were reviewed. Ten random resident interviews were also conducted as were those with staff that complete the risk assessments include staff Counselors and the Program Manager. Two of ten residents had not received the risk assessment intake screen within 72 hours of arrival to the facility, including one that had not received the screening at the time of this audit ten days after admission. Documentation was provided that the aforementioned screening had all been completed prior to leaving the onsite visit.

Corrective Action:

Standards require that both residents classified as potential high risk abusers and/or those at high risk for victimization are identified in order to provide appropriate protections. The objective screening tool utilized at the time of the site visit did not result in a score or specifically classify them in appropriate categories and the system for tracking them had not been developed. Administration was asked to develop such a system and spreadsheet for logging related information, which they initiated during the interim period, but was subsequently fully integrated into standard practice during the corrective action phase. Within this new system, residents can now be identified specifically as being in at least one of four categories, not just two, as described later in this standard's comments. In this way, information can be accessed upon request, high risk residents can be tracked more efficiently, and it will assist with future PREA audit processes as well.

In addition, the age of the resident was not included as an element for consideration to assess risk for sexual victimization. Administration was asked to modify the tool to include age as a factor for consideration and specific risk status assignments as determined by the screening tool results and available information. This was addressed in the 45-day interim period.

At the time of the on-site audit, only CSSD residents would be re-screened for risk within 30 days of the initial risk assessment screening as required or when additional relevant information is obtained. Corrective action required that all residents, not just those from CSSD, are re-screened within 30 days. Staff were asked to provide a log that includes the names of residents, dates of their initial screening, risk level, date of re-screening, and corresponding risk level. Once developed, corrective action included providing this list with evidence that all residents for whom this applies have been re-screened and modifying the policy to reflect that change.

Prior to completion of the interim report, staff had provided the modifications to the protocol and the audit tool as well as the requested documentation; however, the objective screening tool would change once again during the corrective action period. Administration's response to the identified concerns was impressive. Rethinking and modifying their own approach to screening, the process included the development of a new protocol entitled, "PREA Risk Screening", in which newly admitted residents are now housed in a single room for up to 72 hours until the PREA screening process can be completed. Furthermore, a new objective screening tool developed by the South Dakota Department of Corrections was adopted, thereby classifying each resident as a Potential Aggressor (PA), Potential Victim (PV), Mix (MX), or NS (not scored).

Standard 115.242: Use of screening information

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

115.242 (a)

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

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

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

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

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

115.242 (b)

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

115.242 (c)

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

- When making housing or other program assignments for transgender or intersex residents, does the agency consider on a case-by-case basis whether a placement would ensure the resident's health and safety, and whether a placement would present management or security problems? ☒ Yes ☐ No

115.242 (d)

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

115.242 (e)

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

115.242 (f)

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

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

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

Auditor Overall Compliance Determination

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

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In order to determine compliance or noncompliance with this standard, the 'Screening / Re-Assessment for Risk of Sexual Victimization and Abusiveness' protocol and ten risk screening samples were reviewed. Ten random resident interviews were also conducted as were those with the PREA Coordinator and staff that complete the risk assessments including Counselors and the Program Manager.

When a resident is identified as being at risk as a result of the screening and any other information that may be factored in, it is the Program Manager's responsibility to work with staff to determine the best outcome for the residents and the facility. Residents may be assigned to single, multi bed rooms, or next to the staff office on a temporary basis. Residents may also shower and in the single combination bathroom/shower across from the staff office.

Corrective Action:

Standards require that both residents classified as potential high risk for abuse and/or those at high risk for victimization are identified in order to provide appropriate protections. The objective screening tool and process utilized at the time of the site visit did not specifically classify them in appropriate categories and a system for tracking them had not been developed. Administration was asked to modify the tool to include specific risk status assignments as determined by the screening tool results and available information, and to include all required elements of the screening tool.

Administration was also asked to develop a system and spreadsheet for logging and tracking related information, which they initiated during the interim period, but had not been fully integrated into standard practice until the corrective action phase. Within this new system, residents can now be identified specifically as being in at least one of four categories, not just two, which will be described further in this section.

In addition, Administration was asked to incorporate specific elements in the policy so that it is consistent with this standard, including, but not limited to, ensuring that transgender or intersex residents are given housing or programming assignments on a case by case basis and that such decisions are made with serious consideration given to respect to the individual's own safety.

Rethinking and modifying their own approach to screening, the process included the development of a new protocol entitled, "PREA Risk Screening", in which newly admitted residents are now housed in a single room for up to 72 hours until the PREA screening process can be completed. Furthermore, a new objective screening tool developed by the South Dakota Department of Corrections was adopted, thereby classifying each resident as a Potential Aggressor (PA), Potential Victim (PV), Mix (MX), or NS (not scored). As a result of the screening, the following outcomes result in the following placements:

- Clients identified as PA can be housed with another PA or NS
- Clients identified as a PV can be housed with a PV or NS
- Clients identified with an NS can be housed with any other outcome
- Clients identified as MX can be housed with another MX or PV
- Some clients may receive a single room assignment regardless of score.

REPORTING

Standard 115.251: Resident reporting

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

115.251 (a)

- Does the agency provide multiple internal ways for residents to privately report: Sexual abuse and sexual harassment? ☒ Yes ☐ No

- Does the agency provide multiple internal ways for residents to privately report: Retaliation by other residents or staff for reporting sexual abuse and sexual harassment? ☒ Yes ☐ No

- Does the agency provide multiple internal ways for residents to privately report: Staff neglect or violation of responsibilities that may have contributed to such incidents? ☒ Yes ☐ No

115.251 (b)

- Does the agency also provide at least one way for residents to report sexual abuse or sexual harassment to a public or private entity or office that is not part of the agency? ☒ Yes ☐ No

- Is that private entity or office able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials? ☒ Yes ☐ No

- Does that private entity or office allow the resident to remain anonymous upon request? ☒ Yes ☐ No

115.251 (c)

- Do staff members accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously, and from third parties? ☒ Yes ☐ No

- Do staff members promptly document any verbal reports of sexual abuse and sexual harassment? ☒ Yes ☐ No

115.251 (d)

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

Auditor Overall Compliance Determination

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

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

Instructions for Overall Compliance Determination Narrative

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The 'Prison Rape Elimination Act (PREA) Compliance', 'Sexual Harassment, Misconduct, Assault Zero Tolerance', and 'Notification and Reporting' policies were reviewed as were the PREA pamphlet and 'Sexual Assault Prevention for Residents' handout provided to residents upon admission. Interviews with the PREA Coordinator, Program Manager, ten random residents, as well as phone conversations with the Executive Director of Safe Haven of Greater Waterbury also provided information in the determination of compliance.

Therapeutic Shelter provides 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.

Staff accepts reports made verbally, in writing, anonymously, and from third parties and will promptly document any verbal reports. Staff may report sexual abuse and sexual harassment of residents at any time to any member of the command staff that they are comfortable with.

The agency provides 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 hot line numbers. The organization allows for twenty four hour access to facility phones and these agencies or organizations.

Throughout the facility, there were PREA audit announcements that the audit would take place on December 18th and 19th, zero tolerance posters, as well as signs on "How to Report Suspected or Complaints of Abuse at a Wellmore Facility" in both English and Spanish.

Safe Haven in Waterbury, CT is available to residents for toll free private crisis calls and as victim advocates who can accompany residents when meeting with the SANE, if requested. Additional outside resources available to residents are referenced, including contact information, within the Wellmore PREA pamphlet Sexual Abuse Resource List provided to residents upon admission. These resources include the Connecticut Alliance to End Sexual Violence, the Waterbury Police Department, the State of CT Office of Victim Advocate, the National Sexual Violence Resource Center, and the Rape/Abuse Incest National Network.

Corrective Action:

During the on-site visit, it was learned that if residents contact the "PREA Hotline" that it connects to the Program Manager's phone line at the Morris Recovery House (also in Waterbury, CT) which can be answered by any staff member if the Program Manager, who also serves as the agency PREA Coordinator, is not present. Corrective action required that the system for the "PREA Hotline" be revamped such that only upper level designated administration can answer the phone and that calls are answered immediately rather than being left on a voice mail, if possible. As a result, a direct line to the PREA Coordinator was set up. If he cannot answer, then a voice mail message can be left. The PREA Coordinator will check his messages at least twice per day.

Administration was asked to provide refresher training for residents to address any changes to the PREA Hotline, a description of the services available to them including Safe Haven, and make it clear that if phone calls are made for such services they can be made at any time and with facility phones that are not monitored. It was suggested that staff provide key points on a sheet and have residents sign off that the training has been received and is understood. Administration was requested to provide the training sheets with signatures as verification for each staff to ensure compliance. This was not completed by the time the interim report was submitted, but was completed during the corrective action period on 2-27-18..

Standard 115.252: Exhaustion of administrative remedies

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

115.252 (a)

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

115.252 (b)

- Does the agency permit residents to submit a grievance regarding an allegation of sexual abuse without any type of time limits? (The agency may apply otherwise-applicable time limits to any portion of a grievance that does not allege an incident of sexual abuse.) (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- Does the agency always refrain from requiring a resident to use any informal grievance process, or to otherwise attempt to resolve with staff, an alleged incident of sexual abuse? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

115.252 (c)

- Does the agency ensure that: A resident who alleges sexual abuse may submit a grievance without submitting it to a staff member who is the subject of the complaint? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- Does the agency ensure that: Such grievance is not referred to a staff member who is the subject of the complaint? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

115.252 (d)

- Does the agency issue a final agency decision on the merits of any portion of a grievance alleging sexual abuse within 90 days of the initial filing of the grievance? (Computation of the 90-day time period does not include time consumed by residents in preparing any administrative appeal.) (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- If the agency determines that the 90-day timeframe is insufficient to make an appropriate decision and claims an extension of time [the maximum allowable extension of time to respond is 70 days per 115.252(d)(3)] , does the agency notify the resident in writing of any such extension and provide a date by which a decision will be made? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- At any level of the administrative process, including the final level, if the resident does not receive a response within the time allotted for reply, including any properly noticed extension, may a resident consider the absence of a response to be a denial at that level? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

115.252 (e)

- Are third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, permitted to assist residents in filing requests for administrative remedies relating to allegations of sexual abuse? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- Are those third parties also permitted to file such requests on behalf of residents? (If a third-party files such a request on behalf of a resident, the facility may require as a condition of processing the request that the alleged victim agree to have the request filed on his or her behalf, and may also require the alleged victim to personally pursue any subsequent steps in

the administrative remedy process.) (N/A if agency is exempt from this standard.)
☒ Yes ☐ No ☐ NA

- If the resident declines to have the request processed on his or her behalf, does the agency document the resident's decision? (N/A if agency is exempt from this standard.)
☒ Yes ☐ No ☐ NA

115.252 (f)

- Has the agency established procedures for the filing of an emergency grievance alleging that a resident is subject to a substantial risk of imminent sexual abuse? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- After receiving an emergency grievance alleging a resident is subject to a substantial risk of imminent sexual abuse, does the agency immediately forward the grievance (or any portion thereof that alleges the substantial risk of imminent sexual abuse) to a level of review at which immediate corrective action may be taken? (N/A if agency is exempt from this standard.).
☒ Yes ☐ No ☐ NA

- After receiving an emergency grievance described above, does the agency provide an initial response within 48 hours? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- After receiving an emergency grievance described above, does the agency issue a final agency decision within 5 calendar days? (N/A if agency is exempt from this standard.)
☒ Yes ☐ No ☐ NA

- Does the initial response and final agency decision document the agency's determination whether the resident is in substantial risk of imminent sexual abuse? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- Does the initial response document the agency's action(s) taken in response to the emergency grievance? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- Does the agency's final decision document the agency's action(s) taken in response to the emergency grievance? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

115.252 (g)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The 'Resident Grievance' protocol was reviewed and the PREA Coordinator and Program Manager interviewed to determine compliance with this standard.

A resident may file a grievance at any time to bring a problem to staff's attention. Third parties including residents, staff members, family members, attorneys or others shall be permitted to assist a resident in filing requests for administrative remedies relating to sexual abuse and will also be permitted to file such requests on the resident's behalf. If a resident declines to have a request processed on their behalf in situations of alleged sexual abuse, the administration will document the resident's decision.

The agency will ensure that a resident who alleges sexual abuse or harassment may submit a grievance without submitting to the staff person who is the subject of the complaint. A grievance should never be filed with a staff person involved in a complaint, and should be immediately forwarded to the Program Manager/PREA Coordinator. If neither is available at the time of report, the Vice President of Adult Services should be notified immediately.

After receipt of an emergency grievance alleging a resident is subject to substantial risk of imminent sexual abuse the facility 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.

There have been no grievances submitted or allegations of sexual abuse in the past twelve months at Therapeutic Shelter.

Standard 115.253: Resident access to outside confidential support services

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

115.253 (a)

- Does the facility provide residents with access to outside victim advocates for emotional support services related to sexual abuse by giving residents mailing addresses and telephone numbers, including toll-free hotline numbers where available, of local, State, or national victim advocacy or rape crisis organizations? ☒ Yes ☐ No

- Does the facility enable reasonable communication between residents and these organizations and agencies, in as confidential a manner as possible? ☒ Yes ☐ No

115.253 (b)

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

115.253 (c)

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

- Does the agency maintain copies of agreements or documentation showing attempts to enter into such agreements? ☒ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The 'Prison Rape Elimination Act (PREA) Compliance policy and 'Access to Confidential Support Services' protocol were reviewed as were the PREA pamphlet and 'Sexual Assault Prevention for Residents' handout provided to residents upon admission. Interviews with the PREA Coordinator, Program Manager, ten random residents, as well as phone conversations with the Executive Director of Safe Haven of Greater Waterbury also provided information in the determination of compliance.

Therapeutic Shelter provides multiple ways for residents to privately report sexual abuse and sexual harassment, retaliation by other residents or staff for reporting sexual abuse and sexual harassment, and staff neglect or violation of responsibilities that may have contributed to such incidents.

The agency provides 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 hot line numbers. The organization allows for twenty four hour access to facility phones and these agencies or organizations.

Throughout the facility, there were PREA audit announcements that the audit would take place on December 18th and 19th, zero tolerance posters, as well as signs on "How to Report Suspected or Complaints of Abuse at a Wellmore Facility" in both English and Spanish.

Safe Haven in Waterbury, CT is available to residents for toll free private crisis calls and as victim advocates who can accompany residents when meeting with the SANE, if requested. Additional outside resources available to residents are referenced, including contact information, within the Wellmore PREA pamphlet Sexual Abuse Resource List provided to residents upon admission. These resources include the Connecticut Alliance to End Sexual Violence, the Waterbury Police Department, the State of CT Office of Victim Advocate, the National Sexual Violence Resource Center, and the Rape/Abuse Incest National Network.

Corrective Action:

Administration was asked to provide refresher training for residents to provide a description of the services available to them, including Safe Haven, and make it clear that if phone calls are made for such services they can be made at any time and with facility phones that are not monitored. It was suggested that staff provide key points on a sheet and have residents sign off that the training has been received and is understood. Administration was requested to provide the training sheets with signatures as verification for each staff to ensure compliance. At the time of the interim report, this issue was in the process of being addressed, but it was completed as requested in the corrective action period.

Standard 115.254: Third-party reporting

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

115.254 (a)

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

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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The 'Resident Grievance' protocol was reviewed and the PREA Coordinator and Program Manager interviewed to determine compliance with this standard.

Third parties including residents, staff members, family members, attorneys or others shall be permitted to assist a resident in filing requests for administrative remedies relating to sexual abuse and will also be permitted to file such requests on the resident's behalf. If a resident declines to have a request processed on their behalf in situations of alleged sexual abuse, the administration will document the resident's decision.

The PREA pamphlet is provided to all residents upon admission and is available on the agency website. http://wellmore.org/news-info/prea/ Information on how to report sexual abuse or harassment is provided within it, including those made by third parties.

OFFICIAL RESPONSE FOLLOWING A RESIDENT REPORT

Standard 115.261: Staff and agency reporting duties

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

115.261 (a)

- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency? ☒ Yes ☐ No

- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding retaliation against residents or staff who reported an incident of sexual abuse or sexual harassment? ☒ Yes ☐ No

- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding any staff neglect or violation of responsibilities that may have contributed to an incident of sexual abuse or sexual harassment or retaliation? ☒ Yes ☐ No

115.261 (b)

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

115.261 (c)

- Unless otherwise precluded by Federal, State, or local law, are medical and mental health practitioners required to report sexual abuse pursuant to paragraph (a) of this section? ☒ Yes ☐ No

- Are medical and mental health practitioners required to inform residents of the practitioner's duty to report, and the limitations of confidentiality, at the initiation of services? ☒ Yes ☐ No

115.261 (d)

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

115.261 (e)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The 'Prison Rape Elimination Act (PREA) Compliance', 'Sexual Harassment, Misconduct, Assault Zero Tolerance', and 'Notification and Reporting' policies were reviewed as were the PREA pamphlet and 'Sexual Assault Prevention for Residents' handout provided to residents upon admission. The Chief Executive Officer, PREA Coordinator, and the Program Manager were interviewed.

Therapeutic Shelter has a policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment. All staff are required to immediately report any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency; retaliation against 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. Apart from reporting to supervisors, staff will 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.

Therapeutic Shelter is committed to maintaining an environment free from sexual abuse and sexual harassment of residents. Zero tolerance regarding resident sexual assault and harassment is mandated. Sexual abuse and sexual harassment of residents is prohibited by State and Federal law. (28 CFR 115.11). Staff interviews confirmed findings.

The agency policy requires all staff, volunteers and contractors to immediately report any knowledge, information or suspicion of sexual abuse or sexual harassment, and any violation or neglect of responsibility, to administration. Policy and interviews confirmed that staff are not allowed to share information with anyone who does not have a need to know.

Medical and mental health practitioners are required to report sexual abuse and to inform residents of the practitioners' duty to report, and the limitations of confidentiality, at the initiation of service. There are no residents under the age of 18. If the alleged victim is considered a vulnerable adult, the agency will report the allegation to Adult Protection Services.

Standard 115.262: Agency protection duties

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

115.262 (a)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The 'Evidence, Forensic Medical Examinations and Administrative Inquiry' protocol and the PREA Incident Checklist were reviewed. The Chief Executive Officer, PREA Coordinator, Program Manager, as well as twelve random staff were also interviewed to help determine compliance or non-compliance with this standard. While all interviews confirmed compliance with this standard, this auditor requested that administration modify the policy to reflect the practice, which was completed.

The agency requires immediate action to protect residents who report sexual abuse. All staff are required to take immediate action to protect residents from imminent sexual abuse. Staff were able to articulate this requirement during the interviews.

Standard 115.263: Reporting to other confinement facilities

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

115.263 (a)

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

115.263 (b)

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

115.263 (c)

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

115.263 (d)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The 'Notification of Investigations and Reporting' protocol was reviewed and the Chief Executive Officer, PREA Coordinator, and the Program Manager were interviewed to determine compliance.

If a client transferring to a Wellmore facility alleges an instance of sexual abuse at a prior facility, the Program Manager must notify the previous facility of this allegation. This must occur within 72 hours of an allegation being made.

On October 13, 2017 one resident reported a sexual assault that had occurred at a prior facility from another agency to a staff member. The prior facility was contacted that same day and informed of the allegation as required. A well written Incident Accident Report was completed at that time.

Standard 115.264: Staff first responder duties

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

115.264 (a)

- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Separate the alleged victim and abuser? ☒ Yes ☐ No

- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Preserve and protect any crime scene until appropriate steps can be taken to collect any evidence? ☒ Yes ☐ No

- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Request that the alleged victim not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating, if the abuse occurred within a time period that still allows for the collection of physical evidence? ☒ Yes ☐ No

- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Ensure that the alleged abuser does not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating, if the abuse occurred within a time period that still allows for the collection of physical evidence? ☒ Yes ☐ No

115.264 (b)

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

Auditor Overall Compliance Determination

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

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

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

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

The 'PREA Compliance' policy and procedure, 'Evidence, Forensic Medical Examinations and Administrative Inquiry' protocol, and the PREA Incident Checklist were reviewed. The Chief Executive Officer, PREA Coordinator, Program Manager, as well as twelve random staff interviewed to help determine compliance or non-compliance with this standard. There have been no instances that required the first responder protocol to be employed in the past twelve months.

Corrective Action:

Four of twelve random staff were unclear as to their roles in situations where they would have to serve as first responders. As a result of these issues, administration was asked to provide refresher training for staff on the protocol for first responder duties as well as preserving physical evidence. It was suggested that staff provide key points on a sheet and have staff sign off that the training has been received and is understood. Administration was requested to provide the training sheets with signatures as verification for each staff to ensure compliance, which was provided.

Standard 115.265: Coordinated response

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

115.265 (a)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The 'PREA Compliance' policy and procedure, 'Evidence, Forensic Medical Examinations and Administrative Inquiry' protocol, PREA Incident Checklist, and PREA pamphlet were reviewed. The Chief Executive Officer, PREA Coordinator, and Program Manager were also interviewed to help determine compliance or non-compliance with this standard. Policy demonstrates that Therapeutic Shelter has a 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; however, there have been no instances that required this type of coordinated response in the past twelve months. This was confirmed via the interview process as well.

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

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

115.266 (a)

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

115.266 (b)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

According to the 'PREA: Hiring and Promotions' protocol, the agency is not entered into any collective bargaining agreement or other agreement that limits the agency's ability to remove alleged staff sexual assault abusers from contact with any detainees pending the outcome of an investigation or of a determination of whether and to what extent discipline is warranted. This was confirmed through interviews with the Chief Executive Officer and the Director of Human Resources.

Standard 115.267: Agency protection against retaliation

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

115.267 (a)

- Has the agency established a policy to protect all residents and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other residents or staff? ☒ Yes ☐ No

- Has the agency designated which staff members or departments are charged with monitoring retaliation? ☒ Yes ☐ No

115.267 (b)

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

115.267 (c)

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor the conduct and treatment of residents or staff who reported the sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor the conduct and treatment of residents who were reported to have suffered sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Act promptly to remedy any such retaliation? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor any resident disciplinary reports? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor resident housing changes? ☒ Yes ☐ No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor resident program changes? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor negative performance reviews of staff? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor reassignments of staff? ☒ Yes ☐ No

- Does the agency continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need? ☒ Yes ☐ No

115.267 (d)

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

115.267 (e)

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

115.267 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The 'PREA Compliance policy and procedure and 'PREA-Agency Protection Against Retaliation' protocol were reviewed. Interviews with the Chief Executive Officer, PREA Coordinator, and Program Manager confirmed findings.

The agency protects all residents and staff who report sexual abuse or sexual harassment or cooperate with investigations from retaliation by other residents or staff. The Therapeutic Shelter Program Manager is responsible for monitoring retaliation against residents or staff. The agency will employ any necessary protection measures, such as housing changes, 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 that fear retaliation for reporting or cooperating with investigations.

For at least 90 days following a report of sexual abuse, the agency will monitor the conduct and treatment of residents or staff who reported the sexual abuse and of residents who were reported to have suffered sexual abuse to see if there are changes that may suggest retaliation. The Program Manager will monitor retaliation against residents or staff. They will monitor resident disciplinary reports, housing or program changes, negative performance reviews or reassignments of staff. The monitoring will continue beyond 90 days if the initial monitoring indicates a continued need. Such monitoring will include status checks with residents based on presentation and need. If other individuals who cooperate with an investigation express fear of retaliation, the agency will take appropriate measures to protect them. The obligation to monitor will terminate if the allegation is unfounded.

INVESTIGATIONS

Standard 115.271: Criminal and administrative agency investigations

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

115.271 (a)

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

- Does the agency conduct such investigations for all allegations, including third party and anonymous reports? [N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations. See 115.221(a).] ☒ Yes ☐ No ☐ NA

115.271 (b)

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

115.271 (c)

- Do investigators gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data? ☒ Yes ☐ No

- Do investigators interview alleged victims, suspected perpetrators, and witnesses? ☒ Yes ☐ No

- Do investigators review prior reports and complaints of sexual abuse involving the suspected perpetrator? ☒ Yes ☐ No

115.271 (d)

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

115.271 (e)

- Do agency investigators assess the credibility of an alleged victim, suspect, or witness on an individual basis and not on the basis of that individual's status as resident or staff? ☒ Yes ☐ No

- Does the agency investigate allegations of sexual abuse without requiring a resident who alleges sexual abuse to submit to a polygraph examination or other truth-telling device as a condition for proceeding? ☒ Yes ☐ No

115.271 (f)

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

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

115.271 (g)

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

115.271 (h)

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

115.271 (i)

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

115.271 (j)

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

115.271 (k)

- Auditor is not required to audit this provision.

115.271 (l)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The 'PREA Compliance' policy and procedure and 'Evidence, Forensic Medical Examinations and Administrative Inquiry' protocol were reviewed. The Chief Executive Officer, PREA Coordinator, and Program Manager were also interviewed to help determine compliance or non-compliance with this standard. This auditor requested that administration add components of the policy to support practice.

Therapeutic Shelter staff are not responsible for conducting investigations in the event of a sexual abuse incident, but does assist the Waterbury Police Department with the process at their request, including but not limited to surveillance footage, Incident Accident Reports, etc. The agency follows a uniform evidence protocol when investigating allegations of sexual abuse that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions. The agency conducts only administrative investigations. Both the PREA Coordinator and Vice President of Adult Services have received the National Institute of Correction's 'Investigating Sexual Abuse in a Confinement Setting' training.

Investigations are conducted promptly, thoroughly, and objectively for all allegations, including third party reports. Where sexual abuse is alleged, the agency will use investigators who have received special training in sexual abuse investigations pursuant to 115.234. Investigators will gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data; will interview alleged victims, suspected perpetrators, and witnesses; and will review prior complaints and reports of sexual abuse involving the suspected perpetrator. When the quality of evidence appears to support criminal prosecution, the agency will conduct compelled interviews only after consulting with the Waterbury Police Department as to whether compelled interviews may be an obstacle for subsequent criminal prosecution. 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 a resident or staff. The agency will not require 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.

An alleged sexual harassment incident of a resident by staff was reported by the resident on April 25, 2017 and investigated. Although the findings were unsubstantiated, all the elements of this standard that are applicable were met.

Standard 115.272: Evidentiary standard for administrative investigations

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

115.272 (a)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The 'Evidence, Forensic Medical Examinations and Administrative Inquiry' protocol was reviewed. Both the PREA Coordinator and Vice President of Adult Services have received the National Institute of Correction's 'Investigating Sexual Abuse in a Confinement Setting' training. As a result, the PREA Coordinator was also interviewed to help determine compliance or non-compliance with this standard. The agency policy imposes no standard greater than a preponderance of the evidence in determining the outcome of an investigation.

An alleged sexual harassment incident of a resident by staff was reported by the resident on April 25, 2017 and investigated. The findings were unsubstantiated and it was evident that a standard higher than a preponderance of the evidence was not used in that process.

Standard 115.273: Reporting to residents

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

115.273 (a)

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

115.273 (b)

- If the agency did not conduct the investigation into a resident's allegation of sexual abuse in an agency facility, does the agency request the relevant information from the investigative agency

in order to inform the resident? (N/A if the agency/facility is responsible for conducting administrative and criminal investigations.) ☒ Yes ☐ No ☐ NA

115.273 (c)

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

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

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

115.273 (d)

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

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

115.273 (e)

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

115.273 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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The protocol on 'Notification and Reporting' was reviewed and interviews with the Chief Executive Officer and PREA Coordinator conducted to determine compliance or non-compliance with this standard. This auditor requested that missing elements get added to the protocol to make it consistent with the standard and that was completed.

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Although there were no sexual abuse allegations in the past twelve months, following an investigation into a resident's allegation that he suffered sexual abuse in the facility, the agency would inform the resident as to whether the allegation was substantiated, unsubstantiated, or unfounded. Following a resident's allegation that a staff member committed sexual abuse against the resident, the agency would inform the resident (unless the agency has determined the allegation to be unfounded) whenever;

1. The staff member is no longer assigned to the resident's unit;
2. The staff member is no longer employed at the facility;
3. The agency learns from the prosecuting authority that the staff member has been indicted on a charge related to sexual abuse within the facility.

Following a resident's allegation that he had been sexually abused by another resident, the agency will subsequently inform the alleged victim whenever the prosecuting authority has notified the agency that:

1. The alleged abuser has been indicted on a charge related to sexual abuse within the facility or;
2. The alleged abuser has been convicted on a charge related to sexual abuse within the facility.

All such notification or attempted notifications will be documented. An agency's obligation to report under this standard terminates if the resident is released from the agency's custody.

DISCIPLINE

Standard 115.276: Disciplinary sanctions for staff

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

115.276 (a)

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

115.276 (b)

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

115.276 (c)

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

115.276 (d)

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

- Are all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, reported to: Relevant licensing bodies? ☒ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The protocol for 'Disciplinary Sanctions for Staff' was reviewed and the Chief Executive Officer, PREA Coordinator, and Director of Human Resources were interviewed to help determine compliance or non-compliance with this standard. Interviews suggested compliance; however the policy did not include the elements of the standard. As a result, this auditor requested that administration add all components of the policy to support practice, which was addressed January 10th. An alleged sexual harassment incident of a resident by staff was reported by the resident on April 25, 2017 and investigated; however, the findings were unsubstantiated.

Standard 115.277: Corrective action for contractors and volunteers

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

115.277 (a)

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

115.277 (b)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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The 'Notification and Reporting' protocol was reviewed and an interview with the PREA Coordinator conducted to help determine compliance with this standard.

Any contractor or volunteer who engages in sexual abuse will be prohibited from contact with residents is reported to law enforcement agencies, unless the activity was clearly not criminal, and to relevant licensing bodies. The facility takes appropriate remedial measures, and considers whether to prohibit further contact with residents. There have been no incidents involving a contractor or volunteer in the past year.

Standard 115.278: Interventions and disciplinary sanctions for residents

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

115.278 (a)

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

115.278 (b)

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

115.278 (c)

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

115.278 (d)

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

115.278 (e)

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

115.278 (f)

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

115.278 (g)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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The 'Disciplinary Sanctions for Staff' protocol was reviewed and interviews with the Chief Executive Officer, PREA Coordinator, and Director of Human Resources were conducted to assist in determining compliance with this standard. The facility does not offer therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for sexual abuse. All other elements of the standard are included in policy and the one sexual harassment allegation that was reported in April 2017 was unsubstantiated and was not relevant to this standard.

MEDICAL AND MENTAL CARE

Standard 115.282: Access to emergency medical and mental health services

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

115.282 (a)

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

115.282 (b)

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

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

115.282 (c)

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

115.282 (d)

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

Auditor Overall Compliance Determination

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

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

Instructions for Overall Compliance Determination Narrative

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The protocols on 'PREA-Medical and Mental Health Care' and 'Evidence, Forensic Medical Examinations and Administrative Inquiry', a Memorandum of Understanding with Safe Haven of Greater

Waterbury for advocacy services, a letter from St Mary's Hospital in Waterbury explaining their protocol were reviewed and interviews with the PREA Coordinator, Program Manager, Senior Clinician, Executive Director of Safe Haven of Greater Waterbury, and the Chairman of the Department of Emergency Services of St Mary's also provided information in the determination of compliance.

The agency offers all victims of sexual abuse a forensic medical examination at St Mary's Hospital without cost where evidentiary or medically appropriate. A letter from St Mary's Hospital in Waterbury explained that a Sexual Assault Nurse Examiner (SANE) is on staff that follows the guidelines outlined by the Commission for Standardization of Collection of Sexual Assault Evidence in Connecticut. A phone interview with the Chairman of the Department of Emergency Services of St Mary's revealed that the hospital currently has three certified SANE's with another three set to take the class. Evidence that needs to be obtained from a victim's person will be acquired by the hospital emergency department. The medical staff at Therapeutic Shelter will not perform any exams in the event of a sexual abuse case.

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. Victims are offered timely information about and timely access to sexually transmitted infections prophylaxis, in accordance with professionally accepted standards or case, where medically appropriate.

Some of the elements of this standard were not stated in policy and, as a result, this auditor requested that the policy was modified to reflect practice and to meet standard requirements. Prior to the completion of the interim report, all elements had been added to policy as requested. There have been no allegations of sexual abuse at Therapeutic Shelter within the past twelve months.

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

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

115.283 (a)

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

115.283 (b)

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

115.283 (c)

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

115.283 (d)

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

115.283 (e)

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

115.283 (f)

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

115.283 (g)

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

115.283 (h)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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The protocols on 'PREA-Medical and Mental Health Care' and 'Evidence, Forensic Medical Examinations and Administrative Inquiry', a Memorandum of Understanding with Safe Haven of Greater Waterbury for advocacy services were reviewed and interviews with the PREA Coordinator, Program

Manager, Senior Clinician, and the Executive Director of Safe Haven of Greater Waterbury also provided information in the determination of compliance.

The agency offers medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse. The evaluation and treatment of victims includes, as appropriate, follow up services, treatment plans, and when necessary, referrals for continued care following their transfer to other facilities, or their release from custody. SAFE Haven of Greater Waterbury and the Connecticut Alliance to End Sexual Violence are available to provide follow up mental health services. Victims are provided medical and mental health services consistent with the community level of care. Victims of sexual abuse while incarcerated are offered tests for sexually transmitted infections as medically appropriate. Treatment services are 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.

DATA COLLECTION AND REVIEW

Standard 115.286: Sexual abuse incident reviews

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

115.286 (a)

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

115.286 (b)

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

115.286 (c)

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

115.286 (d)

- Does the review team: Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse? ☒ Yes ☐ No

- Does the review team: Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; gang affiliation; or other group dynamics at the facility? ☒ Yes ☐ No

- Does the review team: Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse? ☒ Yes ☐ No

- Does the review team: Assess the adequacy of staffing levels in that area during different shifts? ☒ Yes ☐ No

- Does the review team: Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff? ☒ Yes ☐ No

- Does the review team: Prepare a report of its findings, including but not necessarily limited to determinations made pursuant to §§ 115.286(d)(1) - (d)(5), and any recommendations for improvement and submit such report to the facility head and PREA compliance manager? ☒ Yes ☐ No

115.286 (e)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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The protocols on 'Sexual Abuse Incident Reviews' and 'Incident Accident Reporting' were reviewed as was the PREA Sexual Abuse Incident Review Form. Interviews with the Chief Executive Officer, PREA Coordinator, Director of Systems Operations, and Program Manager confirmed findings.

The facility conducts a sexual abuse incident review at the conclusion of every sexual abuse investigation, including when the allegation has not been substantiated, unless the allegation is

unfounded. This review will occur within 30 days of the conclusion of the investigation. The review team met on May 1, 2017 regarding a sexual harassment allegation and consisted of the Chief Executive Officer, Medical Director, Vice President of Adult Services, PREA Coordinator, Program Manager, and Senior Clinician.

The only completed PREA Sexual Abuse Incident Review form from May 1, 2017 showed evidence that the review team:

- Considered whether the allegations or investigation indicated a need to change policy or practice to better prevent, detect or respond to sexual abuse.
- Considered 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, was motivated or otherwise caused by group dynamics at the facility.
- Considered the area in the facility where the incident allegedly occurred to access whether physical barriers in the area may enable abuse.
- Assessed the adequacy of staffing levels during different shifts.
- Assessed whether monitoring technology should be deployed or augmented to supplement supervision by staff; and
- Prepared a report of its findings, including but not limited to determinations made pursuant to the above points, and any recommendations for improvement, and submit the report to the Program Manager and PREA Coordinator.
- The facility implements the recommendations for improvement or documents its reasons for not doing so.

Although the form included all the elements required by the standard, this auditor requested administration modify policy to reflect the requirements as well, which they did.

Standard 115.287: Data collection

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

115.287 (a)

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

115.287 (b)

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

115.287 (c)

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

115.287 (d)

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

115.287 (e)

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

115.287 (f)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The protocols on 'Sexual Abuse Incident Reviews' and 'Incident Accident Reporting' were reviewed and interviews with the Chief Executive Officer, PREA Coordinator, Director of Systems Operations, and Program Manager confirmed findings.

The agency collects accurate, uniform data for every allegation of sexual abuse at all facilities using a standardized instrument and set of definitions and aggregate the incident-based sexual abuse data at least annually at the end of the calendar year. The data includes at a minimum the data necessary to answer all the questions for the most recent version of the Survey of Sexual Violence. The agency maintains, reviews and collects data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews. Upon request, the agency will provide all such data from the previous calendar year to the Department of Justice no later than June 30th.

In the past twelve months, there have been no allegations of sexual abuse reported at the Therapeutic Shelter.

Standard 115.288: Data review for corrective action

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

115.288 (a)

- Does the agency review data collected and aggregated pursuant to § 115.287 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Identifying problem areas? ☒ Yes ☐ No

- Does the agency review data collected and aggregated pursuant to § 115.287 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Taking corrective action on an ongoing basis? ☒ Yes ☐ No

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

115.288 (b)

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

115.288 (c)

- Is the agency's annual report approved by the agency head and made readily available to the public through its website or, if it does not have one, through other means? ☒ Yes ☐ No

115.288 (d)

- Does the agency indicate the nature of the material redacted where it redacts specific material from the reports when publication would present a clear and specific threat to the safety and security of a facility? ☒ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The protocol on 'Data Review, Storage, Publication and Destruction' was reviewed as was the agency website. Interviews with the PREA Coordinator confirmed findings.

The agency reviews 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:

1. Identifying problem areas;
2. Taking corrective action on an on-going basis; and
3. Preparing an annual report of its findings and corrective actions for each facility as well as the agency as a whole.

The report includes a comparison of the current year's data and corrective actions with those from prior years and provides an assessment of the agency's progress in addressing sexual abuse.

The report is approved by the Sheriff and made readily available to the public through the website. Specific material is redacted from the report when publication would present a clear and specific threat to the safety and security of the facility, but must indicate the nature of the material redacted.

In the past twelve months, there have been no allegations of sexual abuse reported at Therapeutic Shelter.

Standard 115.289: Data storage, publication, and destruction

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

115.289 (a)

- Does the agency ensure that data collected pursuant to § 115.287 are securely retained? ☒ Yes ☐ No

115.289 (b)

- Does the agency make all aggregated sexual abuse data, from facilities under its direct control and private facilities with which it contracts, readily available to the public at least annually through its website or, if it does not have one, through other means? ☒ Yes ☐ No

115.289 (c)

- Does the agency remove all personal identifiers before making aggregated sexual abuse data publicly available? ☒ Yes ☐ No

115.289 (d)

- Does the agency maintain sexual abuse data collected pursuant to § 115.287 for at least 10 years after the date of the initial collection, unless Federal, State, or local law requires otherwise? ☒ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The 'Security Awareness and Training–Password Management' policy and the protocol for 'Data Review, Storage, Publication and Destruction' were reviewed. Interviews with the Chief Executive Officer, Director of Systems Operations, and PREA Coordinator confirmed findings.

The PREA Coordinator ensures that data collected pursuant to 115.287 are securely retained. The agency makes all aggregated sexual abuse data, from all facilities under its control and all facilities with which it contracts, readily available to the public at least annually through the website although there is only one facility within the agency that requires PREA certification. Before making the data available, all personal identifiers are/will be removed. Sexual abuse data collected pursuant to 115.287 will be retained for at least 10 years after the date of the initial collection.

AUDITING AND CORRECTIVE ACTION

Standard 115.401: Frequency and scope of audits

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

115.401 (a)

- During the three-year period starting on August 20, 2013, and during each three-year period thereafter, did the agency ensure that each facility operated by the agency, or by a private organization on behalf of the agency, was audited at least once.? (N/A before August 20, 2016.) ☒ Yes ☐ No ☐ NA

115.401 (b)

- During each one-year period starting on August 20, 2013, did the agency ensure that at least one-third of each facility type operated by the agency, or by a private organization on behalf of the agency, was audited? ☒ Yes ☐ No

115.401 (h)

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

115.401 (i)

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

115.401 (m)

- Was the auditor permitted to conduct private interviews with inmates, residents, and detainees? ☒ Yes ☐ No

115.401 (n)

- Were residents permitted to send confidential information or correspondence to the auditor in the same manner as if they were communicating with legal counsel? ☒ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

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

Wellmore Behavioral Health currently has only one facility that requires PREA Compliance: Therapeutic Shelter. It was audited initially in December 2014 at which time the Therapeutic Shelter was determined to be compliant with the PREA standards. During the on-site visit, this auditor had access to, and the ability to observe, all areas of the facility. The auditor received copies of all requested documentation. All resident and staff interviews were conducted in private rooms. No correspondence was received by the auditor prior to the on-site audit or within the interim prior to completing this report.

Standard 115.403: Audit contents and findings

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

115.403 (f)

- The agency has published on its agency website, if it has one, or has otherwise made publicly available, all Final Audit Reports within 90 days of issuance by auditor. The review period is for prior audits completed during the past three years PRECEDING THIS AGENCY AUDIT. In the case of single facility agencies, the auditor shall ensure that the facility's last audit report was published. The pendency of any agency appeal pursuant to 28 C.F.R. § 115.405 does not excuse noncompliance with this provision. (N/A if there have been no Final Audit Reports issued in the past three years, or in the case of single facility agencies that there has never been a Final Audit Report issued.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

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

The agency has published on its agency website the prior Final PREA report conducted in December 2014 and they have been instructed to post the Final PREA report within ninety days of issuance by this auditor.

AUDITOR CERTIFICATION

I certify that:

☒ The contents of this report are accurate to the best of my knowledge.

☒ No conflict of interest exists with respect to my ability to conduct an audit of the agency under review, and

☒ I have not included in the final report any personally identifiable information (PII) about any resident or staff member, except where the names of administrative personnel are specifically requested in the report template.

Auditor Instructions:

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

Walter J. Krauss, Psy.D. March 11, 2018

Auditor Signature **Date**

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

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