

**PREA AUDIT REPORT    Interim    Final  
COMMUNITY CONFINEMENT FACILITIES**

**Date of report:** September 16, 2016

<b>Auditor Information</b>			
<b>Auditor name:</b> Peter Plant			
<b>Address:</b> 6302 Benjamin Road, Suite 400, Tampa, FL 33634			
<b>Email:</b> pplant@prodigy.net			
<b>Telephone number:</b> (813) 784-4478			
<b>Date of facility visit:</b> May 25-26, 2016			
<b>Facility Information</b>			
<b>Facility name:</b> The Eddy Center			
<b>Facility physical address:</b> 1 Labella Cir. Middletown, CT 06457			
<b>Facility mailing address:</b> <i>(if different from above)</i> Click here to enter text.			
<b>Facility telephone number:</b> (860) 343-5520			
<b>The facility is:</b>	<input type="checkbox"/> Federal	<input type="checkbox"/> State	<input type="checkbox"/> County
	<input type="checkbox"/> Military	<input type="checkbox"/> Municipal	<input type="checkbox"/> Private for profit
	<input checked="" type="checkbox"/> Private not for profit		
<b>Facility type:</b>	<input type="checkbox"/> Community treatment center	<input type="checkbox"/> Community-based confinement facility	
	<input checked="" type="checkbox"/> Halfway house	<input type="checkbox"/> Mental health facility	
	<input type="checkbox"/> Alcohol or drug rehabilitation center	<input type="checkbox"/> Other	
<b>Name of facility's Chief Executive Officer:</b> Rosalyn Biggins			
<b>Number of staff assigned to the facility in the last 12 months:</b> 9			
<b>Designed facility capacity:</b> 28			
<b>Current population of facility:</b> 21			
<b>Facility security levels/inmate custody levels:</b> Low, Community Release			
<b>Age range of the population:</b> Adults			
<b>Name of PREA Compliance Manager:</b> Rosalyn Biggins		<b>Title:</b> Program Director	
<b>Email address:</b> rbiggins@theconnectioninc.org		<b>Telephone number:</b> (860) 343-5513	
<b>Agency Information</b>			
<b>Name of agency:</b> The Connection, Inc.			
<b>Governing authority or parent agency:</b> <i>(if applicable)</i> Click here to enter text.			
<b>Physical address:</b> 100 Roscommon Dr., Suite 203, Middletown, CT			
<b>Mailing address:</b> <i>(if different from above)</i> Click here to enter text.			
<b>Telephone number:</b> (860) 343-5500			
<b>Agency Chief Executive Officer</b>			
<b>Name:</b> Peter Nucci		<b>Title:</b> President & CEO	
<b>Email address:</b> pnucci@theconnectioninc.org		<b>Telephone number:</b> (860) 343-5500	
<b>Agency-Wide PREA Coordinator</b>			
<b>Name:</b> Jacob Hasson		<b>Title:</b> Director	
<b>Email address:</b> jhasson@theconnectioninc.org		<b>Telephone number:</b> (203) 747-1657	

## AUDIT FINDINGS

### NARRATIVE

The Prison Rape Elimination Act (PREA) Onsite audit of The Eddy Center in Middletown, CT, was conducted on May 25-26, 2016 by Peter Plant from Tampa, FL, a U.S. Department of Justice Certified PREA Auditor for juvenile and adult facilities. The audit was initiated on April 13, 2016 with the sending of the Pre-Audit Questionnaire, PREA Audit announcement posters, and instructions as to how the data and materials should be organized. These materials were well organized on a flash drive and timely received.

Pre-audit preparation included a thorough review of all documentation and materials submitted by the facility along with the data included in the completed Pre-Audit Questionnaire. The documentation reviewed included agency policies, procedures, forms, education materials, training curriculum, organizational charts, and other PREA related materials that were provided to demonstrate compliance with the PREA standards. This review prompted several questions that needed to be answered, as well as obtaining clarifications of some of the policies and procedures that were submitted. Several calls between this auditor and the PREA Coordinator were held during the Pre-Audit period to begin the process of communication that lasted through the Onsite visit and up to the submission of the Final Report.

At the request of the agency PREA Coordinator, an entrance meeting was held to explain the PREA audit process and answer any questions the management team might have. Present were the outgoing PREA Coordinator, the incoming PREA Coordinator, and the Program Manager. After the meeting this auditor was provided a private office space where private interviews could be conducted. This auditor was then led on a tour of the facility (detailed in the following section) by the outgoing PREA Coordinator, the incoming PREA Coordinator, and the Program Manager.

Subsequent to the tour resident rosters and resident supervision (security) staff schedules were provided so that random samples of both residents and staff could be selected for private interviews, both on- and off-site. Also scheduled for interviews were both PREA Coordinators; PREA Compliance Manager; staff who provide Intake/Risk Screening, and Human Resources staff. The facility does not employ Medical staff or Mental Health staff. The agency head had been previously interviewed.

The facility reported that there were no allegations of sexual abuse or sexual harassment during the previous twelve months. The facility has a current rated capacity of 28 residents; however, on the day of the site visit there were only 24 residents housed in the facility. Ten residents were randomly selected for private interviews. None of the residents currently at the facility had reported sexual abuse. One staff is disabled (deaf). One resident had limited English proficiency. Two residents had disclosed during risk screening sexual victimization while in the community. None identified as gay, bisexual, transgendered, or intersex.

The facility operates on three shifts daily. A total of six staff cover all three shifts per day. Six staff were on duty during the site visit. Five of these staff were randomly selected for private interviews. Three Case Managers, two of whom were interviewed, conduct the risk assessments and PREA education.

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.

**CORRECTIVE ACTIONS:** At the conclusion of the audit it was determined that three standards under 115.217 were not in compliance. All three were policy issues. All three corrective actions were received on September 16, 2016, and were found to be compliant with the standards.

## DESCRIPTION OF FACILITY CHARACTERISTICS

The Eddy Center, located in Middletown, is a residential treatment center providing intensive supervision, counseling and monitoring for up to 28 individuals over the age of 18 who are offered an alternative to incarceration. The program addresses individual client needs to help ease their transition back into the community and reduce the likelihood of criminal recidivism.

The Eddy Building, which houses Eddy Shelter, Eddy Center and Logano Place, was built in 1955 as a residence for 96 Connecticut Valley Hospital (CVH) employees. It was named Eddy Home in honor of Pearl and Otis Eddy, longtime and dedicated CVH employees. They were members of a family with a long and close relationship with the hospital, as both employees and advocates.

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

- Employment skills
- Educational assistance
- Substance use education
- Life skills, such as anger management, trauma education and health education

That portion of the Eddy House that houses the audited program occupies two floors of this former hospital, both configured in an elongated U-shape. Detailed site and building plans were provided, which greatly assisted in understanding the site configuration, adjacencies, housing unit layout (including the showers and toilet areas), and camera placements of this facility. There are 14 sleeping room with a toilet and shower room between every two rooms. Two residents are assigned to each room. All residents interviewed stated that their privacy is respected. There are cameras that monitor the hallways and common areas, including the lounge and TV room, dining and kitchen areas, as well as the spacious outdoor recreation area.

Notices of the PREA Audit that were sent to initiate the audit were observed posted throughout the facility. Also, posters and signs, regarding PREA services and reporting resources to outside agencies, were prominently posted.

## **SUMMARY OF AUDIT FINDINGS**

Despite the one standard that was not met, the agency and facility is to be commended for its commitment to both the letter and intent of the Prison Rape Elimination Act. At the conclusion of the PREA Audit, this Auditor conducted a post-audit briefing complimenting staff on the work that the agency's administration and the facility staff, in particular, has done to comply with the PREA standards in this first PREA Audit. It is evident from the results discussed in this Report that, with one exception, 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.

### **Interim Report/Final Report**

Number of standards exceeded: 0/0

Number of standards met: 32/33

Number of standards not met: 1/0

Number of standards not applicable: 8/8

**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 has sufficient time and authority to oversee the agency’s efforts to comply with the PREA Standards. This was evident throughout the audit.

**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)

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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 28 residents and takes into consideration specific resident exclusionary criteria, including convictions for arson or other related burning charges; severe or persistent psychiatric condition; current physical addiction to drugs or alcohol requiring detoxification; severe medical condition or physical disability which prohibit full program participation; or offenders with sexual

offenses that merit a rating of Level 2 or above by CTDOC. The plan also incorporates the use of 10 cameras (10 inside on both floors of the facility and 3 outside the facility) that cover the areas of resident movement. The staffing plan is reviewed annually.

**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)

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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. Compliance with this policy was confirmed by all residents who were interviewed. All staff interviewed stated they had been trained on this policy, and this was confirmed by a review of their training records.

Residents are roomed two to a room, and every two rooms share a common bathroom situated between the 14 sleeping rooms. All residents interviewed stated that their privacy is respected and that female staff consistently knock on the door to their sleeping room and announce themselves before entering the room.

**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.

All the staff who were 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. A resident who is Asian was interviewed and stated that his English was sufficiently good that he has not needed an interpreter. A resident who is very hard of hearing was interviewed and he confirmed that the facility has made all accommodations necessary for him to effectively participate in the program.

### 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 CONNSACS 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. 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. 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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Volunteers and contractors receive PREA training similar to that received by employees. Documentation of this training was provided.

### 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. All residents interviewed confirmed that they received information explaining 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. They all confirmed that they received a one-page document entitled, “Your Rights as a Client of The Connection Inc.” This document contains a section, regarding “Humane and dignified treatment,” that addresses the agency’s zero tolerance policy. They also received a pamphlet, written in both English and Spanish, that provides additional information about their rights and how to report abuse or harassment. Documentation of resident education was provided.

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. All residents interviewed confirmed they received a written list of Connecticut Sexual Assault Crisis Services offices with contact information. Several stated that they knew they could call law enforcement, if they wanted to make a report of sexual abuse.

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.

**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. Two of the three staff authorized to make these decisions were available for interview during the On-site visit and both confirmed they had the authority to consider a transgender or intersex resident's own views on the matter of personal safety and to re-assign existing housing assignments, if they need to make a housing assignment for a new admission, based on the results of the screening. There are 14 resident rooms, and a bathroom/shower between every two rooms. All residents shower separately from all other residents.

**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)

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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. To the credit of the program and staff, all of the residents interviewed stated that they would choose to report any allegation to staff, rather than an external entity. 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.

### **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 grievable 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)

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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 CONNSACS member programs that may be contacted for these purposes. These services, as well as forensic examinations, are offered without financial cost to the resident. Residents reported that they received the contact information for these agencies and understood that their communications may be monitored.

### **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 command, 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.**

All staff interviewed emphatically stated that the protection of the residents is their primary duty. All stated that they would take immediate action to protect a resident, whenever they learned that the resident was subject to harm of any kind, not just sexual abuse.

#### **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.

#### **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. Several staff stated that the Program Manager was responsible for contacting law enforcement, rather than themselves. 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 Eddy Center has a coordinated response plan within its First Responders policy that meets the requirements of the standard.

#### **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.

### **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. In that there have been no PREA-related allegations during the previous twelve months, there were no reports to residents required.

#### **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 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.

#### **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.”

**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 (CONNSACS) to provide sexual assault crisis services, which are provided free of charge. Agency policy states that, if the resident agrees, it will contact CONNSACS 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 CONNSACS 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 Eddy Center. 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.



September 16, 2016

Auditor Signature

Date