# Prison Rape Elimination Act (PREA) Audit Report

## Juvenile Facilities

- **Interim**: ☐
- **Final**: ☒

### Date of Report
November 29, 2019

## Auditor Information

<table>
<thead>
<tr>
<th>Name</th>
<th>Mable P. Wheeler</th>
<th>Email</th>
<th><a href="mailto:wheeler5p@hotmail.com">wheeler5p@hotmail.com</a></th>
</tr>
</thead>
<tbody>
<tr>
<td>Company Name</td>
<td>Diversified Correctional Services, LLC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mailing Address</td>
<td>PO Box 5736</td>
<td>City, State, Zip: Macon, GA 31208</td>
<td></td>
</tr>
<tr>
<td>Telephone</td>
<td>478-737-2171</td>
<td>Date of Facility Visit: October 28 - 29, 2019</td>
<td></td>
</tr>
</tbody>
</table>

## Agency Information

<table>
<thead>
<tr>
<th>Name of Agency</th>
<th>Journey House, Natchaug Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Governing Authority or Parent Agency (If Applicable)</td>
<td>Hartford Health Care</td>
</tr>
<tr>
<td>Physical Address</td>
<td>189 Storrs Road</td>
</tr>
<tr>
<td>Mailing Address</td>
<td>189 Storrs Road</td>
</tr>
<tr>
<td>City, State, Zip</td>
<td>Mansfield, CT 06250</td>
</tr>
<tr>
<td>City, State, Zip</td>
<td>Mansfield, CT 06250</td>
</tr>
<tr>
<td>The Agency Is:</td>
<td>☒ Private not for Profit</td>
</tr>
<tr>
<td>☐ Military</td>
<td></td>
</tr>
<tr>
<td>☐ County</td>
<td></td>
</tr>
<tr>
<td>☐ State</td>
<td></td>
</tr>
<tr>
<td>☐ Federal</td>
<td></td>
</tr>
</tbody>
</table>

### Agency Website with PREA Information:
https://natchaug.org/programs-services/journey-house-program

## Agency Chief Executive Officer

<table>
<thead>
<tr>
<th>Name</th>
<th>Patricia Rehmer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Email</td>
<td><a href="mailto:Patricia.Rehmer@hhchealth.org">Patricia.Rehmer@hhchealth.org</a></td>
</tr>
<tr>
<td>Telephone</td>
<td>860-456-1311</td>
</tr>
</tbody>
</table>

## Agency-Wide PREA Coordinator

<table>
<thead>
<tr>
<th>Name</th>
<th>Johnathan Simpson</th>
</tr>
</thead>
<tbody>
<tr>
<td>Email</td>
<td><a href="mailto:Jonathan.Simpson@hhchealth.org">Jonathan.Simpson@hhchealth.org</a></td>
</tr>
<tr>
<td>Telephone</td>
<td>860-336-8761</td>
</tr>
</tbody>
</table>

### PREA Coordinator Reports to:
Roy Sasenaraine

### Number of Compliance Managers who report to the PREA Coordinator:
1
## Facility Information

<table>
<thead>
<tr>
<th>Name of Facility:</th>
<th>Journey House</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Address:</td>
<td>189 Storrs Road</td>
</tr>
<tr>
<td>City, State, Zip:</td>
<td>Mansfield Center, CT 06250</td>
</tr>
<tr>
<td>Mailing Address (if different from above):</td>
<td>Click or tap here to enter text.</td>
</tr>
<tr>
<td>City, State, Zip:</td>
<td>Click or tap here to enter text.</td>
</tr>
<tr>
<td>The Facility Is:</td>
<td>☒ Private not for Profit</td>
</tr>
<tr>
<td>Military</td>
<td>☐</td>
</tr>
<tr>
<td>Private for Profit</td>
<td>☐</td>
</tr>
<tr>
<td>Municipal</td>
<td>☐</td>
</tr>
<tr>
<td>County</td>
<td>☐</td>
</tr>
<tr>
<td>State</td>
<td>☐</td>
</tr>
<tr>
<td>Federal</td>
<td>☐</td>
</tr>
<tr>
<td>Facility Website with PREA Information:</td>
<td><a href="https://natchaug.org/programs-services/journey-house-program">https://natchaug.org/programs-services/journey-house-program</a></td>
</tr>
<tr>
<td>Has the facility been accredited within the past 3 years?</td>
<td>☒ Yes</td>
</tr>
<tr>
<td>☐ No</td>
<td></td>
</tr>
<tr>
<td>If the facility has been accredited within the past 3 years, select the accrediting organization(s) – select all that apply (N/A if the facility has not been accredited within the past 3 years):</td>
<td></td>
</tr>
<tr>
<td>ACA</td>
<td>☐</td>
</tr>
<tr>
<td>NCCHC</td>
<td>☐</td>
</tr>
<tr>
<td>CALEA</td>
<td>☒</td>
</tr>
<tr>
<td>Other (please name or describe: The Joint Commission, DCF</td>
<td>☒</td>
</tr>
<tr>
<td>N/A</td>
<td>☐</td>
</tr>
<tr>
<td>If the facility has completed any internal or external audits other than those that resulted in accreditation, please describe:</td>
<td>Click or tap here to enter text.</td>
</tr>
</tbody>
</table>

### Facility Administrator/Superintendent/Director

| Name: | Johnathan Simpson |
| Email: | Johnathan.Simpson@hhchealth.org |
| Telephone: | 860-336-8761 |

### Facility PREA Compliance Manager

| Name: | Christy Calkins |
| Email: | Christy.calkins@hhchealth.org |
| Telephone: | 860-455-5791 |

### Facility Health Service Administrator

<p>| Name: | Click or tap here to enter text. |
| Email: | Click or tap here to enter text. |
| Telephone: | Click or tap here to enter text. |</p>
<table>
<thead>
<tr>
<th>Facility Characteristics</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Designated Facility Capacity:</td>
<td>16</td>
</tr>
<tr>
<td>Current Population of Facility:</td>
<td>13</td>
</tr>
<tr>
<td>Average daily population for the past 12 months:</td>
<td>7.23</td>
</tr>
<tr>
<td>Has the facility been over capacity at any point in the past 12 months?</td>
<td>No</td>
</tr>
<tr>
<td>Which population(s) does the facility hold?</td>
<td>Females</td>
</tr>
<tr>
<td>Age range of population:</td>
<td>13-18</td>
</tr>
<tr>
<td>Average length of stay or time under supervision</td>
<td>4 to 6 months</td>
</tr>
<tr>
<td>Facility security levels/resident custody levels</td>
<td>Locked Residential Facility/Committed Delinquent</td>
</tr>
<tr>
<td>Number of residents admitted to facility during the past 12 months</td>
<td>22</td>
</tr>
<tr>
<td>Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 72 hours or more:</td>
<td>22</td>
</tr>
<tr>
<td>Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 10 days or more:</td>
<td>22</td>
</tr>
<tr>
<td>Does the audited facility hold residents for one or more other agencies (e.g. a State correctional agency, U.S. Marshals Service, Bureau of Prisons, U.S. Immigration and Customs Enforcement)?</td>
<td>No</td>
</tr>
<tr>
<td>Select all other agencies for which the audited facility holds residents: Select all that apply (N/A if the audited facility does not hold residents for any other agency or agencies):</td>
<td>Federal Bureau of Prisons</td>
</tr>
<tr>
<td></td>
<td>U.S. Marshals Service</td>
</tr>
<tr>
<td></td>
<td>U.S. Immigration and Customs Enforcement</td>
</tr>
<tr>
<td></td>
<td>Bureau of Indian Affairs</td>
</tr>
<tr>
<td></td>
<td>U.S. Military branch</td>
</tr>
<tr>
<td></td>
<td>State or Territorial correctional agency</td>
</tr>
<tr>
<td></td>
<td>County correctional or detention agency</td>
</tr>
<tr>
<td></td>
<td>Judicial district correctional or detention facility</td>
</tr>
<tr>
<td></td>
<td>City or municipal correctional or detention facility (e.g. police lockup or city jail)</td>
</tr>
<tr>
<td></td>
<td>Private corrections or detention provider</td>
</tr>
<tr>
<td></td>
<td>Other - please name or describe: Click or tap here to enter text.</td>
</tr>
<tr>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>Number of staff currently employed by the facility who may have contact with residents:</td>
<td>53</td>
</tr>
<tr>
<td>Number of staff hired by the facility during the past 12 months who may have contact with residents:</td>
<td>9</td>
</tr>
<tr>
<td>Question</td>
<td>Answer</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>--------</td>
</tr>
<tr>
<td>Number of contracts in the past 12 months for services with contractors who may have contact with residents:</td>
<td>0</td>
</tr>
<tr>
<td>Number of individual contractors who have contact with residents, currently authorized to enter the facility:</td>
<td>0</td>
</tr>
<tr>
<td>Number of volunteers who have contact with residents, currently authorized to enter the facility:</td>
<td>0</td>
</tr>
<tr>
<td><strong>Physical Plant</strong></td>
<td></td>
</tr>
<tr>
<td>Number of buildings:</td>
<td>1</td>
</tr>
<tr>
<td>Auditors should count all buildings that are part of the facility, whether residents are formally allowed to enter them or not. In situations where temporary structures have been erected (e.g., tents) the auditor should use their discretion to determine whether to include the structure in the overall count of buildings. As a general rule, if a temporary structure is regularly or routinely used to hold or house residents, or if the temporary structure is used to house or support operational functions for more than a short period of time (e.g., an emergency situation), it should be included in the overall count of buildings.</td>
<td></td>
</tr>
<tr>
<td>Number of resident housing units:</td>
<td>1</td>
</tr>
<tr>
<td>Enter 0 if the facility does not have discrete housing units. DOJ PREA Working Group FAQ on the definition of a housing unit: How is a &quot;housing unit&quot; defined for the purposes of the PREA Standards? The question has been raised in particular as it relates to facilities that have adjacent or interconnected units. The most common concept of a housing unit is architectural. The generally agreed-upon definition is a space that is enclosed by physical barriers accessed through one or more doors of various types, including commercial-grade swing doors, steel sliding doors, interlocking sally port doors, etc. In addition to the primary entrance and exit, additional doors are often included to meet life safety codes. The unit contains sleeping space, sanitary facilities (including toilets, lavatories, and showers), and a dayroom or leisure space in differing configurations. Many facilities are designed with modules or pods clustered around a control room. This multiple-pod design provides the facility with certain staff efficiencies and economies of scale. At the same time, the design affords the flexibility to separately house residents of differing security levels, or who are grouped by some other operational or service scheme. Generally, the control room is enclosed by security glass, and in some cases, this allows residents to see into neighboring pods. However, observation from one unit to another is usually limited by angled site lines. In some cases, the facility has prevented this entirely by installing one-way glass. Both the architectural design and functional use of these multiple pods indicate that they are managed as distinct housing units.</td>
<td></td>
</tr>
<tr>
<td>Number of single resident cells, rooms, or other enclosures:</td>
<td>16</td>
</tr>
<tr>
<td>Number of multiple occupancy cells, rooms, or other enclosures:</td>
<td>14</td>
</tr>
<tr>
<td>Number of open bay/dorm housing units:</td>
<td>1</td>
</tr>
<tr>
<td>Number of segregation or isolation cells or rooms (for example, administrative, disciplinary, protective custody, etc.):</td>
<td>1</td>
</tr>
<tr>
<td>Does the facility have a video monitoring system, electronic surveillance system, or other monitoring technology (e.g. cameras, etc.)?</td>
<td>Yes</td>
</tr>
<tr>
<td>Has the facility installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology in the past 12 months?</td>
<td>Yes</td>
</tr>
</tbody>
</table>
### Medical and Mental Health Services and Forensic Medical Exams

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are medical services provided on-site?</td>
<td>☒</td>
<td>☐</td>
</tr>
<tr>
<td>Are mental health services provided on-site?</td>
<td>☒</td>
<td>☐</td>
</tr>
<tr>
<td>Where are sexual assault forensic medical exams provided? Select all that apply.</td>
<td>☐ On-site</td>
<td>☐ Local hospital/clinic</td>
</tr>
</tbody>
</table>

### Investigations

#### Criminal Investigations

<table>
<thead>
<tr>
<th>Question</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of investigators employed by the agency and/or facility who are responsible for conducting CRIMINAL investigations into allegations of sexual abuse or sexual harassment:</td>
<td></td>
<td>External, local &amp; state</td>
</tr>
<tr>
<td>When the facility received allegations of sexual abuse or sexual harassment (whether staff-on-resident or resident-on-resident), CRIMINAL INVESTIGATIONS are conducted by: Select all that apply.</td>
<td></td>
<td>☐ Facility investigators</td>
</tr>
<tr>
<td>Select all external entities responsible for CRIMINAL INVESTIGATIONS: Select all that apply (N/A if no external entities are responsible for criminal investigations)</td>
<td>☐ Local police department</td>
<td>☐ Local sheriff’s department</td>
</tr>
</tbody>
</table>

#### Administrative Investigations

<table>
<thead>
<tr>
<th>Question</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of investigators employed by the agency and/or facility who are responsible for conducting ADMINISTRATIVE investigations into allegations of sexual abuse or sexual harassment?</td>
<td>Johnathan Simpson</td>
<td></td>
</tr>
<tr>
<td>When the facility receives allegations of sexual abuse or sexual harassment (whether staff-on-resident or resident-on-resident), ADMINISTRATIVE INVESTIGATIONS are conducted by: Select all that apply</td>
<td>☐ Facility investigators</td>
<td>☐ Agency investigators</td>
</tr>
<tr>
<td>Select all external entities responsible for ADMINISTRATIVE INVESTIGATIONS: Select all that apply (N/A if no external entities are responsible for administrative investigations)</td>
<td>☐ Local police department</td>
<td>☐ Local sheriff’s department</td>
</tr>
</tbody>
</table>

### Audit Findings
Audit Narrative

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

The site review for this audit took place at the Journey House, Natchaug Hospital located at 189 Storrs Road, Mansfield Center, CT 06250 on October 28 - 29, 2019. The Journey House is operated by the Natchaug Hospital, for the State of Connecticut. The Journey House hereinafter may be referred to as facility.

Audit Methodology:

The auditor used a triangular approach, by connecting the PREA audit documentations, on-site observation, tour, practice, interviewed staff, residents, and local and national advocates to make determinations for each standard and provision. The auditor is certified in both juvenile and adults facilities.

Pre-onsite Audit Phase

Posting:

The auditor provided the audit notice to the agency PREA Compliance Manager on September 6, 2019, with instructions to post the required PREA Audit Notice of the upcoming audit prior to the audit for confidential communications. The facility posted the notices in English and Spanish. The auditor observed the posted notices during the onsite visit. Prior to the onsite audit, the auditor did not receive any communications from residents, staff or visitors.

Questionnaire (PAQ):

In order to prepare for the audit process, email correspondences and telephone conversations occurred with the agency's PREA Compliance Manager. As the auditor reviewed the materials provided by the facility, she collated documents that were on the flash drive. The Pre-Audit Questionnaire was completed and sent to the auditor as required prior to the onsite audit.

The auditor completed a documentation review using the Pre-Audit Questionnaire, internet search, policies and procedures review, and additional documentation provided to include the facility policy and procedures, agency mission statement, daily population report, schematic/layout for the facility and the last Final PREA Audit Report.

The results of the documentation review were shared with the facility prior to and at the site visit. Phone conversations were conducted, and email exchanges occurred with the facility.

The following documentation was requested:

- Residents roster
- Residents with disabilities
- Residents who are Limited English Proficient (LEP)
- LGBTI residents
- Residents in segregated housing (PREA Related)
- Residents who reported sexual abuse
- Residents who reported sexual victimization during risk screening
- Staff roster
- Specialized staff
- Staff personnel files
- Residents files
- Grievances made in the 12 months preceding the audit
- Allegations of sexual abuse and sexual harassment reported for investigation in the 12 months preceding the audit
- General incident log
- All hotline calls made during the 12 months preceding the audit
- All incidents within the past 12 months

**Website Review**

Prior to the onsite portion of the audit, the auditor conducted a website review of the State of Connecticut Judicial Branch. The reviewed content included but was not limited to:

- Judicial Branch PREA Values
- Judicial Branch PREA Vision
- Judicial Branch PREA Mission
- Division of Investigative Services Hotline
- Prevention of Sexual Offenses toward Juveniles (PDF)
- Investigations (PDF)
- Judicial Branch Policy Statements
- PREA Brochure
- Judicial Branch News
- Jobs
- Local Resources
- Judicial Branch Process
- Natchaug Hospital Website
  - Journey House PREA Audit Report (2016)

**Outreach to National and Local Advocacy Organizations:**

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

Justice Detention International (No information reported)
Sexual Assault Crisis Center of Eastern CT, INC. (No information reported)

**On-Site Audit Phase**

**Entrance Meeting**
On October 28, 2019 the auditor arrived at the facility to conduct the facility PREA audit. The entrance meeting served as initial introductions and onsite logistics with the facility leadership. The audit goals and expectations of the audit were shared with the following attendees:

Johnathan Simpson, Program Director  
Christy Calkins, Assistant Program Director  
John Fitzgerald, Superintendent

Welcomes were given by the facility Program Director. The auditor introduced herself and provided a brief description of her experience, qualifications and auditing background.

Additional pre-audit information, requested weeks prior to, was obtained. The auditor was provided with resident and employee documentation to review. Updated resident and staffing list were also provided allowing the auditor to make randomized selection of interview participants including residents and staff from housing units and specialized categories.

The facility provided the auditors with the requested meeting space, work space with adequate outlets and permissible technology (laptop and cell phone).

Staff interviews

Specialized Staff interview (8)

- Program Director  
- Human Resources  
- Principal  
- Contract Monitor  
- Intake Staff  
- Risk Assessments Staff  
- Mental Health  
- Registered Nurse

Random staff interviews (10)

- Mental Health (1st Shift)  
- Shift Supervisor (1st Shift)  
- Mental Health (2nd Shift)  
- Mental Health Assistant Supervisor (2nd Shift)  
- Shift Supervisor (3rd Shift)  
- Mental Health (3rd Shift)

All Residents were interviewed (7)

- Gay  
- Gays who reported prior victimization  
- Resident who reported victimization  
- Residents

Site Review
The auditor conducted a comprehensive site review of the facility. The auditor was provided a layout of the facility prior to the onsite review.

On the first day of the audit, after the entrance conference, the auditor toured the physical plant. When the auditor paused to speak to a resident or staff, it was requested that the staff on the tour please step away so the conversation may remain private.

During the tour, the auditor observed the locations of video monitoring cameras around the facility, including those outside. None of the cameras field of view included the toilet and shower areas, each unit has PREA shower curtains to block the viewing of cameras. There are 11 cameras located in and around the facility that can be monitored and recorded up to 90 days. The cameras in the facility cover the main sections of the building to include all housing units, hallways, classrooms and recreation areas. The outside cameras cover the surrounding areas, exits, and entrances to the facility. There are no cameras in juvenile’s rooms.

The auditor observed the locations of grievance and medical boxes. Resident risk screenings are completed during intake process. The facility has a staffing ratio of 1 staff to 3 residents during the daytime hours and 1 staff to 5 residents after midnight, the auditor observed the youth movement, living units, and recreation area.

The auditor was provided unimpeded access to all parts of the facility and all secure rooms and storage areas in the facility.

**Exit Briefing**

An exit briefing was conducted with the following: Program Director and Assistant Program Director, Preliminary findings were discussed. The auditor and the PREA Compliance Manager continued to work together following the on-site audit when additional information was needed it was provided in a timely manner.

**Facility Characteristics**

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

Journey House opened in 2004 as a thirteen-bed specialized living community for adolescent females, twelve to eighteen years of age, who were in the care or custody of the Department of Children and Families. Females referred by DCF had identified needs for behavioral health services, and may have had a history of one or more of the following circumstances or behaviors: severe abuse and neglect, trauma, mental illness, Domestic Minor Sex Trafficking, a history of substance abuse, assaultive and/or self-injurious behaviors. Currently adolescent females in the Journey House have been referred by CSSD.

**The mission statement of Journey House:** To provide a safe and nurturing environment where adolescent residents can build healthy relationships, engage in meaningful, purposeful activities that foster positive youth development, gain belief in their own recovery, and reclaim their futures.
The focus of this program is the integrated provision of clinical/mental health, psychosocial and substance abuse services in a manner that is therapeutic, gender-specific, trauma-informed, and responsive to the histories and experiences of the females who will require this level of care. Journey House provides opportunities for each adolescent to explore the various parts of “self”- emotional, physical, intellectual, social and spiritual- in developing new interests and new experiences that can lead to a healthier and more productive life. The Program has been designed to utilize individual strengths as motivators in the healing process. As residents move up the four Phases of the program, there are enhanced responsibilities and privileges that ultimately lead to the development of valued social roles, increased confidence and a stronger sense of self-identity.

The program includes all education services necessary to meet the needs of the residents. All residents of the program are expected to attend at least 5 hours of school instruction each school day.

The development of skills, and community and family supports is fostered through a comprehensive and integrated daily schedule that includes one-to-one counseling, group and family therapy, in-home family therapy, gender-specific and other psychoeducational groups, recreational activities, life skills development, vocational and educational activities, and diverse community and cultural experiences. Skill building in such areas as; emotion regulation, health and safe sex practices, violence prevention, substance abuse, identity and cultural development, conflict resolution, stress and trauma management, loss and grief, interpersonal skill and relationship development, risk reduction, and many other age and gender relevant topics is provided through one-to-one counseling, group and other therapeutic milieus. Each resident is assigned a Primary Therapist and is provided with weekly one-to-one and group counseling sessions. Journey House residents often receive between 20-30 hours of evidence-based/evidence-informed group therapy each month. Family therapy occurs at minimum twice a month and can occur in their home communities.

The Journey House provides Mental Health Worker Advocates, Shift Supervisors, Program Nurses, Primary Therapists, Clinical Director, Teachers, Educational Assistant, Psychiatrist, and a Recreational Coordinator. The Program Director has administrative oversight of the program. All residents develop individualized treatment plans supported by an organized support system that includes Program staff, Probation Officers, DCF, other service providers, and family members and other natural supports. All direct care staff are trained in Natchaug Hospital’s Block Training, CPR, First Aid, Crisis Prevention Institute (CPI) Behavioral Intervention, and gender specific and trauma-informed programming for adolescents.

The Journey House has a total of 53 positions that include 13 full-time and 40 part-time, with no vacancies.

**Staffing**

30 Mental Health Workers
- 3 Full-time
- 27 Part-time
6 Part-time Shift Supervisors
2 Part-time Recreation Coordinators
2 Part-time Registered Nurses
1 Full-time Office Manager
3 Full-time Education Staff
4 Full-time Clinical Staff
2 Full-time Administrative Staff
   • 1 Part-time Administrative Staff
2 Part-time Medical Staff

**Summary of Audit Findings**

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

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

**Concern:** Hotline phone number should be placed in close proximity to phone. Brochure listing hotline number was visible on bulletin board; auditor recommended placing the number above the telephone.

**Corrective Action:** The PREA Compliance Manager has identified a location in close proximity to telephone utilized by residents for posting of hotline number.

### Standards Exceeded

<table>
<thead>
<tr>
<th>Number of Standards Exceeded:</th>
<th>0</th>
</tr>
</thead>
<tbody>
<tr>
<td>List of Standards Exceeded:</td>
<td>Click or tap here to enter text.</td>
</tr>
</tbody>
</table>

### Standards Met

<table>
<thead>
<tr>
<th>Number of Standards Met:</th>
<th>43</th>
</tr>
</thead>
<tbody>
<tr>
<td>115.311- Zero tolerance of sexual abuse and sexual harassment; PREA Coordinator</td>
<td></td>
</tr>
<tr>
<td>115.312 – Contracting with other entities for the confinement of residents</td>
<td></td>
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<tr>
<td>115.313 – Supervision and monitoring</td>
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<td>– Limits to cross-gender viewing and searches</td>
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<tr>
<td>– Residents with disabilities and residents who are limited English proficient</td>
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<tr>
<td>– Hiring and promotion decisions</td>
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<tr>
<td>– Upgrades to facilities and technologies</td>
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<tr>
<td>115.321 – Evidence protocol and forensic medical examinations</td>
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<td>115.322 – Policies to ensure referrals of allegations for investigations</td>
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<td>– Employee training</td>
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<td>– Volunteer and contractor training</td>
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<td>– Resident education</td>
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<td>– Specialized training: Investigations</td>
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<td>– Specialized training: Medical and mental health care</td>
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<td>115.341 – Obtaining information from residents</td>
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<td>115.342 – Placement of residents in housing, bed, program, education, and work assignments</td>
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<td>– Resident reporting</td>
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– Exhaustion of administrative remedies
– Resident access to outside support services and legal representation
– Third-party reporting
– Staff and agency reporting duties
– Agency protection duties
– Reporting to other confinement facilities
– Staff first responder duties
– Coordinated response
– Preservation of ability to protect residents for contact with abusers
– Agency protection against retaliation
– Post-allegation protective custody
– Criminal and administrative agency investigations
– Evidentiary standard for administrative investigations
– Reporting to residents
– Disciplinary sanctions for staff
– Corrective action for contractors and volunteers
– Interventions and disciplinary sanctions for residents
– Medical and mental health screenings; history of sexual abuse
– Access to emergency medical and mental health services
– Ongoing medical and mental health care for sexual abuse victims and abusers
– Sexual abuse incident reviews
– Data collection
– Data review for corrective action
– Data storage, publication, and destruction

115.401 – Frequency and scope of audits
115.403 – Audit contents and finding

**Standards Not Met**

**Number of Standards Not Met:** 0

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

**PREVENTION PLANNING**

**Standard 115.311: Zero tolerance of sexual abuse and sexual harassment; PREA coordinator**

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

**115.311 (a)**

- Does the agency have a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment?  ☒ Yes  ☐ No
• Does the written policy outline the agency’s approach to preventing, detecting, and responding to sexual abuse and sexual harassment? ☒ Yes □ No

115.311 (b)

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

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

• Does the PREA Coordinator have sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards in all of its facilities? ☒ Yes □ No

115.311 (c)

• If this agency operates more than one facility, has each facility designated a PREA compliance manager? (N/A if agency operates only one facility.) ☒ Yes □ No □ NA

• Does the PREA compliance manager have sufficient time and authority to coordinate the facility’s efforts to comply with the PREA standards? (N/A if agency operates only one facility.) ☒ Yes □ No □ NA

Auditor Overall Compliance Determination

□ Exceeds Standard (Substantially exceeds requirement of standards)

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

□ Does Not Meet Standard (Requires Corrective Action)

Instructions for Overall Compliance Determination Narrative

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Policy and Documents Review: Natchaug Hospital Policy and Procedures Manual, 2.2, Resident Rights, requires that residents have a right to be free from harm by caregivers and others and Policy 1.26, Sexual Assault Prevention and Intervention prohibit sexual acts or physical contact between clients. Journey House also has a “No Touch Policy” to promote the building of healthy relationships and healthy boundaries and set clear standards for all residents regarding physical contact. Touch between residents is prohibited (with an exception that there is a provision for staff or residents to give a pat on the back for support or a brief hug which will be supervised by staff).

Horseplay, tickling, touching or sexual contact is absolutely prohibited. Staff are trained in Non-Violent Crisis Intervention that may require contact. Staff receives a power point presentation and training on
“no touch”. The Agency has indicated its commitment to the sexual safety of residents by appointing a PREA Coordinator, who is identified on the agency organizational chart and who has sufficient time and authority to implement PREA. The Journey House Program Director serves as the PREA Coordinator. He reports directly to the Vice President of Operations. The facility has a PREA Compliance Manager as well. The PREA compliance manager has sufficient time and authority to implement the PREA Standards within the program.

The Natchaug Hospital, Journey House annual report reiterates the zero tolerance policy toward all forms of sexual abuse and harassment. Residents are given a copy of a brochure entitled “Sexual Assault Awareness”. Residents are informed of the Zero Tolerance Policy in that brochure. Zero Tolerance Posters are posted throughout the facility in areas accessible and in view of residents and staff.

- **Interview Results:** Interviewed agency head designee confirmed the appointment of an agency statewide PREA coordinator as a full-time position to oversee PREA operations within all facilities.
- Interviewed agency PREA coordinator confirmed appointment as the agency PREA coordinator.
- Interviewed Program Director confirmed the appointment of a facility PREA compliance manager to oversee PREA operations within the facility.
- Interviewed facility PREA compliance manager confirmed appointment as the facility PREA compliance manager.

### Standard 115.312: Contracting with other entities for the confinement of residents

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

**115.312 (a)**

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

**115.312 (b)**

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

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

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

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

Instructions for Overall Compliance Determination Narrative

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Journey House is a private, non-profit agency. Journey House does not contract for the confinement of its clients with other private agencies or entities. The facility provided a copy of the contract with the Connecticut Judicial Branch Court Support Services Division, Juvenile Residential Services. The contract requires compliance with the Prison Rape Elimination Act. In addition, the contracted agency must meet all standards in accordance with all State and Federal Laws.

Medical and psychological trauma of sexual abuse will be minimized as much as possible by prompt and appropriate health interventions. The facility ensures that juveniles and staff are educated about sexual abuse and sexual harassment issues. Juveniles are monitored for risk and referred for appropriate services. Victims of alleged sexual abuse, who are in the custody or the Department, will immediately be referred for treatment.

Standard 115.313: Supervision and monitoring

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

115.313 (a)

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

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Generally accepted juvenile detention and correctional/secure residential practices?
  - ☒ Yes  ☐ No

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Any judicial findings of inadequacy?
  - ☒ Yes  ☐ No
In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Any findings of inadequacy from Federal investigative agencies? ☒ Yes ☐ No

In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Any findings of inadequacy from internal or external oversight bodies? ☒ Yes ☐ No

In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: All components of the facility's physical plant (including "blind-spots" or areas where staff or residents may be isolated)? ☒ Yes ☐ No

In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: The composition of the resident population? ☒ Yes ☐ No

In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: The number and placement of supervisory staff? ☒ Yes ☐ No

In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Institution programs occurring on a particular shift? ☒ Yes ☐ No

In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Any applicable State or local laws, regulations, or standards? ☒ Yes ☐ No

In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration the prevalence of substantiated and unsubstantiated incidents of sexual abuse? ☒ Yes ☐ No

In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Any other relevant factors? ☒ Yes ☐ No

115.313 (b)

Does the agency comply with the staffing plan except during limited and discrete exigent circumstances? ☒ Yes ☐ No

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

115.313 (c)

Does the facility maintain staff ratios of a minimum of 1:8 during resident waking hours, except during limited and discrete exigent circumstances? (N/A if the facility is not a secure juvenile facility per the PREA standards definition of “secure”.) ☒ Yes ☐ No ☐ NA
Does the facility maintain staff ratios of a minimum of 1:16 during resident sleeping hours, except during limited and discrete exigent circumstances? (N/A if the facility is not a secure juvenile facility per the PREA standards definition of “secure”). ☒ Yes ☐ No ☐ NA

Does the facility fully document any limited and discrete exigent circumstances during which the facility did not maintain staff ratios? (N/A if the facility is not a secure juvenile facility per the PREA standards definition of “secure”). ☒ Yes ☐ No ☐ NA

Does the facility ensure only security staff are included when calculating these ratios? (N/A if the facility is not a secure juvenile facility per the PREA standards definition of “secure”). ☒ Yes ☐ No ☒ NA

Is the facility obligated by law, regulation, or judicial consent decree to maintain the staffing ratios set forth in this paragraph? ☒ Yes ☐ No

115.313 (d)

In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: The staffing plan established pursuant to paragraph (a) of this section? ☒ Yes ☐ No

In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: Prevailing staffing patterns? ☒ Yes ☒ No

In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: The facility’s deployment of video monitoring systems and other monitoring technologies? ☒ Yes ☐ No

In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: The resources the facility has available to commit to ensure adherence to the staffing plan? ☒ Yes ☐ No

115.313 (e)

Has the facility implemented a policy and practice of having intermediate-level or higher-level supervisors conduct and document unannounced rounds to identify and deter staff sexual abuse and sexual harassment? (N/A for non-secure facilities) ☒ Yes ☐ No ☐ NA

Is this policy and practice implemented for night shifts as well as day shifts? (N/A for non-secure facilities) ☒ Yes ☐ No ☐ NA

Does the facility have a policy prohibiting staff from alerting other staff members that these supervisory rounds are occurring, unless such announcement is related to the legitimate operational functions of the facility? (N/A for non-secure facilities) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination
☐ Exceeds Standard *(Substantially exceeds requirement of standards)*

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

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

**Instructions for Overall Compliance Determination Narrative**

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**Policy and Document Review:** Natchaug Hospital Policy and Procedure Manual, 7.18, Staffing Levels/Staffing Plan with Assessment, Journey House states that direct care staff at Journey House is determined by contractual obligations. Minimum staffing levels are based by the numbers of residents. Video monitoring enhances supervision. Each residential living area has (2) cameras, school hallway, (1) camera and the kitchen dining area (1) camera, these cameras record video for up to 90 days. The Program Director and Assistant Director have the ability to access the cameras via computer application and view in real time.

In addition, the courtyard has (4) cameras, (1) camera is located in the laundry room and (1) in the seclusion room. The monitors displaying video of the cameras are located in the downstairs staff office and in central area upstairs. Staff monitors the video footage on a regular basis or as needed after an incident.

Policy requires Journey House Supervisors and administrative staff to conduct and document unannounced rounds to identify and deter sexual abuse and sexual harassment. Unannounced visits are implemented for night shifts as well as day shifts and staff are prohibited from alerting other staff members that these supervisory rounds are occurring. The Unannounced Rounds Form is comprehensive and includes documenting the number of staff on duty and current staffing ratios. This form also documents the staff conducting the rounds interviewing staff and youth during the visit. A sample of unannounced rounds forms were provided for review.

Documentation in the contract with the union employees confirmed that the program would provide overtime if needed to maintain the required ratios. In addition to in house monitoring of the staffing ratios the facility is licensed by the State of Connecticut Judicial Branch. Court Supported Services Division (CSSD) monitors Journey House quarterly. The Journey House Director related that CSSD monitors the facility quarterly including unscheduled visits with the last quarter visit consisting of a three day comprehensive review. The facility is licensed every two years. Monitoring ratios is also a part of the CSSD on-site reviews. Reviewed Licensing Visits conducted by CSSD did not address any deficiencies in staffing.

Staffing Levels/Staffing Plan with Assessment, Journey House, minimum staffing levels are based by the numbers of residents as follows:
<table>
<thead>
<tr>
<th>Shift</th>
<th>Day of Week</th>
<th>Number of Residents</th>
<th>Shift Supervisors</th>
<th>Mental Health Workers</th>
</tr>
</thead>
<tbody>
<tr>
<td>7:00 AM – 3:00 PM</td>
<td>Mon – Fri</td>
<td>1-5</td>
<td>1</td>
<td>1</td>
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<td></td>
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<td>6-10</td>
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<td>11-15</td>
<td>1</td>
<td>3</td>
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<td>Sat – Sun</td>
<td>1-4</td>
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<td>5-7</td>
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<td>8-10</td>
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<td>11-13</td>
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<td>14-16</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>3:00 PM – 11:00 PM</td>
<td>Mon – Sun</td>
<td>1-4</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Evening Shift</td>
<td></td>
<td>5-7</td>
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<td>11-13</td>
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<td>14-16</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>11:00 PM – 7:00 AM</td>
<td>Mon - Sun</td>
<td>1-5</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Night Shift</td>
<td></td>
<td>6-10</td>
<td>1</td>
<td>2</td>
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<td></td>
<td>11-15</td>
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<td>3</td>
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**Standard 115.315: Limits to cross-gender viewing and searches**

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

115.315 (a)

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

115.315 (b)

- Does the facility always refrain from conducting cross-gender pat-down searches in non-exigent circumstances?  ☒ Yes  ☐ No  ☐ NA

115.315 (c)

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

- Does the facility document all cross-gender pat-down searches?  ☐ Yes  ☒ No
115.315 (d)

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

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

- Does the facility require staff of the opposite gender to announce their presence when entering a resident housing unit? ☒ Yes ☐ No

- In facilities (such as group homes) that do not contain discrete housing units, does the facility require staff of the opposite gender to announce their presence when entering an area where residents are likely to be showering, performing bodily functions, or changing clothing? (N/A for facilities with discrete housing units) ☒ Yes ☐ No ☐ NA

115.315 (e)

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

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

115.315 (f)

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

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

**Auditor Overall Compliance Determination**

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

☒ **Meets Standard** *(Substantial compliance; complies in all material ways with the standard for the relevant review period)*
Does Not Meet Standard (Requires Corrective Action)

Instructions for Overall Compliance Determination Narrative

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Policy and Document Review: The Journey House Policy 6.1, Searches, prohibits cross-gender personal searches or cross-gender visual body cavity searches except in exigent circumstances or when performed by medical practitioners. This policy also prohibits “pat down” searches of any youth. Searches to determine the resident’s genital status are prohibited and staff are required to conduct searches in a professional and respectful manner.

Youth maybe required to empty their pockets and turn pockets inside out but “pat down” searches are prohibited. Hospital/Journey House policy states that youth identifying as gender non-conforming can request staff of opposite biological identity, “e.g., a male to female transgender youth requesting a search by a female staff person. Youth are housed in single occupancy rooms. Showers and restrooms on each living unit provide privacy for youth while showering and using the restroom.

Interviews: Seven (7) interviewed youth consistently reported that they are never naked in full view of any staff. They stated that staff are thoughtful and knock on the doors of their bedrooms and announce themselves prior to entering and that male staff do not come into the bedrooms while youth are present unless there is an emergency. Eight (8) Specialized Staff and Ten (10) Random interviewed staff reported that the facility does not conduct cross gender searches nor have they ever seen a cross gender search. Staff related that female staff conduct the “strip searches” however youth are allowed to stand behind a screen and hand their clothing over to the staff.

Standard 115.316: Residents with disabilities and residents who are limited English proficient

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

115.316 (a)

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

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

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

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

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

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

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

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

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

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

115.316 (b)

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

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

- Does the agency always refrain from relying on resident interpreters, resident readers, or other types of resident assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the resident’s safety, the performance of first-response duties under §115.364, or the investigation of the resident’s allegations?
  ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ Exceeds Standard (Substantially exceeds requirement of standards)

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

☐ Does Not Meet Standard (Requires Corrective Action)

Instructions for Overall Compliance Determination Narrative

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Policy and Document Review: Journey House Policy, 2.2, Resident Rights, requires that residents have a right to receive culturally competent and linguistically appropriate services. Hospital Policy, 7.17, Interpreter Services, states that the Hospital’s Certified Medical Interpreters or Interpreters and Translators, Inc.; will be used to transmit and facilitate effective verbal communication between the service recipient who does not speak English or has limited English proficiency and Natchaug service provider during the following situations:

- Providing clinic and emergency medical services
  - Obtaining medical histories
  - Provision of information concerning patient’s rights and advanced directives, informed consent or permission for treatment
  - Explaining any diagnosis and plan for medical treatment
  - Explaining any change in regimen or condition
  - Discharge instructions
  - Provision of mental health evaluations, group and individual therapy, counseling and crisis intervention
  - Explaining any medical procedures, tests or surgical interventions
  - Obtaining financial and insurance information

This policy states that all Hospital employees are responsible for taking action to ensure that interpreter services are available for interactions between clients, their families or representatives and other health care providers when interpretation is necessary as identified in policy.
Journey House Policy 7.17, Interpretation Services, requires that in accordance with the DCF Policy 2004-08, Delivery of Services in Native and/or Sign Languages, Journey House supports all residents and their families with the delivery of services in their Native Language or with Sign Language. Interpreters are to be provided a no cost, including a certified sign language interpreter. Policy states that “at no time are children to be used as interpreters.” It also requires that “competent and/or certified interpreters shall be used at all times when working with children. Services for an interpreter for case related matters, translation, including Braille, of case related documents, are to be provided at no cost to the client or family.

Interviews: Ten (10) randomly selected and Eight (8) Specialized staff indicated that they would not use a resident to interpret for another youth and most were aware of the availability of either bilingual staff or of outside translators. None of the interviewed youth were disabled in any manner nor were they limited English proficient.

### Standard 115.317: Hiring and promotion decisions

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

115.317 (a)

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

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

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

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

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

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

115.317 (b)
- Does the agency consider any incidents of sexual harassment in determining whether to hire or promote anyone who may have contact with residents? ☒ Yes ☐ No

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

115.317 (c)

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

- Before hiring new employees, who may have contact with residents, does the agency consult any child abuse registry maintained by the State or locality in which the employee would work? ☒ Yes ☐ No

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

115.317 (d)

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

- Does the agency consult applicable child abuse registries before enlisting the services of any contractor who may have contact with residents? ☒ Yes ☐ No

115.317 (e)

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

115.317 (f)

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

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

115.317 (g)

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

115.317 (h)

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

Auditor Overall Compliance Determination

☐ Exceeds Standard (Substantially exceeds requirement of standards)

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

☐ Does Not Meet Standard (Requires Corrective Action)

Instructions for Overall Compliance Determination Narrative

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

Prior to a conditional offer of employment, Journey House Policy, Pre-Employment Checks, requires the hiring manager to complete and document references by three different sources. Applicants are required to answer the three PREA related questions during the interview process. Following reference checks pre-employment services are completed: 1) Criminal Background Check 2) Social Security 3) Medicaid. Medicare fraud inquiry 4) Address verification 5) Previous names used 6) DMV checks for staff who will be driving as a part of their duties 7) State Police Bureau of Identification check for applicable positions 8) Department of Children and Families for record of substantiated complaints 9) State and federal finger print checks for all school employees 10) CORI check for anyone who has lived in Massachusetts 11) National data banks for applicable positions. Background checks returned by a contracted background screening vendor, State Police or other sources are reviewed by Human Resources for any violations or potential concerns. Failure to disclose a criminal record (except as permitted by law) or other material information of falsification of information will result in the individual not being hired. Post - employment background checks will be conducted for all direct care and other
employees as applicable. Post-employment background checks and the frequency of those checks are as follows:

- Criminal Background Checks (every two years for direct care employees)
- Professional License verification (at time of expiration date)
- Medicaid/Medicare fraud (annually for all employees)
- Department of Children and Families for record of substantiated complaints (every two years for direct care employees)
- State Police Bureau of Identification (every two years for employees in applicable positions)
- CORI check (every two years for direct care employees living in Massachusetts)
- DMV for license status, date of license expiration and violations for employees who will drive Hospital vehicles (every two years)
- DMV - Check of suspended PSI licenses (weekly)

**Interviews:** Human Resources staff indicated a thorough process for conducting background checks. The HR Staff related that the background check includes a check of the NICI, State Police Checks for state checks, CORI checks for employees living in Massachusetts or having lived in Massachusetts, Educational Verification and Motor Vehicle Checks. The Office of Inspector General is responsible for conducting checks for professional credentials. A review of 11 personnel files indicated that the background checks are being conducted as required by policy.

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**Standard 115.318: Upgrades to facilities and technologies**

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

**115.318 (a)**

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

**115.318 (b)**

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

**Auditor Overall Compliance Determination**

- ☐ Exceeds Standard *(Substantially exceeds requirement of standards)*
Meets Standard *(Substantial compliance; complies in all material ways with the standard for the relevant review period)*

Does Not Meet Standard *(Requires Corrective Action)*

**Instructions for Overall Compliance Determination Narrative**

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

An interview with the agency head designee indicated that there have been upgrades to the facility during the past twelve months there have been several additional cameras added to provide inside and outside coverage, seven (7) additional cameras were installed inside. The Program Director provided verification of upgrades to the camera monitoring system since the last PREA Audit period. In addition, a digital video recorder with the capacity to retain video footage for 90 days was also installed.

**Interviews:** An interview with the Program Director indicated that staff would be consulted and involved in decision making about any modifications or upgrades to monitoring technology. They would ensure that modifications or upgrades to technology would enhance sexual safety at the facility.

**RESPONSIVE PLANNING**

### Standard 115.321: Evidence protocol and forensic medical examinations

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

#### 115.321 (a)

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

#### 115.321 (b)

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

- Is this protocol, as appropriate, adapted from or otherwise based on the most recent edition of the U.S. Department of Justice’s Office on Violence Against Women publication, “A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents,” or similarly
115.321 (c)

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

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

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

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

115.321 (d)

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

- If a rape crisis center is not available to provide victim advocate services, does the agency make available to provide these services a qualified staff member from a community-based organization, or a qualified agency staff member? (N/A if the agency always makes a victim advocate from a rape crisis center available to victims.) ☒ Yes ☐ No ☐ NA

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

115.321 (e)

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

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

115.321 (f)

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

115.321 (g)
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- Auditor is not required to audit this provision.

### 115.321 (h)

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

**Auditor Overall Compliance Determination**

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

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

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

### Instructions for Overall Compliance Determination Narrative

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

The investigating agency for criminal allegations at Journey House is the Connecticut State Police. The Department of Children and Families conducts administrative investigations. The facility does not conduct any investigations.

**Policy and Document Review:** Journey House Policy, Evidence Protocol and Forensic Medical Examinations, requires Journey House to contact local authorities to investigate allegations of sexual abuse. Journey House offers all victims of sexual abuse access to forensic medical examinations without financial cost.

Journey House has a MOU with Windham Hospital to conduct SANE/SAFE examinations. The MOU indicates that the hospital will offer victims of sexual abuse access to forensic medical exams via Windham Hospital Emergency Room. These are performed by Sexual Assault Forensic Examiners or Sexual Assault Nurse Examiners. If SAFES or SANES are not available, the exam will be performed by other qualified medical practitioners. Journey House has a MOU with Sexual Assault Crisis Center of Eastern CT, Inc., to serve as an advocate for a victim of sexual assault.

**A.** The Connecticut State Police is responsible for investigating allegations of sexual abuse at Journey House. The investigators follow a uniform evidence protocol that is used in obtaining usable physical evidence for administrative
and criminal proceedings. Administrative investigations are conducted by Family and Children Support Services.

**B.** According to interviews, the agency protocol is appropriate and adapted from or otherwise based on the most recent edition of the "National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents."

**C.** Residents are offered access to forensic medical examinations at the Windham hospital without financial cost. The Windham hospital or the rape crisis center provides a Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) if available. However, if a SAFE or SANE is not available, a qualified medical practitioner will perform the examination. The facility will document activities.

**D.** The facility makes available to the victim a victim advocate. If not available to provide victim advocate services, the facility makes available (to provide services) a qualified staff member from Sexual Assault Crisis Center of Eastern CT, INC, or a qualified facility staff member.

**E.** The victim advocate, if used, will meet the requirements of qualified organization staff that accompanies and supports the victim through the forensic medical examination process and investigatory interviews, and provides emotional support, crisis intervention, information, and referrals as needed.

**F.** If the agency turns the investigative case over to an outside entity, the agency is responsible for follows up on the outside process.

**G.** The facility defines a qualified community-based staff member as an individual who has been screened for appropriateness to serve in this role and has received education concerning sexual assault and forensic examination issues in general.

A review of the Pre-Audit Questionnaire Juvenile Facilities and confirmed by staff interviews:

- The number of forensic medical exams conducted during the past 12 months reported was zero.
- The number of exams performed by SANEs/SAFEs during the past 12 months reported was zero.
- The number of exams performed by a qualified medical practitioner during the past 12 months reported was zero.

**Interview Results:**

- One hundred percent of the staff could describe the process and steps required to protect physical evidence; which included but not limited to: notifying the supervisor, securing the area, separating the victim and perpetrator, protecting the physical evidence, not allowing the victim to shower or brush teeth, change clothes, and immediately seeking medical
attention.

- Interviewed staff, including the PREA compliance manager, was familiar with the evidence protocol and roles they would play as first responders. The staff stated, “They would make sure the resident victim was stable, preserve the evidence and if, the mental health is on site, the mental health staff would conduct an assessment.”

- Previously interviewed investigator indicated when outside agencies are responsible for investigating allegations of sexual abuse, the facility requests that the investigating agency follows the requirements of PREA. This includes standard provision (g) 1 and 2. Policy requires the facility to request that outside investigative authorities conduct the investigation in accordance with PREA investigation standards.

- Interviewed medical and mental health staff indicated that the facility will offer all victims of sexual assault access to forensic medical examinations without financial cost. Staff indicated that SANEs/SAFEs are provided by the Windham Hospital.

### Standard 115.322: Policies to ensure referrals of allegations for investigations

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

**115.322 (a)**

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

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

**115.322 (b)**

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

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

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

**115.322 (c)**
If a separate entity is responsible for conducting criminal investigations, does the policy describe the responsibilities of both the agency and the investigating entity? (N/A if the agency/facility is responsible for criminal investigations. See 115.321(a.),) ☒ Yes ☐ No ☐ NA

115.322 (d)

- Auditor is not required to audit this provision.

115.322 (e)

- Auditor is not required to audit this provision.

**Auditor Overall Compliance Determination**

- ☒ Exceeds Standard *(Substantially exceeds requirement of standards)*
- ☐ Meets Standard *(Substantial compliance; complies in all material ways with the standard for the relevant review period)*
- ☐ Does Not Meet Standard *(Requires Corrective Action)*

**Instructions for Overall Compliance Determination Narrative**

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

Journey House has not had any allegations of sexual assault/sexual abuse or sexual harassment during the audit period. Policy (Journey House, Referrals of Allegations for Investigations) requires that allegations of sexual abuse or sexual harassment are referred for investigation by the local agency responsible for investigations.

The Connecticut State Police has been identified as the agency with the legal authority to conduct criminal investigations. The reviewed PREA Incident Check List for Journey House identifies Connecticut State Police. Most of the interviewed staff were aware that the agency responsible for conducting investigations at Journey House is the Connecticut State Police.

A. According to interview with the Program Director, the facility ensures that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment reported for resident-on-resident or staff-on-resident misconduct.

B. The initial investigation begins immediately by the Department of Department of Children and Families and/or Connecticut State Police. Investigating agencies use a uniform evidence protocol that maximizes the potential for obtaining physical evidence for administrative proceedings and criminal prosecutions. In accordance with agency letter, the local police department is to be notified immediately and
assume control of the investigation when appropriate.

Investigations are documented in a written report that contains a thorough description of physical, testimonial, and documentary evidence and attached copies of all documentary evidence.

An additional interview confirmed the process for receiving an allegation and for conducting the investigation if an alleged sexual abuse was reported. Interviewed staff stated, they have been trained to report everything for investigations, including reporting, knowledge, allegations and suspicion of sexual abuse or sexual harassment. Staff affirmed they are trained to accept reports from all sources, including third parties and anonymous reports.

C. The agency has in place a policy to ensure that allegations of sexual abuse or sexual harassment are referred for investigation to an agency with the legal authority to conduct criminal investigations. Per policy, substantiated allegations of conduct that appears to be criminal are referred for prosecution. Investigations staff imposes no standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated.

A review of the Pre-Audit Questionnaire Juvenile Facilities and confirmed by staff interviews:

- The number of allegations of sexual abuse and sexual harassment receive during the past 12 months was zero
- The number of allegations resulting in an administrative investigation during the past 12 months was zero.

Interviews: All staff interviewed Ten (10) Random staff and Eight (8) Specialized staff related they have been trained to report everything, including suspicions, allegations, knowledge or reports of sexual abuse or sexual harassment. Staff are aware they would contact the Connecticut State Police to conduct the investigation on site. If the allegation is sexual harassment the agency responsible for investigating will be the Department of Children and Families. Staff affirmed they are trained to accept reports from all sources, including third parties and anonymous reports.

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**TRAINING AND EDUCATION**

**Standard 115.331: Employee training**

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

115.331 (a)
Does the agency train all employees who may have contact with residents on its zero-tolerance policy for sexual abuse and sexual harassment? ☒ Yes ☐ No

Does the agency train all employees who may have contact with residents on how to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures? ☒ Yes ☐ No

Does the agency train all employees who may have contact with residents on residents’ right to be free from sexual abuse and sexual harassment? ☒ Yes ☐ No

Does the agency train all employees who may have contact with residents on the right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment? ☒ Yes ☐ No

Does the agency train all employees who may have contact with residents on the dynamics of sexual abuse and sexual harassment in juvenile facilities? ☒ Yes ☐ No

Does the agency train all employees who may have contact with residents on the common reactions of juvenile victims of sexual abuse and sexual harassment? ☒ Yes ☐ No

Does the agency train all employees who may have contact with residents on how to detect and respond to signs of threatened and actual sexual abuse and how to distinguish between consensual sexual contact and sexual abuse between residents? ☒ Yes ☐ No

Does the agency train all employees who may have contact with residents on how to avoid inappropriate relationships with residents? ☒ Yes ☐ No

Does the agency train all employees who may have contact with residents on how to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents? ☒ Yes ☐ No

Does the agency train all employees who may have contact with residents on how to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities? ☒ Yes ☐ No

Does the agency train all employees who may have contact with residents on relevant laws regarding the applicable age of consent? ☒ Yes ☐ No

115.331 (b)

Is such training tailored to the unique needs and attributes of residents of juvenile facilities? ☒ Yes ☐ No

Is such training tailored to the gender of the residents at the employee’s facility? ☒ Yes ☐ No

Have employees received additional training if reassigned from a facility that houses only male residents to a facility that houses only female residents, or vice versa? ☒ Yes ☐ No
115.331 (c)

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

115.331 (d)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Policy and Document Review: Journey House Policy, 3.1, New Employee Orientation, requires all newly employed staff to participate in the HHC Behavioral Health Network/Natchaug Hospital’s New Employee Orientation Program. Orientation includes completion of assigned on-line learning programs within 30 days of start and then annually as indicated.

Journey House Policy, 7.8, Orientation and Training, provides a brief description of the orientation training provided new employees. Policy requires that PREA Training is provided during orientation and annually thereafter. Interviewed staff related they received their PREA Training via a Power Point presentation. The reviewed power point presentation slides were comprehensive and included the following: PREA and the PREA Standards, Purpose of PREA, Zero Tolerance Policy, Definitions.

A. The facility has trained staff that has contact with residents based on the requirements stated in this standard. According to staff interviews, sexual abuse and sexual harassment
training is provided in pre-service orientation training, in-service, and other additional training and includes:

- Zero tolerance for sexual abuse and sexual harassment;
- Responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures;
- Residents' right to be free from sexual abuse and sexual harassment;
- The right to be free from retaliation;
- Dynamics of sexual abuse and sexual harassment in juveniles' facilities;
- Common reactions of juvenile victims of sexual abuse and sexual harassment;
- How to detect and respond to signs of threatened and actual sexual abuse;
- How to avoid inappropriate relationships with residents;
- Communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents;
- Comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities; and
- Relevant laws regarding age of consent.

B. Training is tailored to the gender of the residents at the employee's facility. Review of documentation revealed that staff receive additional training if the staff is reassigned from a facility that houses only male residents to a facility that houses only female residents, or vice versa. The staff will receive this training through additional pre-service training.

C. The agency requires that each employee receive refresher training every two years to ensure that all employees know the agency's current sexual abuse and sexual harassment policies and procedures.

D. The facility documents, through employee signature verification, the staff understands the training they have received. The facility documents staff training using the training roster, which requires the signature, date and job title of the staff and instructor.

A review of the Pre-Audit Questionnaire Juvenile Facilities and confirmed by staff interviews:

- In the past 12 months, the number of staff employed by the facility, which may have contact with residents, who were trained on the PREA requirements reported, was 53.
Interviews: Ten (10) Random and Eight (8) Specialized staff interviewed stated they had received training in each of the 11 topics identified and required by the standards. Their responses indicated that they have been trained and that they are aware of their roles as mandatory reporters and first responders. Staff related they are trained on the zero tolerance policy for any form of sexual contact, sexual abuse, sexual harassment or retaliation for reporting or making an allegation of sexual abuse or sexual harassment.

Standard 115.332: Volunteer and contractor training

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

115.332 (a)

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

115.332 (b)

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

115.332 (c)

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

Auditor Overall Compliance Determination

☐ Exceeds Standard (Substantially exceeds requirement of standards)

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

☐ Does Not Meet Standard (Requires Corrective Action)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor’s analysis and reasoning, and the auditor’s conclusions. This discussion must also include corrective action recommendations where the facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.
**Policy and Document Review:** Journey House Policy, 3.1, New Employee Orientation, requires all newly employed staff, interns, volunteers and contractual staff to participate in the HHC Behavioral Health Network/Natchaug Hospital’s New Employee Orientation Program. Orientation includes completion of assigned on-line learning programs within 30 days of start and then annually as indicated. Journey House Policy, 7.8, Orientation and Training, provides a brief description of the orientation training provided new employees.

Policy requires that PREA Training is provided during orientation and annually thereafter. Interviewed staff related they received their PREA Training via a Power Point presentation. The reviewed power point presentation slides were comprehensive and included the following:

- PREA and the PREA Standards
- Purpose of PREA
- Zero Tolerance Policy
- Definitions and Dynamics of Sexual Abuse and Sexual Harassment
- Signs and Symptoms of Abuse and Harassment
- Resident Education, Red Flags, Trauma, Dynamics of Residential Care
- Organizational Culture
- Code of Silence
- Reporting-Who reports and how
- First Responders
- Mandatory Reporting
- Protection from Retaliation.

**Interviews:** An interview with the Program Director and PREA Compliance Manager confirmed this facility does not have any volunteers or contractors.

**Standard 115.333: Resident education**

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

**115.333 (a)**

- During intake, do residents receive information explaining the agency’s zero-tolerance policy regarding sexual abuse and sexual harassment? ☒ Yes ☐ No
- During intake, do residents receive information explaining how to report incidents or suspicions of sexual abuse or sexual harassment? ☒ Yes ☐ No
- Is this information presented in an age-appropriate fashion? ☒ Yes ☐ No

**115.333 (b)**

- Within 10 days of intake, does the agency provide age-appropriate comprehensive education to residents either in person or through video regarding: Their rights to be free from sexual abuse and sexual harassment? ☒ Yes ☐ No
- Within 10 days of intake, does the agency provide age-appropriate comprehensive education to residents either in person or through video regarding: Their rights to be free from retaliation for reporting such incidents? ☒ Yes ☐ No

- Within 10 days of intake, does the agency provide age-appropriate comprehensive education to residents either in person or through video regarding: Agency policies and procedures for responding to such incidents? ☒ Yes ☐ No

115.333 (c)

- Have all residents received the comprehensive education referenced in 115.333(b)? ☒ Yes ☐ No

- Do residents receive education upon transfer to a different facility to the extent that the policies and procedures of the resident’s new facility differ from those of the previous facility? ☒ Yes ☐ No

115.333 (d)

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

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

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

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

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

115.333 (e)

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

115.333 (f)

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

Auditor Overall Compliance Determination

☐ Exceeds Standard (Substantially exceeds requirement of standards)
- **Meets Standard** *(Substantial compliance; complies in all material ways with the standard for the relevant review period)*

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

**Instructions for Overall Compliance Determination Narrative**

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

**Policy and Document Review:** Journey House Policy 1.5, Client Education, requires that during the intake process, staff notify all clients that Journey House has a zero tolerance for all forms of sexual abuse and sexual harassment, multiple ways for clients to privately report sexual abuse and sexual harassment, retaliation by other clients or staff for reporting sexual abuse and sexual harassment and staff neglect or violation of responsibilities that may have contributed to such incidents and a way to report to authorities allowing the resident to remain anonymous. This information is provided in the Resident Handbook.

A. Staff interviews and documentation review indicated that during the intake process, residents receive information explaining the facility’s zero-tolerance policy regarding sexual abuse and sexual harassment and how to report incidents or suspicions of sexual abuse or sexual harassment.

B. Policies require that within 10 days of intake, the facility provides comprehensive age-appropriate education to residents either in person or through video regarding their rights to be free from sexual abuse and sexual harassment and to be free from retaliation for reporting these incidents. During intake, residents are given the handbook. During orientation, additional PREA related information is provided and the video is shown. The staff conducting intake/orientation gives residents the opportunity to ask questions to clarify anything they do not understand. Residents acknowledge through interviews and documentation that they received PREA information.

C. All residents at the facility received information and have been educated on PREA. Residents that transfer to the facility also receive the required PREA education.

D. Resident interviews confirmed that the facility provides resident education in formats accessible to all residents, including limited English proficient, deaf, visually impaired, disabled, as well as to residents who have limited reading skills. Staff and resident interviews reveal that the facility provides the PREA education in English and Spanish, to include resident handbooks and posters.

E. The facility maintains documentation of resident participation and receiving PREA information in the education sessions. The residents are required to sign a roster; the roster is dated and is witnessed by staff signature. In addition to providing PREA
education, the facility ensures that key information is continuously and readily available and visible to residents through posters, resident handbooks, and other written formats.

A review of the Pre-Audit Questionnaire for Juvenile Facilities and confirmed by staff interview:

- The number of residents admitted during past 12 months who were given this information at intake reported was 22.

**Interview Results:**

Interviewed residents stated they felt safe in this facility and that they had direct care staff as well as clinicians that they trusted to report to. They stated they were told about zero tolerance for all forms of sexual activity, that they had the right to be free from sexual abuse, how to report it and that they had the right not to be punished for reporting it.

Residents indicated they received that information the same day as admission and several reported the Clinical Director covered that information when she interviewed them prior to their coming to the facility. Samples of acknowledgment statements documenting that the resident received and understand the PREA information provided were provided for review.

**Standard 115.334: Specialized training: Investigations**

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

**115.334 (a)**

- In addition to the general training provided to all employees pursuant to §115.331, does the agency ensure that, to the extent the agency itself conducts sexual abuse investigations, its investigators have received training in conducting such investigations in confinement settings? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a.)
  □ Yes  □ No  ☒ NA

**115.334 (b)**

- Does this specialized training include techniques for interviewing juvenile sexual abuse victims? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a.)
  □ Yes  □ No  ☒ NA

- Does this specialized training include proper use of Miranda and Garrity warnings? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a.)
  □ Yes  □ No  ☒ NA

- Does this specialized training include sexual abuse evidence collection in confinement settings? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a.)
  □ Yes  □ No  ☒ NA

- Does this specialized training include the criteria and evidence required to substantiate a case for administrative action or prosecution referral? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a.)
  □ Yes  □ No  ☒ NA
☐ Yes  ☐ No  ☒ NA

115.334 (c)

- Does the agency maintain documentation that agency investigators have completed the required specialized training in conducting sexual abuse investigations? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).)
  ☐ Yes  ☐ No  ☒ NA

115.334 (d)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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This facility does not conduct investigations. However the PREA Compliance Coordinator/Program Director has been trained on Investigating Sexual Abuse in a Confinement Setting. If an allegation is an allegation of sexual harassment, investigations are conducted by the Department of Child and Family and if allegations are criminal, investigations are conducted by the Connecticut State Police.

**Standard 115.335: Specialized training: Medical and mental health care**

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

115.335 (a)

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to detect and assess signs of sexual abuse and sexual harassment? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)
  ☒ Yes  ☐ No  ☐ NA
- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to preserve physical evidence of sexual abuse? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.) ☒ Yes ☐ No ☐ NA

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to respond effectively and professionally to juvenile victims of sexual abuse and sexual harassment? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.) ☒ Yes ☐ No ☐ NA

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How and to whom to report allegations or suspicions of sexual abuse and sexual harassment? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.) ☒ Yes ☐ No ☐ NA

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

115.335 (c)
- Does the agency maintain documentation that medical and mental health practitioners have received the training referenced in this standard either from the agency or elsewhere? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.) ☒ Yes ☐ No ☐ NA

115.335 (d)
- Do medical and mental health care practitioners employed by the agency also receive training mandated for employees by §115.331? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.) ☒ Yes ☐ No ☐ NA

- Do medical and mental health care practitioners contracted by or volunteering for the agency also receive training mandated for contractors and volunteers by §115.332? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners contracted by or volunteering for the agency.) ☐ Yes ☐ No ☒ NA

**Auditor Overall Compliance Determination**

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

☒  Meets Standard *(Substantial compliance; complies in all material ways with the standard for the relevant review period)*
Does Not Meet Standard *(Requires Corrective Action)*

Instructions for Overall Compliance Determination Narrative

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Documentation was provided to indicate that medical staff have received the specialized training as required in the standards. The facility is on the grounds of a mental hospital and medical staff are located on the grounds and are available to provide services to the youth.

Certificates were provided to confirm that mental health staff have received the on-line training for behavioral health staff for dealing with sexual abuse in confinement settings. Certificates confirming training were provided documenting that this training was completed on-line as offered by the National Institute for Corrections (NIC).

Interview Results:

a. Facility PREA coordinator
   b. Medical staff
   c. Mental health staff

- Interview with the medical/mental health staff indicated that all full-time and part-time medical and mental health care practitioners who work regularly in the program have been trained around:
  - How to detect and assess signs of sexual abuse and sexual harassment.
  - How to preserve physical evidence of sexual abuse.
  - How to respond effectively and professionally to victims of sexual abuse and sexual harassment.
  - How and to whom to report allegations or suspicions of sexual abuse and sexual harassment.

- The medical staff does not conduct forensic examinations. The Windham Hospital conducts all emergency care or treatment to include Sexual Assault Forensic Examinations. The Windham Hospital examiners are qualified SAFE and SANE practitioners that comply with the National Protocol for Sexual Assault Medical Forensic Examinations.

- The facility maintains documentation that medical/mental health practitioners have received the training referenced in this standard. Training rosters and staff meetings sign in sheets were submitted to the auditor.

- Interviewed health service administrator and documentation confirmed the following training.
Interview Results:
Interviewed health service administrator and healthcare staff confirmed that the facility does not conduct forensic examinations and they have received the required PREA training.

SCREENING FOR RISK OF SEXUAL VICTIMIZATION AND ABUSIVENESS

Standard 115.341: Screening for risk of victimization and abusiveness

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

115.341 (a)

- Within 72 hours of the resident’s arrival at the facility, does the agency obtain and use information about each resident’s personal history and behavior to reduce risk of sexual abuse by or upon a resident? ☒ Yes ☐ No

- Does the agency also obtain this information periodically throughout a resident’s confinement? ☒ Yes ☐ No

115.341 (b)

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

115.341 (c)

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (1) Prior sexual victimization or abusiveness? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (2) Any gender nonconforming appearance or manner or identification as lesbian, gay, bisexual, transgender, or intersex, and whether the resident may therefore be vulnerable to sexual abuse? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (3) Current charges and offense history? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (4) Age? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (5) Level of emotional and cognitive development? ☒ Yes ☐ No
During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (6) Physical size and stature? ☒ Yes ☐ No

During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (7) Mental illness or mental disabilities? ☒ Yes ☐ No

During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (8) Intellectual or developmental disabilities? ☒ Yes ☐ No

During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (9) Physical disabilities? ☒ Yes ☐ No

During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (10) The residents’ own perception of vulnerability? ☒ Yes ☐ No

During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (11) Any other specific information about individual residents that may indicate heightened needs for supervision, additional safety precautions, or separation from certain other residents? ☒ Yes ☐ No

115.341 (d)

Is this information ascertained through conversations with the resident during the intake process and medical mental health screenings? ☒ Yes ☐ No

Is this information ascertained during classification assessments? ☒ Yes ☐ No

Is this information ascertained by reviewing court records, case files, facility behavioral records, and other relevant documentation from the resident’s files? ☒ Yes ☐ No

115.341 (e)

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

Auditor Overall Compliance Determination

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

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

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

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

Policy and Document Review: Journey House Policy 3.3 Assessments requires that Journey House ensure all residents are screened to assess their risk of being sexually abused or being sexually abusive toward other residents using an objective assessment/screening instrument. Residents are assessed during the intake process or upon transfer to another facility. The assessment must take place within 72 hours of arrival at the facility. The instrument being used is the Screening for Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB). This instrument addresses the following:

- Prior sexual victimization or abusiveness.
- Whether the resident has a mental, physical, or developmental disability.
- The age of the resident.
- The physical build of the resident.
- Whether the resident has previously been incarcerated.
- Whether the resident’s criminal history is exclusively nonviolent.
- Whether the resident has prior convictions for sex offenses against an adult or child.
- Whether the resident is or is perceived to be gay, lesbian, bisexual, transgender, intersex, or gender nonconforming.
- Whether the resident has previously experienced sexual victimization.
- The resident’s own perception of vulnerability.
- Other specific information about individual residents that may indicate heightened needs for supervision, additional safety precautions, or separation forms certain other residents.

B. Staff interviews for conducting Screening for Risk of Victimization and Abusiveness indicated that the facility uses information from conversations with the resident during the intake process, medical and mental health screenings (during classification assessments) and by reviewing court records, case files, facility behavioral records, and other relevant documentation from the resident’s files.

Interviews and documentation reviewed indicated that the staff does reassess the residents’ risk level for sexual victimization or sexual abusiveness whenever warranted and within 30 days of arrival at the institution if the resident is identified at risk for victimization or for being at risk for being sexually abusive.

Residents are not disciplined for refusing to answer, or for not disclosing complete information in response to any PREA questions.

C. The agency implements appropriate controls on the dissemination within the facility of responses to questions asked pursuant to this standard in order to ensure that sensitive information is not exploited to the resident’s detriment by staff or other residents as descript above.

A review of the Pre-Audit Questionnaire Juvenile Facilities and confirmed by staff
interviews:
  o The number of residents entering the facility (either through intake or transfer) within the past 12 months (whose length or stay in the facility was for 72 hours or more) who were screened for medical or mental health within 72 hours of their entry into the facility was 22.

Interview Results:
  o All the interviewed residents have entered the facility within the past 12 months. All but one interviewed resident could recall if they were asked questions about prior sexual history of sexual abuse, or whether they identified as being gay, lesbian, or bisexual, had a disability, or felt in danger of sexual abuse. These questions were asked upon arrival and during the intake process.
  o One hundred percent of the residents reported feeling safe and that sexual assault and such behaviors do not occur at the facility.
  o Interviewed facility administrator, PREA compliance manager, and intake and counseling staff are the only staff members who have access to resident’s assessments, in order to protect sensitive information from exploitation.
  o Interviewed staff indicated that the initial intake screening assessment did consider all the requirements listed in this standard.
  o Interviewed staff indicated that the process for conducting the initial intake screening is a checklist and in written format.
  o Interviewed staff indicated that the staff does reassess resident’s risk level as needed due to referrals, request, incident of sexual abuse, or receipt of additional information that bears on the resident’s risk of sexual victimization or abusiveness.

**Standard 115.342: Use of screening information**

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

**115.342 (a)**

- Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Housing Assignments? ☒ Yes ☐ No
- Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Bed assignments? ☒ Yes ☐ No
Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Work Assignments? ☒ Yes ☐ No

Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Education Assignments? ☒ Yes ☐ No

Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Program Assignments? ☒ Yes ☐ No

115.342 (b)

Are residents isolated from others only as a last resort when less restrictive measures are inadequate to keep them and other residents safe, and then only until an alternative means of keeping all residents safe can be arranged? (N/A if the facility never places residents in isolation for any reason.) ☐ Yes ☐ No ☒ NA

During any period of isolation, does the agency always refrain from denying residents daily large-muscle exercise? (N/A if the facility never places residents in isolation for any reason.) ☐ Yes ☐ No ☒ NA

During any period of isolation, does the agency always refrain from denying residents any legally required educational programming or special education services? (N/A if the facility never places residents in isolation for any reason.) ☐ Yes ☐ No ☒ NA

Do residents in isolation receive daily visits from a medical or mental health care clinician? (N/A if the facility never places residents in isolation for any reason.) ☐ Yes ☐ No ☒ NA

Do residents in isolation also have access to other programs and work opportunities to the extent possible? (N/A if the facility never places residents in isolation for any reason.) ☐ Yes ☐ No ☒ NA

115.342 (c)

Does the agency always refrain from placing lesbian, gay, and bisexual (LGB) residents in particular housing, bed, or other assignments solely on the basis of such identification or status? ☒ Yes ☐ No

Does the agency always refrain from placing transgender residents in particular housing, bed, or other assignments solely on the basis of such identification or status? ☒ Yes ☐ No

Does the agency always refrain from placing intersex residents in particular housing, bed, or other assignments solely on the basis of such identification or status? ☒ Yes ☐ No

Does the agency always refrain from considering lesbian, gay, bisexual, transgender, or intersex (LGBTI) identification or status as an indicator or likelihood of being sexually abusive? ☒ Yes ☐ No
### 115.342 (d)

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

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

### 115.342 (e)

- Are placement and programming assignments for each transgender or intersex resident reassessed at least twice each year to review any threats to safety experienced by the resident? ☒ Yes ☐ No

### 115.342 (f)

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

### 115.342 (g)

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

### 115.342 (h)

- If a resident is isolated pursuant to provision (b) of this section, does the facility clearly document: The basis for the facility’s concern for the resident’s safety? (N/A if the facility never places residents in isolation for any reason.) ☐ Yes ☒ No ☐ NA

- If a resident is isolated pursuant to provision (b) of this section, does the facility clearly document: The reason why no alternative means of separation can be arranged? (N/A if the facility never places residents in isolation for any reason.) ☒ Yes ☐ No ☐ NA

### 115.342 (i)

- In the case of each resident who is isolated as a last resort when less restrictive measures are inadequate to keep them and other residents safe, does the facility afford a review to determine whether there is a continuing need for separation from the general population EVERY 30 DAYS? (N/A if the facility never places residents in isolation for any reason.) ☐ Yes ☐ No ☒ NA
Auditor Overall Compliance Determination

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

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Policy and Document Review: Journey House Policy 3.1 Treatment Model, states that Journey House staff will use the information from the risk screening to inform the program manager or designee of clients at high risk of being sexually victimized and those at high risk of being sexually abusive. Safety plans are developed identifying triggers and other factors that staff need to be aware of in working with the residents.

Each youth is housed in single occupancy rooms regardless of how they would score out on the risk assessment. Staff interacts with all residents at a very high level and clinicians are in continuous contact with residents on their caseloads. Journey House does not use the screening information to determine housing for transgender or intersex residents, housing would be determined on a case by case basis and there are no separate or dedicated housing arrangements for either transgender or intersex residents. Staff indicated that transgender and intersex resident’s views with regard to their own safety would be given serious consideration.

The facility did not have any transgender or intersex residents during the on-site audit. Interviewed youth who identified as bisexual or gay related they were treated no differently from any other resident and that they were not housed any differently.

Interviews: Most of the seven (7) interviewed youth remembered being asked the questions on the VSAB during the intake process. Interviews also confirmed that if a resident scored high for either vulnerability or abusiveness they would be placed in a room closer to the direct care staff desk on the living unit. The treatment team would consider the most appropriate plan to keep residents safe. An additional action that staff would take would be to increase monitoring of the resident.

A. The facility has a PREA screening instrument, and uses the information from a risk screening to inform housing, bed, education and program assignments with the goal of keeping separate those residents at high risk for being sexually victimized by those at high risk of being sexually abusive.

B. Interviewed staff indicated that lesbian, gay, bisexual, transgender, or intersex residents are not placed in housing units, beds, or other assignment solely on the basis on their
sexual identification or status. According to staff the facility does not consider lesbian, gay, bisexual, transgender, or intersex identification or status as an indicator of being sexually abusive.

C. The facility did not have any transgender or intersex residents during the audit period. If the facility receives a transgender resident, and in deciding whether to assign a transgender or intersex resident to which male living unit and in making other programming assignments, the facility will consider on a case-by-case basis whether a placement would ensure the resident’s health and safety, and whether the placement would present management or security problems.

Staff interviews indicated that when making placement and programming assignments for each transgender or intersex resident the facility will reassess them to review any threats to safety experienced by the resident.

D. Staff interviews also indicated if they were to have a transgender or intersex resident, the resident’s own views with respect to his or her own safety will be given serious consideration.

E. Transgender and intersex residents will be given the opportunity to shower separately from other residents.

A review of the Pre-Audit Questionnaire Juvenile Facilities confirmed by staff interviews:

- In the past 12 months, the number of residents at risk of sexual victimization who were placed in isolation was zero.

- In the past 12 months, the number of residents at risk of sexual victimization who were placed in isolation who have been denied daily access to large muscle exercise, and/or legally required education, treatment or special education services was zero. This facility does not utilize isolation.

- In the past 12 months, the average period of time residents at risk of sexual victimization were held in isolation to protect them from sexual victimization was zero.

**Interview Results:**

- Interviewed facility PREA compliance manager indicated that the facility will not place lesbian, gay, bisexual, transgender, or intersex residents in dedicated units or wings solely based on identification status for protecting such residents.

- Interviewed staff, to include the facility administrator and PREA compliance manager, indicated that the facility is not subject to a consent decree, legal settlement, or legal judgment. Staff indicated that the facility ensures against placing lesbian, gay, bisexual, transgender, or intersex residents in dedicated units or wings solely on the basis of their sexual orientation, genital status, or gender
identity. The facility will house them in the general population unless requested by the resident for special housing for safety issues.

### REPORTING

#### Standard 115.351: Resident reporting

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

**115.351 (a)**

- Does the agency provide multiple internal ways for residents to privately report: Sexual abuse and sexual harassment? ☒ Yes ☐ No
- Does the agency provide multiple internal ways for residents to privately report: Retaliation by other residents or staff for reporting sexual abuse and sexual harassment? ☒ Yes ☐ No
- Does the agency provide multiple internal ways for residents to privately report: Staff neglect or violation of responsibilities that may have contributed to such incidents? ☒ Yes ☐ No

**115.351 (b)**

- Does the agency also provide at least one way for residents to report sexual abuse or sexual harassment to a public or private entity or office that is not part of the agency? ☒ Yes ☐ No
- Is that private entity or office able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials? ☒ Yes ☐ No
- Does that private entity or office allow the resident to remain anonymous upon request? ☒ Yes ☐ No
- Are residents detained solely for civil immigration purposes provided information on how to contact relevant consular officials and relevant officials at the Department of Homeland Security to report sexual abuse or harassment? (N/A if the facility never houses residents detained solely for civil immigration purposes.) ☒ Yes ☐ No ☐ NA

**115.351 (c)**

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

**115.351 (d)**
 Does the facility provide residents with access to tools necessary to make a written report? ☒ Yes ☐ No

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

Auditor Overall Compliance Determination

☐ Exceeds Standard (Substantially exceeds requirement of standards)

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

☐ Does Not Meet Standard (Requires Corrective Action)

Instructions for Overall Compliance Determination Narrative

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Policy and Document Review: Journey House Policy, Resident Reporting, 1.27 Abuse and Neglect, 1.15 Clients Complaints and Grievances, 2.14 Mail, 2.3 Residents Grievances, requires that the program provide multiple internal ways for residents and staff to privately report sexual abuse and sexual harassment, retaliation by other clients or staff for reporting sexual abuse and sexual harassment, and staff neglect or violation or responsibilities that may have contributed to such incidents.

Operating procedures state that staff will accept reports in writing, anonymously and from third parties and can privately report thru the electronic event reporting system under Professional Conduct, and contact the appropriate state agency/accreditation agencies: Joint Commission and the Department of Children and Families. One hundred percent of interviewed staff stated they are mandated reporters. They also stated they have been trained that they are to take any allegation or report or even a suspicion of sexual abuse or sexual harassment seriously and report it. When asked, they stated they did not care how the report or knowledge or allegation came to them, they would accept it and report and let someone else investigate.

Staff, when asked about their response to an allegation of sexual abuse or sexual harassment, stated they would report it immediately, after stopping the abuse and protecting the resident, to their supervisor. This verbal report would be followed with a written report as soon as possible but not later than the end of the shift. Staff were aware that the PREA Compliance Manager would be notified and then most were aware that the Connecticut State Police would also receive the notification and report and would then investigate. A number of the interviewed staff reported that the Department of Children and Families would be notified as well.
Natchaug Hospital Policy, Significant Event Reporting Protocol, identifies a host of events that qualify as “significant” and how they are to be reported. Any time a staff believes a significant event has occurred he/she will refer, as needed, to the “on-call” list. A list of staff to be called include the Program Director or Clinical Director, Parole/Probation Officer, Master Control Careline, Therapist, Parent/Guardian or DCF Social Worker as needed and Local Police (if applicable).

Written documentation is to be completed within the shift and not later than 12 hours include: Report incident via Natchaug Hospital’s on-line system, fax a summary progress note to the Parole/Probation Officer, DCF (Master Control after hours), document in the resident’s chart and hold a Critical incident review meeting within 5 days of the incident.

The facility reported they have had no allegations of sexual abuse or sexual harassment during the past 12 months.

A. Interviews with staff and documentation review indicated that the facility has established procedures allowing for multiple internal ways for residents to report privately to agency/facility officials regarding sexual abuse and sexual harassment, retaliation by other residents or staff, to include staff neglect or violation of responsibilities that may contribute to PREA incidents. The following are internal reporting ways:
   - Grievance process
   - Tell the social worker
   - Reporting to any staff member either verbally or in writing
   - Hotline
   - Staff Request Form
   - Writing an anonymous note

B. Interviews with staff and documentation indicated that the facility has established at least one way for residents to report abuse or harassment to a public or private entity that is not part the facility, that can receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials, and allow the resident to remain anonymous upon request. The following are external reporting ways:
   - Hotline
   - Family members as third-party

C. Staff interviews indicated that they accept reports made verbally, in writing, anonymously, and from third parties and report and document any verbal reports by the ended of the shift.

A review of the Pre-Audit Questionnaire Juvenile Facility confirmed by interviewed staff:
   - In the past 12 months, the number of residents detained solely for civil immigration purposes was zero.
   - In the past 12 months, the number of residents detained solely for civil immigration that was provided information on how to contact relevant consular officials and relevant officials of the Department of Homeland Security zero.
Interview Results:

- The facility does not detain residents solely for civil immigration purposes. However, if they receive and reside solely for civil immigration purposes, the facility will provide the resident with information on how to contact relevant consular officials and relevant officials at the Department of Homeland Security.

- All seven interviewed residents stated that they had multiple ways to report. Most residents reported that they could communicate with staff, write a grievance report, or tell family. All the residents indicated that they could report sexual abuse or harassment to someone who does not work at the facility; however, three residents reported feeling unsure that they could make a report without providing their name.

- Resident interview question #10, Do you know if you are allowed to make a report of sexual abuse or sexual harassment without having to give your name? Three out of seven residents interviewed stated no, they did not know that they can report without giving their name.

- One hundred percent of the interviewed staff reported that they have multiple means to privately report sexual abuse or harassment. Such reporting opportunities included the hotline number, shift supervisor, written statement, or PREA compliance manager. The interviewed staff reported that the residents can privately report by calling the hotline number, completing a grievance form, notifying staff or write a letter.

Concern: Hotline phone number should be placed in close proximity to phone. Brochure listing hotline number was visible on bulletin board; auditor recommended placing the number above the telephone.

Corrective Action: The PREA Compliance Manager has identified a location in close proximity to telephone utilized by residents for posting of hotline number.

Standard 115.352: Exhaustion of administrative remedies

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

115.352 (a)

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

115.352 (b)

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

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

### 115.352 (c)

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

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

### 115.352 (d)

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

- If the agency determines that the 90-day timeframe is insufficient to make an appropriate decision and claims an extension of time [the maximum allowable extension of time to respond is 70 days per 115.352(d)(3)], does the agency notify the resident in writing of any such extension and provide a date by which a decision will be made? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

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

### 115.352 (e)

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

- Are those third parties also permitted to file such requests on behalf of residents? (If a third party, other than a parent or legal guardian, files such a request on behalf of a resident, the facility may require as a condition of processing the request that the alleged victim agree to have the request filed on his or her behalf, and may also require the alleged victim to personally pursue any subsequent steps in the administrative remedy process.) (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA
- If the resident declines to have the request processed on his or her behalf, does the agency document the resident’s decision? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- Is a parent or legal guardian of a juvenile allowed to file a grievance regarding allegations of sexual abuse, including appeals, on behalf of such juvenile? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- If a parent or legal guardian of a juvenile files a grievance (or an appeal) on behalf of a juvenile regarding allegations of sexual abuse, is it the case that those grievances are not conditioned upon the juvenile agreeing to have the request filed on his or her behalf? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

115.352 (f)

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

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

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

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

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

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

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

115.352 (g)

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

Auditor Overall Compliance Determination
Exceeds Standard (Substantially exceeds requirement of standards)

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

Does Not Meet Standard (Requires Corrective Action)

Instructions for Overall Compliance Determination Narrative

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

Policy and Document Review: Exhaustion of Administrative Remedies Policy 1.15 Clients Complaints and Grievances ensures a formal administrative process to address client grievances regarding sexual abuse. Journey House prohibits an informal grievance process to otherwise attempt to resolve with staff, an alleged incident of sexual abuse. There is no time limit on when a client may submit a grievance regarding an allegation of sexual abuse. This policy allows a client to submit a grievance without submitting it to a staff member who is the subject of the complaint and grievances alleging sexual abuse are immediately directed to the PREA Coordinator and/or PREA Manager.

Third parties, including fellow clients, staff members, family members, attorneys and outside advocates shall be permitted to assist clients in filing requests for administrative remedies and are also permitted to file on behalf of clients. Journey House may request that the alleged victim agree to have the request filed on her behalf. Sexual abuse allegations may be filed as emergency grievances. After receiving an emergency grievance alleging a client is subject to a substantial risk of imminent sexual abuse, Journey House will immediately forward the grievance to a level of review at which immediate corrective actions may be taken and an initial response provided within 48 hours and an agency decision within 5 calendar days.

An additional Journey House Policy provides a grievance process for the girls anytime they feel their rights have been violated. Policy requires that grievances may be filed without fear of retaliation or barriers to services. Youth have access to the grievance process through filling out a grievance form and giving it to her advocate or any team member. Within 48 hours after filing the grievance the supervisor will meet with the resident filing the grievance, conduct an investigation and report the decision regarding the grievance back to the resident within 3 days.

Following that notice, the youth has the right to request a meeting with the Program Director/Clinical Director within 3 days after which the Program Director/Clinical Director has an additional three days to further investigate if necessary and report back to the youth within 3 days.

Interviews Results:

Seven (7) youth interviewed reported they have access to the grievance process but none mentioned they would use it as a means of reporting allegations of sexual abuse or sexual harassment or retaliation. They consistently stated they would tell a staff or their clinician. The facility reported they
have not had any grievances filed during the audit period alleging sexual abuse or sexual harassment. PREA related grievance forwarded to the PREA Compliance Manager or PREA Coordinator.

Standard 115.353: Resident access to outside confidential support services and legal representation

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

115.353 (a)

- Does the facility provide residents with access to outside victim advocates for emotional support services related to sexual abuse by providing, posting, or otherwise making assessable mailing addresses and telephone numbers, including toll-free hotline numbers where available, of local, State, or national victim advocacy or rape crisis organizations? ☒ Yes ☐ No
- Does the facility provide persons detained solely for civil immigration purposes mailing addresses and telephone numbers, including toll-free hotline numbers where available of local, State, or national immigrant services agencies? (N/A if the facility never has persons detained solely for civil immigration purposes.) ☐ Yes ☐ No ☒ NA
- Does the facility enable reasonable communication between residents and these organizations and agencies, in as confidential a manner as possible? ☒ Yes ☐ No

115.353 (b)

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

115.353 (c)

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

115.353 (d)

- Does the facility provide residents with reasonable and confidential access to their attorneys or other legal representation? ☒ Yes ☐ No
- Does the facility provide residents with reasonable access to parents or legal guardians? ☒ Yes ☐ No
Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Policy and Document Review: Journey House Policy, Client Access to Outside Confidential Support Services, requires Journey House to provide clients with access to outside victim advocates for emotional support services related to sexual abuse. Journey House will inform clients, prior to giving them access to the outside advocacy services, of the extent to which their communications will be monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws.

Journey House will also provide residents with mailing addresses and phone numbers, including toll free numbers of local, state or national victim advocacy or rape crisis organizations. Reasonable communications will be provided and confidentiality will be provided as much as possible. Natchaug has a MOU Windham Hospital as service providers. Youth are provided access in an exceptional way to their parents/legal guardians as well as to their attorneys if they have one. Youth are able to make calls daily and to their attorneys when needed.

Journey House Zero Tolerance Posters provide information related to Victim Support Services. The poster states that Journey House has partnered with Windham Hospital to provide survivors of sexual assault with emotional support services. To access these services, contact (phone number provided) or send a letter to Windham Hospital.

Interviews: Four (4) of the Seven (7) youth interviewed indicated that they received the information about outside advocacy services. The youth did say the information was on the posters throughout the facility.

A. The facility provides residents with access to outside victim advocates for emotional support services related to sexual abuse by giving residents the mailing address to the Rape Crisis Center and a toll-free hotline number.

B. For residents detained solely for civil immigration purposes, the facility provides immigrant services information. Policy requires that facilities enable reasonable communication between residents and these organizations and agencies, in as confidential a manner as possible.
C. The facility informs residents prior to them communicating with outside organizations that phone calls may be monitored and that reports of sexual abuse or sexual violence will be forwarded to authorities in accordance with mandatory reporting laws. Residents receive this information in their orientation.

D. The facility has a memorandum of understanding with Sexual Assault Crisis Center of Eastern CT, INC, to provide residents with emotional support services related to sexual abuse. Residents are provided with reasonable and confidential access to their attorney, other legal representation, and reasonable access to parents or legal guardians.

**Concern:** Resident interview question #13, Do you know if there are services available outside of this facility for dealing with sexual abuse, if you ever need it? Four out of seven residents stated no.

**Concern:** Resident interview question #14, Can you tell me about what kind of services these are, all four of seven residents were able to identify at least two services provided by outside agencies.

**Corrective Active:** Standard 115.333(a) requires residents to be educated regarding information in an age appropriate fashion on the agency’s zero tolerance policy regarding sexual abuse and sexual harassment and how to report incidents or suspicions of sexual abuse or sexual harassment. The mailing addresses and telephone numbers for outside victim advocates for emotional support services related to sexual abuse is printed on the PREA Zero Tolerance posters. Refresher training will be provided by the PREA Compliance Manager.

**Standard 115.354: Third-party reporting**

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

115.354 (a)

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

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

**Auditor Overall Compliance Determination**

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

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

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

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

Policy and Document Review: Policy (Journey House, Third Party Reporting) requires that third party reports are responded to according to Journey House policy by staff. Staff are required, upon receiving such a report, to forward it to the Program Director and/or the PREA Coordinator who will follow the proper PREA reporting guidelines. It also allows third parties, including fellow residents, staff members, family members, attorneys and outside advocates to assist a resident in filing requests for administrative remedies relating to allegations of sexual abuse. They will also be permitted to file requests on behalf of residents.

The resident may require as a condition of processing that she agrees to have it filed on her behalf. The Journey House website provides instructions for anyone to report an act of sexual abuse or harassment. These instructions provide for the reporter to contact either the Program Director or the PREA Coordinator. Phone numbers for both are provided on the site.

A. The facility uses the www.natchaug.org website as their method of third-party reporting of sexual abuse and sexual harassment. The public is made aware through a visitor information package.

Third-party information is being provided to all visitors regarding their family members that are incarcerated by letter and/or website. If at any time a resident makes an allegation of being a victim of a sexual assault or sexual harassment and does not feel comfortable telling, writing, or using the posted hotline, the family member can make an official report of the resident's behalf by contacting assigned staff. All sexual abuse or sexual harassment reports are done in a discreet manner to not compromise the offender.

Interview Results:

Interviewed Program Director and facility PREA compliance manager confirmed that the hospital website may be used for third-party reporting of sexual abuse and sexual harassment.

OFFICIAL RESPONSE FOLLOWING A RESIDENT REPORT

Standard 115.361: Staff and agency reporting duties

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

115.361 (a)

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

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

### 115.361 (b)

- Does the agency require all staff to comply with any applicable mandatory child abuse reporting laws? ☒ Yes ☐ No

### 115.361 (c)

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

### 115.361 (d)

- Are medical and mental health practitioners required to report sexual abuse to designated supervisors and officials pursuant to paragraph (a) of this section as well as to the designated State or local services agency where required by mandatory reporting laws? ☒ Yes ☐ No

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

### 115.361 (e)

- Upon receiving any allegation of sexual abuse, does the facility head or his or her designee promptly report the allegation to the appropriate office? ☒ Yes ☐ No

- Upon receiving any allegation of sexual abuse, does the facility head or his or her designee promptly report the allegation to the alleged victim’s parents or legal guardians unless the facility has official documentation showing the parents or legal guardians should not be notified? ☒ Yes ☐ No

- If an alleged victim is under the guardianship of the child welfare system, does the facility head or his or her designee promptly report the allegation to the alleged victim’s caseworker instead of the parents or legal guardians? ☒ Yes ☐ No

- If a juvenile court retains jurisdiction over the alleged victim, does the facility head or designee also report the allegation to the juvenile’s attorney or other legal representative of record within 14 days of receiving the allegation? ☒ Yes ☐ No

### 115.361 (f)
Does the facility report all allegations of sexual abuse and sexual harassment, including third-party and anonymous reports, to the facility’s designated investigators? ☐ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Policy and Document Review: Natchaug Hospital Policy 1.26 requires staff to report immediately any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment. Procedures require that upon learning of an allegation that a resident was sexually abused or sexually harassed, the first staff member to respond to the report is required to follow the coordinated response procedures.

Staff at Journey House, are required by law to comply with mandatory child abuse reporting laws. Apart from reporting to designated supervisors or officials and designated State or local services agencies, staff are prohibited from revealing any information related to a sexual abuse report to anyone other than to the extent necessary to make treatment, investigation and other security and management decisions.

If the alleged victim is under the age of 18 or considered a vulnerable adult under a State or local vulnerable person’s statute, the agency shall report the allegation to the designated State of local services agency under applicable mandatory reporting laws. Upon receiving any allegation of sexual abuse, the facility head or designee will report promptly to the appropriate agency office and to the alleged victim’s parents or legal guardians, unless the facility has official documentation showing the parents or legal guardians should not be notified if the victim is under the guardianship of the child welfare system, the report shall be made to the alleged victim’s caseworker instead of the parents or legal guardians.

Interview Results:

- One hundred percent of the eighteen staff interviewed reported being aware of the agencies procedure for reporting any information related to a resident allegation of sexual abuse. Interviewed staff could clearly articulate the necessity to report any incident or alleged incident of sexual abuse or harassment immediately. They are aware of various methods of reporting in
writing or verbally to include but not limited to report to shift supervisor, staff hotline number or medical staff.

- Interviewed PREA compliance manager indicated that all allegations of sexual abuse and sexual harassment to include third-party and anonymous sources are reported directly to the Department of Children and Families or Connecticut State Police.

- Interviewed mental health staff indicated that they are required to report any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment to a designated supervisor or official immediately upon learning of the incident.

### Standard 115.362: Agency protection duties

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

**115.362 (a)**

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

#### Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** *(Substantially exceeds requirement of standards)*
- ☒ **Meets Standard** *(Substantial compliance; complies in all material ways with the standard for the relevant review period)*
- ☐ **Does Not Meet Standard** *(Requires Corrective Action)*

#### Instructions for Overall Compliance Determination Narrative

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

Interviews with the staff of Journey House, including both ten (10) randomly selected and eight (8) specialized, stated that in the event a resident reported to them that they were subject to a substantial risk of imminent sexual abuse they would take the report seriously, keep the resident safe and either with them or in a safe location separate from the potential abuser and report it immediately to their supervisor. They stated they would ensure the resident was kept safe until a decision would be made about housing or other actions necessary to protect the resident making the report.

Journey House policy requires that when learning that a resident is subject to a substantial risk of imminent sexual abuse. It shall take immediate action to protect the resident.

**Interviews Results:**
All seven (7) youth consistently indicated that they feel safe in this facility and trust staff to protect them. None of the interviewed youth reported any allegations that they have been at risk of sexual abuse in this facility. Youth in this facility are housed in single occupancy rooms. They would also be placed in separate classes if the potential aggressor was another youth. An investigation would be conducted but the youth would be protected during that process.

### Standard 115.363: Reporting to other confinement facilities

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

**115.363 (a)**

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

**115.363 (b)**

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

**115.363 (c)**

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

**115.363 (d)**

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

**Auditor Overall Compliance Determination**

- ☐ **Exceeds Standard** *(Substantially exceeds requirement of standards)*
- ☒ **Meets Standard** *(Substantial compliance; complies in all material ways with the standard for the relevant review period)*
- ☐ **Does Not Meet Standard** *(Requires Corrective Action)*

**Instructions for Overall Compliance Determination Narrative**

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

Journey House Policy 7.14 DCF Mandated Reporting, the Program Director confirmed that the Journey House has not had an instance where as, having to reporting sexual abuse or sexual harassment that occurred at another facility nor have they every received a report from a another facility of sexual abuse or harassment occurring at their facility.

A. If the facility received an allegation that resident was sexually abused while confined at another facility. Per staff interviews, the facility notifies the head of the facility or appropriate office of the agency where the alleged abuse occurred.

B. The facility provided a process that they use when a resident alleged sexual assault or sexual harassment at another facility. The process includes reporting with the 72 hours timeframe and documentation.

C. Staff interviews indicated that when receiving allegations reported from other facilities, they would complete an incident report and notify Program Director/PREA Coordinator.

A review of the Pre-Audit Questionnaire for Juvenile Facilities and confirmed by staff interview:

- During the past 12 months, the number of allegations the facility received that a resident was abused while confined at another facility was zero.
- During the past 12 months, the number of allegations of sexual abuse the facility received from other facilities was zero.

**Standard 115.364: Staff first responder duties**

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

115.364 (a)

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

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

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

115.364 (b)

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

Auditor Overall Compliance Determination

☐ Exceeds Standard (Substantially exceeds requirement of standards)

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

☐ Does Not Meet Standard (Requires Corrective Action)

Instructions for Overall Compliance Determination Narrative

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

Policy and Document Review: Policy requires staff, upon learning that a resident was sexually abused, to separate the alleged victim from the alleged abuser, preserve and protect any crime scene until appropriate steps can be taken to collect any evidence and if the abuse occurred within a time period that still allows for the collection of physical evidence, request that the alleged victim not take any actions that could destroy physical evidence, including as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking or eating with the same instructions for the abuser. If the first staff responder is not a security staff member, the responder is required to request that the alleged victim not take any actions that could destroy physical evidence, and the notify security staff.

Natchaug Hospital Policy, 1.26 Client Rights, Procedures, Paragraph 3, requires that any client who reports having been involved in an incident of sexual abuse or sexual assault, allegedly occurring while the client was on hospital property, will immediately be escorted from the scene and a hospital staff will be assigned to provide 1:1 observation and support. The client will also be afforded immediately an assessment by a RN or a physician to determine if the client needs immediate transfer to an emergency medical facility.

The same procedures would apply to any alleged perpetrator. The alleged victim or perpetrator should be allowed to shower, bathe, brush their teeth, change clothes or toilet until a preliminary investigation
has been completed. No one should be allowed to touch anything, remove anything or clean anything at the scene of the alleged incident until a preliminary investigation is completed. Policy requires that the Program Director, Principal or Nursing Supervisor on duty should notify an appropriate member of the Hospital Administration that an alleged incident has occurred and what steps have been taken to deal with it. This hospital administrator will assist the Program Director in completing an Adverse Event report and will report to the appropriate state agency as needed.

A. Interviews with staff and staff training indicated when staff learn of an allegation that a resident is sexually abused, the first security staff to respond separates the victim and abuser; preserves and protects the crime scene; and if the incident occurred within the appropriate time period for the collection of physical evidence, they will request that the alleged victim not take actions that could destroy physical evidence, to include washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating.

B. According to staff, if they are the first responder, they will request that the alleged victim not take any actions that could destroy physical evidence, and notify security staff.

A review of the Pre-Audit Questionnaire for Juvenile Facilities and confirmed by staff interview:

- In the past 12 months, the number of allegations that a resident was sexually abused or sexual harassed was zero.
- In the past 12 months, the number of allegations where staff was notified within a time that still allowed for the collection of physical evidence was zero.
- Of the allegations that a resident was sexually abused made in the past 12 months, the number of times staff member was the first responder zero.

Interview Results:

Interviews were conducted with twelve staff who are considered first responders. All the interviewed staffs consistently reported that the duties of a first responder to include but not limited to: take immediate action, stay with the resident, separate the victim from the perpetrator, isolate/secure the scene and secure evidence, take to medical, and notify supervisor.

- Interviewed staff as first responders described the actions taken to an allegation of sexual abuse is to:
  - Separate the alleged victim and abuser;
  - Contact the supervisor;
  - Preserve and protect the crime scene;
  - Request that the alleged victim does not to wash, brush teeth, change clothes or use the bathroom;
  - Request the same for the alleged abuser.
Standard 115.365: Coordinated response

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

115.365 (a)

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

Auditor Overall Compliance Determination

☐ Exceeds Standard (Substantially exceeds requirement of standards)

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

☐ Does Not Meet Standard (Requires Corrective Action)

Instructions for Overall Compliance Determination Narrative

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

Policy and Document Review: Policy 1.26, Natchaug Hospital, Client Rights identifies in detail the roles of first responders, medical staff, staff responsible for notifying the hospital administration and the role of the hospital administration. Journey House policy entitled, Critical Response Following a Resident Report, describes the facility’s institutional plan to coordinate actions taken in response to an incident of sexual abuse among staff first responders, medical and mental health practitioners, investigators and facility leadership.

The facility has developed a PREA Incident Check List for Journey House. This form details required actions as a result of an allegation of sexual abuse. The plan identifies the Connecticut State Police as the agency to contact for investigations and provides contact information for ready reference. A staff training module, Prison Rape Elimination Act PREA, is used to train staff in their first responder duties. The roles of the responders are detailed and include training explaining why it is important to understand the dynamics of residential care prior to understanding the role of the first responder.

The Primary Objective of First Responders to Abuse outlines the following: stop the abuse, separate the perpetrator, cordon off the scene to protect evidence and avoid compromising the investigation, asking the victim and perpetrator not to take any actions that could destroy physical evidence and follow your facility’s policy on reporting, calling investigators, calling in medical and mental health staff and use of the PREA Incident Checklist.
Ten additional first responder duties are identified and training includes explaining to the victim the importance of maintaining physical evidence, explaining the investigation process and gathering essential information. First responders are trained how to avoid compromising the investigation process. Lastly the training deals with the primary objectives of first responders to reports of past abuse.

**Interview Results:** Interviewed staff as first responders described the actions taken to an allegation of sexual abuse is to:

- Separate the alleged victim and abuser;
- Contact the supervisor;
- Preserve and protect the crime scene;
- Request that the alleged victim does not to wash, brush teeth, change clothes or use the bathroom;
- Request the same for the alleged abuser.

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**Standard 115.366: Preservation of ability to protect residents from contact with abusers**

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

**115.366 (a)**

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

**115.366 (b)**

- Auditor is not required to audit this provision.

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**Auditor Overall Compliance Determination**

- ☐ **Exceeds Standard** *(Substantially exceeds requirement of standards)*
- ☒ **Meets Standard** *(Substantial compliance; complies in all material ways with the standard for the relevant review period)*
- ☐ **Does Not Meet Standard** *(Requires Corrective Action)*

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

An Interview with Program Director confirmed that Journey House has (4) four collective bargaining unit agreements with staff, there is nothing in the contract language that prohibits the administration from removing any staff member upon receiving an allegation of sexual abuse while the investigation is being conducted. Staff reported that the individual would most likely be placed on administrative leave and if the investigation is substantiated the allegation the employee would be terminated.

Standard 115.367: Agency protection against retaliation

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

115.367 (a)

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

115.367 (b)

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

115.367 (c)

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

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

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

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

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

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

115.367 (d)

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

115.367 (e)

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

115.367 (f)

Auditor is not required to audit this provision.

**Auditor Overall Compliance Determination**

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

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

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

**Instructions for Overall Compliance Determination Narrative**

75
The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

**Policy and Document Review:** Journey House Policy, Official Response Following a Resident Report, requires protecting all residents and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other residents or staff and requires the agency to designate the staff members who will be responsible for monitoring retaliation.

**Interviews:** The Journey House PREA Compliance Manager is the designated retaliation monitor. An interview with the retaliation monitor indicated that she would make contact with the resident or staff to see if they have any concerns that they may be retaliated against. She related she would talk with the resident to see if they were comfortable with their housing arrangement, their placement in school, etc. as well as telling them who they could talk to if they felt unsafe. She stated she would move staff, if it involved with the allegation. The youth would be move to room close to the security station/desk and ensure that the numbers of checks on the youth would be increased.

Additionally, she related a new victimization screening would be conducted. She and the members of the treatment team would monitor things like conversations, anything out of the ordinary, increased restrictions, acting out or other changes in behavior or increased observation status. A high risk assessment would be conducted and the youth’s therapist would communicate with them as well. Monitoring would continue the entire time the youth is at the facility.

In addition, she related she would also see if they needed access to a phone, writing materials or other means to communicate. There have been no allegations of retaliation during the audit period. None of the interviewed youth had made any reports or allegations of sexual abuse, sexual harassment or retaliation for having made a report or cooperated with an investigation.

**A.** The facility prohibits retaliatory behavior by residents or staff in regards to the reporting of sexual abuse, sexual harassment or cooperation with investigators as it relates PREA related incidents and allegations. Resident's rights documentation and staff policy establishes expected conduct. The facility PREA compliance manager is responsible for monitoring retaliation along with supervisors to monitor residents as it relates to PREA allegations and incidents.

**B.** The facility has several protections and reporting measures, for residents. They can utilize the grievance process to document retaliatory acts or other PREA related concerns and issues. The facility has the option to change resident housing or transfer resident victims or abusers, remove alleged staff or resident abusers from contact with victims, and provide emotional support services for residents or staff that fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations.

**C.** The facility reported that there is no retaliation for this audit period. If the facility were to have issues with retaliation, the policy will guide them on this standard. For example, for at least 90 days following a report of sexual abuse, the facility monitors the conduct and treatment of residents or staff who reported the sexual abuse and of residents who were reported to have suffered sexual abuse, to see if there are changes that may suggest possible retaliation by residents or staff, and act promptly to remedy any retaliation.
the facility should monitor include resident disciplinary reports, housing or program changes, and negative performance reviews or reassignments of staff. The facility continues monitoring beyond 90 days if the initial monitoring indicates a continuing need.

D. In the case of residents, monitoring includes periodic status checks. If any individual cooperates with an investigation expresses a fear of retaliation, the facility takes appropriate measures to protect the individual against retaliation.

A review of the Pre-Audit Questionnaire for Juvenile and confirmed by staff interview: The number of times an incident of retaliation occurred in the past 12 months was zero.

Interview Results

- Interviewed staff indicated that they monitor retaliation against residents and staff who report sexual abuse or sexual harassment or who cooperate with sexual abuse or sexual harassment investigations. When preventing retaliation against staff, they would change the staff shift or change the staff work details.
- Interviewed staff indicated that they will monitor the resident at least weekly. However, this process would end around 90 days.

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**Standard 115.368: Post-allegation protective custody**

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

115.368 (a)

- Is any and all use of segregated housing to protect a resident who is alleged to have suffered sexual abuse subject to the requirements of § 115.342? ☒ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

*The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor’s analysis and reasoning, and the auditor’s conclusions. This discussion must also include corrective action recommendations where the facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.*
**Policy and Documents Review:** Journey House Policy, Official Response Following a Resident Report, requires that any use of segregated housing to protect a resident who is alleged to have suffered sexual abuse is subject to the requirements of 115.42. Journey House would use multiple protection measure, such as room changes or transfers for resident victims or abusers, removal of alleged staff or resident abuser’s from contact with victims, and emotional support services for residents or staff that fear retaliation for reporting. Victims will not be placed in segregated housing for protection.

**Interviews Results:**

An interview with the PREA Compliance Manager confirmed that residents will not be placed in segregated housing for protection.

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**INVESTIGATIONS**

**Standard 115.371: Criminal and administrative agency investigations**

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

115.371 (a)

- When the agency conducts its own investigations into allegations of sexual abuse and sexual harassment, does it do so promptly, thoroughly, and objectively? [N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations. See 115.321(a).] ☒ Yes ☐ No ☒ NA

- Does the agency conduct such investigations for all allegations, including third party and anonymous reports? [N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations. See 115.321(a).] ☒ Yes ☐ No ☒ NA

115.371 (b)

- Where sexual abuse is alleged, does the agency use investigators who have received specialized training in sexual abuse investigations involving juvenile victims as required by 115.334? ☒ Yes ☐ No

115.371 (c)

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

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

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

115.371 (d)
Does the agency always refrain from terminating an investigation solely because the source of the allegation recants the allegation?  ☒ Yes  ☐ No

115.371 (e)

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

115.371 (f)

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

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

115.371 (g)

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

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

115.371 (h)

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

115.371 (i)

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

115.371 (j)

Does the agency retain all written reports referenced in 115.371(g) and (h) for as long as the alleged abuser is incarcerated or employed by the agency, plus five years unless the abuse was committed by a juvenile resident and applicable law requires a shorter period of retention?  ☒ Yes  ☐ No

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

115.371 (I)

Auditor is not required to audit this provision.

115.371 (m)

When an outside agency investigates sexual abuse, does the facility cooperate with outside investigators and endeavor to remain informed about the progress of the investigation? (N/A if an outside agency does not conduct administrative or criminal sexual abuse investigations. See 115.321(a).) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Policy and Document Reviews: Journey House Policy requires the agency to report all allegations of sexual abuse and sexual harassment to the Department of Children and Families. The requirement is to report promptly, thoroughly and objectively for all allegations including third party and anonymous reports. Policy states that where sexual abuse is alleged Natchaug Hospital will allow law enforcement who has received special training in sexual abuse investigations to conduct the investigation.

If the allegation is sexual abuse, the report will be made to the Department of Children and Families and Connecticut State Policy. Local operating procedures describe the responsibilities of investigators. Law Enforcement investigators will gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence, electronic monitoring data, interview alleged victims, suspected perpetrators and witnesses and review prior complaints or reports of sexual abuse involving the suspected perpetrator. Law enforcement will review the quality of evidence and if it appears to support criminal prosecution, as determined by the law enforcement officials, will conduct interviews...
after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution.

Journey House does not require a resident who alleges sexual abuse to submit to a polygraph exam or other truth-telling device as a condition for proceeding with an investigation of an allegation. Interviews with staff confirmed all employees are to report any suspicion, allegation, knowledge of sexual abuse or sexual harassment and appropriate staff to report allegations of sexual abuse to the Connecticut State Police and allegations of sexual harassment to the Department of Children and Families.

The Coordinated Response Plan identifies the Connecticut State Police as the agency with the legal authority to conduct criminal investigations. During the audit period there have been no allegations of sexual abuse or sexual harassment.

**Interviews:** The Program Director and PREA Compliance Manager confirmed that there have been no allegations of sexual abuse or sexual harassment reported during the audit period.

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### Standard 115.372: Evidentiary standard for administrative investigations

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

115.372 (a)

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

**Auditor Overall Compliance Determination**

- ☐ Exceeds Standard *(Substantially exceeds requirement of standards)*
- ☒ Meets Standard *(Substantial compliance; complies in all material ways with the standard for the relevant review period)*
- ☐ Does Not Meet Standard *(Requires Corrective Action)*

**Instructions for Overall Compliance Determination Narrative**

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

**Policy and Document Review:** Neither Natchaug Hospital nor Journey House conducts investigations, either administrative or criminal. The agency responsible for conducting criminal investigations is the Connecticut State Police while the agency responsible for conducting administrative investigations is the Department of Children and Families.
Interviews: An interview with the Program Director and PREA Compliance Manager confirmed that Journey House does not conduct investigations criminal or administrative.

Standard 115.373: Reporting to residents

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

115.373 (a)

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

115.373 (b)

- If the agency did not conduct the investigation into a resident’s allegation of sexual abuse in the agency’s facility, does the agency request the relevant information from the investigative agency in order to inform the resident? (N/A if the agency/facility is responsible for conducting administrative and criminal investigations.) ☒ Yes ☐ No ☐ NA

115.373 (c)

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

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

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

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

115.373 (d)

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

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

115.373 (e)

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

115.373 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Policy and Document Review: Journey House Policy, Investigations, requires that following the conclusion of the Law Enforcement Investigation into a resident’s allegation of sexual abuse, the agency will inform the resident as to whether the allegation has been determined to be substantiated, unsubstantiated or unfounded. Journey House has not had any allegations of sexual abuse or sexual harassment during the audit period however policy requires notification in accordance with the PREA Standard.

The agency will request the information from the investigative agency to enable them to make that report. Policy further requires that the agency subsequently inform the resident unless unfounded whenever:

- The staff member is no longer posted within the resident’s unit
- The staff member is no longer employed at the facility,
- The agency learns that the staff member has been indicted on a charge related to sexual abuse within the facility or
- The agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility.
Following an allegation that the resident was abused by another resident the agency will inform the alleged victim when:

- The facility learns that the alleged abuser has been indicted on a charge related to sexual abuse within the facility
- The facility learns that the alleged abuser has been convicted on a charge related to abuse within the facility.

All notifications and/or attempts to notify the resident are documented.

Interviews: The Program Director and the PREA Compliance Manager confirmed that they are aware of the requirements for notifying residents of the outcome of any investigation conducted either by the local law enforcement or by the Department of Children and Families.

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**Standard 115.376: Disciplinary sanctions for staff**

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

115.376 (a)

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

115.376 (b)

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

115.376 (c)

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

115.376 (d)

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

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Policy and Document Review: Natchaug Hospital Policy and Procedure Manual, 1.27, Client Rights, states that whenever Department of Children and Families, based on the results of an investigation, has reasonable cause to believe that a child has been abused or neglected by a staff member of a public or private institution or facility providing child care, they will notify the institution, school or facility and provide records concerning the investigation to the executive director.

A. Agency policy states that staff shall be subject to disciplinary sanctions up to and including termination for violating agency resident sexual abuse and/or harassment policies. The directive indicates that termination is the presumptive disciplinary sanction for staff that has been found to have engaged in sexual abuse. All terminations for violations of agency resident sexual abuse or harassment policies or resignations by staff who would have been terminated before their resignation, will be reported to law enforcement agencies, unless the activity was clearly not criminal, and to any relevant licensing bodies.

A review of the Pre-Audit Questionnaire for Juvenile and confirmed by interviewed staff.

- In the past 12 months, the number of staff from the facility who has violated agency sexual abuse or sexual harassment policies was zero.
- In the past 12 months, the number of staff from the facility that have been terminated (or resigned prior to termination) for violating agency sexual abuse or sexual harassment policies was zero.
- In the past 12 months, the number of staff from the facility that have been disciplined, short of termination, for violation of agency sexual abuse or sexual harassment policies reported were zero.
- In the past 12 months, the number of staff from the facility that have been reported to law enforcement or licensing boards following their termination (or resignation prior to termination) for violating agency sexual abuse or sexual harassment policies reported was zero.

Interview Results:
Interviews with the administrator confirmed staff violating agency sexual abuse policies will be disciplined and that termination is the presumptive action and referral for prosecution where indicated.

**Standard 115.377: Corrective action for contractors and volunteers**

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

**115.377 (a)**

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

**115.377 (b)**

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

**Auditor Overall Compliance Determination**

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

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

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

**Instructions for Overall Compliance Determination Narrative**

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

Journey House does not utilize volunteers or contractors however there is a process in place for conducting background checks, training and advising them of the zero tolerance policy and reporting.

**Interviews:** Ten Random (10) and Eight (8) Specialized staff indicated that a volunteers or contractors would be suspended from their services pending an investigation and if the allegations were
substantiated, the individuals involved would be prohibited from further admission to the facility, if the violations were criminal, the volunteer or contractor would be referred for prosecution. The Program Director confirmed that the facility has no volunteers or contractors at the Journey House.

**Standard 115.378: Interventions and disciplinary sanctions for residents**

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

115.378 (a)

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

115.378 (b)

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

- In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident is not denied daily large-muscle exercise? ☒ Yes ☐ No

- In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident is not denied access to any legally required educational programming or special education services? ☒ Yes ☐ No

- In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident receives daily visits from a medical or mental health care clinician? ☒ Yes ☐ No

- In the event a disciplinary sanction results in the isolation of a resident, does the resident also have access to other programs and work opportunities to the extent possible? ☒ Yes ☐ No

115.378 (c)

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

115.378 (d)

- If the facility offers therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse, does the facility consider whether to offer the offending resident participation in such interventions? ☒ Yes ☐ No

- If the agency requires participation in such interventions as a condition of access to any rewards-based behavior management system or other behavior-based incentives, does it
always refrain from requiring such participation as a condition to accessing general programming or education? ☒ Yes ☐ No

115.378 (e)

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

115.378 (f)

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

115.378 (g)

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

Auditor Overall Compliance Determination

☐ Exceeds Standard (Substantially exceeds requirement of standards)

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

☐ Does Not Meet Standard (Requires Corrective Action)

Instructions for Overall Compliance Determination Narrative

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

Journey House employs a behavioral assistance grid to provide supportive and non-punishing responses to a resident’s behaviors. Youth, who are involved in sexual activity, contact, coercion or abuse would be placed on an individual plan and the following restrictions imposed:

- All unnecessary items are not allowed in the resident’s room for a minimum of 30 days.
- Electronics and any items that could potentially be used as a weapon would be removed from their room.
- All off ground privileges suspended for a minimum of 30 days or until safe/responsible behavior is demonstrated by the resident.
Interviews: All interviewed Ten (10) random and Eight (8) specialized staff confirmed that there have been no reports or allegations of sexual abuse or sexual harassment during the last twelve (12) months.

MEDICAL AND MENTAL CARE

Standard 115.381: Medical and mental health screenings; history of sexual abuse

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

115.381 (a)

- If the screening pursuant to § 115.341 indicates that a resident has experienced prior sexual victimization, whether it occurred in an institutional setting or in the community, do staff ensure that the resident is offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening? ☒ Yes ☐ No

115.381 (b)

- If the screening pursuant to § 115.341 indicates that a resident has previously perpetrated sexual abuse, whether it occurred in an institutional setting or in the community, do staff ensure that the resident is offered a follow-up meeting with a mental health practitioner within 14 days of the intake screening? ☒ Yes ☐ No

115.381 (c)

- Is any information related to sexual victimization or abusiveness that occurred in an institutional setting strictly limited to medical and mental health practitioners and other staff as necessary to inform treatment plans and security management decisions, including housing, bed, work, education, and program assignments, or as otherwise required by Federal, State, or local law? ☒ Yes ☐ No

115.381 (d)

- Do medical and mental health practitioners obtain informed consent from residents before reporting information about prior sexual victimization that did not occur in an institutional setting, unless the resident is under the age of 18? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ Exceeds Standard (Substantially exceeds requirement of standards)

☒ Meets Standard (Substantial compliance; complies in all material ways with the standard for the relevant review period)
Instructions for Overall Compliance Determination Narrative

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

Policy and Document Review: Natchaug Policy 1.27, Medical and Mental Health Services, ensures that residents are provided timely, unimpeded access to emergency medical treatment and crisis intervention services, the nature and scope of which are determined by medical and mental health practitioners according to their professional judgment.

If no qualified medical or mental health practitioners are on duty at the time and a report of sexual abuse is made, staff first responders take the preliminary steps to protect the victim and immediately notify the appropriate medical and mental health staff. Journey House Policy, Screening for Risk of Victimization and Abusiveness, requires that Journey House must ensure all residents are screened to assess their risk of being sexually abused or being sexually abusive toward other residents using an objective assessment/screening instrument.

Residents are assessed during the intake process or upon transfer to another facility. The assessment must take place within 72 hours of arrival at the facility. The instrument being used is the Screening for Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB). This instrument addresses the following: experience in institutions, social skills, perception of risk, identification, history of victimization (past sexual abuse or victimization), age of the youth, intellectual impairment and mental health issues.

Interviews: An interview with the Clinical Director, who conducts risk screening, indicated a very thorough screening process. Risk screening is one of a number of screenings conducted following admission. This facility is a treatment facility and multiple assessments contribute to the information pool about each resident enabling staff to develop the most appropriate treatment and safety plans. In addition to the victimization risk screening the facility provides in depth mental health and medical assessments. If the screening indicates that a resident has experienced prior sexual victimization, whether it occurred in an institutional setting or in the community, staff ensure that the resident is offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening. Examples of those assessments include the following:

- Personal Safety
- Triggers
- Psychosocial Assessment
- Sleep Assessment
- Energy/Rests Assessment
- Memory-Executive Functioning Assessment
- Mood-Affect Assessment
- Nutrition Assessment
- Substance Use History
- Educational Needs
- Hospitalizations and a thorough physical assessment.

**Interviews:** Ten (10) random and eight (8) specialized staff both medical and mental health staff were knowledgeable of the standard. They indicated they screen youth on admission. Screening includes victimization risk screening. Youth who report prior sexual victimization are referred to mental health immediately and are assigned a Clinician.

**Interview Result:**
- Interviewed medical and mental health staff indicated residents reporting prior sexual victimization or prior perpetration would be seen by a mental health professional within 14 days of the initial screening.
- Three current residents disclosed sexual victimization during the risk screening process.

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**Standard 115.382: Access to emergency medical and mental health services**

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

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<tr>
<th>115.382 (a)</th>
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<tbody>
<tr>
<td>▪ Do resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services, the nature and scope of which are determined by medical and mental health practitioners according to their professional judgment? ☒ Yes ☐ No</td>
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<th>115.382 (b)</th>
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<tr>
<td>▪ If no qualified medical or mental health practitioners are on duty at the time a report of recent sexual abuse is made, do staff first responders take preliminary steps to protect the victim pursuant to § 115.362? ☒ Yes ☐ No</td>
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<tr>
<td>▪ Do staff first responders immediately notify the appropriate medical and mental health practitioners? ☒ Yes ☐ No</td>
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<tr>
<td>▪ Are resident victims of sexual abuse offered timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate? ☒ Yes ☐ No</td>
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<th>115.382 (d)</th>
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- Are treatment services provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident?
  ❑ Yes  ☐ No

Auditor Overall Compliance Determination

☐ Exceeds Standard (Substantially exceeds requirement of standards)

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

☐ Does Not Meet Standard (Requires Corrective Action)

Instructions for Overall Compliance Determination Narrative

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

Policy and Document Review: Journey House Policy requires that victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services, the nature and scope of which are determined by medical and mental health practitioners according to their professional judgment. If there are no qualified medical or mental health practitioners on duty, staff first responders take preliminary steps to stop the abuse, protect the victim and immediately notify the appropriate medical and mental health practitioners.

The facility does not have any forensic examiners on staff. Forensic examiners are available through Windham Hospital emergency room. Journey House is staffed heavily with licensed and qualified mental health professionals. The Clinical Director is exceptionally qualified and the facility has a Psychiatrist who is frequently on site and available via phone as needed.

Interview Results

- Interviewed staff described the following actions they would take as a first responder: Separate the alleged victim and abuser, preserving and protecting evidence on the victim, abuser, and the location where the incident occurred.

- Interviewed staff indicated that they would ask the alleged victim and abuser not to take any actions that could destroy physical evidence; washing, brushing teeth, changing clothes, urinating, defecating, drinking, eating, etc.

- Interviewed staff indicated that they would immediately notify their supervisor.

- Interviewed mental health care staff indicated that resident victims of sexual abuse receive timely and unimpeded access to emergency medical treatment and crisis intervention services from the local hospital.
Interviewed mental health care staff indicated that evaluation and treatment of residents who have been victimized entails follow-up services, treatment plans, and when necessary, referrals for continued care after leaving the facility.

Standard 115.383: Ongoing medical and mental health care for sexual abuse victims and abusers

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

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

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

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

115.383 (d)
- Are resident victims of sexually abusive vaginal penetration while incarcerated offered pregnancy tests? (N/A if “all-male” facility. Note: in “all-male” facilities, there may be residents who identify as transgender men who may have female genitalia. Auditors should be sure to know whether such individuals may be in the population and whether this provision may apply in specific circumstances.) ☒ Yes ☐ No ☐ NA

115.383 (e)
- If pregnancy results from the conduct described in paragraph § 115.383(d), do such victims receive timely and comprehensive information about and timely access to all lawful pregnancy-related medical services? (N/A if “all-male” facility. Note: in “all-male” facilities, there may be residents who identify as transgender men who may have female genitalia. Auditors should be sure to know whether such individuals may be in the population and whether this provision may apply in specific circumstances.) ☒ Yes ☐ No ☐ NA

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

115.383 (g)

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

115.383 (h)

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

Auditor Overall Compliance Determination

☐ Exceeds Standard (Substantially exceeds requirement of standards)

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

☐ Does Not Meet Standard (Requires Corrective Action)

Instructions for Overall Compliance Determination Narrative

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

The facility is on the grounds of a mental health hospital and has access to multiple medical and mental health practitioners both within Journey House. Each resident in this program is assigned to a Clinician, whom are licensed. The Clinical Director is the consummate professional and imminently qualified. The facility has access to a psychiatrist as well for consultation, medication and treatment services. Victims of sexual abuse would be taken to the local hospital (Windham Hospital) for a forensic exam and STI prophylaxis.

Interviews: An interview with the facility’s registered nurse, related that the facility does STI testing regularly and also maintains Plan B as an option, as indicated, for youth who were sexually assaulted. Mental health services are provided throughout the youth’s stay. Services are provided to residents at no cost to the resident.

Interview Results
- Interviewed staff confirmed that evaluations and services of victims include follow-up services, referrals for continued care following residents transfer to, or placement in, other facilities, or their release from custody.

- Interviewed staff confirmed that the facility provides victims with medical/mental health services consistent with the community level of care.

## DATA COLLECTION AND REVIEW

### Standard 115.386: Sexual abuse incident reviews

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

#### 115.386 (a)

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

#### 115.386 (b)

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

#### 115.386 (c)

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

#### 115.386 (d)

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

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

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

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

- Does the review team: Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff? ☒ Yes ☐ No
- Does the review team: Prepare a report of its findings, including but not necessarily limited to determinations made pursuant to §§ 115.386(d)(1) - (d)(5), and any recommendations for improvement and submit such report to the facility head and PREA compliance manager? ☒ Yes ☐ No

115.386 (e)

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

Auditor Overall Compliance Determination

☐ Exceeds Standard (Substantially exceeds requirement of standards)

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

☐ Does Not Meet Standard (Requires Corrective Action)

Instructions for Overall Compliance Determination Narrative

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

The program has not had any allegations of either sexual abuse or sexual harassment during the audit period. The facility administration is aware of the requirements for conducting sexual abuse incident reviews.

Policy and Document Review: Journey House Policy requires that the facility conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation, including where the allegation has not been substantiated, unless the allegation has been determined to be unfounded. This review would ordinarily occur within 30 days of the conclusion of the investigation. Policy identifies each of the items this team must consider during the review.

Interviews: Eight (8) specialized staff interviewed indicated that the following staff would be on the incident review team: the Directors, PREA Compliance Manager, clinical, medical, human resources, and quality with input from the PREA Coordinator.

Standard 115.387: Data collection

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report
115.387 (a)

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

115.387 (b)

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

115.387 (c)

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

115.387 (d)

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

115.387 (e)

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

115.387 (f)

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

Auditor Overall Compliance Determination

☐ Exceeds Standard (Substantially exceeds requirement of standards)

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

☐ Does Not Meet Standard (Requires Corrective Action)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor’s analysis and reasoning, and the auditor’s conclusions. This discussion must also include corrective action recommendations where the facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.
**Policy and Document Review:** Policy requires Journey House to collect accurate and uniform data for every allegation of sexual abuse. It also indicates that Natchaug will aggregate the incident-based sexual abuse data at least annually to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice.

Journey House will maintain, review, and collect data as needed from all available incident-based documents, including reports, investigation files and sexual abuse incident reviews. The facility provided a copy of the PREA Annual Report, 2018. Between January 1, 2018 to December 31, 2018, there were no cases of resident on resident sexual acts, no cases of resident to resident sexual harassment, no cases of staff to resident’s sexual acts, no staff to resident sexual harassment and no staff to resident misconduct.

**Interviews Results:**

An interview with the PREA Compliance Manager confirmed Journey House has had no reports of sexual harassment or sexual abuse during the last 12 months.

**Standard 115.388: Data review for corrective action**

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

**115.388 (a)**

- Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Identifying problem areas? ☒ Yes ☐ No

- Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Taking corrective action on an ongoing basis? ☒ Yes ☐ No

- Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Preparing an annual report of its findings and corrective actions for each facility, as well as the agency as a whole? ☒ Yes ☐ No

**115.388 (b)**

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

**115.388 (c)**

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

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

Auditor Overall Compliance Determination

☐ Exceeds Standard (Substantially exceeds requirement of standards)

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

☐ Does Not Meet Standard (Requires Corrective Action)

Instructions for Overall Compliance Determination Narrative

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

Policy and Document Review: Natchaug Hospital Policy, Journey House, requires that Natchaug will review data collected and aggregated in order to assess and improve the effectiveness of its sexual abuse prevention, detection and response policies, practices and training, including identifying problem areas, taking corrective action on an ongoing basis and preparing an annual report of its findings and corrective actions as a whole. Reports will compare current year’s data and corrective actions with those from prior years and will provide an assessment of the agency’s progress in addressing sexual abuse.

The report will be made available to the public through its website. Personally identifying information would be redacted as well as any specific threat to the safety and security of the facility. The nature of redacted information will be indicated.

A. The agency and the facility reviews data collected and aggregated pursuant to § 115.387 to assess and improve the effectiveness of the facility’s sexual abuse prevention, detection, and response policies, practices, and training, including by identifying problem areas, taking corrective action on an ongoing basis. Interviews reveal that the agency prepares an annual report of its findings and corrective action that includes the facility and the agency.

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

C. The report is approved by the agency head/designee and made readily available to the public through its website.

D. The agency redacts specific material from the reports that would present a clear and specific threat to the safety and security of a facility.
# Standard 115.389: Data storage, publication, and destruction

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

## 115.389 (a)
- Does the agency ensure that data collected pursuant to § 115.387 are securely retained?  ☒ Yes   ☐ No

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

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

## 115.389 (d)
- Does the agency maintain sexual abuse data collected pursuant to § 115.387 for at least 10 years after the date of the initial collection, unless Federal, State, or local law requires otherwise?  ☒ Yes   ☐ No

### Auditor Overall Compliance Determination

- ☐ Exceeds Standard *(Substantially exceeds requirement of standards)*
- ☒ Meets Standard *(Substantial compliance; complies in all material ways with the standard for the relevant review period)*
- ☐ Does Not Meet Standard *(Requires Corrective Action)*

### Instructions for Overall Compliance Determination Narrative

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

The agency, according to policy will ensure that data collected pursuant to 115.387, are securely retained. Policy also requires and staff indicated in their interviews that the agency will maintain sexual abuse data for at least 10 years after the date of its initial collection unless Federal, State, or local law requires otherwise.
A. The agency’s aggregated sexual abuse data from the facility under its direct control is made readily available to the public at least annually through its website. Before making aggregated sexual abuse data publicly available the agency removes all personal identifiers.

B. The agency has removed personal identifiers before making aggregated sexual abuse data publicly available.

C. The agency maintains sexual abuse data collected for at least 10 years after the date of initial collection.

**AUDITING AND CORRECTIVE ACTION**

**Standard 115.401: Frequency and scope of audits**

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

115.401 (a)

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

115.401 (b)

- Is this the first year of the current audit cycle? *(Note: a “no” response does not impact overall compliance with this standard.)* ☐ Yes ☒ No

- If this is the second year of the current audit cycle, did the agency ensure that at least one-third of each facility type operated by the agency, or by a private organization on behalf of the agency, was audited during the first year of the current audit cycle? *(N/A if this is not the second year of the current audit cycle.)* ☒ Yes ☐ No ☐ NA

- If this is the third year of the current audit cycle, did the agency ensure that at least two-thirds of each facility type operated by the agency, or by a private organization on behalf of the agency, were audited during the first two years of the current audit cycle? *(N/A if this is not the third year of the current audit cycle.)* ☐ Yes ☐ No ☒ NA

115.401 (h)

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

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

115.401 (m)

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

115.401 (n)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The State of Connecticut ensures that 1/3 of their hospitals are audited each year for compliance with the PREA Standards each year so that at the end of the 3-year cycle, all hospitals have been audited. The Journey House was previously audited for compliance with the PREA Standards September 15, 2016.

**Policy and Documents Reviewed**: Natchaug Hospital Policy and Procedure Manual, 1.27; Prison Rape Elimination Act-PREA, Sexually Abusive Behavior Prevention and Intervention Program. Each facility operated by the Agency will be audited every three years or on a schedule determined by the PREA Coordinator.

A. The agency has ensured that each facility operated by the agency is audited at least once every three years. The agency did ensure that a third of each facility type is audit every year as well. However, the agency PREA coordinator presented a plan to ensure that all facilities will receive a PREA audit according to DOJ PREA standards.

B. The agency and/or facility demonstrated compliance with the PREA standards by submitting policies, procedures, reports, internal and external audits, and accreditations of the most recent one-year period. The auditor conducted on-site visit that included
sampling of relevant documents, other records, and additional information for the 12-month timeframe.

C. During the on-site audit, the auditor was given access to all areas of the facility during the site observes; the auditor requested and received copies of relevant documents to include electronically stored information.

D. The auditor has retained and preserves documentation used to make audit determinations and the documentation is available to the Department of Justice upon request, however, the agency/facility agreed to provide any additional information as requested.

E. The auditor interviewed representative samples to include those listed below and was permitted to conduct all formal interviews privately.

- Agency and facility leadership
- Random staff
- Specialized staff
- Supervisors
- Administrators
- Random residents
- Targeted residents
- Etc.

F. The PREA Audit Notice was posted to permit residents to send confidential information or correspondence to the auditor.

**Interview Results:**

An interview with PREA coordinator indicated that the agency has conducted the required PREA audits every year. The agency has ensured that at least one-third of each type is audited beginning 2018.

The on-site audit of the Journey House was conducted by one Auditor, certified in both Juvenile and Adult Standards. During the on-site audit, the auditor was provided complete and unfettered access to all areas of the facility and to all the inmates. The auditor was to move about the facility any time they needed to. Adequate space was provided for auditor to conducted interview in complete privacy. During the on-site review, the auditor freely walked around the facility without impediment.

The Notice of PREA Audit was observed posted. The notice contained contact information for the auditor. During the site review of the facility the auditor talked with staff and residents. All seven (7) residents were interviewed by the auditor in private. The auditor did not receive any correspondence from residents prior to the onsite audit.

The auditor reviewed resident’s files, made observations throughout the on-site audit, thoroughly reviewed large samples of documentation, tested processes (including checking victim/aggressor assessment time periods) and interviewed staff. Multiple personnel files were reviewed to assess the hiring process and background checks.

An exit briefing was conducted with the following: Program Director and Assistant Program Director, Preliminary findings were discussed. The auditor and the PREA Compliance Manager continued to
work together following the on-site audit when additional information was needed it was provided in a timely manner.

### Standard 115.403: Audit contents and findings

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

#### 115.403 (f)

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

#### Auditor Overall Compliance Determination

- ☐ Exceeds Standard *(Substantially exceeds requirement of standards)*
- ☒ Meets Standard *(Substantial compliance; complies in all material ways with the standard for the relevant review period)*
- ☐ Does Not Meet Standard *(Requires Corrective Action)*

#### Instructions for Overall Compliance Determination Narrative

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

The Program Director and the PREA Compliance Manager ensures that all PREA Reports are published on the agency’s website within 90 days of the completion of the report. Reports for all facilities for all reporting periods are posted on the agency’s website and easily accessible to the public.

The auditor reviewed the Agency’s website and reviewed the previous PREA reports as well as annual reports that were posted on the website.

Interviewed Program Director indicated the PREA Report as well as annual reports are posted for public viewing. The PREA Report will be posted within 90 days of issuing the final report to the facility.
AUDITOR CERTIFICATION

I certify that:

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

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

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

Auditor Instructions:

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

Mable P. Wheeler ___________________________ November 29, 2019

Auditor Signature Date

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