PREA AUDIT REPORT ☐ Interim ☒ Final

COMMUNITY CONFINEMENT FACILITIES

Date of report: July 11, 2016

Auditor Information			
Auditor name: Bobbi Pohlman-Rodgers			
Address: PO Box 4068, Deerfield Beach, FL 33442-4068			
Email: bobbi.pohlman@us.g4s.com			
Telephone number: (954) 818-5131			
Date of facility visit: May 26, 2016			
Facility Information			
Facility name: The Connection House			
Facility physical address: 167 Liberty Street, Middletown, CT 06457			
Facility mailing address: *(if different from above)*			
Facility telephone number: (860) 343-5510			
The facility is:	☐ Federal	☐ State	☐ County
	☐ Military	☐ Municipal	☐ Private for profit
	☒ Private not for profit		
Facility type:	☐ Community treatment center ☒ Halfway house ☐ Alcohol or drug rehabilitation center	☐ Community-based confinement facility ☐ Mental health facility ☐ Other	
Name of facility's Chief Executive Officer: Rosalyn Biggins			
Number of staff assigned to the facility in the last 12 months: 9			
Designed facility capacity: 14			
Current population of facility: 13			
Facility security levels/inmate custody levels: Low, Community Release			
Age range of the population: Adults			
Name of PREA Compliance Manager: Rosalyn Biggins		**Title:** Program Director	
Email address: rbiggins@theconnectioninc.org		**Telephone number:** (860) 343-5513	
Agency Information			
Name of agency: The Connection, Inc.			
Governing authority or parent agency: *(if applicable)*			
Physical address: 100 Roscommon Dr., Suite 203, Middletown, CT			
Mailing address: *(if different from above)*			
Telephone number: (860) 343-5500			
Agency Chief Executive Officer			
Name: Peter Nucci		**Title:** President & CEO	
Email address: pnucci@theconnectioninc.org		**Telephone number:** (860) 343-5500	
Agency-Wide PREA Coordinator			
Name: Jacob Hasson		**Title:** Director	
Email address: jhasson@theconnectioninc.org		**Telephone number:** (203) 747-1657	

AUDIT FINDINGS

NARRATIVE

On May 26, 2016 the Connection House received an on-site PREA audit by DOJ Certified PREA Auditor Bobbi Pohlman-Rodgers. Prior to this on-site audit, the agency policies and procedures were reviewed by DOJ Certified PREA Auditor Peter Plant, and a discussion was held between these auditors to review any deficiencies in the policies. Approximately one week prior to the on-site audit, auditor Pohlman-Rodgers made contact with Rosalyn Biggins, Program Director to review additional documentation that would be needed on the first day, as well as provided to her a timeline of the one-day audit process. The auditor was informed at this time that Program Director Biggins would not be present for the audit. In her place, the Agency PREA Coordinator, Director Jacob Hasson would be present.

The PREA auditor met with the Agency PREA Coordinator upon arrival at the program. A brief conversation was held and the auditor was provided the information requested prior to the audit which allowed the auditor to select the residents and staff who would be interviewed. Due to some residents having left for work, there were nine residents selected to interview. Two refused to participate, so seven interviews were conducted. One inmate interviewed had a disability and one had reported a prior victimization that occurred in the community and he was currently receiving outside services. There were no residents who reported being LGBTI, had reported an allegation of sexual abuse or sexual harassment, or who were limited English proficient.

The program is run with a ratio of 1:7 during the day and 1:14 during the sleep hours. Of the four staff on duty the day of the audit, the auditor interviewed two staff (one from each shift) who provide for the safety and security of the residents. The auditor returned to the program later in the evening to interview the evening staff. The other two staff were interviewed for specialized services. Additionally, the auditor interviewed for seven specialized staff positions, including the Agency Head, PREA Coordinator, Program Director, Intake Staff, Risk Assessment Staff, Incident Review Staff, Retaliation Monitor, and a First Responder Staff. Many of these positions are held by the same person. The Human Resources staff was previously interviewed by DOJ Certified Auditor Peter Plant. The facility does not conduct investigation, employ medical or mental health staff, contract with other facilities to house residents, have SANE/SAFE staff on site, or utilize volunteers.

Forensic examinations are conducted at Middlesex Hospital. Contact with the charge nurse confirmed that examinations are conducted here. Sexual Assault Nurse Examiners (SANE) are available through contact with the Connecticut Alliance to End Sexual Violence (formerly known as CONNSACS). The Alliance will also provide a victim advocate.

There are currently thirteen residents residing at the program. There were nine available for interview. These nine included one resident with hearing disabilities and one who reported a prior victimization in the community. There were no residents who reported being gay, bisexual, transgender or intersex. There were no residents who were identified as limited English proficient. Segregation is not used at this facility.

The facility reported no allegations of sexual abuse or sexual harassment during the previous twelve months. There was no correspondence received prior to the audit

The agency maintains a dedicated PREA page on its website that includes the agency's PREA zero-tolerance policy, contact information for the agency's PREA Coordinator, and contact information for making a third-party PREA allegation. The web page also includes the agency's aggregated PREA data for 2014 and 2015, and links to PREA Audit Final Reports.

DESCRIPTION OF FACILITY CHARACTERISTICS

The Connection House, located in Middletown, CT., is a licensed residential substance abuse treatment program for men. The program assist residents in reclaiming their lives and personal dignity from the ravages of addiction. By providing a drug-free environment and effective programming, The Connection House lessens the destructive impact of substance use in the community.

The program was founded by Katchen Coley and her friend, Nancy Flanner. With the help of Dr. Edward Friedman and other local community members, The Connection House opened its doors in 1972 and has since served individuals who suffer from substance abuse. A portion of the beds are designated for individuals coming out of the correctional system in need of substance use treatment.

Clients are referred by the Parole Departments throughout the state and are assessed within 24 hours of admission. Program services include:

- Individual and group counseling
- Vocational assistance
- Educational assistance
- Medical and/or psychiatric care
- Assistance in accessing community resources

A tour of the facility followed the selection of staff and residents for interview. A three-level townhouse with basement is the site of this program. The townhouses were opened up allowing for access on the bottom floor. Each side contains a staircase, as well as a central staircase at the back of the house that allow for emergency exit from the top floor in the event of a fire. This area is off-limits to residents except in an emergency. The staircase provides for blind areas; however, there are alarms at both exits of this staircase that provide for staff knowing if residents have entered the area. Staff must turn off the alarm at a central button in the staff office on the 2nd floor and are required to check the area if the alarm does sound. A second emergency escape from the 3rd floor is located in one of the resident rooms.

Housing is located on the upper two floors. The second floor contains two bathrooms and the third floor contains one bathroom and each are individual use and provide for appropriate privacy, as well as single and double rooms that provide for resident sleeping quarters (six rooms on the 2nd floor and 3 rooms on the third floor). Female staff are required to announce their presence on both the 2nd and 3rd floors, and these were heard during the audit. Administration, dining, kitchen, living room, and one office are located on the main floor of the building. The basement of the building houses an indoor recreation area for weights, laundry, and three locked storage rooms. There is also another emergency exit here that goes to a trap-door in the back staircase to allow for egress in the event of an emergency. This door is unlocked and no alarm is on the door. This was discussed with the PREA Coordinator regarding the supervision of this area.

There is also a garage where outside recreations items are stored. This area is monitored only when the garage door is in the open position, indicating that residents are utilizing the area.

There are eight cameras. Four of these are outside the building and four are inside. All staff have access to viewing the cameras. None of the cameras violates a resident's privacy.

Notices of the PREA audit were observed posted throughout the facility. "Break the Silence" posters giving contact information for the Department of Corrections PREA Hotline and the Connecticut State Police Hotline were observed in prominent areas.

SUMMARY OF AUDIT FINDINGS

At the conclusion of the PREA onsite audit, this Auditor conducted a post-audit briefing discussing those standards where additional information or actions would be needed to take. In the three weeks prior to this report, the facility has provided all information needed with the exception of one standard that was not met. Despite this, the agency and the facility have shown a strong commitment to both the letter and the intent of the Prison Rape Elimination Act. It is evident from this report that policies, procedures, and practices have been developed and effectively implemented to prevent, detect and respond to allegations of sexual abuse and sexual harassment. The leadership and support of the outgoing PREA Coordinator has been critical in achieving this outcome and is commended for his efforts in this regard.

Number of standards exceeded: 0

Number of standards met: 32

Number of standards not met: 0

Number of standards not applicable: 9

Standard 115.211 Zero tolerance of sexual abuse and sexual harassment; PREA Coordinator

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The agency has a dedicated written PREA policy that states support for a zero tolerance towards sexual abuse and sexual harassment. This policy and related policies and procedures detail the agency's approach to preventing, detecting, and responding to allegations and incidents of sexual abuse and sexual harassment. All staff interviewed displayed a thorough understanding of the agency's zero tolerance policy.

The agency has a dedicated PREA Coordinator who reports to the agency's Quality Assurance Director (per the agency's organizational chart). Agency policy states that the PREA Coordinator is responsible for the development, implementation, and oversight of the agency's efforts to comply with the PREA standards. The PREA Coordinator reports that he oversees eight programs and spends approximately 10% of his time dedicated to PREA related issues. He reports sufficient time and authority to oversee the agency's efforts to comply with the PREA Standards

Standard 115.212 Contracting with other entities for the confinement of residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

This standard is not applicable. The agency is not a public agency, nor does it contract with other entities for the confinement of its residents.

Standard 115.213 Supervision and monitoring

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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The facility staffing plan is based on fourteen residents. There are six full-time employees: one Program Director, three Case Managers, and

two Client Service Aides. There are per diem staff that are utilized. The plan also incorporates the use of eight cameras (4 inside and 4 outside the facility) that cover the areas of resident movement. The staffing plan was last reviewed in 2015 and is based on the physical layout and composition of resident population.

There were two blind areas that required staff acknowledgement of ensuring that these areas are checked on a regular basis and one blind on the staff office window that prevented supervision of that area. The facility updated their staffing plan to include hourly check in the garage and basement. An alarm was added to the basement fire exit for staff notification. Additionally, the blinds in the staff office are now required to remain open with the exception of during times where clients are self-administering their medications.

Standard 115.215 Limits to cross-gender viewing and searches

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

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

Agency policy states that pat downs, body cavity, and strip searches are prohibited regardless of the gender of the staff or resident, even in exigent circumstances. There were no reported instances of cross-gender searches. Compliance with this policy was confirmed by all residents who were interviewed who reported that they are searched by male staff. All staff interviewed stated they had been trained on this policy, and this was confirmed by a review of their training records.

There are single use bathrooms on each housing floor allowing for privacy during toileting, showers, and changing clothing. All residents interviewed stated that their privacy is respected and that female staff knock on the bedroom doors before entering.

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

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

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

Agency policy entitled "Americans with Disabilities," states that the agency shall take appropriate steps to ensure that clients 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. The policy further states that to ensure effective communication with residents who are deaf or hard of hearing, the agency will provide access to interpreters who can effectively interpret, accurately and impartially, both receptively and expressively, using any necessary specialized vocabulary. The policy also states that the agency shall 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, limited reading skills, or who are blind or have low vision. When interpretation services are needed, which is rare, the agency uses Language Line Services. Agency policy prohibits the use of resident interpreters. There were no instances during the previous twelve months where a resident was used to interpret in an emergency circumstance.

Staff interviewed had received training on this policy, as documented in their training records, and all stated that they knew they were not allowed to use a resident as an interpreter. There were no limited English proficient residents at the program. One resident who reported a

loss of hearing confirmed that he has been provided all information in writing and that he is aware of additional services if needed.

Standard 115.217 Hiring and promotion decisions

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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Agency policy, regarding Criminal Records Check for Staff, states that the agency 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 residents, who:
(1) Has engaged in sexual abuse in a prison, jail, lockup, or community confinement facility.
(2) Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse.
(3) Has been civilly or administratively adjudicated to have engaged in the activity described above

Agency policy, regarding background checks, states that one is conducted for all prospective employees, contracted professionals, volunteers, trainees, interns, and students. The agency contracts with a third-party vendor to conduct comprehensive background checks that include criminal court records, OIG records, Sex Offender Registry, Motor Vehicle and depending on the position, a credit check is also conducted. Also included are checks of civil child abuse and neglect registries. These checks are also conducted for promotions. The policy also states that full background checks will be conducted every five years or as deemed necessary by management to assure the safety and protection of clients. The agency also verifies that background checks are conducted as part of the licensing process for all licensed staff in addition to licensing and credentialing verification. Agency policy states that applicants are required to provide accurate information during the hiring process; failure to do so results in termination of employment. Documentation of background checks for current facility staff and contractors was provided and reviewed.

CORRECTIVE ACTIONS NEEDED:

The agency's new hire forms were reviewed during the Pre-Audit phase, but none of these contained the requirement under §115.217(f) that all applicants are asked about previous misconduct "…in written applications or interviews for hiring or promotions and in any interviews or written self-evaluations conducted as part of reviews of current employees." In response the agency did add a PREA Disclosure section (asking the three questions, relating to misconduct) to its Applicant Authorization and Consent for Release of Information form; however, no other documentation to confirm compliance with the other elements of the standard noted was provided. The agency did provide a paragraph from their Employee Handbook that states that staff who fail to maintain proper standards of conduct are subject to disciplinary action, but does not state they have a continuing affirmative duty to disclose any such misconduct. The agency will need to make the required revisions to their policies, and then train HR and facility staff, accordingly, on the new policies and procedures. When completed, the revised policies and procedures, as well as documentation of required staff training, will need to be submitted to the auditor.

There appears to be a conflict between two policies. 8/2/13 Criminal Records Check for Staff policy states the wording of standard §115.217(h), but does not state the agency will or will not provide the information when requested. The 3/16/15 Reference Check Disclosure policy states that information given by phone will be limited to verification of employment dates, position title and salary unless a release of information is signed by the staff involved. The agency's policy on this needs to be clarified and submitted to the auditor, when clarified or revised.

CORRECTIVE ACTION VERIFICATION: Revised policies were received on September 16, 2016, and found to now be in compliance with the standards.

Standard 115.218 Upgrades to facilities and technologies

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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This standard is N/A. No upgrades have been made.

Standard 115.221 Evidence protocol and forensic medical examinations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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Neither the agency, nor facility, conducts investigations of allegations of sexual abuse. Allegations are referred to either the Connecticut State Police or the Connecticut Department of Corrections, as appropriate.

The agency has entered into a Memorandum of Agreement with the Connecticut Sexual Assault Crisis Services, Inc. for the provision of sexual assault support and advocacy services. The Agreement lists five member programs that may be contacted for these purposes. If the resident victim is a CDOC referred client, the forensic examination is conducted at the Corrigan-Radgowski Correctional Institution. If the resident is not a CDOC referred client, the resident is taken to Middlesex Hospital. These services, as well as forensic examinations, are offered without financial cost to the resident.

The agency submitted a letter to the Connecticut State Police, requesting that it comply with the requirements of the standard. Based on this auditor's previous contact with the CSP, it has agreed to do so.

Standard 115.222 Policies to ensure referrals of allegations for investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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The agency's PREA policy states that all PREA allegations within CSSD and DMHAS funded programs will be referred to the Connecticut State Police for investigation, and all PREA allegations in DOC funded programs will be referred to the Connecticut Department of Correction's PREA Investigation Unit for investigation. This was confirmed in the interview with the Director of Statewide Community Justice Services. The agency has a dedicated PREA web page that directs the public to either report a PREA allegation to the agency's PREA Coordinator, or to a third party, two of which are listed with contact information.

Standard 115.231 Employee training

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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The agency uses a dedicated PREA training module that was reviewed during the Pre-Audit. It was found that several elements were either missing or incomplete. The agency accepted this finding and immediately revised the module to address the missing elements. It then conducted a supplemental training session with the staff at the facility. Documentation of this training, as well as the original training, was provided. All staff interviewed stated they had received the training.

Standard 115.232 Volunteer and contractor training

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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This standards is Not Applicable as there are no contractors or volunteers providing services.

Standard 115.233 Resident education

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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Agency policy states that at intake and orientation residents are to be given PREA-related literature. The form "Your Rights as a Client of The Connection Inc." contains information regarding the agency's zero tolerance policy, regarding sexual abuse and sexual harassment, how to report allegations or suspicions, their rights to be free from sexual abuse and sexual harassment, and to be free from retaliation for reporting such incidents. This document contains a section, regarding "Humane and dignified treatment," that addresses the agency's zero tolerance policy. The PREA brochure defines sexual abuse and sexual harassment, discusses PREA, and includes the PREA Coordinators contact Information. "Break the Silence" posters throughout the facility identify the Department of Corrections and Connecticut State Police Hotline numbers. A one-page "Connecticut Sexual Assault Crisis Services, Inc. also includes a Hotline phone number. All information is available in other languages as needed.

Interviews with residents confirmed that they are provided information at the time of intake on sexual abuse, sexual harassment, and how to report. They are provided the "Your Rights as a Client of the Connection, Inc." to sign. They are also provided the PREA brochure and other material that describes sexual abuse and sexual harassment and how to report. .However, a file review indicated that the client rights forms were not present in all files. The facility immediately provided refresher education to all residents and proof of this education was provided to the auditor.

Agency policy states that it provides multiple internal and external avenues for staff and clients to report sexual abuse and sexual harassment, and retaliation for making a report. Interviews with residents, and posters throughout the facility, identified that they may contact the PREA Coordinator, Connecticut State Policy or the Department of Corrections Hotline. There is also information available through a written list of Connecticut Sexual Assault Crisis Services offices with contact information.

The agency has resources available to it to provide education in formats, including access to interpreters and sign language staff, as needed. "BREAK the Silence!" posters in English and Spanish (ROMPE el Silencio!) were observed throughout the facility. These posters contained contact information for making PREA-related reports.

Standard 115.234 Specialized training: Investigations

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

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This standard is N/A. The agency does not conduct criminal or administrative investigations of sexual abuse.

Standard 115.235 Specialized training: Medical and mental health care

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

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This standard is N/A. The facility does not employ or contract with medical and mental health staff or providers. Residents utilize medical and mental health agencies in the community.

Standard 115.241 Screening for risk of victimization and abusiveness

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Agency policy assigns to the Program Director the responsibility for ensuring that incoming residents are assessed during admission for their risk of being sexually abused by other residents or sexually abusive toward other residents. Three facility staff are authorized and trained to conduct these screenings. The agency utilizes a risk screening instrument that is clearly objective and includes all of the elements required by the standard. The policy requires a reassessment of risk when warranted due to a referral, request, incident of sexual abuse, or receipt of additional information that bears on the resident's risk of sexual victimization or abusiveness. The policy further states that residents may not be disciplined for refusing to answer or for not disclosing complete information. Interviews with intake staff who conduct these screenings confirmed that the risk assessment instruments can only be accessed on a need to know basis. All the residents who were interviewed confirmed that they were risk screened. None reported that they refused to answer any of the questions asked and there is no system to allow discipline if a resident refuses to answer a question. File reviews found that these documents were completed as required by standard and policy and within the 72 hours.

Standard 115.242 Use of screening information

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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Agency policy requires the facility staff conducting the risk screening to make an individualized determination about how to best ensure the safety of each resident. The policy also states that the facility must make any housing and program assignment for transgender or intersex residents in the facility on a case-by-case basis. The Risk for Victimization or Abusiveness Tool contains a section at the end of the instrument that requires the staff conducting the screening to document how the findings of the screening are reflected in the housing assignment for that resident. This form is then placed in the residents file. Interviews confirmed that the results of the screening is kept on an excel sheet that is available to all staff in the staff office, and that room assignments and changes are made utilizing this information. All residents are provided the opportunity to shower separately. There is no special housing assignments for gay, bisexual, transgender or intersex residents at this facility.

Standard 115.251 Resident reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance

determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The agency has a separate policy addressing the Avenues of Reporting PREA Allegations. It requires the establishment of multiple internal and external avenues for staff and residents to report sexual abuse and sexual harassment, retaliation for making a report, and any staff negligence that may have contributed to such incidents. The policy requires that during intake and orientation residents are given PREA-related literature and contact information for both internal and external entities, including several that are not part of the agency (which allow anonymous reports to be made). This policy also requires all staff to accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously, and from third parties.

All the residents and staff interviewed confirmed that there are multiple ways to make a report, both internally and externally. All resident interviews confirmed that they are aware they can tell staff, call the Department of Corrections PREA Hotline or the Connecticut State Police. All staff interviewed stated that they are required to accept any PREA-related report, regardless of the means used to report. All staff also confirmed that they knew that they could make a private report to the PREA Coordinator or Connecticut State Police.

Standard 115.252 Exhaustion of administrative remedies

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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This standard is N/A. Agency policy states that sexual assaults and sexual harassment are not grieveable matters. None of the residents interviewed listed the grievance system, as a means to report a PREA-related matter.

Standard 115.253 Resident access to outside confidential support services

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The agency has entered into a Memorandum of Agreement with the Connecticut Sexual Assault Crisis Services, Inc. for the provision of sexual assault support and advocacy services. The Agreement lists five member programs that may be contacted for these purposes. These services, as well as forensic examinations, are offered without financial cost to the resident. A list of ten local agencies is provided on a one page document that is posted in the facility, along with a map to show the counties these agencies serve.

Resident interviews confirmed that they had received the information, and see it posted in the facility.

Standard 115.254 Third-party reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The agency has a dedicated web page, regarding PREA, that contains information on third-party reporting. Also, "BREAK the Silence!" posters in English and Spanish (ROMPE el Silencio!) were observed throughout the facility, including areas where visitors may be present. These posters contain contact information for making PREA-related reports. Finally, all visitors receive a "Guide to PREA" pamphlet that contains contact information for the agency PREA Coordinator. The most recent Visitor Log was reviewed, confirming that all visitors confirmed in writing that they had received the pamphlet.

Standard 115.261 Staff and agency reporting duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

All staff interviewed stated that they are required to immediately report any knowledge, suspicion, or information regarding sexual abuse or sexual harassment, as well as any retaliation, to their supervisor, Program Director, or agency PREA Coordinator. They also stated that they understood they were not to share this with anyone outside of their chain of commanded, unless directed to do so by a supervisor. All residents must be 18 or older. Agency policy requires that PREA-related incidents be reported to the Office of Protection and Advocacy for Persons with Disabilities if the victim is a person with intellectual disabilities and to the Department of Social Services if the victim is 60 years of age or older.

Standard 115.262 Agency protection duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Staff interviews confirmed that they are required to protect any resident who reported sexual abuse, sexual harassment or other type of harm. Protections would be immediate.

Standard 115.263 Reporting to other confinement facilities

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Agency policy states that if an alleged PREA-related incident occurred while the resident resided in another facility not operated by the agency, the PREA Coordinator is required to immediately notify that facility within 72 hours of learning of the incident. The policy further requires that this notification be documented. There were no reports within the past 12 months.

Standard 115.264 Staff first responder duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Agency policy, regarding First Responders to a PREA Incident, mirrors the requirements of the standard. All staff interviewed stated their understanding of these duties, especially separating the participants, protection against the destruction of evidence by the participants, and securing the scene of the incident in order to preserve evidence. Staff reported that they would then report the incident to the Program Manager and to 9-1-1 if necessary. All staff are considered to be first responders.

Standard 115.265 Coordinated response

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The Connection House has a facility specific Coordinated Response Plan that addresses the actions of the first responder, Program Manager, and PREA Coordinator. The facility does not employ medical staff, mental health staff or investigators.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

This standard is N/A. The agency, nor facility, has entered into a collective bargaining agreement.

Standard 115.267 Agency protection against retaliation

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The agency has established a dedicated policy on protection against retaliation against staff and residents who cooperate with PREA-related investigations that mirrors the requirements of the standard. The policy designates the PREA Coordinator with ensuring that all parties are safe from any form of retaliation. An interview with the PREA Coordinator confirmed his awareness. There have been no allegations of sexual abuse or sexual harassment and therefore no files to review.

Standard 115.271 Criminal and administrative agency investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

This standard is N/A. The agency does not conduct criminal or administrative investigations.

Standard 115.272 Evidentiary standard for administrative investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

This standard is N/A. The agency does not conduct criminal or administrative investigations.

Standard 115.273 Reporting to residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The agency has a policy that exactly mirrors the requirements of the standard regarding notification to the victim and obtaining investigation information. The policy also requires the notification to the victim of the status of any criminal case against the alleged perpetrator. There have been no allegations of sexual abuse or sexual harassment and therefore no files to review.

Standard 115.276 Disciplinary sanctions for staff

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Agency policy states that all substantiated allegations against staff will result in sanctions, including but not limited to, termination and referral to criminal prosecution. The agency policy on Employee Harassment states that "(W)hen it has been determined that harassment did indeed take place, takes responsive action which may include…training, referral to counseling, monitoring of the offender and/or disciplinary action up to and including termination. Both the PREA Coordinator and the HR Director confirmed (interview by USDOJ Certified PREA Auditor Peter Plant) that termination would always be the presumptive disciplinary sanction for staff who have engaged in sexual abuse. Both also confirmed that all alleged criminal behavior is referred to law enforcement agencies, even if the alleged staff resigns.

Standard 115.277 Corrective action for contractors and volunteers

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

All agency PREA-related policies apply equally to volunteers and contractors. All PREA-related allegations against a volunteer or contractor is handled in the same manner as an allegation against staff. Agency policy, relating to Contracted Services, prohibits contracting with any individual who engages in a criminal act, including sexual assault. Any volunteer who engages in sexual abuse is immediately barred from continued volunteer work in any agency facility. It is noted that at this time there are no contractors or volunteers providing services at this program.

Standard 115.278 Disciplinary sanctions for residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Agency policy states that consensual, romantic relationships between residents will be treated by staff as a violation of program rules and will not be considered a PREA incident. In cases where residents are found to have committed a sexual assault of another resident, it is the policy of the CTDOC to remand and immediately remove that resident from the facility. The CTDOC would determine the disciplinary process that would be used, as well as the sanctions that would be imposed. A representative of the CTDOC stated that "A PREA allegation would not necessarily require a remand. It would have to be an allegation of sexual abuse and not harassment, but even then it would have to be on a case by case basis." There have been no allegations of sexual abuse or sexual harassment at this program.

Standard 115.282 Access to emergency medical and mental health services

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The agency has a Memorandum of Agreement with the Connecticut Sexual Assault Crisis Services (formerly CONNSACS) to provide sexual assault crisis services, which are provided free of charge. Agency policy states that, if the resident agrees, it will contact the Connecticut Sexual Assault Crisis Services so that the resident can receive timely and unimpeded access to emergency medical treatment services, regardless of whether the resident cooperates with the investigation. These services are available on an on-going basis, until the resident is released from the facility. These services provided by Connecticut Sexual Assault Crisis Services include timely access to sexually transmitted infections prophylaxis at a licensed medical facility.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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Standard 115.286 Sexual abuse incident reviews

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Agency policy states that the PREA Coordinator will conduct a PREA incident review within 30 days of receiving a final sexual abuse investigation. The PREA Coordinator is required to make findings, as required by the standard. There were no sexual abuse investigations during the previous twelve months, hence, there were no incident reviews, nor recommendations, to implement.

Standard 115.287 Data collection

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The agency collect data required by the standard, as evidenced by its completion and submission of the USDOJ Survey of Sexual Victimization, 2015. The agency website has a dedicated page to display the data it collects and maintains. There were no allegations of sexual abuse reported during the year.

Standard 115.288 Data review for corrective action

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The agency has published on its website a comprehensive listing of comparative PREA data for 2014 and 2015 for all of its facilities, including the Connection House. As there were no PREA allegations at this facility for either year, there was no need for a comparative analysis.

Standard 115.289 Data storage, publication, and destruction

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The agency has a comprehensive policy and procedures on Computing Resources that details how data is to be securely maintained. The agency has a dedicated webpage on its Internet site that details its aggregated data. None of these data contain personal identifiers. The agency HIPAA Compliance Policy and Procedure states that the agency shall maintain case records for at least seven years after the case has been closed, *unless otherwise mandated by law*. This includes PREA data which the agency confirms it will maintain for the required 10-year period.

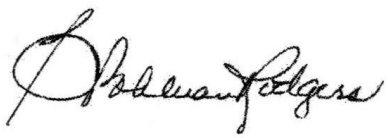
AUDITOR CERTIFICATION

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 inmate or staff member, except where the names of administrative personnel are specifically requested in the report template.



October 6, 2016

Auditor Signature Date