PREA AUDIT REPORT ☐ INTERIM ■ FINAL

COMMUNITY CONFINEMENT FACILITIES

NATIONAL PREA RESOURCE CENTER

BJA Bureau of Justice Assistance U.S. Department of Justice

Auditor Information			
Auditor name: Kevin Maurer			
Address: P.O. Box 4068, Deerfield Beach, FL 33442			
Email: kevin.maurer@us.g4s.com			
Telephone number: 954-790-3735			
Date of facility visit: 06/01/2015			
Facility Information			
Facility name: Warner House			
Facility physical address: 58 High Street, Torrington, CT 06790			
Facility mailing address: *(if different from above)*			
Facility telephone number: 860-496-2104			
The facility is:	☐ Federal	☐ State	☐ County
	☐ Military	☐ Municipal	☐ Private for profit
	■ Private not for profit		
Facility type:	☐ Community treatment center ☐ Halfway house ☐ Alcohol or drug rehabilitation center	■ Community-based confinement facility ☐ Mental health facility	☐ Other
Name of facility's Chief Executive Officer: Anthony Ryans			
Number of staff assigned to the facility in the last 12 months: 10			
Designed facility capacity: 11			
Current population of facility: 10			
Facility security levels/inmate custody levels: Level II			
Age range of the population: 18+			
Name of PREA Compliance Manager:		**Title:**	
Email address:		**Telephone number:**	
Agency Information			
Name of agency: McCall Foundation, Inc.			
Governing authority or parent agency: *(if applicable)*			
Physical address: 58 High Street, Torrington, CT 06790			
Mailing address: *(if different from above)*			
Telephone number: 860-496-2100			
Agency Chief Executive Officer			
Name: Maria Coutant Skinner		**Title:**	Executive Director
Email address: maria.coutant@mccall-foundation.org		**Telephone number:**	860-496-2100
Agency-Wide PREA Coordinator			
Name: Albert Stokes		**Title:**	Qual Assur Dir
Email address: albert.stokes@mccall-foundation.org		**Telephone number:**	860-496-2100

AUDIT FINDINGS

NARRATIVE

McCall Foindation, Inc.'s Warner House was audited June 2, 2015 by DOJ PREA Auditor Kevin Maurer. Prior to the on-site audit, a review of all pre-audit documents was completed. During the initial audit meeting, Albert Stokes, PREA Coordinator, and Anthony Ryans, Program Director, was present. A facility tour was conducted, which included all rooms of the program's facility as well as outside grounds. During the tour, it was noted that the Notice of PREA Audit and other PREA related materials were posted in several locations.

Interviewees were identified from a list of staff and residents. The interviewees included 10 residents and 2 random staff. 6 Specialized Staff interviews were also conducted. There were no residents who identified with being LGBTI. There were no PREA allegations in the past 12 months.

It should be noted that the staff of McCall Foundation, Inc. and Warner House were very well prepared and organized for the on-site audit, and all pre-audit materials were in order and well highlighted. This shows the dedication and concern for the PREA program from both a corporate as well as a program level.

DESCRIPTION OF FACILITY CHARACTERISTICS

Warner House is located in Torrington, CT in an older residential area. Warner House is a 2-story house with a basement. There are several multi-person bedrooms with a single occupancy bathroom on the second floor. The first floor consists of offices, kitchen/dining areas, common area/living room and entry way. The basement consists of weight benches, laundry, and storage.

Warner House serves men who have been referred by the Department of Corrections because of their problems with alcohol and other drugs. Warner House participants are completing their sentencing and in the process of returning.

The design of both these intermediate programs supports these clients' ongoing recovery and successful return to life on their own. Counseling and education sessions focus on relapse prevention, furthering their formal K-12 education, and job skill development. An on-campus GED program helps clients complete their high school diplomas.

In addition to supporting relapse prevention, individual and group counseling sessions focus on participants' development of healthy social consciousness, solid decision-making skills, and sound money management ability.

The mission of the McCall Foundation is to provide comprehensive substance abuse treatment and outpatient mental health treatment in an integrated fashion so that those who suffer from these disorders might lead more healthy and productive lives.

SUMMARY OF AUDIT FINDINGS

On June 2, 2015, McCall Foundation, Inc.'s Warner House had its on-site PREA Audit completed. The results of the audit indicate that the facility is in full compliance with PREA Standards, and a final report is being issued.

Number of standards exceeded: 1

Number of standards met: 29

Number of standards not met: 0

Number of standards not applicable: 9

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

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

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

McCall Foundation / Warner House have written policies and procedures mandating zero tolerance toward all forms of sexual abuse and sexual harassment in the facility. The policies detail the approaches it uses to prevent, detect, and respond to sexual abuse and sexual harassment. The definitions of prohibited behaviors are clearly defined, as are the sanctions for those who violate policy.

The agency has designated the Quality Assurance Director as PREA Coordinator. He is very knowledgeable of PREA requirements, devotes sufficient time and effort in assisting facility staff with PREA-related issues, and has the authority to implement corrective actions.

Standard 115.212 Contracting with other entities for the confinement of residents

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

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

N/A - Warner House does not contract with other entities for the confinement of residents

Standard 115.213 Supervision and monitoring

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

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

PREA Policy 115.213 and Staffing Plan for Warner House mandates that the McCall Foundation will provide staffing and monitoring at facilities in accordance with contractual and PREA obligations. These plans will be evaluated at minimum annually. The staffing plan outlines the minimum number of staff required for the program during all 3 shifts, 7 days per week. It further indicates the frequency of headcounts and rounds.

Standard 115.215 Limits to cross-gender viewing and searches

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

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

Policy 115.215 Limits to Cross Gender Viewing and Searches Policy states that staff at Warner House do not conduct strip searches, pat down searches, or visual body cavity searches. It is prohibited for staff to search or physically examine a transgender or intersex resident for the sole purpose of determining the resident's genital status. Warner House enables residents to shower, perform bodily functions, and change clothing without staff of the opposite gender viewing such activity.

The policy further states that if the resident's genital status is unknown, it may be determined during conversations with the resident or by reviewing records from the referral source(s), if deemed necessary by the Program Manager. Staff of the opposite gender will announce their presence when entering an area where residents are likely to be showering, performing bodily functions, or changing clothing. Transgender and intersex residents are given the opportunity to shower separately from other residents.

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

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

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

Policy 115.216 Residents with Disabilities and Residents who are LEP mandates that staff takes appropriate steps to ensure residents who are LEP or have disabilities (including residents who are deaf or hard of hearing, those who are blind or have low vision, or those who have intellectual, psychiatric, or speech disabilities), have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment.

Additionally, the program does not rely 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, or the investigation of the resident's allegations. Several Local Service Providers are listed for assistance with residents with disabilities.

Staff interviews indicate that resident interpreters, resident readers, or other types of resident assistants are not utilized.

Standard 115.217 Hiring and promotion decisions

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

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

Hiring procedures policies address that all applicants for employment, contracted services, will be appropriately screened for appropriateness for position and contact with residents. It further details that a criminal background record check will be conducted for staff who may have contact with residents prior to employment, and at least every 5 years thereafter for current staff. Additionally, the McCall Foundation will make a best effort approach to contacting 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.

The policies also state that the McCall Foundation will not hire or promote anyone who may have contact with residents who has engaged in sexual abuse any confinement or treatment setting; 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; or has been civilly or administratively adjudicated to have engaged those activities. Additionally, they consider any incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any contractor, who may have contact with residents.

Standard 115.218 Upgrades to facilities and technologies

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

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

N/A - there have been no upgrades to facilities and technologies at Warner House.

Standard 115.221 Evidence protocol and forensic medical examinations

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

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

N/A - During the onsite visit it was determined that the facility is not responsible for conducting investigations or performing forensic examinations. This part if the standard is N/A. The Torrington Police Department is responsible for the investigations. Charlotte Hospital is responsible for SAFE/SANE forensic examinations.

Standard 115.222 Policies to ensure referrals of allegations for investigations

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

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

Facility policy ensures that the administrative/criminal investigation is completed as required. Allegations that are criminal in nature are reported to the Torrington Police Department and the Department of Corrections (DOC).

Standard 115.231 Employee training

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

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

New hire orientation PREA training as well as the staff training curriculum provides for the initial and annual training on PREA regulations, which includes all 10 required items listed in the standard. Documentation shows that 100% of staff has received the required training within the last 12 months. There is on-going staff training conducted on a regular basis. Staff interviews confirm training and the training topics.

Standard 115.232 Volunteer and contractor training

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

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

Warner House requires that all contractors entering the facility are properly trained on PREA as outlined in Standard 115.232. Sign-off sheets indicate that contractors have received and understand the required training.

Standard 115.233 Resident education

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

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

Policy 115.233 Resident Education addresses that during the intake process, residents shall receive information explaining the agency's zero-tolerance policy regarding sexual abuse and sexual harassment, how to report incidents or suspicions of sexual abuse or sexual harassment, their rights to be free from sexual abuse and sexual harassment and to be free from retaliation for reporting such incidents, and regarding agency policies and procedures for responding to such incidents.

The PREA Notice is available in both English and Spanish. Additional PREA information is contained in the Resident Handbook, as well as posted throughout the facility.

Documentation shows that all residents have received the required PREA training upon their intake into the facility. Resident interviews confirm training and topics.

Standard 115.234 Specialized training: Investigations

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

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

N/A - McCall Foundation / Warner House does not conduct investigations

Standard 115.235 Specialized training: Medical and mental health care

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

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

N/A - McCall Foundation / Warner House does not have in-house medical and mental health care

Standard 115.241 Screening for risk of victimization and abusiveness

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

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

Policy 115.241 Screening for Risk of Victimization and Abusiveness requires that an assessment be made using a objective screening tool. The staff must follow the instructions on the assessment form for making this assessment by asking each resident questions about their perceived risk of being abused. Staff may also consider their own assessment of risk factors. Completed assessments must be retained with the program's daily paperwork as well as in the resident's file. 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 assessment screening considers prior acts of sexual abuse, prior convictions for violent offenses, and history of prior institutional violence or sexual abuse, as known to the agency, in assessing residents for risk of being sexually abusive.

A re-assessment is made within a set time period, not to exceed 30 days from the resident's arrival at the facility, the facility will reassess the resident's risk of victimization or abusiveness based upon any additional, relevant information received by the facility since the intake screening.

The PREA Risk Assessment screening tool takes into account the 9 criteria identified in the standard. Additionally, the policy states that residents answer questions voluntarily, and no repercussions occur if a resident declines to answer a question, or declines to disclose all relevant information.

Standard 115.242 Use of screening information

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

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

Policy 115.242 Use of Screening Information addresses a resident's assignment to appropriate housing units will take into account the results of the resident's PREA risk assessment, sexual orientation, gender identity, and any other relevant factors. If a transgender or intersex resident was assigned to the program, appropriate arrangements would be made to allow them the opportunity to shower separately from other residents. There are no dedicated facilities for the purpose placement of LGBTI residents.

Standard 115.251 Resident reporting

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

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Policy 115.251 Resident Reporting addresses resident reporting. It states that residents can privately report sexual abuse and sexual harassment, retaliation by other residents or staff for reporting sexual abuse and sexual harassment, and staff neglect or violation of responsibilities that may have contributed to such incidents by written notes, or verbal communication to a case manager, the Program Director, or the PREA coordinator. Residents also have access to a telephone and may contact the Sexual Assault Crisis Center or the police. There are five was of reporting a PREA allegation contained in the Resident Handbook. The reporting of sexual abuse or sexual harassment may remain anonymous and may be reported by third parties. This information is made available to the residents upon intake, when they are provided a PREA Pamphlet, Resident Handbook, and advised of the PREA related postings throughout the facility. Resident interviews confirm understanding of reporting procedures.

Staff is advised of their duty to report incidents of sexual abuse and sexual harassment and is provided contact information for reporting privately to the PREA Coordinator.

Standard 115.252 Exhaustion of administrative remedies

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

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

N/A - According to PREA: Avenues of Reporting PREA Allegations Policy and Procedure, sexual assaults and/or sexual harassment are not grieve-able offenses. All alleged incidents of sexual abuse and sexual harassment must be reported to staff.

Standard 115.253 Resident access to outside confidential support services

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

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

The residents at Warner House are provided with information that an outside victim advocate for emotional support and treatment services are available, and not provided at facility. The Connecticut Sexual Assault Crisis Center (CONNSACS) provides this service. This information is provided to the residents in writing through the Resident Handbook given to them during their intake. Additionally, the residents are informed that the communications with the outside service will be kept strictly confidential, however, they are made aware of CONNSACS mandatory reporting requirement.

Standard 115.254 Third-party reporting

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

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McCall Foundation / Warner House offers two ways of third-party reporting sexual abuse and sexual harassment of residents. The McCall Foundation website, www.mccall-foundation.org, provides contact information to receive third-party reports of sexual abuse and sexual harassment on behalf of residents either by phone or in writing. Additionally, the PREA pamphlet provides this information as well. Interviews with residents and staff verify that they are aware of third-party reporting.

Standard 115.261 Staff and agency reporting duties

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

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

Policy 115.261 Staff and Agency Reporting Duties addresses the requirement that 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; retaliation against residents or staff who reported such an incident; and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation.

The policy further addresses that staff is 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. Additionally, Warner House will report all allegations of sexual abuse, including third party and anonymous reports, to the supervising Parole / Probation Officer and the local authorities for further investigation. During the PREA screening, residents are made aware of their duty to report sexual abuse.

Interviews with staff confirm their understanding of their duty to report.

Standard 115.262 Agency protection duties

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

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Policy 115.262 Agency Protection Duties addresses agency protection duties, and states when the program learns by any means of notice listed in this policy or by any other means that a resident is subject to a substantial risk of imminent sexual abuse, staff must take immediate action to protect the resident. This may include consultation with the referral source (DOC), keeping potential victim and abuser separated, direct sight and sound supervision, changing housing assignments, and emotional support.

Interviews with staff confirm their understanding of protection duties.

Standard 115.263 Reporting to other confinement facilities

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

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

Policy 115.263 Reporting to Other Confinement Facilities states that upon receiving an allegation that a resident was sexually abused while confined at another facility, the Program Manager/PREA Coordinator of the program that received the allegation shall notify the head of the facility or appropriate office of the agency where the alleged abuse occurred.

This communication will occur no longer than 72 hours after the PREA Coordinator was made aware of the alleged incident.

Standard 115.264 Staff first responder duties

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

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Policy 115.264 Staff First Responder Duties and the Sexual Abuse Response Plan addresses the requirements for staff response to a PREA Incident. It states that the first responding staff members are responsible for the following: separate the victim and the alleged abuser; determine the safety of the client and, if need be, contact emergency medical services; preserve and protect any crime scene until appropriate steps can be taken to collect evidence; if the abuse occurred within a time period that allows for the collection of physical evidence, staff will request that the alleged victim(s) and/or abuser(s) not take any actions that could destroy physical evidence. This includes, but is not limited to washing; brushing teeth; changing clothes; urinating; defecating; smoking; drinking; and eating.

Interviews with staff indicated that they had been provided with this training.

Standard 115.265 Coordinated response

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

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Warner House has a written Sexual Abuse Response Plan (PREA Coordinated Response Plan) which outlines the duties of first responders,Program Manager, Staff, PREA Coordinator, Dept. of Corrections, and PREA Team. It provides for the immediate notification of law enforcement, emergency medical transport if needed, and notification to the Sexual Assault Crisis Service, if needed.

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

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

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

N/A - Warner House is Non-Unionized, Non-Profit facility and does not enter into collective bargaining agreements.

Standard 115.267 Agency protection against retaliation

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

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

Warner House provides for the response to retaliation for reporting a PREA Incident. In the event that a client or staff member a fear of retaliation, the agency shall take appropriate measures to protect that individual.

The PREA Coordinator will ensure that the alleged victim, witness, and/or staff member will feel safe during and after the conclusion of the PREA investigation. Protective measures, in case of retaliations, may include housing Changes; removal of alleged abusers from contact with victims; and emotional support services.

For at least 90 days following a report of sexual abuse, Warner House 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 shall act promptly to remedy any such retaliation.

Items the PREA team will monitor include any resident disciplinary reports, housing, or program changes, or negative performance reviews or reassignments of staff. Monitoring may continue beyond 90 days if the initial monitoring indicates a continuing need. In the case of residents, such monitoring also include periodic status checks. The agency's obligation to monitor terminates if the agency determines that the alleged allegation is unfounded.

Standard 115.271 Criminal and administrative agency investigations

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

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

N/A - McCall Foundation / Warner House does not conduct investigations.

Standard 115.272 Evidentiary standard for administrative investigations

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

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

N/A - McCall Foundation / Warner House does not conduct investigations.

Standard 115.273 Reporting to residents

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

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

Policy 115.273 Reporting to Residents mandates that at the conclusion of a PREA investigation, the PREA Coordinator provide a written notification to the alleged victim stating whether the allegation was determined to be substantiated, unsubstantiated, or unfounded. In the event of a staff on client PREA allegation, the PREA Coordinator will inform the alleged victim whenever the staff member is no longer posted within the unit; the staff member is no longer employed with the agency; the agency learns that the staff member has been indicted on a change 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.

In the event of a client on client PREA allegation, the PREA Coordinator will inform the client whenever the agency learns that the alleged abuser has been indicted on a charge related to sexual abuse within the facility; or the agency learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility.

All notifications to alleged victims will be documented by the PREA Coordinator. McCall Foundation / Warner House obligation to report under this standard will terminate if the resident is released from the agency's custody.

Standard 115.276 Disciplinary sanctions for staff

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

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

Policy 115.276 Disciplinary Sanctions for Staff states that Staff shall be subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies.

Disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) shall be commensurate with the nature and circumstances of the acts committed, the staff member's disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories.

All terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and to any relevant licensing bodies.

Standard 115.277 Corrective action for contractors and volunteers

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

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

McCall Foundation / Warner House shall ensure a prompt response to any allegation of sexual abuse or sexual harassment by a contractor or volunteer. Any substantiated allegation of sexual abuse or sexual harassment by a contractor or volunteer shall be immediate grounds for removal from the program/agency.

Any contractor or volunteer who engages in sexual abuse shall be immediately prohibited from contact with residents. Such conduct will be reported to local authorities and relevant licensing bodies as applicable. McCall Foundation / Warner House shall take appropriate remedial measures and consider whether to prohibit further contact with residents in the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or vendor.

Standard 115.278 Disciplinary sanctions for residents

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

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

Policy 115.278 Disciplinary Sanctions for Residents addresses disciplinary sanctions for residents. It states that Warner House prohibits all sexual activity between residents and may discipline residents for such activity. It will not, however, deem such activity to constitute sexual abuse if it determines that the activity is not coerced.

Residents shall be subject to disciplinary sanctions pursuant to a formal disciplinary process following a finding that the resident engaged in resident-on-resident sexual abuse or following a criminal finding of guilt for resident-on-resident sexual abuse. Sanctions shall be 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.

The disciplinary process shall consider whether a resident's mental disabilities or mental illness contributed to his behavior when determining what type of sanction, if any, should be imposed.

All disciplinary sanctions for residents are determined by the referral agency, DOC.

Standard 115.282 Access to emergency medical and mental health services

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

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

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 health practitioners according to their professional judgment.

Warner House does not employ medical and mental health staff and will therefore rely on the services of qualified outside providers for these services for residents as necessary. Currently, McCall Foundation / Warner House has an MOU with CONNSACS / Susan B. Anthony Project to provide these services.

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

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

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

McCall Foundation / Warner House do not employ medical or mental health care staff. All residents in need of such care shall be referred to local providers for assistance.

Warner House refers residents in need of medical and mental health care, pertinent to sexual abuse, to local providers who are PREA compliant such as Charlotte Hungerford Hospital. The program, by policy,attempts to secure treatment services for victims at no cost, regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident.

Warner House also attempts to refer all known resident on resident abusers for a mental health evaluation and/or treatment within 30 days of learning of such abuse history.

Standard 115.286 Sexual abuse incident reviews

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

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

Policy 115.286 Sexual Abuse Incident Reviews requires that a sexual abuse incident review is conducted 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. Reviews shall occur within 30 days of the conclusion of the investigation.

The review team includes upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners if available and applicable.

The PREA Incident Review Team will assess if was the incident motivated by race, ethnicity, gender identity, gang affiliation, other group dynamics; does the area contain physical barriers that may enable further abuse; is the staffing adequate for the time period and activities at the time of the incident; and is additional video monitoring or staff deployment to that area needed in the area or during the activity. The incident review report contains recommendations based on the findings from the above considerations, recommendations of DOC, and/or recommendations of the DOC report, if applicable.

Standard 115.287 Data collection

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

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

McCall Foundation / WarnerHouse collects accurate uniform data for every allegation of sexual abuse in its programs using a standard instrument and set of definitions. The BJS Survey of Sexual Violence adult incident form is utilized as well as an internal reporting forms.

The data collected aggregates the incident-based sexual abuse data at least annually. The incident-based data collected includes, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice. McCall Foundation / Warner House maintains, reviews, and collects data as needed from all available incident-based documents including reports, investigation files, and sexual abuse incident reviews.

Standard 115.288 Data review for corrective action

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

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

The McCall Foundation reviews data collected and aggregated in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training. This includes identifying problem areas, taking corrective action on an ongoing basis, and preparing an annual report of its findings and corrective actions for each facility, as well as the agency as a whole. The report includes a comparison of the current year's data and corrective actions with those from prior years and provides an assessment of the agency's progress in addressing sexual abuse. The report is approved by the agency head and made readily available to the public through its website.

Standard 115.289 Data storage, publication, and destruction

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

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

The McCall Foundation ensures that data collected pursuant to Standard 115.287 are securely retained. PREA data is entered into the McCall Foundation's computer network by a member of the PREA team. This system is password protected, housed within a secure network, and closely monitored by the agency's IT Department.

The McCall Foundation makes all aggregated sexual abuse data from its programs readily available to the public at least annually via its website. Before making aggregated sexual abuse data publicly available, all personal identifiers are removed.

The McCall Foundation shall maintain sexual abuse data collected pursuant to Standard 115.287 for at least 10 years after the date of the initial collection unless Federal, State, or local law requires otherwise. The agency's IT Director will securely dispose of the PREA data once it exceeds the 10 year mark.

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.

Kevin M. Maurer — 07/02/2014

Auditor Signature — Date