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

☐ **Interim** ☒ **Final**

Date of Interim Audit Report: January 24, 2021 ☐ **N/A**

Date of Final Audit Report: **June 09, 2021**

Auditor Information			
Name: Michael B. Vitiello		**Email:** preaauditorme@gmail.com	
Company Name: The Nonantum Group LLC			
Mailing Address: Post Office Box 7026		**City, State, Zip:** Ocean Park, ME 04063	
Telephone:		**Date of Facility Visit:** December 9-10, 2020	
Agency Information			
Name of Agency: Pharos House			
Governing Authority or Parent Agency *(If Applicable)*:			
Physical Address: 5 Grant Street		**City, State, Zip:** Portland, ME 04101	
Mailing Address: same		**City, State, Zip:** same	
The Agency Is:	☐ Military	☐ Private for Profit	☒ Private not for Profit
☐ Municipal	☐ County	☐ State	☐ Federal
Agency Website with PREA Information: **www.pharoshouse.org**			
Agency Chief Executive Officer			
Name: James Vincent			
Email: jvincent@pharoshouse.org		**Telephone:** (207) 774-6021	
Agency-Wide PREA Coordinator			
Name: Lisa Nash			
Email: lnash@pharoshouse.org		**Telephone:** (207) 774-6021	
PREA Coordinator Reports to: James Vincent, Executive Director		**Number of Compliance Managers who report to the PREA Coordinator:** **0**	

Facility Information			
Name of Facility: Pharos House			
Physical Address: 5 Grant Street		**City, State, Zip:** Portland, ME 04101	
Mailing Address (if different from above): same		**City, State, Zip:** same	
The Facility Is:	☐ Military	☐ Private for Profit	☒ Private not for Profit
☐ Municipal	☐ County	☐ State	☐ Federal
Facility Website with PREA Information: www.pharoshouse.org			
Has the facility been accredited within the past 3 years? ☐ Yes ☒ No			
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): ☐ ACA ☐ NCCHC ☐ CALEA ☐ Other (please name or describe: ☒ N/A			
If the facility has completed any internal or external audits other than those that resulted in accreditation, please describe: Federal Bureau of Prisons (BOP) contract monitoring audits.			
Facility Director			
Name: James Vincent			
Email: jvincent@pharoshouse.org		**Telephone:** (207) 774-6021	
Facility PREA Compliance Manager			
Name: Lisa Nash			
Email: lnash@pharoshouse.org		**Telephone:** (207) 774-6021	
Facility Health Service Administrator ☒ N/A			
Name:			
Email:		**Telephone:**	
Facility Characteristics			
Designated Facility Capacity:		20	

Current Population of Facility:	18
Average daily population for the past 12 months:	18
Has the facility been over capacity at any point in the past 12 months?	☐ Yes ☒ No
Which population(s) does the facility hold?	☐ Females ☐ Males ☒ Both Females and Males
Age range of population:	18-70
Average length of stay or time under supervision	174 days
Facility security levels/resident custody levels	Community
Number of residents admitted to facility during the past 12 months	91
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for *72 hours or more*:	75
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for *30 days or more:*	16
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)?	☒ Yes ☐ No
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):	☒ Federal Bureau of Prisons ☐ U.S. Marshals Service ☐ U.S. Immigration and Customs Enforcement ☐ Bureau of Indian Affairs ☐ U.S. Military branch ☐ State or Territorial correctional agency ☐ County correctional or detention agency ☐ Judicial district correctional or detention facility ☐ City or municipal correctional or detention facility (e.g. police lockup or city jail) ☐ Private corrections or detention provider ☐ Other - please name or describe: ☐ N/A
Number of staff currently employed by the facility who may have contact with residents:	15
Number of staff hired by the facility during the past 12 months who may have contact with residents:	4
Number of contracts in the past 12 months for services with contractors who may have contact with residents:	0
Number of individual contractors who have contact with residents, currently authorized to enter the facility:	0
Number of volunteers who have contact with residents, currently authorized to enter the facility:	0

Physical Plant	
Number of buildings: **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.**	1
Number of resident housing units: **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 "housing unit" 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.**	0
Number of single resident cells, rooms, or other enclosures:	2
Number of multiple occupancy cells, rooms, or other enclosures:	8
Number of open bay/dorm housing units:	0
Does the facility have a video monitoring system, electronic surveillance system, or other monitoring technology (e.g. cameras, etc.)?	☒ Yes ☐ No
Has the facility installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology in the past 12 months?	☒ Yes ☐ No

Medical and Mental Health Services and Forensic Medical Exams	
Are medical services provided onsite?	☐ Yes ☒ No
Are mental health services provided onsite?	☐ Yes ☒ No
Where are sexual assault forensic medical exams provided? Select all that apply.	☐ Onsite ☒ Local hospital/clinic ☐ Rape Crisis Center ☐ Other (please name or describe:)

Investigations	
Criminal Investigations	
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:	0
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.	☐ Facility investigators ☐ Agency investigators ☒ An external investigative entity
Select all external entities responsible for CRIMINAL INVESTIGATIONS: Select all that apply (N/A if no external entities are responsible for criminal investigations)	☒ Local police department ☐ Local sheriff's department ☐ State police ☒ A U.S. Department of Justice component ☐ Other (please name or describe:) ☐ N/A
Administrative Investigations	
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?	2
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	☒ Facility investigators ☐ Agency investigators ☒ An external investigative entity
Select all external entities responsible for ADMINISTRATIVE INVESTIGATIONS: Select all that apply (N/A if no external entities are responsible for administrative investigations)	☐ Local police department ☐ Local sheriff's department ☐ State police ☒ A U.S. Department of Justice component ☐ Other (please name or describe) ☐ N/A

Audit Findings

Audit Narrative (including Audit Methodology)

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 onsite, 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 Pharos House contacted this United States Department of Justice (USDOJ) – Certified PREA Auditor via the Auditor Contact tool on the PREA Resource Center website, in July of 2020 to begin the discussion of what the process would be to conduct a PREA audit of this Community Confinement facility located in Portland, Maine. This auditor had conducted the previous (initial) audit for this facility in 2017. The auditor submitted an audit proposal, and the facility returned a signed contract on October 14, 2020. The contract called for the audit to involve a lead auditor and an associate auditor, with the onsite portion to be conducted on December 9-10, 2020. Due to scheduling conflicts the associate auditor did not participate in the audit; this auditor performed all the interviews and document review for this audit. There were no additional services or fees stipulated, outside of those directly associated with this audit.

The auditor sent the facility PREA Audit Notices in English and Spanish, which were posted on October 27th, six weeks prior to the onsite audit. The facility sent the auditor pictures of the audit notices posted in the facility. The notices contained the auditor's name and mailing address for any individual to provide information relevant to the PREA audit. The notice stated that information would remain confidential unless:
(1) when a person was in immediate danger to her/himself,
(2) allegations of suspected child abuse, neglect, or maltreatment,
(3) legal proceedings where information has been subpoenaed by a court of appropriate jurisdiction,
(4) if the information was requested by the United States Department of Justice or the PREA Management Office.

The auditor did not receive any communications regarding the audit of Pharos House.

Pharos House underwent a PREA audit on March 20-22 and 31, 2017. The Final Audit Report was posted to the Pharos House website and it was reviewed by this auditor as part of the Pre-Onsite Phase of this audit. During all phases of the audit facility staff were available to the auditor by phone and email for questions as well as document and information requests. This audit took place during the global pandemic of COVID-19. This pandemic presented unique circumstances during the audit, to include reduced volunteer, and visitor access to the facility, required illness symptom screenings upon entrance to the facility, social distancing during staff and resident interviews and mandatory facial coverings (masks) for the auditor and all occupants of the facility. There was one resident who had recently arrived who was placed in a room by himself for a mandatory 14-day quarantine. The auditor reviewed facility records and confirmed that this resident had received the PREA orientation material immediately upon his arrival. There was no reassessment required due to his recent arrival, although the facility was aware of the requirement to conduct one within 30 days.

The auditor requested and received a complete list of all residents in the facility on the first day of the audit. The facility count was 17 (15 males and 2 females) at the start of the audit. The auditor randomly selected residents from each floor of the facility for interviews.

Pharos House requested to utilize paper audit instruments from the PREA Resource Center (PRC) for this audit. The auditor downloaded the Community Confinement audit tools from the PRC website.

The auditor and the PREA Coordinator (PC) conducted an audit kickoff phone call on October 23rd. During the call, the auditor reviewed the goals and purpose of the audit, the logistics for auditor travel (no lodging required), the process for additional email and telephone communication (if necessary), the timeline for the facility to complete and send the Pre-Audit Questionnaire (PAQ) to the auditor and the process for Corrective Action (if necessary). The PC was identified as the primary point of contact with the Executive Director serving as the secondary point of contact. The auditor notified the PC that there was a PREA Process Map available if requested.

Pharos House prepared a flash drive which contained the completed PAQ, the facility's Mission Statement, the facility PREA policy, lesson plans used for staff PREA training, a copy of the Memorandum of Understanding with the Sexual Assault Response Services of Southern Maine (SARSSM) and a letter from the City Attorney for Portland, Maine on behalf of the Portland Police Department, confirming that the agency would respond and investigate incidents of sexual abuse at Pharos House. The attorney also confirmed that the police department employs universal evidence collection methods consistent with the requirements of the PREA Standards.

The auditor reviewed the information contained on the flash drive and identified questions for the PREA Coordinator (PC). The auditor contacted the PC on December 3rd and discussed issues identified during the review of the PAQ and confirmed audit logistics. Prior to the onsite portion of the audit, the auditor downloaded the *PREA Specialized Inmate Identification Form* and the *PREA Specialized Staff Identification Form* from the PRC Auditor Training and Resource Portal. These templates were customized for the facility by editing the targeted categories of interviews that applied to this facility. The categories included for resident interviews were: *Residents with Disabilities, Residents who are Limited English Proficient* (LEP)*, and Residents who Identified as Lesbian/Gay/Bisexual/Transgender/Intersex* (LGBTI). The categories included for staff interviews were: *First Responders* (to an incident of Sexual Abuse*), Intake Staff*, *Designated Staff Members Charged with Monitoring Retaliation*, *Staff on the Incident Review Team, Volunteers & Contractors Who May Have Contact with Residents, Investigative Staff, Staff who Perform Screening for Risk of Victimization and Abusiveness, Administrative/Human Resources Staff,* and *Intermediate of Higher Staff.* The lists were sent to the facility on December 4th and were completed and returned on December 8th. This streamlined the auditor's identification and selection of specialized staff and residents for interviews. The auditor also notified the facility that the following information would need to be available on the start of the onsite audit:

- ❑ Complete Staff Roster
- ❑ Incident reports from the prior 12 months
- ❑ Grievances and allegations made in the prior 12 months
- ❑ Reported allegations of SA / SH in the prior 12 months

This requested information was provided to the auditor upon arrival on December 9th.

The auditor contacted Community Based Organizations to obtain information that they were aware of regarding incidents of Sexual Abuse and Sexual Harassment at the Pharos House, including Just Detention International (JDI), a United States-based international health and human rights organization that works to end sexual abuse of those in detention. JDI reported that they had no record of receiving reports regarding Sexual Abuse or Sexual Harassment involving the Pharos House. The facility has a current Memorandum of Understanding (MOU) with the Sexual Assault Response Services of Southern Maine (SARSSM) to provide counseling, victim advocacy and support to any resident of the Pharos House, without cost to the resident. The auditor emailed SARSSM to confirm the MOU and the Executive Director responded and confirmed the existence of the MOU and the availability of support and advocacy services to residents of Pharos House.

During the Pre-Onsite Phase, the auditor discovered that the facility was using a local rape crisis center as their external reporting entity. The PREA Resource Center published an FAQ to their website on February 06, 2020, which provided guidance that "generally" local rape crisis centers are not appropriate entities to serve as the External Reporting Entity. The auditor advised the PREA Coordinator of this guidance and assisted Pharos House with identifying a qualified external entity to accept PREA reports. Prior to this report being issued, an MOU was established with an external entity. Standard #155.251 (b) was still cited for

Corrective Action so that all PREA program documents for staff and residents could be updated with the name and contact information for the new entity. The auditor also reviewed the facility's PREA policy and identified a deficiency relating to Standard #115.222 (c), which requires agencies who do not conduct their own criminal investigations of incidents of sexual abuse, which Pharos House does not, to describe the responsibilities for both the agency and the investigating entity. As a result, this Standard was included in Corrective Action.

On Wednesday morning, December 9th, the auditor arrived at the facility to conduct the site review. The auditor rang the doorbell and identified himself through an intercom and was granted access to the facility. Immediately upon entering, the auditor was required to produce picture identification and had a temperature check as part of the facility's COVID-19 screening process. The auditor then signed into the facility's visitor log and was escorted to the conference room located in the basement, which served as the auditor's workspace and private interview room during the audit. The auditor held an in-brief here with the Facility Director, and the PREA Coordinator. The auditor reviewed the purpose of the audit, the audit process, and the anticipated schedule of activities during the audit. The auditor was escorted through the house by the PREA Coordinator (PC) for the site review, which included a complete walkthrough of the entire facility. All spaces in the facility were observed except a resident room on the second floor which housed an individual who was on quarantine as a precaution against COVID-19. During the site review, the auditor observed the audit notice posted in several areas of the facility and the facility's PREA Reporting Notice for residents posted in common areas. This posting included the toll-free telephone number for the National Sexual Assault Hotline and the local rape crisis center affiliate, Sexual Assault Services of Southern Maine (SARSSM). On the first floor adjacent to the entrance, the facility has PREA information posted which includes contact information for SARSSM.

There were no intakes during the onsite audit, therefore, the auditor did not observe an intake, initial PREA assessment or the PREA orientation of a new arrival. Additionally, there were no individuals who required a reassessment while the auditor was onsite. During their interviews, Monitors explained the room assignment process, where rooms are tentatively assigned by the Facility Director and then confirmed or revised based upon the information received during the resident's intake and screening processes. Interviews with staff confirmed that staff had the authority and conducted changes to room assignments when necessary. All resident PREA orientation acknowledgement forms, risk screening information and the documentation of the facility's service referrals for emotional support and victim advocacy to residents who disclose prior sexual victimization, are kept in locked file cabinets inside the locked office of the PREA Coordinator. Staff interviews confirmed that only authorized staff may access these records. Security staff, who have the title of Monitor, conduct the initial PREA orientation to new residents on their first day at the facility and then show them a PREA orientation video within 72 hours. Grievance forms are available to residents by asking any staff member. Once completed, the grievance may be handed to a staff member or placed in a locked mailbox in the hallway of the foyer on the first floor. There is one payphone in the basement and there is a "house phone" that residents can use. They make a request to the Monitor on duty and can take the phone into another room to complete a call privately. Monitors do not require the residents to explain the use of the phone or to identify the party being called.

The facility is a duplex home that has been converted into a single living space, however, two separate stairwells were left intact. The auditor started the walkthrough on the third floor and observed the four resident rooms located adjacent to the top of the stairwells, each room has entrance door. One of these rooms is the only female room in the house, with occupancy for two residents and a private bathroom with toilet and shower. The auditor then walked down the stairs to the second floor, which consists of six male resident rooms and two bathrooms; one located adjacent to each stairwell. Each bathroom has a sink, shower, and toilet. During resident interviews, a resident expressed a concern about having another resident walk into the bathroom when they were getting changed. I brought this issue to the attention of the PREA Coordinator. The auditor recommended the installation of a second shower curtain in the bathroom which would create a changing area hidden from view of the entrance door was opened. The facility agreed with the recommendation and committed to installing it. The auditor then walked downstairs to the first floor and visited each space, which consists of: front entrance foyer, monitor's office, living room with resident

computer, dining room with adjacent resident bathroom, kitchen, Executive Director's office, Case Manager work area and resident records storage, two Case Manager offices and a staff-only bathroom. The auditor then went to the basement which includes the conference room that was designated as the auditor's private workspace and interview room, a resident recreation and television room, resident laundry equipment, mechanical spaces for boiler and HVAC equipment, oil storage tank, food storage room and the PREA Coordinator's office. The basement contains two exits to the back yard of the facility. One of these doors has been designated for use when conducting an intake and COVID-19 screening for new residents. New residents were previously allowed to enter the facility through the front entrance on the first floor. With this change, the facility installed an additional camera in the basement and in the back yard facing the entrance door, so that there would not be a blind spot during the intake process.

Audit notices and resident reporting posters were observed in common areas throughout the facility. All showers had shower curtains installed to limit viewing inside the shower areas. The camera coverage in the facility allows the security staff to see all areas of the facility. The facility staffing plan calls for one male and one female Monitor on duty at all times. Monitor vacancies are supplemented by full-time staff working overtime, part-time staff, and Case Managers. This ensures that pat searches of residents arriving from work or out of facility programming can be performed by the same gender and that there are no limitations to accessing programs because of a lack of gender-appropriate staff. If there is a vacancy for either gender, residents can enter the facility and to leave to access programming without a pat search. Residents are required to empty the contents of all their pockets and then their coats and bags (if any) are searched. The facility is equipped with 20 cameras which record to a digital drive capable of storing 30 days of activity. There are no medical or mental health services provided onsite. Residents can make appointments and see providers in the community. After the completion of the site review, the auditor returned to the conference room and reviewed the resident lists to select residents for interviews.

The auditor used the conference room to conduct private interviews of all residents and staff. The auditor interviewed 12 of the 15 staff employed at Pharos House. The breakdown for staff interviews consisted of the Executive Director, the PREA Coordinator, 2 Case managers, the Food Service Manager, all three full-time Monitors, both Lead Shift Monitors and two part-time Monitors. The 7 Monitors interviewed were the only Monitors working on shift during the audit. In several instances, multiple categories of specialized staff interviews were represented by a single staff member. This can occur in smaller facilities, where management staff "wear more than one hat".

Table 3 of the *PREA Auditor Handbook (p.52)* lists the required number of resident interviews for a Community Confinement facility with 0-50 residents as 10; 5 random and 5 targeted. The facility housed residents who met criteria for five targeted interviews, (1) *Residents who Identify as Lesbian, Gay, Bisexual,* (2) *Residents Who Reported Sexual Victimization During Risk Screening,* (3) *Residents Who Reported Sexual Victimization During Risk Screening*, (4) *Residents with a Physical Disability*, and (5) *Residents who Identify as Transgender or Intersex.* Ten residents were interviewed, five who represented each of the required target categories and five random residents.

The auditor reviewed the records for all 17 residents, which contained documentation of residents' PREA orientation, a Resident Acknowledgement of Prohibition Against Sexual Misconduct signed by the resident, documentation that the residents watched the PREA orientation video and the completed Risk Assessment form for risk of victimization or of abusiveness and finally a copy of the required Reassessment for risk of victimization or risk of abusiveness. The auditor's review revealed that 8 of the 17 (47%) residents did not have their initial assessment completed within the required 72 hours (see Standard #115.241) and 17 of 17 residents (100%) did not have their reassessment completed within 30 days as required (see Standard #115.241).

The auditor reviewed the personnel files for all 15 employees. All had a criminal background check completed by the US Federal Bureau of Prisons (BOP). Nine of the 15 employees were not asked to disclose prior acts of sexual abuse or sexual harassment, termination from employment because of sexual abuse or sexual harassment or resignations after receiving notice of or pending an investigation for acts of

sexual abuse or sexual harassment. There were no new employees hired who had prior institutional employment. There were two promotions for Lead Shift Monitor positions that occurred during the audit period, where the promotional process did not require employees to disclose prior acts of sexual abuse or sexual harassment in the community or in an institutional setting, allowing the facility to consider this information during the promotional process, as required by Standard (see PREA Standard #115.217).

The auditor reviewed the training records for all employees and identified one part-time employee who had not received the required PREA training. This issue was brought to the attention of the PREA Coordinator and the employee was provided the training within two weeks of the onsite audit. All employees have now received their initial training and the auditor reviewed documentation which confirmed that employees had received their required refresher training throughout the year (usually during house staff meetings). There were no grievances relating to sexual abuse or sexual harassment. Incident reports were included in the investigation files for three PREA incidents during the audit period. In 2019 there was one substantiated incident of resident-on-resident sexual abuse which included sexual harassment and in 2020 there was one unfounded incident of staff-on-resident sexual abuse and one unsubstantiated incident of resident -on-resident sexual harassment. There were no medical or mental health staff to interview or corresponding training files to review as no such staff work onsite.

On Thursday, December 10th at 3:00 pm (EST), the auditor conducted an exit briefing with the Facility Director and the PREA Coordinator. Preliminary details of the onsite audit were reviewed. The auditor informed all participants that final compliance determinations will be made during the Post-Onsite phase of the audit.

Corrective Action:

115.217, ***Hiring and Promotion Decisions***
Provision ‘f’ of this Standard requires the agency to screen 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. At the time of the Onsite Audit, these practices were not fully implemented.

115.222, ***Policies to Ensure Referrals of Allegations for Investigations***
When an agency does not conduct their own criminal investigation, provision ‘C’ of Standard #222 requires the agency to describe the responsibilities of the agency and the investigating entity in their policy detailing investigations. The agency is required to publish this policy on their website. The auditor discussed this issue with the agency and submitted draft policy language for consideration. At the time of the Interim Report, the agency had not yet modified its policy and posted it to their website.

115.233, ***Resident Education***
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. At the time of the Onsite Audit documentation of Resident Education was missing for three (3) residents.

115.241, ***Screening for Risk of Victimization and Abusiveness***
All residents shall be assessed during an intake screening and upon transfer to another facility for their risk of being sexually abused by other residents or sexually abusive toward other residents. Intake screening shall ordinarily take place within 72 hours of arrival at the facility. 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. At the time of the Onsite Audit, 8 of 17 residents did not have their Intake Screening completed

within 72 hours and all 17 of the residents had their reassessment completed outside of the 30-day time limit.

115.251, ***Resident Reporting***
The agency shall also inform residents of at least one way to report abuse or harassment to a public or private entity or office that is not part of the agency (External Reporting Entity) and that is able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials, allowing the resident to remain anonymous upon request. At the time of the Onsite Audit, the External Reporting Entity identified by the facility was a Rape Crisis Center, which has been flagged by the PREA Resource Center via its FAQ section (published February 2020), as an ineligible party to serve in this capacity.

115.263, ***Reporting to Other Confinement Facilities***
Upon receiving an allegation that a resident was sexually abused while confined at another facility, the head of the facility that received the allegation shall notify the head of the facility or appropriate office of the agency where the alleged abuse occurred. No later than 72 hours after receiving the allegation. At the time of the Onsite Audit the auditor identified an instance where notification was made to another facility outside of the 72-hour timeframe.

UPDATE – CORRECTIVE ACTION

The auditor worked with the Facility Director and the PREA Coordinator for several months after the Interim Report was issued. The facility corrected the noted deficiencies and provided documentation to the auditor. At the time of this Final Report, the facility has demonstrated substantial compliance with all Standards.

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.

The Pharos House is a halfway house in Portland, Maine that has been operated as a non-profit organization for approximately 33 years. The house is a duplex that has been converted to a single space. It sits on a residential street in the city's Parkside neighborhood, close to the city center, which allows residents to walk to most areas of the city for employment, personal services, medical care, and shopping. Currently, the house is occupied exclusively with residents from the United States Federal Bureau of Prisons (BOP). These residents are nearing the end of their federal sentence and are transitioning back into the community in Maine. Pharos House is the only halfway house in Maine for these federal inmates. In addition to the facility beds, Pharos House operates a Home Confinement program for individuals who are approved to leave the house and reside in the community. Home Confinement can also be used by the US Probation agency as an intermediate sanction for individuals under their supervision who may require an increase ("step up") in their level of community supervision. The individuals on Home Confinement were not residing at the facility and were excluded from this PREA audit.

The facility has a basement and three floors, with staff offices, resident common areas and the kitchen with a male bathroom containing a sink, toilet, and shower, located on the first floor. The security office is located on the first floor and houses the security surveillance system and camera monitors. Resident rooms located on the second and third floors which consist of ten resident living rooms with a total capacity for 20 residents: two rooms with 3 male beds each, five rooms with 2 male beds each, two single bed male rooms and one female room with two beds. The basement contains a resident recreation room (TV lounge), laundry equipment and a pay phone.

The Average Daily Population (ADP) for the previous year was 18. On the first day of the audit there were 17 residents in the house, 15 males and 2 females. There are a total of 15 staff members, with 2 Lead Shift Monitors, 3 full-time Shift Monitors and 5 part-time Shift Monitors. There are no volunteers, contractors or interns operating at the facility. The facility is a community security level without a secure perimeter. There is a video monitoring system with 20 cameras that are digitally recorded onto a hard drive and saved for approximately 30 days. Residents access programming via telehealth video conferencing or by making appointments with providers in the community. There are no in-person services provided at the facility.

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.*

Standards Exceeded

Number of Standards Exceeded: 0

List of Standards Exceeded:

Standards Met

Number of Standards Met: 41

Standards Not Met

Number of Standards Not Met: 0

List of Standards Not Met:

PREVENTION PLANNING

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

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

115.211 (a)

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

115.211 (b)

- Has the agency employed or designated an agency wide PREA Coordinator? ☒ Yes ☐ No
- Is the PREA Coordinator position in the upper level of the agency hierarchy? ☒ Yes ☐ No
- Does the PREA Coordinator have sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards in all of its facilities? ☒ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making the compliance determination:

Documents:

1. Pharos House Pre-Audit Questionnaire (PAQ)
2. Pharos House Policy: *Staff and Resident Sexual Abuse and Sexual Harassment (PREA)*
3. Pharos House Organizational Chart

Interviews:

1. Pharos House Executive Director
2. Pharos House PREA Coordinator

Site Review Observations:

1. PREA posters within the facility

Findings:

Pharos House policy *Staff and Resident Sexual Abuse and Sexual Harassment* states that the facility will comply with the Prison Rape Elimination Act (PREA). The Policy also declares the facility's "zero tolerance" policy towards sexual abuse and sexual harassment. Section I, *Policy* (*p.*1) states:

In compliance with PREA, Pharos House has a zero-tolerance stance towards all forms of sexual abuse and sexual harassment and is applicable to residents, staff, volunteers, visitors, and contractors. The zero-tolerance policy includes education, prevention, detection and responding to sexual abuse and sexual harassment incidents immediately. All residents are prohibited from engaging in sexual contact with each other. All sexual contact between residents is deemed to be non-consensual and consent is not an affirmative defense, due to the custodial status of residents. Pharos House strictly prohibits any sexual contact between staff and residents and expects staff to keep professional boundaries in all their interactions with residents. Sexual contact between staff and residents is deemed to be non-consensual under all circumstances. Consent is not an affirmative defense to sexual contact between staff and resident, due to the custodial status of residents, and the unequal nature of the relationship.

Swift corrective action will occur with residents, staff, volunteers, visitors, and contractors who violate this policy.

This Policy details the facility's approach to implementing the PREA standards and preventing, detecting, and responding to allegations and incidents of sexual abuse and sexual harassment. contains definitions of prohibited behaviors regarding sexual abuse and sexual harassment for Pharos House employees, facility contractors and volunteers and residents (*p.1*).

Pharos House employs a part-time PREA Coordinator who conducts staff training, reviews PREA policies and forms, investigates incidents of sexual abuse and sexual harassment and keeps the records and data required by local policy and PREA Standard. The PREA Coordinator is identified in the Pharos House organizational chart.

Interviews Executive Director and the PREA Coordinator (PC), confirmed that the PC has sufficient time, resources, and authority to develop, implement and oversee the facility's efforts to comply with the PREA standards. These two interviews established that although the position is part-time, there are no restrictions in the number of hours or the payroll costs for the PREA Coordinator to work in support of the facility's PREA program. Indeed, during spikes in workload for specific events, such as preparation for annual staff training or working to investigate a PREA case, the PREA Coordinator is allowed to work as many hours as necessary. The PREA Coordinator explained to the auditor how Pharos House utilizes the PREA Resource Center (PRC) website to obtain additional information on standards, such as the PRC's publication of "Standard in Focus" which is a targeted review of an individual standard as well as the Frequently Asked Questions (FAQ) section of the website to learn of interpretation clarifications on standards. Additionally, the website is used to access information to deliver staff training and resident education.

Pharos House demonstrated to the auditor that their zero-tolerance policy permeates the entire facility culture. Their allocation of resources and efforts to implement and monitor compliance with the PREA standards meet the minimum requirements of this standard.

Based upon this analysis, the auditor finds the facility is substantially compliant with this standard.

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

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

115.212 (a)

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

115.212 (b)

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

115.212 (c)

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

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making the compliance determination:

Documents:

1. Pharos House Pre-Audit Questionnaire (PAQ)
2. Pharos House Policy: *Staff and Resident Sexual Abuse and Sexual Harassment*
3. US Federal Bureau of Prisons *Notice to Proceed* (contract authorization) to Pharos House

Interviews:

1. Pharos House Executive Director
2. Pharos House PREA Coordinator

Findings:

Pharos House is operated by Pharos House, Incorporated, a private nonprofit that has a contract with the Federal Bureau of Prisons (FBOP) to house prisoners who are transitioning back into the community at the end of their federal sentence. The facility houses individuals in a community setting and also supervises residents who participate in Home Confinement. A review of the Scope of Work contract with the FBOP confirmed that Pharos House is required to adopt and follow the PREA standards. This facility does not contract or board residents out to any other facilities. There was no Contract Administrator to interview because Pharos House does not contract out for the confinement of its residents.

Based upon this analysis, the auditor finds the facility is substantially compliant with this standard.

Standard 115.213: Supervision and monitoring

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

115.213 (a)

- Does the 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: The physical layout of each facility? ☒ 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 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

115.213 (b)

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

115.213 (c)

- In the past 12 months, has the facility assessed, determined, and documented whether adjustments are needed to the staffing plan established pursuant to paragraph (a) of this section? ☒ Yes ☐ No
- In the past 12 months, has the facility assessed, determined, and documented whether adjustments are needed to prevailing staffing patterns? ☒ Yes ☐ No
- In the past 12 months, has the facility assessed, determined, and documented whether adjustments are needed to the facility's deployment of video monitoring systems and other monitoring technologies? ☒ Yes ☐ No
- In the past 12 months, has the facility assessed, determined, and documented whether adjustments are needed to the resources the facility has available to commit to ensure adequate staffing levels? ☒ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

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

The following evidence was analyzed in making the compliance determination:

Documents:

1. Pharos House Pre-Audit Questionnaire (PAQ)
2. Pharos House Policy: *Staff and Resident Sexual Abuse and Sexual Harassment (PREA)*
3. Pharos House Employee Handbook
4. Pharos House Staffing Plan Report (used internally to document discussion of staffing issues)
5. Facility Floor Plan with Camera Locations Marked
6. Pharos House PREA Annual PREA Compliance Report

Interviews:

1. PREA Coordinator
2. Agency Head Designee
3. Pharos House Facility Director
4. Pharos House Lead Shift Monitors (two)

Site Review Observations:

1. Security staff on duty
2. Video monitoring system and camera locations

Pharos House policy *Staff and Resident Sexual Abuse and Sexual Harassment* states (*p.6-7*):

Procedure B: Administration/Staffing
1.The program has developed a staffing plan that provides for expected levels of program supervision and monitoring, to ensure that the facility is safe and secure.
2.Video monitoring is also used to monitor and supervise residents in common areas and provides additional protection against sexual abuse
a. All staff are trained in how to use the video monitoring system.
b. The PREA Compliance Manager or his/her designee is responsible for having all video recorded information that covers the period of 24 hours before and after any alleged sexual assault.
c. Recorded video is kept for 90 days before being written over.
3. Once a year, during the budget preparation period, the staffing plan is reviewed to assess for any necessary adjustments:
a. in the staffing plan,
b. in prevailing staffing patterns,
c. with the deployment of video monitoring systems and
d. with other monitoring practices or the allocation of facility resources to commit to the staffing plan to ensure PREA compliance.
e. if a deviation ever occurs in the staffing plan, it is documented and the reason for noncompliance is justified.

The auditor interviewed the Executive Director, the PREA Coordinator (PC) and both Lead Shift Monitors who each discussed the facility's staffing plan and confirmed their understanding of the intent of the PREA

standards and how sexual safety considered when reviewing the facility's physical plant and staffing plan. Pharos House's contract with the federal government requires them to develop, propose and upon approval, implement a staffing plan to monitor residents from the Federal Bureau of Prisons. According to the interview with the PREA Coordinator, when Pharos House is developing a facility staffing plan, consideration is given to the physical layout including *blind spots*, the type of residents that are going to be supervised (i.e., sex offenders, residents at risk for sexual abusiveness), and any other relevant factors, such as the demographics of the population (i.e., male versus female). The Executive Director confirmed during an interview that the facility's annual review of the staffing plan considers incidents of sexual abuse and sexual harassment including the results of any investigations (i.e., substantiated versus unsubstantiated) to identify if modifications to the physical plant, video monitoring systems or to the staffing plan are required. The Executive Director also confirmed that he reviews the monthly facility schedule to assess compliance with the staffing plan. Interviews with the Executive Director and the PC, who each serve on the Incident Review Team, confirmed that the staffing plan and the physical plant are reviewed and discussed within the context of an incident's review. The PAQ revealed that there was one allegation in 2019 and two allegations in 2020 of sexual abuse and sexual harassment during the audit period. The facility's minimum staffing plan is always to have one male and one female security staff member on duty. The completed PAQ stated that there were consistent deviations from the facility's staffing plan. Deviation is documented on monthly reporting forms, which were provided to the auditor during the Pre-Onsite Phase. During the onsite audit, the auditor observed the staffing plan being followed on each of the three 8-hour shifts and reviewed random monthly facility schedules, which demonstrated that the facility attempted to always provide one male and one female staff member on duty. The facility was in the process of hiring additional staff to fill vacancies and stabilize staffing deployment. The expectation for on duty staffing of one male and one female was verified by the auditor's interviews of random facility staff. The facility submitted electronic files containing documents as part of the PAQ submission. This included a copy of the most-recent PREA Annual Compliance Report. This form demonstrated that the Facility Director, both Assistant Directors and a Case Manager reviewed staffing plans, locations of video monitoring technology, and PREA incidents during the previous year. The Report did not identify the need to modify the staffing plan or the video monitoring system.

The facility disclosed and interviews confirmed deviations from the staffing plan. The auditor reviewed the intent of the PREA Standards regarding staff supervision and monitoring to ensure the sexual safety of residents with the Executive Director and the PREA Coordinator. The facility and its Board of Directors continue to work to recruit and hire qualified candidates for the position of Shift Monitor.

Based upon this analysis, the auditor finds the facility is substantially compliant with this standard.

Standard 115.215: Limits to cross-gender viewing and searches

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

115.215 (a)

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

115.215 (b)

- Does the facility always refrain from conducting cross-gender pat-down searches of female residents, except in exigent circumstances? (N/A if the facility does not have female residents.) ☒ Yes ☐ No ☐ NA

- Does the facility always refrain from restricting female residents' access to regularly available programming or other outside opportunities in order to comply with this provision? (N/A if the facility does not have female residents.) ☒ Yes ☐ No ☐ NA

115.215 (c)

- Does the facility document all cross-gender strip searches and cross-gender visual body cavity searches? ☒ Yes ☐ No
- Does the facility document all cross-gender pat-down searches of female residents? (N/A if the facility does not have female residents). ☒ Yes ☐ No ☐ NA

115.215 (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 enables residents to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks? ☒ Yes ☐ No
- Does the facility require staff of the opposite gender to announce their presence when entering an area where residents are likely to be showering, performing bodily functions, or changing clothing? ☒ Yes ☐ No

115.215 (e)

- Does the facility always refrain from searching or physically examining transgender or intersex residents for the sole purpose of determining the resident's genital status? ☒ Yes ☐ No
- If a resident's genital status is unknown, does the facility determine genital status during conversations with the resident, by reviewing medical records, or, if necessary, by learning that information as part of a broader medical examination conducted in private by a medical practitioner? ☒ Yes ☐ No

115.215 (f)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making the compliance determination:

Documents:

1. Pharos House Pre-Audit Questionnaire (PAQ)
2. Pharos House Policy: *Staff and Resident Sexual Abuse and Sexual Harassment (PREA)*

Interviews:

1. Random Staff
2. Random Residents
3. Facility Director

Site Review Observations:

1. Resident rooms and facility bathrooms, toilets, and showers.

The facility responded in the PAQ that it did not conduct cross-gender pat searches, strip searches or body cavity searches during the audit period. Pharos House policy *Staff and Resident Sexual Abuse and Sexual Harassment* (*p.16*) states that:

"d. Limits to Cross-Gender Viewing

(1) Residents at the program are able to shower, perform bodily functions, and change clothing without staff of the opposite gender viewing their buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine room checks. Staff of the opposite gender announce their presence when entering a resident room or bathroom where residents are likely to be showering, performing bodily functions or changing clothes.

(2) Staff of the opposite gender announce their presence when entering a resident room or bathroom where residents are likely to be showering, performing bodily functions, or changing clothes.

e. Staff Searches of Residents

(1) Pharos House authorizes only one type of body search, a pat frisk.

(a) A pat frisk may be conducted randomly by staff on residents at any time.

(b) The employee conducting this type of search shall be thorough, yet must not offend the dignity of the resident being searched.

(c) Pat frisk searches will be conducted by gender, male staff to male resident and female staff to female resident.

(2) Transgender or Intersex Residents

(a) Staff are prohibited from searching or physically examining a transgender or intersex resident for the sole purpose of determining the resident's genital status.

(b) When gender is unknown, it may be determined:

(aa) during conversations with the resident,

(bb) by reviewing medical records or prior custody situation

(cc) If necessary, by learning that information as part of a broader medical examination conducted in private by a medical practitioner.

(3) Strip searches and body cavity searches are prohibited."

During the interview with the PREA Coordinator the auditor confirmed that there were no cross-gender strip or pat-down searches conducted during the audit period. There are no medical staff onsite at Pharos House to conduct cross-gender strip searches. Interviews with random female residents revealed that they were not subjected to cross-gender pat or strip searches and that their ability to attend programming or outside-facility activities was not limited in any way due to the lack of female staff. Interviews with random staff confirmed that they are prohibited from conducting strip searches (same gender or cross-gender) at the facility and that they are also prohibited from conducting cross-gender pat searches. Security staff reacted surprisingly to my question of whether they had conducted strip searches of individuals to determine their genital status; all staff interviewed stated that this type of search has never happened at Pharos House. Staff reiterated the facility's policy prohibiting strip and visual body cavity searches. There were no documented incidents of cross-gender viewing during the audit period.

During the site review the auditor observed all resident bathrooms. Showers in every bathroom had a privacy curtain installed which prevented anyone from seeing inside of the shower. The auditor observed staff announcing themselves whenever they entered a resident room of the opposite gender. Interviews with random residents confirmed that staff announce themselves before entering a resident room and interviews with random staff confirmed that they have been trained to always announce themselves before entering a resident room of the opposite gender. Staff were observed announcing themselves whenever they entered a resident room regardless of whether the occupant(s) were of the same or opposite gender. Random interviews with staff and a review of staff training records confirmed that staff were trained on how to conduct pat-searches and searches of transgender and intersex residents.

Based upon this analysis, the auditor finds the facility is substantially compliant with this standard.

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

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

115.216 (a)

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

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

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

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

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and

respond to sexual abuse and sexual harassment, including: Residents who have speech disabilities? ☒ Yes ☐ No

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Other? (if "other," please explain in overall determination notes.) ☒ Yes ☐ No
- Do such steps include, when necessary, ensuring effective communication with residents who are deaf or hard of hearing? ☒ Yes ☐ No
- Do such steps include, when necessary, providing access to interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary? ☒ Yes ☐ No
- Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Have intellectual disabilities? ☒ Yes ☐ No
- Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Have limited reading skills? ☒ Yes ☐ No
- Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Are blind or have low vision? ☒ Yes ☐ No

115.216 (b)

- Does the agency take reasonable steps to ensure meaningful access to all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment to residents who are limited English proficient? ☒ Yes ☐ No
- Do these steps include providing interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary? ☒ Yes ☐ No

115.216 (c)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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 following evidence was analyzed in making the compliance determination:

Documents:

1. Pharos House Pre-Audit Questionnaire (PAQ)
2. Pharos House Policy: *Staff and Resident Sexual Abuse and Sexual Harassment (PREA)*
3. Pharos House PREA Booklet for Residents (2017)

Interviews:

1. Executive Director
2. PREA Coordinator
3. Random Staff

Site Review Observations:

1. PREA posters within the facility

The facility responded in the PAQ that it has established procedures to provide residents with limited English proficiency equal opportunity to access the agency's efforts to implement the PREA Standards. Additionally, the PAQ response confirmed that resident interpreters will only be used during limited circumstances. Pharos House policy *Staff and Resident Sexual Abuse and Sexual Harassment* (*p.12-13*) states that:

g. The program provides residents with PREA education in formats accessible to all residents, including those who are limited English proficient (LEP), deaf, visually impaired, or otherwise disabled as well as residents who have limited reading skills.
h. The program documents resident participation in PREA education sessions (Attachment J).
i. In addition to providing such education, the program ensures that key information is continuously and readily available and visible to residents through posters, resident handbooks, and brochures.

2. Residents with Disabilities and/or Limited English Proficiency
a. Residents under this category include:
(1) Limited English proficient
(2) Deaf
(3) Visually impaired
(4) Otherwise disabled
(5) Limited in their reading skills
b. These residents are provided equal opportunities to participate in or benefit from all aspects of Pharos Houses' efforts to prevent, detect, and respond to sexual abuse and sexual harassment
c. To ensure effective communications, all efforts will be made to bring interpreters or other skilled professionals into the program as soon as staff discover any residents with disabilities and/or has limited English proficiency.
d. The use of resident interpreters, resident readers, or other types of resident assistants will not be used, except in limited circumstances, where an extended delay in obtaining an effective interpreter could compromise the

resident's safety, the performance of first -responder duties or the investigation of the resident's allegations.
e. Those exceptions or limited circumstances shall be clearly documented.
f. When a potential resident whose primary language is not English is accepted to Pharos House then Pharos House shall provide the house PREA policy, the Sexual Abuse/Assault Prevention, and Intervention Information, the Resident Acknowledgment of Prohibition of Sexual Misconduct/PREA Orientation form and the Resident agreement in said resident's language within 72 hours of the resident's arrival to the Pharos House.
g. When a resident whose primary language is not English arrives at the Pharos House, they will be provided an "ESL Resident PREA Information form" (Attachment O1) in their primary language immediately upon arrival. Instructions regarding how to make this transfer are readily available (Attachment O2).
h. Pharos House will provide additional information and forms to residents whose primary language is not English regarding other PREA related material as needed.
. *i. The Executive Director or their staff designee will read out loud the PREA policy for Pharos House to any resident who is blind or visually impaired. This staff member will also read all the Sexual Abuse/Assault Prevention and Intervention Information, the Resident Acknowledgment of Prohibition of Sexual Misconduct/PREA Orientation form and the Resident Agreement to said resident within 72 hours of the resident's arrival to the Pharos House.*
j. The Executive Director or their staff designee will read out loud the "Initial Arrival Information Sheet" to any resident who is blind or visually impaired immediately upon their arrival to Pharos House.
k. Assigned Pharos House Staff will provide additional information and forms to residents who are blind or visually impaired regarding other PREA related material as needed.

At the time of the audit, there was one Pharos House resident with a physical disability and no residents who were limited English proficient (LEP). Interviews with random staff confirmed that the facility makes the Resident PREA Booklet and the PREA orientation video available in English and Spanish languages. The Booklet is also available to be printed in large print format when necessary. Interviews with the Executive Director and the PREA Coordinator established the Federal Bureau of Prisons (BOP) provides advance notice of resident transfers to Pharos House. During this advance notice, Pharos House received specific information on any special needs, disabilities or language barriers that exist. This allows Pharos House to make necessary arrangements in advance. Pharos House has the ability to decline a BOP placement if the individual cannot be managed at the facility (*i.e., medical care, mental health issues, disability*).

The Monitor's workstation in the front office of the facility contains information and instructions for staff to access the facility's interpretation services vendor. Random staff interviews confirmed staff's awareness of the availability of the interpreter vendor.

Based upon this analysis, the auditor finds the facility is substantially compliant with this standard.

Standard 115.217: Hiring and promotion decisions

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

115.217 (a)

- Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997)? ☒ Yes ☐ No
- Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse? ☒ Yes ☐ No
- Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has been civilly or administratively adjudicated to have engaged in the activity described in the question immediately above? ☒ Yes ☐ No
- Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997)? ☒ Yes ☐ No
- Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse? ☒ Yes ☐ No
- Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has been civilly or administratively adjudicated to have engaged in the activity described in the question immediately above? ☒ Yes ☐ No

115.217 (b)

- Does the agency consider any incidents of sexual harassment in determining whether to hire or promote anyone 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

115.217 (c)

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

115.217 (d)

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

115.217 (e)

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

115.217 (f)

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

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

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

115.217 (g)

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

115.217 (h)

- 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.

The following evidence was analyzed in making the compliance determination:

Documents:

1. Pharos House Pre-Audit Questionnaire (PAQ)

2. Pharos House Policy *Staff and Resident Sexual Abuse and Sexual Harassment (PREA)*
3. United States Department of Justice (USDOJ) Background Report Summary (contained in employee personnel file)

Interviews:

1. Executive Director
2. PREA Coordinator

The facility responded in the PAQ that it has established procedures to prohibit the hiring of applicants and the enlisting of contractors who may have contact with residents if they have engaged in sexual abuse or sexual harassment in an institution or in the community. Pharos House policy *Staff and Resident Sexual Abuse and Sexual Harassment* (*p.8-9*) states that:

7. Hiring and Promotion Decisions
a. Pharos House prohibits hiring or promoting anyone who may have contact with residents, and prohibits enlisting the services of any contractor who may have contact with residents, who:
(1) Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution;
(2) Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or
(3) Has been civilly or administratively adjudicated to have engaged In the activity described in paragraph a., (2) of this section.
b. Pharos House considers 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.
c. Pharos House requires that before any new employee, who may have contact with residents, is hired:
(1) a criminal background record checks are conducted, and
(2) best efforts are made 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 (consistent with federal, state, and local law).
(3) In addition, Pharos House requires that a criminal background record check be completed before enlisting the services of any contractor who may have contact with residents.
(4) Pharos House requires that either criminal background record checks be conducted at least every five years for current employees and contractors who may have contact with residents or that a system is in place for otherwise capturing such information for current employees and contractors.
(5) Any material omissions regarding such misconduct, or the provision of materially false information, shall be grounds for termination.
(6) Pharos House will check the backgrounds of all applicants and employees who have contact with residents directly, about previous misconduct described in paragraph a. of this section.
(7) Pharos House also imposes upon employees a continuing affirmative duty to disclose any such misconduct.

The auditor reviewed the background and criminal history checks of all 15 existing Pharos House employees. The records are stored in a locked cabinet the Executive Director's secured office and were brought to the conference room where the auditor was working during the onsite audit. The Federal Bureau of Prisons (BOP) requires all individuals who have contact with their offenders to undergo a criminal background check performed by BOP and to receive written clearance from the BOP prior to the individual's access to the facility. A review of available documentation revealed that staff all had the required criminal

background checks every five years. Further review of the personnel files indicated that employees being hired were not screened for incidents of sexual abuse and sexual harassment, as required by this standard and facility policy. The facility promoted two individuals to the position of Lead Shift Monitor and did not consider sexual abuse and sexual harassment as part of the promotional process, as required by this standard and facility policy. During interviews with the Executive Director and PREA Coordinator, the auditor discussed the incomplete information in the personnel files as prescribed by this Standard.

The auditor informed the facility that they would be placed into Corrective Action for this standard until the personnel files of those hired or promoted were reconciled against the requirements in this standard. Pharos House policy establishes a continuing affirmative duty to report any misconduct as defined by this standard, however, the facility did not incorporate these into annual employee reviews. During the Post Onsite Phase, the auditor created blank forms that the facility could use to supplement the existing employee performance review documents that questioned staff about sexual abuse and sexual harassment and notified them of their continuing affirmative duty to disclose any such misconduct.

There were no contractors or volunteers approved to work at the facility at the time of the audit.

During subsequent email and telephone communications with the PREA Coordinator, the auditor worked with the facility to address the required Corrective Action. The facility revised their application and promotion forms to include the required screening questions of this Standard.

Based upon this analysis, the auditor finds the facility is substantially compliant with this standard.

Corrective Action:

Complete screening of personnel and recent promotions for sexual abuse and sexual harassment conduct as required by this standard. Require all employees to sign an annual interview/evaluation form that confirms there has been no misconduct involving sexual abuse and sexual harassment and that the employees acknowledge their continuing affirmative duty to disclose any such misconduct; as required by this standard.

Update:

The facility provided documentation to the auditor which demonstrated that all personnel and the two promotions made since the last audit were screened for sexual abuse and sexual harassment conduct. Additionally, the auditor assisted the facility in revising their employee evaluation instrument to include a sign-off for employees to acknowledge their continuing affirmative duty to disclose any such misconduct (sexual abuse or sexual harassment). The facility required all employees to sign the revised form, which satisfied the requirements of this Standard.

Standard 115.218: Upgrades to facilities and technologies

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

115.218 (a)

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

115.218 (b)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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 following evidence was analyzed in making the compliance determination:

Documents:

1. Pharos House Pre-Audit Questionnaire (PAQ)
2. Pharos House policy *Staff and Resident Sexual Abuse and Sexual Harassment* (*PREA)*

Interviews:

1. Executive Director
2. PREA Coordinator
3. Lead Shift Monitor (oversees electronic surveillance system)

Site Review Observations:

1. Review of camera and monitor locations

The facility responded in the PAQ that it has not acquired new facilities or made any substantial expansions of the facility and that it did update its video monitoring system by installing two additional cameras and two new video monitors since the last audit. The cameras were installed in response to the location change for processing new resident intakes. One exterior camera was added to allow security staff to view residents who are now instructed to enter the facility through the rear of the building for intake processing. The second camera was added in the basement hallway where the new resident intake processing is now conducted. The security office on the first floor had two new video monitors installed to all maintain social distancing while viewing the electronic surveillance system. Both changes were made as result of operational changes during COVID-19

Pharos House policy *Staff and Resident Sexual Abuse and Sexual Harassment* (*p.6-7*) states that:

2. Video monitoring is also used to monitor and supervise residents in common areas and provides additional protection against sexual abuse

a. All staff are trained in how to use the video monitoring system.
b. The PREA Compliance Manager or his/her designee is responsible for having all video recorded information that covers the period of 24 hours before and after any alleged sexual assault.
c. Recorded video is kept for 90 days before being written over.

Interviews with the Executive Director and PREA Coordinator confirmed that the video monitoring system is considered during the annual review of the facility and the staffing plan. The steps taken during the pandemic demonstrate that the facility modifies the video monitoring system to meet the safety needs of staff and residents.

Based upon this analysis, the auditor finds the facility is substantially compliant with this standard.

RESPONSIVE PLANNING

Standard 115.221: Evidence protocol and forensic medical examinations

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

115.221 (a)

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

115.221 (b)

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

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

115.221 (c)

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

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

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

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

115.221 (d)

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

115.221 (e)

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

115.221 (f)

- If the agency itself is not responsible for investigating allegations of sexual abuse, has the agency requested that the investigating 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

115.221 (g)

- Auditor is not required to audit this provision.

115.221 (h)

- If the agency uses a qualified agency staff member or a qualified community-based staff member for the purposes of this section, has the individual been screened for appropriateness to serve in this role and received education concerning sexual assault and forensic examination issues in general? (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 following evidence was analyzed in making the compliance determination:

Documents:

1. Pharos House Pre-Audit Questionnaire (PAQ)
2. Pharos House policy *Staff and Resident Sexual Abuse and Sexual Harassment (PREA)*
3. Memorandum of Understanding (MOU) with Sexual Assault Response Services of Southern Maine (SARSSM)
4. Letter from Maine Medical Center RE: Standard of Care
5. Letter from Portland, Maine City Attorney RE: Compliance with National PREA Standards
6. National Institute of Corrections course: Investigating Sexual Abuse in a Confinement Setting, *Certificate of Completion*

Interviews:

1. Pharos House PREA Coordinator
2. Pharos House PREA Investigator (PREA Coordinator)
3. Random Staff

Pharos House policy *Staff and Resident Sexual Abuse and Sexual Harassment* (*p.26-31*) states that:

> *(6) If the abuse occurred within a time period that would still allow for the collection of physical evidence (up to 96 hours), request that the alleged victim not take any action that could destroy physical evidence, including washing or showering, drinking, or eating (unless medically indicated), brushing teeth, changing clothes, or toileting.*
> *(a)If toileting needs to take place, the resident should be instructed to not wipe.*
> *(7) In the event of an allegation of sexual abuse within the last 96 hours, including but not limited to those involving penetration, staff will have resident transported to a local hospital, with the victim's permission, equipped to evaluate and treat sexual abuse/rape victims, where he/she may receive a forensic medical exam by medical personnel not employed by the program.*
> *(a)Staff will request that the resident to wash, shower, toilet, change clothes, brush teeth, eat or drink (unless medically indicated) before examination, as evidence may be destroyed.*
> *(8) Where possible, examinations performed at the community medical facility are performed by Sexual Assault Forensic Examiners (SAFE) and Sexual Assault Nurse Examiners (SANE) nurses.*
> *(a)If SAFEs or SANEs cannot be made available, the examination will be performed by other qualified medical practitioners.*
> *(9) If the victim refuses medical attention following a sexual misconduct incident or allegation, staff will document the refusal on the PREA Victim Medical Refusal Form (Attachment M).*
> *(10) Staff will have the resident transported to the medical facility, ensuring that the resident feels safe with the program staff chosen to accompany him or her.*
> *(11) Staff shall record the medical facility contact information and details of physical injury in a written Incident Report before the end of the shift.*
> *(12) If a disclosure is made of a sexual assault more than 24 hours after the incident, staff should follow the reporting steps and refer the*

resident to counseling services.

(a)Law enforcement or an ambulance will transport the victim transported to a community medical facility for evidence collection.

(13) If requested by the victim, a victim advocate, qualified program staff member, or qualified staff from a community-based agency shall accompany and support the victim through the forensic medical examination process and investigatory reviews and shall provide emotional support, crisis intervention, information, and referrals.

(14) The Executive Director, or designee, will contact the local rape crisis center (or other similar local agency) to provide follow up support and services to the resident.

(15) The Executive Director, or designee, in consultation with the local mental health provider, shall determine if the resident requires one-to-one observation in accordance with Pharos Houses' Suicide Policy

(16) The shift monitor on duty shall take steps to preserve any physical evidence of the alleged sexual abuse. The Executive Director should prevent anyone from entering the area, altering the area, or removing anything from the area, until investigators can arrive and document it.

(17) The staff member who receives an initial report of sexual abuse must separate the victim from the alleged assailant to protect the victim and prevent further violence, and are required to promptly intervene on the victim's behalf to ensure the victim receives prompt medical and psychological assistance, as appropriate to his or her needs and the circumstances of the alleged offense.

(18) Psychological trauma may also occur to individuals of sexual abuse or sexual harassment. Mental health staff must be available to support and assist those in need.

(19) Pharos House will ensure that all 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 potential criminal behavior.

(a) Pharos House will document all such referrals.

(b) Pharos House's policy on this issue will be made publicly available by requesting a copy from the Pharos House PREA Coordinator.

(c.) Separating Staff and Residents

(1) If there appears to be evidence of sexual abuse or sexual harassment between staff and resident, supervising staff shall take steps to separate them so there is no possibility of further unmonitored contact between them until an investigation is completed.

(2) The Executive Director shall determine if the staff member should be placed on administrative leave pending the results of an investigation.

(3) In less serious abuse situations (administrative), the appropriate staff shall consider whether to separate the staff and residents or take other steps for safety and to prevent intimidation or retaliation.

(4) The appropriate staff should also consider whether there are any staff or resident witnesses who should be relocated to ensure their safety and protect them from intimidation or retaliation.

d. Sexual Contact with Family Members of Current Residents

(1) Pharos House staff are strictly prohibited from engaging in any sexual contact with family members of current Pharos House residents.

(2) Staff who engage in sexual contact with family members of current Pharos House residents shall be deemed to have engaged in sexual misconduct and will be subject to discipline up to and including termination.

e. Sexual Contact with Former Residents and their Families

(1) Pharos House staff are prohibited from engaging in any sexual contact with former Pharos House residents or their family members for three years.

(2) Staff who engage in sexual contact with former residents or their family members during this time period may be subject to possible discipline.

2. Services Provided/Treatment for Victims

a. Pharos House ensures that an administrative (internal) or criminal investigation is completed for all allegations of sexual abuse or sexual harassment. Sexual abuse allegations are referred for investigation to local law enforcement to document criminal investigations, unless the allegation does not involve potentially criminal behavior. All such referrals are documented.

b. Victims of sexual misconduct and residents who allege that they are victims have access to the following services:

(1) medical examination, documentation, and treatment of injuries, including testing for HIV and other sexually transmitted diseases;

(2) mental health crisis intervention and treatment;

(3) social, family, and peer support; and

(4) reasonable measures taken to protect and prevent future assaults such as screening procedures to identify predator and vulnerable offenders and separation needs.

c. Victim services for residents will include crisis intervention and trauma-specific treatment provided by mental health and/or medical professionals.

d. Staff will also attempt to make available to the victim, a victim advocate from a rape crisis center, either in person or by other means.

e. Victim services will be made available to all program residents while they reside at the program, who were victims of sexual abuse or sexual harassment by program staff, contract employees, volunteers, or other residents while in the program or in other community programs.

f. Resident Access to Outside Confidential Support Services:

(1) The program will provide residents with access to outside victim advocates for emotional support including toll-free hot line numbers where available, of local, state, and national victim advocacy or rape crisis organizations, and by enabling reasonable communication between residents and these organizations, in as confidential a manner as possible.

(2) The program will 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.

(3) The program will maintain or attempt to enter into memoranda of understanding (MOUs) or other agreements with community service providers that are able to provide residents with confidential emotional support services related to sexual abuse.

(a)The program maintains copies of agreements or documentation showing attempts to enter into such agreements.

g. Access to Emergency Medical and Mental Health Services

(1) Resident victims of sexual abuse shall 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.

(a) At the time a report of recent abuse is made, staff first responders shall take preliminary steps to protect the victim

pursuant to the program's protection duties and shall immediately notify the appropriate medical and mental health practitioners.
(b) Resident victims of sexual abuse while in community confinement shall be 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.
(c) Treatment services shall be 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.

h. Ongoing Medical and Mental Health Care for Sexual Abuse Victims and Abusers
(1) The program shall offer medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse in any criminal justice setting.
(2) The evaluation and treatment of such victims shall 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.
(3) The program shall provide such victims with medical and mental health services consistent with the community level of care.
(4) Female residents who have been victims of sexually abusive vaginal penetration while in the program shall be offered pregnancy testing to be completed by local medical treatment agencies.
(5) If pregnancy results from conduct specified in paragraph (4) of this section, such victims shall receive timely and comprehensive information about and timely access to all lawful pregnancy related medical services.
(6) Resident victims of sexual abuse while incarcerated shall be offered tests for sexually transmitted infections as medically appropriate.
(7) On-going treatment services shall be 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.
(8) The program shall 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.

Pharos House is responsible for conducting Administrative Investigations and has two staff members who have completed the online training courses provided by the National Institute of Corrections for investigating incidents of sexual abuse in a confinement setting. The facility provided copies of the training certificates for both employees during the Pre-Audit Phase. The Portland Police Department is responsible for conducting criminal investigations for incidents that take place at the facility. The Federal Bureau of Prisons (BOP) has the right to assign its own investigators to conduct administrative investigations. The BOP also has the ability to refer criminal incidents to federal law enforcement agents of the BOP Internal Affairs section or to the US Department of Justice Inspector General's Office. Pharos House is required by contract to notify BOP of any incidents of sexual abuse or sexual harassment. The BOP evaluates each incident independently and determines what action(s) (if any) they will take. Interviews of random staff confirmed that they understood the facility's policy and the protocols for maximizing the potential for obtaining usable physical evidence. Staff were able to identify that the Portland Police Department was responsible for conducting criminal investigations at the facility.

Pharos House sent a letter to the Chief of Police in Portland and requested that the Portland Police Department follow a uniform evidence protocol when responding to incidents of sexual abuse at the facility. The Portland City Attorney assigned to the Portland Police Department responded with a letter which confirmed that the police have policies and protocols in place for the investigation of sexual assault which include evidence protocols identified in the PREA Standards and that they would use these protocols when responding to incidents at Pharos House.

Pharos House has confirmed with the Maine Medical Center, a hospital with level one trauma services in Portland, that its residents who are victims of sexual abuse can access sexual assault treatment services at the hospital without cost. These services include SANE/SAFE exams conducted by trained hospital staff. The facility did not report any incidents of sexual abuse during the audit period.

Pharos House has an MOU with Sexual Assault Response Services of Southern Maine (SARSSM), which allows residents who are victims of sexual abuse, access to a victim advocate who will respond to Maine Medical Center and provide support during SANE/SAFE exams (if consented to by the victim). Residents can also access follow-up care, counseling, and community contact information for crisis intervention. SARSSM has also agreed to accept reports of sexual abuse through their toll-free reporting hotline. This information is posted throughout the facility. Pharos House does not have any staff member who is qualified to serve as a victim advocate. The auditor interviewed one resident who reported sexual assault. The resident confirmed that they were offered victim advocacy and support services. The resident declined services. The PREA Coordinator confirmed during interview that incident reviews occur after each incident to identify the possible cause. Aggregate incident data is used to evaluate PREA policies, protocols as well as the physical plant to determine if any changes are warranted.

Based upon this analysis, the auditor finds the facility is substantially compliant with this standard.

Standard 115.222: Policies to ensure referrals of allegations for investigations

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

115.222 (a)

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

115.222 (b)

- Does the agency have a policy and practice in place to ensure that allegations of sexual abuse or sexual harassment are referred for investigation to an agency with the legal authority to conduct criminal investigations unless the allegation does not involve potentially criminal behavior? ☒ Yes ☐ No
- Has the agency published such policy on its website or, if it does not have one, made the policy available through other means? ☒ Yes ☐ No
- Does the agency document all such referrals? ☒ Yes ☐ No

115.222 (c)

- If a separate entity is responsible for conducting criminal investigations, does the policy describe the responsibilities of both the agency and the investigating entity? (N/A if the agency/facility is responsible for conducting criminal investigations. See 115.221(a).) ☒ Yes ☐ No ☐ NA

115.222 (d)

- Auditor is not required to audit this provision.

115.222 (e)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

☒ **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 following evidence was analyzed in making the compliance determination:

Documents:

1. Pharos House Pre-Audit Questionnaire (PAQ)
2. Pharos House policy *Staff and Resident Sexual Abuse and Sexual Harassment (PREA)*
3. Pharos House website (http://pharoshouse.org/wp-content/uploads/2017/06/2017-PREA-POLICY.doc)

Interviews:

1. Executive Director
2. PREA Coordinator

Pharos House policy *Staff and Resident Sexual Abuse and Sexual Harassment (PREA) states* (*p.22*):

c. All allegations of sexual abuse or sexual harassment must be reported as PREA violations.
(1) Allegations of sexual harassment between residents will be reported for investigation by the Executive Director;
(2) Allegations of sexual harassment of residents by staff will be reported for investigation by the Executive Director.

The interviews with the Executive Director and the PREA Coordinator confirmed that all allegations regardless of how reported, are investigated. The Executive Director identified the steps taken after an allegation is reported and reviewed the facility's investigation process. The auditor reviewed the investigation files for three PREA incidents during the audit period. Each investigation was completed in accordance with facility policy and PREA standard. The facility has two investigators trained to conduct Administrative investigations. The Portland Police Department is responsible for conducting criminal investigations at the facility.

The auditor visited the Pharos House website and confirmed that the PREA policy includes information regarding investigations and was posted on the site.

115.222 (c):

The auditor reviewed the agency PREA policy that was posted to the Pharos House website,

this policy did not "… *describe the responsibilities of both the agency and the investigating entity."* (PREA Standard 115.222, element 'c') as required by this standard. The auditor communicated this issue with the PREA Coordinator. During the onsite audit, the auditor provided suggested language to add to the agency policy, which would describe the investigation responsibilities as required. The PREA Coordinator is working on revising this policy and will post the revision to the website when approved by the Executive Director. The PREA policy was not revised prior to the completion of the Interim Audit Report, therefore, this Standard was determined to be non-compliant.

The facility revised and published their PREA policy to the website, which now includes a description of the responsibilities for the agency and the investigating entity, as required by this Standard. The auditor visited the agency website on Wednesday, June 9, 2021, and confirmed the presence of the revised policy.

Based upon this analysis, the auditor finds the facility is substantially compliant with this standard.

Corrective Action:

Modify policy *Staff and Resident Sexual Abuse and Sexual Harassment (PREA)* to include a description of the responsibilities of the facility and of the investigating entity, as required by provision 'c' of this standard. Publish the revised policy to the agency website.

Update:

The auditor verified that the facility revised their PREA policy and posted it to their website. The facility is now substantially compliant with this Standard.

TRAINING AND EDUCATION

Standard 115.231: Employee training

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

115.231 (a)

- Does the agency train all employees who may have contact with residents on: Its zero-tolerance policy for sexual abuse and sexual harassment? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: How to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures? ☒ Yes ☐ No

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

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

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

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

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

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

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

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

115.231 (b)

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

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

115.231 (c)

- Have all current employees who may have contact with residents received such training? ☒ Yes ☐ No

- Does the agency provide each employee with refresher training every two years to ensure that all employees know the agency’s current sexual abuse and sexual harassment policies and procedures? ☒ Yes ☐ No

- In years in which an employee does not receive refresher training, does the agency provide refresher information on current sexual abuse and sexual harassment policies? ☒ Yes ☐ No

115.231 (d)

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

Auditor Overall Compliance Determination

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

☒ **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 following evidence was analyzed in making the compliance determination:

Documents:

1. Pharos House Pre-Audit Questionnaire (PAQ)
2. Pharos House policy Staff and Resident Sexual Abuse and Sexual Harassment *(PREA)*
3. Agency PREA Training Lesson Plans
4. Agency Employee Training Records

Interviews:

1. PREA Coordinator
2. Random staff

Pharos House policy *Staff and Resident Sexual Abuse and Sexual Harassment (PREA) states* (*p.11-12*):

Procedure D: Training

1. Training for Staff
a. Training on staff and resident sexual misconduct, staff, and resident boundary violations, and staff response shall be incorporated into New Employee Orientation (NEO) and included in the basic training for all new employees. The training will include, but not be limited to:
(1) Pharos House's zero-tolerance stance for sexual abuse and sexual harassment;
(2) How to fulfill their responsibilities under Pharos House use sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures;
(3) Resident's right to be free from sexual abuse and sexual harassment;
(4) The right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment;
(5) The dynamics of sexual abuse and sexual harassment in confinement;
(6) The common reactions of sexual abuse and sexual harassment victims;
(7) How to detect and respond to signs of threatened and actual sexual abuse;
(8) How to avoid inappropriate relationships with residents;
(9) How to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents; and

(10) How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities.

b. such training shall be tailored to both males and/or female residents (if applicable) at the employee's program.

2. *Pharos House documents that employees understand the PREA training they have received (Attachment F).*
3. *Training for Volunteers and Contractors*

   a. All volunteers who have contact with residents and contractors with a contractual agreement to provide services on a reoccurring basis to residents shall be trained on their responsibilities under the agency's policies and procedures regarding sexual abuse, harassment prevention, detection, and response (Attachment G).

   b. The level and type of training provided to volunteers and contractors is based on the services they provide and level of contact they have with residents.

   c. All volunteers and contractors (as stipulated above in Section 1.) shall have at least been notified of the agency's zero-tolerance stance regarding sexual abuse and sexual harassment and informed how to report such incidents.

   d. The program shall maintain documentation confirming that volunteers and contractors understand the training they have received.

The auditor's interviews with random staff confirmed that staff have received initial PREA training prior to assignment in the facility and those employed for more than one year have received annual refresher PREA training thereafter. The facility presented the training records for all Pharos House employees. The facility provided the auditor with a copy of the three separate PowerPoint presentations used to provide the initial and the refresher training. These PowerPoints were downloaded from the PREA Resource Center (PRC) website and tailored to the specifics of Pharos House. Pharos House houses both male and female residents. Pharos House employees are required to acknowledge their attendance and understanding of the PREA training that they receive. During the auditor's review of records, one part-time employee was identified as not having received the initial PREA training. This discrepancy was brought to the attention of the PREA Coordinator and the employee was trained prior to the writing of this Interim Audit Report. This employee was also placed on the list of employees required to receive the annual refresher training in 2021.

The training was developed by the Moss Group for the PRC and includes all the mandated topics identified in this standard. The training is for staff who work with both male and female residents, which is the case at Pharos House.

Based upon this analysis, the auditor finds the facility is substantially compliant with this standard.

Standard 115.232: Volunteer and contractor training

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

115.232 (a)

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

115.232 (b)

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

115.232 (c)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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 following evidence was analyzed in making the compliance determination:

Documents:

1. Pharos House Pre-Audit Questionnaire (PAQ)
2. Pharos House policy *Staff and Resident Sexual Abuse and Sexual Harassment (PREA*

Interviews:

1. PREA Coordinator

Pharos House policy *Staff and Resident Sexual Abuse and Sexual Harassment (PREA) states* (*p.11-12*):

3. Training for Volunteers and Contractors
a. All volunteers who have contact with residents and contractors with a contractual agreement to provide services on a reoccurring basis to residents shall be trained on their responsibilities under the agency's policies and procedures regarding sexual abuse, harassment prevention, detection, and response (Attachment G).
b. The level and type of training provided to volunteers and contractors is based on the services they provide and level of contact they have with residents.
c. All volunteers and contractors (as stipulated above in Section 1.) shall have at least been notified of the agency's zero-tolerance stance regarding sexual abuse and sexual harassment and informed how to report such incidents.
d. The program shall maintain documentation confirming that volunteers and contractors understand the training they have received.

The interview with the PREA Coordinator revealed that there are no contractors or vendors who provide ongoing services in the facility (i.e., food service, medical, mental health, programs). The only access by outside personnel is when specific contractors are requested to enter the facility for defined purposes (i.e., electrician, plumber, HVAC technician). These individuals are required to sign an acknowledgement form of the agency's zero tolerance policy and are advised of how to report incidents of sexual abuse and sexual harassment and are then escorted to their work location in the house. These individuals are not left alone

with residents at any time. The auditor reviewed records which demonstrated that contractors completed the form when working at the facility.

Based upon this analysis, the auditor finds the facility is substantially compliant with this standard.

Standard 115.233: Resident education

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

115.233 (a)

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

115.233 (b)

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

115.233 (c)

- Does the agency provide resident education in formats accessible to all residents, including those who: Are limited English proficient? ☒ Yes ☐ No
- Does the agency provide resident education in formats accessible to all residents, including those who: Are deaf? ☒ Yes ☐ No
- Does the agency provide resident education in formats accessible to all residents, including those who: Are visually impaired? ☒ Yes ☐ No
- Does the agency provide resident education in formats accessible to all residents, including those who: Are otherwise disabled? ☒ Yes ☐ No
- Does the agency provide resident education in formats accessible to all residents, including those who: Have limited reading skills? ☒ Yes ☐ No

115.233 (d)

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

115.233 (e)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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 following evidence was analyzed in making the compliance determination:

Documents:

1. Pharos House Pre-Audit Questionnaire (PAQ)
2. Pharos House policy *Staff and Resident Sexual Abuse and Sexual Harassment (PREA) states* (*p.30-31*):
3. Pharos House Organizational Chart

Interviews:

1. Intake Staff (Monitors)
2. Random resident

Site Review Observations:

1. PREA posters within the facility

Pharos House policy *Staff and Resident Sexual Abuse and Sexual Harassment (PREA) states* (*p.12-13*):

Procedure E: Resident Intake/Orientation and Education

1. Resident Intake/Orientation
a. As part of orientation for residents during intake, staff will communicate PREA information verbally and in writing, in a manner that is clearly understood by residents (Attachment H) Information will include but is not limited to:
(1) Presentation of this policy
(2) Resident Grievance process
(3) Pharos House zero tolerance stance
(4) Self-protection methods

(5) Prevention and intervention
(6) Treatment and counseling
(7) Reporting incidents
(8) Protection against retaliation
(9) Consequences of false allegations (Attachment I)

b. Staff shall make every resident aware of PREA and the program's zero tolerance stance prohibiting sexual contact, sexual abuse and sexual harassment between residents or between residents and staff while at the program.

c. Staff shall communicate to residents the definitions of sexual abuse and Sexual harassment violations, and information on the various reporting mechanisms for residents who believe they are a victim of or witness to this behavior.

(1) Residents will be informed about the multiple ways to privately report sexual abuse and sexual harassment, retaliation by other residents or staff for reporting such behavior and staff neglect or violation of responsibilities that may have contributed to such incidents (Attachment H and I).

d. Staff shall distribute to each resident a Resident Handbook which includes the above information in language easily understood by residents. Staff shall also orient the residents to the section of the Handbook which discusses disciplinary sanctions for residents who intentionally make false allegations.

e. The Case Manager shall also address this information with the new residents as part of their resident orientation.

f. Staff will document verification of resident orientation and education on PREA by completing the Resident Acknowledgment of Prohibition on Sexual Misconduct (Attachment I). Staff will maintain the original signed acknowledgment form in the resident's case file.

g. The program provides residents with PREA education in formats accessible to all residents, including those who are limited English proficient (LEP), deaf, visually impaired, or otherwise disabled as well as residents who have limited reading skills.

h. The program documents resident participation in PREA education sessions (Attachment J).

i. In addition to providing such education, the program ensures that key information is continuously and readily available and visible to residents through posters, resident handbooks, and brochures.

2. Residents with Disabilities and/or Limited English Proficiency

a. Residents under this category include:

(1) Limited English proficient
(2) Deaf
(3) Visually impaired
(4) Otherwise disabled
(5) Limited in their reading skills

b. These residents are provided equal opportunities to participate in or benefit from all aspects of Pharos Houses' efforts to prevent, detect, and respond to sexual abuse and sexual harassment

c. To ensure effective communications, all efforts will be made to bring interpreters or other skilled professionals into the program as soon as staff discover any residents with disabilities and/or has limited English proficiency.

d. The use of resident interpreters, resident readers, or other types of resident assistants will not be used, except in limited circumstances, where an extended delay in obtaining an effective interpreter could compromise the resident's safety, the performance of first -responder duties or the

investigation of the resident's allegations.
e. Those exceptions or limited circumstances shall be clearly documented.
f. When a potential resident whose primary language is not English is accepted to Pharos House then Pharos House shall provide the house PREA policy, the Sexual Abuse/Assault Prevention, and Intervention Information, the Resident Acknowledgment of Prohibition of Sexual Misconduct/PREA Orientation form and the Resident agreement in said resident's language within 72 hours of the resident's arrival to the Pharos House.
g. When a resident whose primary language is not English arrives at the Pharos House, they will be provided an "ESL Resident PREA Information form" (Attachment O1) in their primary language immediately upon arrival. Instructions regarding how to make this transfer are readily available (Attachment O2).
h. Pharos House will provide additional information and forms to residents whose primary language is not English regarding other PREA related material as needed.
. *i. The Executive Director or their staff designee will read out loud the PREA policy for Pharos House to any resident who is blind or visually impaired. This staff member will also read all the Sexual Abuse/Assault Prevention and Intervention Information, the Resident Acknowledgment of Prohibition of Sexual Misconduct/PREA Orientation form and the Resident Agreement to said resident within 72 hours of the resident's arrival to the Pharos House.*
j. The Executive Director or their staff designee will read out loud the "Initial Arrival Information Sheet" to any resident who is blind or visually impaired immediately upon their arrival to Pharos House.
k. Assigned Pharos House Staff will provide additional information and forms to residents who are blind or visually impaired regarding other PREA related material as needed.

The auditor interviewed 5 of the 8-security staff (Monitors) and both Lead Shift Monitors, who all indicated that residents are provided with an orientation immediately upon arrival. This includes being issued a resident PREA information sheet and signing an acknowledgement form which includes the Pharos House zero tolerance policy and how to report incidents of Sexual Abuse and Sexual Harassment. Within 72 hours, residents are shown and sign an acknowledgement of viewing, a PREA orientation video, *PREA What you Need to Know* produced by Just Detention International for the PREA Resource Center (PRC).

Interviews with security staff who conduct intakes for new arrivals, confirmed that residents receive an orientation immediately upon arrival. Pharos House receives residents through a contract with the Federal Bureau of Prisons (FBOP). The FBOP provides advance notice of the transfer of any resident, which allows the facility to plan for the arrival and orientation of any new resident. The auditor interviewed 10 residents, who all confirmed that they were provided with an orientation, a copy of the information sheet and watched the PREA video. The auditor reviewed the resident files for all 17 residents and identified missing documentation for 1 resident's acknowledgement form and two residents' acknowledgement that they viewed the video. There were no transfers from other facilities, however, residents arriving from FBOP facilities are considered new intakes and are provided with a complete orientation.

PREA posters stating the facility's zero-tolerance policy and providing reporting information are posted in common areas in the facility. In each resident room has reporting information for residents posted on the wall. Residents can access the Pharos House website and review PREA information directly without having to involve staff or other residents. All residents interviewed disclosed that they have a "smart phone" capable of accessing the internet independently. PREA Coordinator confirmed that the resident education materials can be translated into other languages if needed.

Pharos House utilizes a local community service organization for interpreter services to communicate with a resident who cannot speak English. Staff at the facility could not identify and there was no documentation of a need for an interpreter during the audit period. Random staff interviews confirmed that staff were informed of the availability of interpreter services.

Based upon this analysis, the auditor finds the facility is substantially compliant with this standard.

Corrective Action:

Complete resident education for the 3 residents that currently have no documentation indicating that it was completed. Once the auditor reviews that this has been completed and documented, the facility will be compliant with this standard.

Update:

The facility has effectively demonstrated compliance during the Corrective Action period by providing supporting documentation to the auditor. The facility is now substantially compliant with this Standard.

Standard 115.234: Specialized training: Investigations

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

115.234 (a)

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

115.234 (b)

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

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

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

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

115.234 (c)

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

115.234 (d)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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 following evidence was analyzed in making the compliance determination:

Documents:

1. Pharos House Pre-Audit Questionnaire (PAQ)
2. Pharos House policy *Staff and Resident Sexual Abuse and Sexual Harassment (PREA)*
3. National Institute of Corrections Training Certificate of Attendance

Interviews:

1. Pharos House PREA Coordinator (Investigator)
2. Pharos House Case Manager (Investigator)

The facility provided the auditor a copy the *Certificate of Attendance* for the National Institute of Corrections courses titled: *Specialized Training: Investigating Sexual Abuse in a Confinement Setting*, and *Specialized Training: Investigating Sexual Abuse in a Confinement Setting – Advanced* for the PREA Coordinator and the Case Manager. These are the only staff who are authorized to conduct Administrative Investigations. Pharos House does not conduct Criminal Investigations; those are handled by the Portland Police Department. The auditor reviewed documentation that the PREA Coordinator and Case Manager attended the required initial and yearly in-service refresher trainings on PREA that was the same as for facility staff.

Based upon this analysis, the auditor finds the facility is substantially compliant with this standard.

Standard 115.235: Specialized training: Medical and mental health care

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

115.235 (a)

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to detect and assess signs of sexual abuse and sexual harassment? (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 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

115.235 (b)

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

115.235 (c)

- Does the agency maintain documentation that medical and mental health practitioners have received the training referenced in this standard either from the agency or elsewhere? (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

115.235 (d)

- Do medical and mental health care practitioners employed by the agency also receive training mandated for employees by §115.231? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners employed by the agency.) ☐ Yes ☐ No ☒ NA

- Do medical and mental health care practitioners contracted by and volunteering for the agency also receive training mandated for contractors and volunteers by §115.232? (N/A 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

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 following evidence was analyzed in making the compliance determination:

Documents:

1. Pharos House Pre-Audit Questionnaire (PAQ)
2. Pharos House policy *Staff and Resident Sexual Abuse and Sexual Harassment (PREA)*
3. Pharos House Organizational Chart

Interviews:

1. Pharos House PREA Coordinator

Pharos House does not employ any part-time or full-time medical or mental health staff. The auditor's review of the facility's Organizational Chart, staffing roster and training records confirmed the absence of these employees. Residents receive medical and mental health care in the community. Maine Medical Center has confirmed that sexual abuse victims are eligible to receive treatment without cost to the victim.

Based upon this analysis, the auditor finds the facility is substantially compliant with this standard.

SCREENING FOR RISK OF SEXUAL VICTIMIZATION AND ABUSIVENESS

Standard 115.241: Screening for risk of victimization and abusiveness

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

115.241 (a)

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

115.241 (b)

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

115.241 (c)

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

115.241 (d)

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has a mental, physical, or developmental disability? ☒ Yes ☐ No
- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: The age of the resident? ☒ Yes ☐ No
- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: The physical build of the resident? ☒ Yes ☐ No
- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has previously been incarcerated? ☒ Yes ☐ No
- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident's criminal history is exclusively nonviolent? ☒ Yes ☐ No
- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has prior convictions for sex offenses against an adult or child? ☒ Yes ☐ No
- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident is or is perceived to be gay, lesbian, bisexual, transgender, intersex, or gender nonconforming (the facility affirmatively asks the resident about his/her sexual orientation and gender identity AND makes a subjective determination based on the screener's perception whether the resident is gender non-conforming or otherwise may be perceived to be LGBTI)? ☒ Yes ☐ No
- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has previously experienced sexual victimization? ☒ Yes ☐ No
- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: The resident's own perception of vulnerability? ☒ Yes ☐ No

115.241 (e)

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

115.241 (f)

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

115.241 (g)

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

115.241 (h)

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

115.241 (i)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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 following evidence was analyzed in making the compliance determination:

Documents:

1. Pharos House Pre-Audit Questionnaire (PAQ)
2. Pharos House policy *Staff and Resident Sexual Abuse and Sexual Harassment (PREA)*
3. Pharos House PREA Risk Assessment Tool

Interviews:

1. Pharos House PREA Coordinator
2. Pharos House Staff Responsible for Risk Screening
3. Pharos House Intake Staff
4. Random Residents

Site Review Observations:

1. PREA posters within the facility

Pharos House policy *Staff and Resident Sexual Abuse and Sexual Harassment (PREA) states* (*p.14-16*):

3.Screening for Risk of Sexual Victimization and Abusiveness
a. All residents arriving at the program shall be assessed during an intake screening (and upon transfer to another facility) for their risk of being sexually abused by other residents or sexually abusive toward other residents, using the PREA Victim and/or Predator Screening Instrument Checklist (Attachment C).
(1) Intake screening shall ordinarily take place within 72 hours of arrival at the program.
(2) Such assessments shall be conducted using an objective screening instrument.
(3) The intake screening shall consider, at a minimum, the following criteria to assess residents for risk of sexual victimization:
(a.) Whether the resident has a mental, physical, or developmental disability;
(b.) The age of the resident;
(c.) The physical build of the resident;
(d.) Whether the resident has previously been incarcerated;
(e.) Whether the resident's criminal history is exclusively nonviolent;
(f.) Whether the resident has prior convictions for sex offenses against an adult or child;
(g.) Whether the resident is or is perceived to be (by staff or residents) gay, lesbian, bisexual, trans gender, intersex, or gender nonconforming;
(h.) Whether the resident has previously experienced sexual victimization; and
(i.) The resident's own perception of vulnerability.
(4) In assessing residents for risk of being sexually abusive, the intake screening shall consider prior acts of sexual abuse, prior convictions for violent offenses, and history of prior institutional violence or sexual abuse, as known to the agency.
(5) Each completed PREA Victim and/or Predator Screening Instrument will be stored in the residents confidential file which is kept in a locked filing cabinet.
(6) Within a set time period, not to exceed 30 days from the resident's arrival at the program, staff will reassess the resident's risk of victimization or abusiveness based upon any additional, relevant information received by the program since the intake screening.
(a) A resident's risk level shall also be reassessed when warranted due to a referral, request, incident of sexual abuse, or receipt of additional information that bears on the resident's risk of sexual victimization or abusiveness.
(b) Using the PREA Victim and/or Predator Screening Instrument the Program Director, or designee, will conduct the 30-day reassessment of the resident's risk level of victimization or abusiveness.
(c) The case manager or Social Services Coordinator supervisor managing the case will track the date of the assessment and reassessment for each resident in the program.

(7) Residents may not be disciplined for refusing to answer, or for not disclosing complete information in response to, questions asked pursuant to:

(a)Whether the resident has a mental, physical, or developmental disability.

(b) Whether the resident is or is perceived to be gay, lesbian, bisexual, transgender, intersex, or gender nonconforming

(c) Whether the resident has previously experienced sexual victimization.

(d) The resident's own perception of vulnerability.

(8) Program staff shall implement appropriate controls on the dissemination within the program of responses to questions asked pursuant to the intake screening in order to ensure that sensitive information is not exploited to the resident's detriment by staff or other residents.

(9) The program makes individualized determinations about how to ensure the safety of each resident.

Interviews with two staff members who conduct risk screening revealed that residents are not consistently screened within 72 hours of arrival at the facility. The auditor's review of resident records confirmed that 8 of the 17 residents (47%) in the facility during the audit had their screening later than 72 hours. The objective tool incorporates the nine criteria listed in this Standard (see policy above). Staff confirmed that the screening instrument has check boxes used to quantify resident's responses, however, the tool is also used to interview the resident to inform the determination of risk for victimization or risk of abusiveness. As required by Standard the intake screening considers *prior acts of sexual abuse, prior convictions for violent offenses, and history of prior institutional violence or sexual abuse*. The auditor also reviewed the records for the required 30-day reassessments. All 17 residents had their reassessment completed outside of the 30-day time requirement. The PREA Coordinator reviewed the resident records and confirmed the punctuality of both the intake screening and the reassessments. The facility's two Case Managers were interviewed and confirmed that residents may be reassessed at any time when a staff member makes a referral, when a resident is involved in an alleged incident of sexual abuse or sexual harassment, when the resident requests a reassessment or when the facility receives information relating to a resident's risk of sexual abusiveness or victimization. Intake staff and Case Managers confirmed that residents are encouraged to answer all questions of the screening and reassessment instruments, however, residents are not disciplined for refusing to answer any questions or for failing to provide complete responses to questions. The facility made resident discipline records available to the auditor. Upon review, there were no instances where a resident was disciplined for refusing to answer or not completely answering screening or reassessment questions. The PREA Coordinator confirmed that all resident screening and reassessment forms are secured in locked file cabinets and only staff who need to utilize the forms for their work with residents can access them. Random security staff interviews confirmed that they do not have access to this information.

The facility revised their process for competing and tracking the intake screenings and 30-day reassessments. The facility provided documentation which demonstrated that compliance with the timeframes in this Standard had been institutionalized.

Based upon this analysis, the auditor finds the facility is substantially compliant with this standard.

Corrective Action:

This standard requires that the intake screening and reassessment be conducted within 72 hours and 30 days, respectively. The facility needs to demonstrate that it has adopted as an institutional practice, the compliance with these time requirements. The auditor will review resident records during the Corrective Action period to validate that this has been done. At a minimum, the facility will need to demonstrate consistent compliance for a period of 90-120 days.

Update:

The facility has effectively demonstrated compliance during the Corrective Action period with supporting documentation. The facility is now substantially compliant with this Standard.

Standard 115.242: Use of screening information

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

115.242 (a)

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

115.242 (b)

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

115.242 (c)

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

115.242 (d)

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

115.242 (e)

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

115.242 (f)

- Unless placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting lesbian, gay, bisexual, transgender, or intersex residents, does the agency always refrain from placing: lesbian, gay, and bisexual residents in dedicated facilities, units, or wings solely on the basis of such identification or status? (N/A if the agency has a dedicated facility, unit, or wing solely for the placement of LGBT or I residents pursuant to a consent decree, legal settlement, or legal judgement.) ☒ Yes ☐ No ☐ NA

- Unless placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting lesbian, gay, bisexual, transgender, or intersex residents, does the agency always refrain from placing: transgender residents in dedicated facilities, units, or wings solely on the basis of such identification or status? (N/A if the agency has a dedicated facility, unit, or wing solely for the placement of LGBT or I residents pursuant to a consent decree, legal settlement, or legal judgement.) ☒ Yes ☐ No ☐ NA

- Unless placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting lesbian, gay, bisexual, transgender, or intersex residents, does the agency always refrain from placing: intersex residents in dedicated facilities, units, or wings solely on the basis of such identification or status? (N/A if the agency has a dedicated facility, unit, or wing solely for the placement of LGBT or I residents pursuant to a consent decree, legal settlement, or legal judgement.)
☒ 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 following evidence was analyzed in making the compliance determination:

Documents:

1. Pharos House Pre-Audit Questionnaire (PAQ)
2. Pharos House policy *Staff and Resident Sexual Abuse and Sexual Harassment (PREA)*
3. Pharos House Victim/Predator Screening Instrument

Interviews:

1. PREA Coordinator
2. Pharos House Staff Responsible for Risk Screenings
3. Residents who Identified as Transgender/Intersex
4. Residents who Identified as Gay/Lesbian

Site Review Observations:

1. Facility Room Layout and Resident Housing Assignments

Pharos House policy *Staff and Resident Sexual Abuse and Sexual Harassment (PREA) states* (*p.16-17*):

b. Use of Screening Information
(1) The program uses information from the PREA Victim and/or Predator Screening Instrument to inform housing, bed, work, education, and program assignments with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive.
(2) The program makes individualized determinations about how to ensure the safety of each resident.
(3) The program makes housing and program assignments for transgender or intersex residents in the facility on a case-by-case basis considering whether a placement would ensure the residents health and safety, and whether the placement would present management or security problems.
(4) A transgender or intersex resident's own views with respect to his or her (if applicable) own safety shall be given serious consideration.
(5) Transgender and intersex residents shall be given the opportunity to shower separately from other residents.
(6) The placement of lesbian, gay, bisexual, trans gender, or intersex residents in dedicated units, or wings solely on the basis of such identification or status, (unless such placement is in a dedicated unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting such residents) is prohibited.
c. Roommate and Room Assignments
(1) Supervisory staff shall be proactive in the prevention of sexual abuse and sexual harassment when making roommate and room selections for residents. Staff will use the results of the PREA Victim and/or Predator Screening Instrument and will consider the following factors:
(a) Compatibility of resident's chronological age
(b) Maturity
(c) Gang affiliation
(d) Level of sophistication
(e) Functioning level
(f) Size and strength
(g) Disabilities
(h) Infirmities
(i) Behavioral history
(j) Detaining or committing offenses.
(2) If a resident has a known history of being a sexual predator, as evidenced through detaining or committing offenses, reports from prior placements, or other credible information, that resident shall be placed in a single room if space allows.
(3) Staff shall take seriously a resident's request for a room change and discretely inquire whether the resident is feeling unsafe. If the resident

answers yes, the staff member should bring this to the attention of a Supervisor and Program Director for investigation.

The auditor interviewed the Pharos House PREA Coordinator, who confirmed that intake screening information is used to inform decisions regarding housing, bed, work, education, and program assignments within the facility. Pharos House receives information on arriving residents from the Federal Bureau of Prisons weeks (and sometimes months) in advance. This information includes any special considerations, disabilities or institutional behavior history that may impact the resident's stay. With this information, the Executive Director makes a provisional housing determination on where the incoming resident should be housed. Interviews with Case Managers confirmed that the initial housing assignment is sometimes changed based upon the results of the intake risk screening. When this occurs, staff notify the Executive Director of the change and the justification. According to staff, they always make individualized determinations and assign residents to housing, work and programs based upon the screening information. During the onsite audit, there was one transgender and no intersex residents in the facility. Interview with the transgender resident revealed that the resident was asked about their safety during intake, was placed in a general population resident room, which was single occupancy. The facility layout provides private bathrooms with showers adjacent to the stairwells, for all resident use. The auditor interviewed one resident who identified as Gay. The resident confirmed that his housing and program assignments were the same as other residents in the facility. During the site review, the auditor observed that there were no special housing areas identified for residents who were Lesbian, Gay, Bisexual, Transgender, or Intersex (LGBTI).

Based upon this analysis, the auditor finds the facility is substantially compliant with this standard.

REPORTING

Standard 115.251: Resident reporting

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

115.251 (a)

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

115.251 (b)

- Does the agency also provide at least one way for residents to report sexual abuse or sexual harassment to a public or private entity or office that is not part of the agency? ☒ Yes ☐ No
- Is that private entity or office able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials? ☒ Yes ☐ No
- Does that private entity or office allow the resident to remain anonymous upon request? ☒ Yes ☐ No

115.251 (c)

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

115.251 (d)

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

Auditor Overall Compliance Determination

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

☒ **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 following evidence was analyzed in making the compliance determination:

Documents:

1. Pharos House Pre-Audit Questionnaire (PAQ)
2. Pharos House policy *Staff and Resident Sexual Abuse and Sexual Harassment (PREA)*
3. Resident PREA Information (undated)

Interviews:

1. PREA Coordinator
2. Random Staff
3. Random Residents
4. Residents who Reported Sexual Harassment

Site Review Observations:

1. PREA posters within the facility
2. PREA Reporting Notices
3. Pharos House website (www.pharoshouse.org)

Pharos House policy *Staff and Resident Sexual Abuse and Sexual Harassment (PREA) states* (*p.18-19*):

Procedure F: Resident Reporting/ Investigations

1.The program shall provide multiple internal ways for residents to privately report sexual abuse and sexual harassment, retaliation by other residents or
staff for reporting sexual abuse and sexual harassment, and staff neglect or violation of responsibilities that may have contributed to such incidents.
2. The program has standardized reporting forms (Attachment B) available to
residents to fill out. Residents can submit confidential reports of sexual abuse.
3. Residents can submit confidential reports of sexual abuse or sexual harassment violations by completing the reporting form, putting it in an envelope and placing the envelope at the front desk or designated locked box.
4. The program also shall inform residents of at least one way to report sexual abuse or sexual harassment to a public or private entity or office that is not part of the agency and that is able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials, allowing the resident to remain anonymous upon request.
5.Staff shall accept reports made verbally, in writing, anonymously, and from third parties and shall promptly document and respond to any verbal reports.
6.The program shall provide a method for staff to privately report sexual abuse and sexual harassment of residents.
7.Third Party Reporting
a. The program shall allow for third parties to report sexual abuse or sexual harassment for any resident and distributes information explaining how to report sexual abuse and sexual harassment on behalf of a resident.
(1) The PREA Third Party Reporting Form (Attachment K) is available for individuals to report sexual abuse or sexual harassment on behalf of an offender.
(2) Copies of the form can be found in the PREA manual.
(a)All reports of sexual abuse and sexual harassment received from third parties shall be responded to according to Pharos House policy by agency staff.
(b)Any staff receiving a third-party report of sexual abuse or sexual harassment shall forward such report to their immediate supervisor who will in turn forward it to the Executive Director and the PREA Compliance Manager who will follow the proper PREA reporting guidelines.
(c)Third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, shall be permitted to assist residents in filing requests for administrative remedies relating to allegations of sexual abuse and sexual harassment, and shall also be permitted to file such requests on behalf of residents;
(d) If third-party files such a request on behalf of a resident, Pharos House may require as a condition of processing the request, that the alleged victim agrees 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;
(e)If the resident declines to have the request processed on his or her behalf, Pharos House shall document the residents' decision.

The Resident PREA information (undated) provides a list of resident reporting options. This list includes informing any staff member, reporting to the PREA Coordinator, calling Sexual Assault Response Service of Southern Maine (SARSSM) Hotline, call the National Sexual Assault Hotline, call the SARSSM business line and dialing 911 to talk to the Portland Police. At the start of this audit, Pharos House identified a local rape crisis center as the External Reporting Entity. The auditor reviewed the PREA Resource Center's FAQ

section and found guidance that was issued in February of 2020 that identified rape crisis centers as not sufficient to meet the requirements of this standard. Between the time of the onsite audit and the writing of this Interim Report, the auditor worked with the facility to identify a new Entity, which was Midcoast Regional Reentry Center, a community confinement facility managed by the Waldo County Sheriff's Office in Belfast, Maine. The facility was in the process of revising their PREA information with this new entity. There was insufficient time to rebrand all documents, distribute them to residents and staff and post them in the facility. As a result, this element of this standard is being cited as noncompliant (see below).

Interviews with random residents confirmed that they were aware of multiple reporting methods. Residents stated that they could report incidents of Sexual Abuse and Sexual Harassment in the following ways: *tell a staff member, tell the Executive Director, call the hotline number, write a request, submit a grievance, tell their Case Manager, call the police* (Portland Police Department). Random staff interviews confirmed their understanding of how to accept a report and initiate a response. Staff confirmed that they would accept reports verbally, in writing, anonymously and through a third party. Staff confirmed that verbal reports would be reduced to writing as soon as possible but no later than the end of their shift. The auditor visited the facility website and verified that reporting information for third parties is posted to the website. Staff also recited several ways that they could privately report allegations of sexual abuse or sexual harassment, which include verbal reports, email correspondence and phone calls to the Executive Director or PREA Coordinator. Random staff were interviewed and were able to identify multiple ways that residents could report incidents of Sexual Abuse and Sexual Harassment. Staff reported these methods as: *telling a staff member, filing a grievance, completing a request form, calling the police, and using the hotline number*. All residents acknowledged viewing PREA Reporting Notices in the facility.

The facility entered into an MOU with an external agency, who is capable of receiving and immediately forwarding resident reports of sexual abuse and sexual harassment to the facility. This information has been provided to all existing residents and staff and is now included in the orientation package for future new residents to receive.

Based upon this analysis, the auditor finds the facility is substantially compliant with this standard.

Corrective Action:

Revise all PREA documentation and forms to include the new name and process for contacting the new External Reporting Entity. This information should also be incorporated into the reporting option located on the facility website. Require all existing residents and staff to sign a document which acknowledges their receipt and understanding of the existence of the revised external reporting process.

Update:

The facility has effectively demonstrated compliance during the Corrective Action period with the supporting documentation. The facility is now substantially compliant with this Standard.

Standard 115.252: Exhaustion of administrative remedies

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

115.252 (a)

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

115.252 (b)

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

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

115.252 (c)

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

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

115.252 (d)

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

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

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

115.252 (e)

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

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

115.252 (f)

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

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

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

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

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

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

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

115.252 (g)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making the compliance determination:

Documents:

1. Pharos House Pre-Audit Questionnaire (PAQ)
2. Pharos House policy *Staff and Resident Sexual Abuse and Sexual Harassment (PREA)*

Interviews:

1. PREA Coordinator

Site Review Observations:

1. PREA posters within the facility
2. Grievance mailbox located in the entrance foyer

Pharos House policy *Staff and Resident Sexual Abuse and Sexual Harassment (PREA) states* (*p.20-21*):

8. Exhaustion of Administrative Remedies
a. The program ensures a formal administrative process to address resident grievances regarding sexual abuse and sexual harassment. The program prohibits an informal grievance process or to otherwise attempt to resolve with staff, an alleged incident of sexual abuse or sexual harassment.
b. Residents who wish to file a grievance related to sexual harassment or sexual abuse may contact, either verbally or in writing, the Executive Director to file their grievance.
c. When a grievance is filed the Executive Director will contact the Bureau of Prisons to review the matter.
d. When a grievance is filed the Executive Director will contact the local law enforcement agency to determine whether or not there could be any criminal charges.
e. Whether or not a grievance that involves an allegation of sexual abuse or sexual harassment is a crime will be determined by the local law enforcement agency
f. Filing a grievance does not change the responsibilities of Pharos House to comply with all aspects of the PREA policy.
g. If the allegation involves a behavior that is not considered criminal then the matter may be handled through a formal Administrative process.
h. If the allegation involves a behavior that is determined then the matter will be handled through the local District Attorney's office and the Bureau of Prisons will be informed.
i. The program shall not impose a time limit on when a resident may submit a grievance regarding an allegation of sexual abuse or sexual harassment.
j. A resident who alleges sexual abuse or sexual harassment may submit a grievance without submitting it to a staff member who is the subject of the complaint.
k. Such grievances will not be referred to a staff member who is the subject of the complaint.
l. Pharos House shall 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.
m. Computation of the 90-day time period shall not include time consumed by residents in preparing any administrative appeal.
n. Pharos House may claim an extension of time to respond, of up to 70 days, if the normal time period for response is insufficient to make an appropriate decision; Pharos House shall notify the resident in writing of any such extension and provide a date by which a decision will be made.
o. 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, the resident may consider the absence of a response to be a denial at that level.

p. Emergency Grievances

(1) The program shall provide procedures for the filing of an emergency grievance alleging that a resident is subject to a substantial risk of imminent sexual abuse or sexual harassment.

(2) After receiving an emergency grievance alleging a resident is subject to a substantial risk of imminent sexual abuse or sexual harassment, the program shall immediately forward the grievance (or any portion thereof that alleges the substantial risk of imminent sexual abuse or sexual harassment) to a level of review at which immediate corrective action may be taken, shall provide an initial response within 48 hours, and shall issue a final agency decision within 5 calendar days. The initial response and final decision shall document the program's determination whether the resident is in substantial risk of imminent sexual abuse or sexual harassment and the action taken in response to the emergency grievance.

q. Unsubstantiated Grievances

(1) The program may discipline a resident for filing a grievance related to alleged sexual abuse only where the program demonstrates that the resident filed the grievance in bad faith.

Pharos House has administrative procedures in place to address resident grievances regarding sexual abuse and is not exempt from this standard. The auditor's interview with the PREA Coordinator confirmed that there is a grievance process in place and that there is no time limit on when a resident can submit a grievance regarding an allegation of sexual abuse. The facility does not require residents to utilize any informal grievance process prior to filing a formal grievance relating to sexual abuse. Interviews with random staff confirmed that when a resident requests a grievance form the staff member issues a blank grievance form to the resident without requiring any explanation of what the grievance is for. The front entrance foyer contains a locked mailbox which is mounted to the wall, for residents to file grievances. The mailbox is accessed by the Executive Director, which prevents other staff members, who may be the subject of the grievance, from handling the grievance. Pharos House policy also established a resident's right to file an Emergency Grievance and establishes the response timeframes, which are consistent with the requirements of this standard. Pharos House policy cited above, prescribes the time limits for response, agency extension of the time limits and the automatic response of a denial, whenever the agency does not meet the time limits for any level of the grievance process. Third parties can assist residents in filing requests for administrative remedies.

During the audit period, there were no grievances related to sexual abuse and no Emergency Grievances related to imminent risk of sexual abuse. The facility reported that there were no instances of a resident being disciplined for filing a grievance related to sexual abuse.

Based upon this analysis, the auditor finds the facility is substantially compliant with this standard.

Standard 115.253: Resident access to outside confidential support services

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

115.253 (a)

- Does the facility provide residents with access to outside victim advocates for emotional support services related to sexual abuse by giving residents mailing addresses and telephone numbers, including toll-free hotline numbers where available, of local, State, or national victim advocacy or rape crisis organizations? ☒ Yes ☐ No
- Does the facility enable reasonable communication between residents and these organizations and agencies, in as confidential a manner as possible? ☒ Yes ☐ No

115.253 (b)

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

115.253 (c)

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

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making the compliance determination:

Documents:

1. Pharos House Pre-Audit Questionnaire (PAQ)
2. Pharos House policy *Staff and Resident Sexual Abuse and Sexual Harassment (PREA)*
3. Pharos House Resident PREA information (undated)
4. MOU with Sexual Assault Response Services of Southern Maine (SARSSM)

Interviews:

1. PREA Coordinator
2. Random Residents

Site Review Observations:

1. PREA posters within the facility

Pharos House policy *Staff and Resident Sexual Abuse and Sexual Harassment (PREA) states* (*p.29-30*):

f. Resident Access to Outside Confidential Support Services:
(1) The program will provide residents with access to outside victim advocates for emotional support including toll-free hot line numbers

where available, of local, state, and national victim advocacy or rape crisis organizations, and by enabling reasonable communication between residents and these organizations, in as confidential a manner as possible.
(2) The program will 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.
(3) The program will maintain or attempt to enter into memoranda of understanding (MOUs) or other agreements with community service providers that are able to provide residents with confidential emotional support services related to sexual abuse.
(a)The program maintains copies of agreements or documentation showing attempts to enter into such agreements.

The facility has PREA posters posted in common areas in the facility, which include the name and toll-free contact information for a local rape crisis center, Sexual Assault Response Services of Southern Maine (SARSSM). The facility has an MOU in place with SARSSM which provides residents access to victim advocates, follow-up and crisis intervention resources related to sexual abuse. As part of the auditor's contacts with community-based organizations, the auditor contacted SARSSM and confirmed with the Executive Director, the MOU and the services provided to residents at Pharos House. The auditor's review of facility sexual abuse and sexual harassment incident investigation files confirmed that outside victim advocates and emotional support was offered to residents. Random interviews with residents confirmed that they were aware of the availability of victim advocacy and emotional support services and understood that conversations with these resources would remain confidential.

Based upon this analysis, the auditor finds the facility is substantially compliant with this standard.

Standard 115.254: Third-party reporting

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

115.254 (a)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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 following evidence was analyzed in making the compliance determination:

Documents:

1. Pharos House Pre-Audit Questionnaire (PAQ)
2. Pharos House policy *Staff and Resident Sexual Abuse and Sexual Harassment (PREA)*
3. Resident Acknowledgement of Prohibition on Sexual Misconduct
4. Pharos House Website (www.pharoshouse.org)

Site Review Observations:

1. PREA posters within the facility

Pharos House policy *Staff and Resident Sexual Abuse and Sexual Harassment (PREA) states* (*p.18-19*):

7.Third Party Reporting
a. The program shall allow for third parties to report sexual abuse or sexual harassment for any resident and distributes information explaining how to report sexual abuse and sexual harassment on behalf of a resident.
(1) The PREA Third Party Reporting Form (Attachment K) is available for individuals to report sexual abuse or sexual harassment on behalf of an offender.
(2) Copies of the form can be found in the PREA manual.
(a)All reports of sexual abuse and sexual harassment received from third parties shall be responded to according to Pharos House policy by agency staff.
(b)Any staff receiving a third-party report of sexual abuse or sexual harassment shall forward such report to their immediate supervisor who will in turn forward it to the Executive Director and the PREA Compliance Manager who will follow the proper PREA reporting guidelines.
(c)Third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, shall be permitted to assist residents in filing requests for administrative remedies relating to allegations of sexual abuse and sexual harassment, and shall also be permitted to file such requests on behalf of residents;
(d) If third-party files such a request on behalf of a resident, Pharos House may require as a condition of processing the request, that the alleged victim agrees 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;
(e)If the resident declines to have the request processed on his or her behalf, Pharos House shall document the residents' decision.

During the site review the auditor observed PREA posters and PREA Reporting Notices, which contained information on how to report incidents of sexual abuse and sexual harassment on behalf of someone else (third-party reporting). The Resident Acknowledgement of Prohibition on Sexual Misconduct also informs residents that they can make third-party reports on behalf of others. The auditor visited the Pharos House website and confirmed that information on how to make a third-party report of an allegation of sexual abuse or sexual harassment was listed on the website.

Based upon this analysis, the auditor finds the facility is substantially compliant with this standard.

OFFICIAL RESPONSE FOLLOWING A RESIDENT REPORT

Standard 115.261: Staff and agency reporting duties

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

115.261 (a)

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

115.261 (b)

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

115.261 (c)

- Unless otherwise precluded by Federal, State, or local law, are medical and mental health practitioners required to report sexual abuse pursuant to paragraph (a) of this section? ☒ Yes ☐ No
- Are medical and mental health practitioners required to inform residents of the practitioner's duty to report, and the limitations of confidentiality, at the initiation of services? ☒ Yes ☐ No

115.261 (d)

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

115.261 (e)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making the compliance determination:

Documents:

1. Pharos House Pre-Audit Questionnaire (PAQ)
2. Pharos House policy *Staff and Resident Sexual Abuse and Sexual Harassment (PREA)*

Interviews:

1. PREA Coordinator
2. Executive Director
3. Random Staff

Pharos House policy *Staff and Resident Sexual Abuse and Sexual Harassment (PREA) states* (*p.21-23*):

9.Staff and Agency Reporting Duties
a. Reporting Duties
(1) Any staff must immediately report to the Executive Director or designee, any knowledge, suspicion, or information regarding:
(a) an incident of sexual abuse or sexual harassment that occurred in the program;
(b) retaliation against residents or staff who reported an incident of sexual abuse or sexual harassment;
(c) any staff neglect or violation of responsibilities that may have contributed to such an incident or retaliation.
b. All reports of sexual abuse and sexual harassment that are received from third parties must be received and responded to according to policy by all staff.
(1) As soon as practical, program staff must report all allegations of sexual abuse or sexual harassment, including third party and anonymous reports, to the Executive Director and/or the PREA Compliance Manager.
(2) The PREA Compliance Manager will interview the alleged victim as soon as possible but no later than the end of that work shift. The PREA Compliance Manager may also assign the investigation to the Social Service Coordinator or the Case Manager. The completed report will be provided to the Executive Director by the end of the day that the complaint was received.
(3) If the alleged victim does not wish to file a report they will be asked to sign a refusal form (Attachment L).
(4) The Executive Director will provide this information to the Bureau of Prisons.
(5) The Executive Director will provide this information to the local law enforcement agency who will determine if the reported activity is a crime.
(6) The Bureau of Prisons will determine whether Pharos House or the Bureau of Prisons is conducting the internal investigation.

(7) If the resident states they have been sexually abused within the last 96 hours, staff must request that the resident not take any action that could destroy physical evidence, including washing, drinking, or eating, unless medically indicated. If toileting needs to take place, the resident should be instructed to not wipe;

(8) If the report alleges sexual abuse the Executive Director or their supervisory designee must contact the local Rape Crisis Center or similar local agency to arrange for a sexual assault advocate to go to the hospital where the resident is being transported.

(9) Reporting staff must also comply with all BOP requirements regarding resident disciplinary actions including the completion of an incident report (Attachment B) prior to the end of their shift.

c. All allegations of sexual abuse or sexual harassment must be reported as PREA violations.

(1) Allegations of sexual harassment between residents will be reported for investigation by the Executive Director;

(2) Allegations of sexual harassment of residents by staff will be reported for investigation by the Executive Director.

d. Upon receiving an allegation that a resident was sexually abused while residing at the program, the staff receiving this information must immediately notify the Executive Director or designee.

e. The Executive Director, or designee, must then:

(1) institute the Incident Report process;

(2) call the local authorities to begin a criminal investigation

(3) call the Bureau of Prisons

(4) notify the PREA Compliance Manager as soon as possible, but no longer than by the end of the business day of the day the report of the allegation was received.

(5) document such report and notification in the facility log.

(6) The PREA Compliance Manager, receiving this information, must immediately document such report and notification in the PREA data log.

(7) If the allegations of sexual abuse are reported to staff after the alleged victim has been transported to a medical facility, staff must:

(a)Notify the receiving medical facility of the allegation of sexual abuse and the victim's potential need for medical or social services unless the victim has requested otherwise.

(b)Complete an Incident Report in accordance with program procedures no later than the end of their current workday.

(8) A copy of all Incident Reports regarding sexual abuse and sexual harassment will be sent to the PREA Compliance Manager.

(9) If the allegation is made after a resident has left the facility, or right before they are leaving, the Executive Director will interview all parties involved (and available) and document the situation.

(10) If a crime is determined to have been committed, the Executive Director will notify the local law enforcement agency and the contracting agency and await further guidance.

(11) The applicable staff (Executive Director, the PREA Compliance Manager or designee) will keep a record of the details of the notifications, including: (Attachment A)

(a) All persons notified

(b) Date and time of notification

(c) Date and time notice of allegation was received

(d) Any details of the allegation

(e) Date and time of notification of PREA Manager

(f) Confidentiality - Apart from reporting to designated supervisors or

agency officials, staff shall not reveal 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.

The auditor interviewed random staff including 5 of the 8-security staff (Monitors) and both Lead Shift Monitors who were working onsite during the audit. All seven staff confirmed Pharos House's requirement that they immediately report any knowledge, suspicion, or information regarding any incident of sexual abuse or sexual harassment. These staff also stated that they would report the incidents to the Executive Director or PREA Coordinator and that they would keep the information confidential and not disclose it to anyone else unless directed to do so.

Pharos House does not employ medical or mental health staff onsite, therefore, there were no staff for the auditor to interview. The Executive Director, and the PREA Coordinator both confirmed during interview that the facility is aware of state law for the mandatory reporting to law enforcement and to the state, of incidents of abuse against the elderly or dependent adults (the facility does not house juveniles). The auditor's review of records did not identify any PREA incidents that required mandatory reporting to law enforcement or state officials during the audit period.

Based upon this analysis, the auditor finds the facility is substantially compliant with this standard.

Standard 115.262: Agency protection duties

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

115.262 (a)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making the compliance determination:

Documents:

1. Pharos House Pre-Audit Questionnaire (PAQ)
2. Pharos House policy *Staff and Resident Sexual Abuse and Sexual Harassment (PREA)*

Interviews:

1. Executive Director
2. Random Staff

Pharos House policy *Staff and Resident Sexual Abuse and Sexual Harassment (PREA) states* (*p.9*):

2. Substantial Risk of Imminent Sexual Abuse - 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.

The Executive Director confirmed during interview that when Pharos House learns that a resident is subject to substantial risk of imminent sexual abuse, staff are trained and required to take immediate action to protect the resident. The Executive Director stated during interview that protection could include removing the at-risk resident from their room and placing them in a staff office under the constant supervision of a staff member until the facility could obtain more information about the imminent risk being posed. The auditor interviewed 5 of the 8 security staff members (Monitors) and the two Lead Shift Monitors employed at Pharos House. All confirmed during interview that they would immediately separate and protect any resident who was in substantial risk of imminent sexual abuse. Facility records indicated that there were no residents identified as being in substantial risk of imminent sexual abuse during the audit period.

Based upon this analysis, the auditor finds the facility is substantially compliant with this standard.

Standard 115.263: Reporting to other confinement facilities

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

115.263 (a)

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

115.263 (b)

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

115.263 (c)

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

115.263 (d)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making the compliance determination:

Documents:

1. Pharos House Pre-Audit Questionnaire (PAQ)
2. Pharos House policy *Staff and Resident Sexual Abuse and Sexual Harassment (PREA)*
3. Documentation of Pharos House Report to Other Confinement Facility

Interviews:

1. Executive Director

Pharos House policy *Staff and Resident Sexual Abuse and Sexual Harassment (PREA) states* (*p.19*):

7. Reporting to Other Confinement Facilities
a. Upon receiving an allegation that a resident was sexually abused or sexually harassed while confined at another facility, the Executive Director shall notify the head of the facility or appropriate office of the agency where the alleged abuse or harassment occurred.
b. Such notification shall be provided as soon as possible, but no later than 72 hours after receiving the allegation.
c. Pharos House shall document that it has provided such notification.
d. The agency head that receives such notification shall ensure that the allegation is investigated in accordance with these standards (however, this is outside of Pharos House's control).

As part of the Pre-Onsite audit phase, the facility provided copies of email correspondence from the Pharos House PREA Coordinator to another confinement facility, which forwarded information that a new resident of Pharos House reported an allegation of sexual abuse that took place approximately 8 years ago at a Federal Bureau of Prisons (BOP) facility. The report was forwarded seven days after the information was disclosed by the resident. The incident took place 8 years ago and the resident stated that they did not want the matter investigated.

The records revealed that the notification did not come from the Executive Director of Pharos House as required by local policy and PREA Standard. Additionally, the notification was made outside of the time limits expressed in local policy and PREA standard. This information triggers a determination of noncompliance. The auditor will work with the facility to review their policy and this standard to ensure compliance moving forward.

Based upon this analysis, the auditor finds the facility is substantially compliant with this standard.

Corrective Action:

Review existing agency policy regarding requirements for reporting to other confinement facilities. Ensure that reported allegations from other facilities are forwarded within the prescribed time limits.

Update:

The facility reviewed their PREA policy and committed to meeting the timeframe for notification to other facilities in the future. The facility is now substantially compliant with this Standard.

Standard 115.264: Staff first responder duties

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

115.264 (a)

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

115.264 (b)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making the compliance determination:

Documents:

1. Pharos House Pre-Audit Questionnaire (PAQ)
2. Pharos House policy *Staff and Resident Sexual Abuse and Sexual Harassment (PREA)*

Interviews:

1. Random Staff

Pharos House policy *Staff and Resident Sexual Abuse and Sexual Harassment (PREA) states* (*p.26-27*):

b. Upon learning that a resident was sexually abused, the first staff member to respond to the scene must:
(1) Separate the alleged victim and alleged abuser (to protect the victim and prevent further violence);
(2) Not leave the alleged victim alone;
(3) Ensure no one else enters the area to preserve and protect the crime scene;
(4) Check victim for immediate medical attention and call 911 if warranted.
(5) Contact the Person-in-Charge (Executive Director or designee) to request the assistance (including notifying FBOP of incident);
(6) If the abuse occurred within a time period that would still allow for the collection of physical evidence (up to 96 hours), request that the alleged victim not take any action that could destroy physical evidence, including washing or showering, drinking, or eating (unless medically indicated), brushing teeth, changing clothes, or toileting.
(a)If toileting needs to take place, the resident should be instructed to not wipe.
(7) In the event of an allegation of sexual abuse within the last 96 hours, including but not limited to those involving penetration, staff will have resident transported to a local hospital, with the victim's permission, equipped to evaluate and treat sexual abuse/rape victims, where he/she may receive a forensic medical exam by medical personnel not employed by the program.
(a)Staff will request that the resident to wash, shower, toilet, change clothes, brush teeth, eat or drink (unless medically indicated) before examination, as evidence may be destroyed.
(8) Where possible, examinations performed at the community medical facility are performed by Sexual Assault Forensic Examiners (SAFE) and Sexual Assault Nurse Examiners (SANE) nurses.
(a)If SAFEs or SANEs cannot be made available, the examination will be performed by other qualified medical practitioners.
(9) If the victim refuses medical attention following a sexual misconduct incident or allegation, staff will document the refusal on the PREA Victim Medical Refusal Form (Attachment M).
(10) Staff will have the resident transported to the medical facility, ensuring that the resident feels safe with the program staff chosen to accompany him or her.
(11) Staff shall record the medical facility contact information and details of physical injury in a written Incident Report before the end of the shift.
(12) If a disclosure is made of a sexual assault more than 24 hours after the incident, staff should follow the reporting steps and refer the resident to counseling services.
(a)Law enforcement or an ambulance will transport the victim transported to a community medical facility for evidence collection.

(13) If requested by the victim, a victim advocate, qualified program staff member, or qualified staff from a community-based agency shall accompany and support the victim through the forensic medical examination process and investigatory reviews and shall provide emotional support, crisis intervention, information, and referrals.

(14) The Executive Director, or designee, will contact the local rape crisis center (or other similar local agency) to provide follow up support and services to the resident.

(15) The Executive Director, or designee, in consultation with the local mental health provider, shall determine if the resident requires one-to-one observation in accordance with Pharos Houses' Suicide Policy.

(16) The shift monitor on duty shall take steps to preserve any physical evidence of the alleged sexual abuse. The Executive Director should prevent anyone from entering the area, altering the area, or removing anything from the area, until investigators can arrive and document it.

(17) The staff member who receives an initial report of sexual abuse must separate the victim from the alleged assailant to protect the victim and prevent further violence, and are required to promptly intervene on the victim's behalf to ensure the victim receives prompt medical and psychological assistance, as appropriate to his or her needs and the circumstances of the alleged offense.

(18) Psychological trauma may also occur to individuals of sexual abuse or sexual harassment. Mental health staff must be available to support and assist those in need.

(19) Pharos House will ensure that all 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 potential criminal behavior.

(a) Pharos House will document all such referrals.

(b) Pharos House's policy on this issue will be made publicly available by requesting a copy from the Pharos House PREA Coordinator.

As noted above Pharos House policy requires security staff first responders to (1) separate the victim, (2) preserve and protect any crime scene, (3) when an incident is reported within a timeframe that still allows for the collection of physical evidence, request that the alleged victim not take any actions that could destroy physical evidence, (4) when an incident is reported within a timeframe that still allows for the collection of physical evidence, request that the alleged abuser not take any actions that could destroy physical evidence; which meets the requirements of this standard. There are no non-security staff that have unescorted contact with residents. There were no security staff who acted as First Responders to an incident of sexual abuse, for the auditor to interview. There was one incident of sexual abuse (inappropriate touching) that occurred in 2019. The resident was no longer at the facility and could not be interviewed. were also no residents who reported sexual abuse for the auditor to interview. Security staff members interviewed were able to describe the steps that they have been trained to take to protect the alleged victim, preserve and protect any crime scene, instruct the alleged victim not to destroy any physical evidence and take steps to ensure that the victim does not destroy any physical evidence.

Based upon this analysis, the auditor finds the facility is substantially compliant with this standard.

Standard 115.265: Coordinated response

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

115.265 (a)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making the compliance determination:

Documents:

1. Pharos House Pre-Audit Questionnaire (PAQ)
2. Pharos House policy *Staff and Resident Sexual Abuse and Sexual Harassment (PREA)*

Interviews:

1. Pharos House Facility Director

Pharos House policy *Staff and Resident Sexual Abuse and Sexual Harassment (PREA) states* (*p.26*):

1.Coordinated Response to Alleged Incidents of Sexual Abuse/Staff First Responders.
a. The program will work towards providing a coordinated response to all allegations of sexual abuse, including interventions by first responder staff, medical facility staff, mental health practitioners, local law enforcement, investigators and program staff. This policy and procedure serves as a written plan for providing coordinated actions taken in response to an incident of sexual abuse.

The Executive Director confirmed during interview that Pharos House has an institutional plan to coordinate actions taken in response to an incident of sexual abuse, among staff, first responders and medical and mental health practitioners, investigators, and facility leadership. The Plan provides step-by-step instructions for security staff to take when responding to an incident of sexual abuse. Pharos House does not have medical or mental health staff onsite and the Plan states that local health providers will be contacted. Pharos House has an MOU with Sexual Assault Response Services of Southern Maine (SARSSM) for victim advocacy and emotional support.

Based upon this analysis, the auditor finds the facility is substantially compliant with this standard.

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

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

115.266 (a)

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

115.266 (b)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making the compliance determination:

Documents:

1. Pharos House Pre-Audit Questionnaire (PAQ)
2. Pharos House policy *Staff and Resident Sexual Abuse and Sexual Harassment (PREA)*

Interviews:

1. Executive Director

The Executive Director confirmed during interview that Pharos House was not part of a Collective Bargaining Agreement.

Based upon this analysis, the auditor finds the facility is substantially compliant with this standard.

Standard 115.267: Agency protection against retaliation

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

115.267 (a)

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

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

115.267 (b)

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

115.267 (c)

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

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

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

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

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

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

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

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

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

115.267 (d)

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

115.267 (e)

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

115.267 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making the compliance determination:

Documents:

1. Pharos House Pre-Audit Questionnaire (PAQ)
2. Pharos House policy *Staff and Resident Sexual Abuse and Sexual Harassment (PREA)*

Interviews:

1. Executive Director
2. PREA Coordinator
3. Social Services Coordinator
4. Case Manager

Pharos House policy *Staff and Resident Sexual Abuse and Sexual Harassment (PREA) states* (*p.9-10*):

4. Protection Against Abuse and Retaliation
a. The program must employ all available measures to protect vulnerable residents from abuse or prevent abusers from having the opportunity to abuse by:

(1) Consultation with the referral source;
(2) Removing alleged resident abusers from contact with victims;
(3) Removing alleged staff abusers from contact with victims;
(4) Monitoring resident rooms, including by direct observation, if necessary;
(5) Transferring potential victims/abusers to other facilities, if operationally possible;
(6) Actively monitoring, for at least 90 days, the conduct and treatment of residents or staff who reported abuse or harassment, and, of residents who were reported to have suffered abuse to see if there are changes that may suggest possible retaliation by residents or staff;
a. The Case Manager or Social Services Coordinator will monitor the conduct and treatment of any client assigned to them who is involved in a PREA incident using the Monitoring Against Retaliation form (Attachment P).
b. The Case Manager or Social Services Coordinator will also monitor the conduct and treatment of any of the residents assigned to them that cooperated with a PREA investigation.
c. The Case Manager or Social Services Coordinator will contact the PREA Compliance Manager should they detect any signs of retaliation against any resident involved in any way in a PREA incident.
d. Should the Case Manager or Social Services Coordinator be unavailable the remaining Case Manager will monitor the situation.
e. The Case Manager or Social Service Coordinator will check in with the alleged victim of any PREA incidents at least once per week to ensure that no retaliation is occurring.
(7) Promptly remedying any signs of retaliation detected;
(8) Monitoring any resident disciplinary reports, housing program changes, or negative performance reviews or reassignments of staff;
(9) Continuing monitoring beyond 90 days if the initial monitoring indicates a continuing need;
(10) Providing monitoring that includes periodic status checks for residents; and
(11) Protecting individuals who cooperate in investigations who express fear of retaliation.
b. The program's obligation to protect against retaliation ends if any allegation is unfounded.

Pharos House policy establishes that the Case Manager and Social Services Coordinator are responsible for monitoring residents and staff for retaliation. Interviews with the Executive Director, PREA Coordinator and Case Managers and Social Services Coordinator confirmed that Pharos House has a tracking system in place to monitor residents and staff who have reported sexual abuse and sexual harassment and protect them from retaliation by other residents or staff for at least 90 days, as required by this standard. Pharos House can change a resident's room assignment, change an alleged abuser's room assignment, remove residents from a room to create a single room for the resident who reported the incident and in extreme cases, Pharos House can contact the Federal Bureau of Prisons and ask that a resident be removed from the facility and returned to custody. The facility can also implement schedule changes which prohibit residents from being in the dining area or recreation room at the same time (this was occurring for two residents at the time of the onsite audit). There was one resident who reported sexual harassment at the facility during the onsite audit. The resident stated during their interview that they felt safe and that the facility responded to the situation immediately. The resident confirmed that status checks were occurring at least weekly. There were no instances of a staff member or other individual reporting an incident, therefore there was no documentation of retaliation monitoring for the auditor to review.

Based upon this analysis, the auditor finds the facility is substantially compliant with this standard.

INVESTIGATIONS

Standard 115.271: Criminal and administrative agency investigations

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

115.271 (a)

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

115.271 (b)

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

115.271 (c)

- Do investigators gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data? ☒ Yes ☐ No
- Do investigators interview alleged victims, suspected perpetrators, and witnesses? ☒ Yes ☐ No
- Do investigators review prior reports and complaints of sexual abuse involving the suspected perpetrator? ☒ Yes ☐ No

115.271 (d)

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

115.271 (e)

- Do agency investigators assess the credibility of an alleged victim, suspect, or witness on an individual basis and not on the basis of that individual's status as resident or staff? ☒ Yes ☐ No
- Does the agency investigate allegations of sexual abuse without requiring a resident who alleges sexual abuse to submit to a polygraph examination or other truth-telling device as a condition for proceeding? ☒ Yes ☐ No

115.271 (f)

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

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

115.271 (g)

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

115.271 (h)

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

115.271 (i)

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

115.271 (j)

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

115.271 (k)

- Auditor is not required to audit this provision.

115.271 (l)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making the compliance determination:

Documents:

1. Pharos House Pre-Audit Questionnaire (PAQ)
2. Pharos House policy *Staff and Resident Sexual Abuse and Sexual Harassment (PREA)*
3. National Institute of Corrections Specialized Training *Certificate of Attendance*

Interviews:

1. Executive Director
2. PREA Coordinator
3. Pharos House PREA Investigator (PREA Coordinator)

Pharos House policy *Staff and Resident Sexual Abuse and Sexual Harassment (PREA) states* (*p.28*):

> *(19) Pharos House will ensure that all 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 potential criminal behavior.*
>
> *(a) Pharos House will document all such referrals.*
>
> *(b) Pharos House's policy on this issue will be made publicly available by requesting a copy from the Pharos House PREA Coordinator.*

Pharos House policy requires all allegations of sexual abuse and sexual harassment to be investigated. The PREA Coordinator and the Social Services Coordinator serve as the facility's trained PREA Investigators. The auditor verified that both individuals have attended specialized training for investigators of sexual abuse in a confinement setting, as required by PREA standard. During interview, the PREA Coordinator confirmed that an administrative investigation is initiated immediately upon receipt of an allegation. The PREA coordinator also confirmed that allegations reported anonymously or via a third party are treated the same way as allegations reported directly from a victim.

Criminal investigations at Pharos House would be conducted by the Portland Police Department. Pharos House staff are trained to preserve the crime scene and any evidence of the incident. This includes monitoring the alleged victim and the alleged abuser to prevent either from showering, brushing teeth, changing clothes, or taking any other action that may alter usable physical evidence. The PREA Coordinator and Social Services Coordinator have been trained to collect evidence and may do so if the alleged incident is not criminal. The PREA Coordinator and the Social Services Coordinator confirmed that for administrative investigations, they would interview alleged victims, suspected perpetrators, and witnesses. They would also review prior complaints and reports of sexual abuse involving the suspected perpetrator. Pharos House staff would not conduct any compelled interviews unless the incident was not criminal. The Portland Police Department would be responsible for consulting with prosecutors prior to initiating a compelled interview in a criminal case.

The PREA Coordinator and the Social Services Coordinator confirmed during interviews that an administrative investigation would continue and would not be terminated if the alleged victim or abuser terminated employment or was released from the facility. They also confirmed that Pharos House policy requires the facility to cooperate with the outside investigating entity and to periodically contact the entity to request updates and to remain informed about the progress of the investigation (to the extent that law enforcement would provide details).

Based upon this analysis, the auditor finds the facility is substantially compliant with this standard.

Standard 115.272: Evidentiary standard for administrative investigations

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

115.272 (a)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making the compliance determination:

Documents:

1. Pharos House Pre-Audit Questionnaire (PAQ)
2. Pharos House policy *Staff and Resident Sexual Abuse and Sexual Harassment (PREA)*
3. National Institute of Corrections Specialized Training *Certificate of Attendance*

Interviews:

1. PREA Coordinator
2. Social Services Coordinator

Pharos House policy *Staff and Resident Sexual Abuse and Sexual Harassment (PREA) states* (*p.24*):

> *(d) Pharos House shall impose no standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated.*

The PREA Coordinator and the Social Services Coordinator serve as the facility's investigators for administrative investigations involving allegations of sexual abuse and sexual harassment. The facility provided documentation verifying that the both attended specialized training for PREA Investigators. This specialized training includes information that the evidentiary standard for administrative investigations is no higher than a preponderenace of the evidence.

Based upon this analysis, the auditor finds the facility is substantially compliant with this standard.

Standard 115.273: Reporting to residents

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

115.273 (a)

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

115.273 (b)

- If the agency did not conduct the investigation into a resident's allegation of sexual abuse in 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

115.273 (c)

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

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

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

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

115.273 (d)

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

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

115.273 (e)

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

115.273 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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 following evidence was analyzed in making the compliance determination:

Documents:

1. Pharos House Pre-Audit Questionnaire (PAQ)
2. Pharos House policy *Staff and Resident Sexual Abuse and Sexual Harassment (PREA)*

Interviews:

1. Executive Director
2. PREA Coordinator

Pharos House policy *Staff and Resident Sexual Abuse and Sexual Harassment (PREA) states* (*p.25-26*):

12. Results of Investigation
a. When an investigation has been completed the PREA Compliance Manager will inform the resident as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded (Attachment Q).
b. If Pharos House did not conduct the investigation the PREA Compliance Manager shall request that the investigative agency involved provide the relevant information in order to inform the resident involved.
c. If the resident's allegation involves a staff member the agency shall form the resident whenever the following occurs:
(1) The staff member is no longer employed at the facility
(2) The agency learns that the staff member has been indicted on a charge related to sexual abuse within the facility OR
(3) The agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility.
d. All such notifications or attempted notifications shall be documented by the PREA Compliance Manager.

e. Pharos Houses' obligation to report under this standard is terminated when the resident is released from the agency's custody.

The PREA Coordinator confirmed during interview that Pharos House policy requires the facility to notify residents of the determination of an allegation (i.e., Substantiated, Unsubstantiated, Unfounded). Pharos House conducts administrative investigations, and the Portland Police Department is responsible for conducting criminal investigations. The PREA Coordinator confirmed that Pharos House policy requires the facility to contact the investigating entity to request information on the outcome of the investigation. For allegations against a staff member, the facility must notify the resident when there is a change in staff member's post or the termination of their employment and when facility learns that the alleged staff abuser has been indicted or convicted). The facility is also required to notify the resident when an alleged resident abuser is indicted and when they are convicted. These notifications shall be documented.

Based upon this analysis, the auditor finds the facility is substantially compliant with this standard.

DISCIPLINE

Standard 115.276: Disciplinary sanctions for staff

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

115.276 (a)

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

115.276 (b)

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

115.276 (c)

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

115.276 (d)

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

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making the compliance determination:

Documents:

1. Pharos House Pre-Audit Questionnaire (PAQ)
2. Pharos House policy *Staff and Resident Sexual Abuse and Sexual Harassment (PREA) states*

Interviews:

1. Executive Director

Site Review Observations:

1. PREA posters within the facility

Pharos House policy *Staff and Resident Sexual Abuse and Sexual Harassment (PREA) states* (*p.31*):

1.Disciplinary Sanctions for Staff
a. Staff shall be subject to disciplinary sanctions up to and including termination for violating Pharos House sexual abuse or sexual harassment policies.
(1) Termination shall be the presumptive disciplinary sanction for staff who have engaged in sexual abuse.
b. Disciplinary sanctions for violations of Pharos House policies relating to sexual abuse or sexual harassment (other than 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.
c. All terminations for violations of Pharos House 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.

The facility responded in the PAQ that there have not been any substantiated cases of staff sexual abuse or sexual harassment during this audit period. Pharos House policy declares a zero tolerance towards sexual abuse and sexual harassment and states that employees will be disciplined, up to and including termination for engaging in sexual abuse or sexual harassment. The Executive Director confirmed that termination would be the presumptive disciplinary action for staff who engage in sexual abuse, and that disciplinary sanctions for violations of agency policies relating to sexual abuse and sexual harassment 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. The Executive Director confirmed that Pharos House policy requires the reporting of terminations or resignations from employees who would have been terminated to law enforcement, unless the actions were clearly not criminal, and to any relevant licensing bodies.

Based upon this analysis, the auditor finds the facility is substantially compliant with this standard.

Standard 115.277: Corrective action for contractors and volunteers

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

115.277 (a)

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

115.277 (b)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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 following evidence was analyzed in making the compliance determination:

Documents:

1. Pharos House Pre-Audit Questionnaire (PAQ)
2. Pharos House policy *Staff and Resident Sexual Abuse and Sexual Harassment (PREA)*

Interviews:

1. Executive Director

Pharos House policy *Staff and Resident Sexual Abuse and Sexual Harassment (PREA) states* (*p.31*):

2.Corrective Action for Contractors and Volunteers

a. Any contractor or volunteer who engages in sexual abuse or sexual harassment shall be prohibited from entry to Pharos House and shall be reported to law enforcement agencies, (unless the activity was clearly not criminal), and to relevant licensing bodies.

The facility reported during the Pre-Audit phase that it had no contractors or volunteers who had contact with residents at the facility. Pharos House policy protects residents from volunteers or contractors who engage in sexual abuse or sexual harassment. The Executive Director confirmed during interview that the facility was prepared to take remedial action against volunteers or contractors who violate Pharos House's zero tolerance policy against sexual abuse and sexual harassment. This action could include additional training or a prohibition of having future contact with residents. Pharos House policy also requires the facility to report volunteers or contractors who engage in sexual abuse, to law enforcement and any relevant licensing authority.

Based upon this analysis, the auditor finds the facility is substantially compliant with this standard.

Standard 115.278: Interventions and disciplinary sanctions for residents

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

115.278 (a)

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

115.278 (b)

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

115.278 (c)

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

115.278 (d)

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

115.278 (e)

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

115.278 (f)

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

115.278 (g)

- 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.

The following evidence was analyzed in making the compliance determination:

Documents:

1. Pharos House Pre-Audit Questionnaire (PAQ)
2. Pharos House policy *Staff and Resident Sexual Abuse and Sexual Harassment (PREA) states*

Interviews:

1. Pharos House Facility Director

Site Review Observations:

1. PREA posters within the facility

Pharos House policy *Staff and Resident Sexual Abuse and Sexual Harassment (PREA) states* (*p.30-31*):

3.Disciplinary Sanctions for Residents
a. Residents shall be subject to disciplinary sanctions pursuant to a formal disciplinary process following an administrative finding that the resident engaged in resident-on-resident sexual abuse or sexual harassment or following a criminal finding of guilt for resident-on-resident sexual abuse or sexual harassment. 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.
4.The disciplinary process shall consider whether a resident's mental disabilities or mental illness contributed to his or her behavior when determining what type of sanction, if any, should be imposed.
5.The program may offer therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse and shall consider whether to require the offending resident to participate in such interventions as a condition of continued access to programming or other benefits.

6.The program may discipline a resident for sexual contact with staff only upon a finding that the staff member did not consent to such contact.
7.For the purpose of disciplinary action, a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred shall not
constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation.
8.The program prohibits all consensual sexual activity between residents and will discipline residents for such activity. However, according to PREA, Pharos House may not deem such activity to constitute sexual abuse if it determines that the activity was not coerced.

The facility reported that there were no residents who were disciplined for sexual abuse or sexual activity during the audit period. The Executive Director confirmed during interview that the *Resident Handbook* contains sanctions for sexual abuse, sexual activity between residents and sexual contact with staff that was not consensual. Pharos House's zero tolerance policy towards sexual abuse and sexual harassment requires that sanctions would be commensurate with factors such as the nature and circumstances of the offense committed, the resident's discipline history, and the sanctions imposed for similar situations (*p.31*). The policy also considers a resident's mental illness of disability must be considered when determining what type of sanction, if any, to impose (*p.31*). The facility does not provide medical or mental health services onsite. Case Managers can refer residents to community providers for services if indicated. Pharos House policy also states that residents who make reports in good faith, even if the resulting investigation does not substantiate the allegation, are not subject to discipline (*p.31*).

Based upon this analysis, the auditor finds the facility is substantially compliant with this standard.

MEDICAL AND MENTAL CARE

Standard 115.282: Access to emergency medical and mental health services

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

115.282 (a)

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

115.282 (b)

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

115.282 (c)

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

115.282 (d)

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

Auditor Overall Compliance Determination

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

☒ **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 following evidence was analyzed in making the compliance determination:

Documents:

1. Pharos House Pre-Audit Questionnaire (PAQ)
2. Pharos House policy *Staff and Resident Sexual Abuse and Sexual Harassment (PREA)*
3. Letter from Maine Medical Center
4. Memorandum of Understanding with Sexual Assault Response Services of Southern Maine (SARSSM)

Interviews:

1. PREA Coordinator
2. Random Staff
3. Residents who Reported Sexual Abuse

Site Review Observations:

1. PREA posters within the facility

Pharos House policy *Staff and Resident Sexual Abuse and Sexual Harassment (PREA) states* (*p.29*):

g. Access to Emergency Medical and Mental Health Services
(1) Resident victims of sexual abuse shall 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.
(a) At the time a report of recent abuse is made, staff first responders shall take preliminary steps to protect the victim pursuant to the program's protection duties and shall immediately notify the appropriate medical and mental health practitioners.
(b) Resident victims of sexual abuse while in community

confinement shall be 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.
(c) Treatment services shall be 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.

The PREA Coordinator confirmed during interview that there were no residents referred to outside medical or mental providers during the audit period. A review of investigation records revealed that there were no security or non-security staff who acted as a first responder to a sexual abuse incident. The auditor's interviews with random staff confirmed that staff are trained in how to respond to incidents of sexual abuse and the immediate steps that they need to take to protect the victim, preserve evidence and to notify law enforcement and emergency medical personnel (if necessary). Pharos House policy requires the facility to offer victims timely information and access to emergency contraception and sexually transmitted disease prophylaxis as required by this Standard (*p.29*). The policy also requires treatment services to be provided without cost to the victim regardless of whether the victim names the abuser or cooperates with the investigation (*p.29*).

Based upon this analysis, the auditor finds the facility is substantially compliant with this standard.

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

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

115.283 (a)

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

115.283 (b)

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

115.283 (c)

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

115.283 (d)

- Are resident victims of sexually abusive vaginal penetration while incarcerated offered pregnancy tests? (N/A if "all-male" facility. *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

115.283 (e)

- If pregnancy results from the conduct described in paragraph § 115.283(d), do such victims receive timely and comprehensive information about and timely access to all lawful pregnancy-related medical services? (N/A if "all-male" facility. *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

115.283 (f)

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

115.283 (g)

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

115.283 (h)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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 following evidence was analyzed in making the compliance determination:

Documents:

1. Pharos House Pre-Audit Questionnaire (PAQ)
2. Pharos House policy *Sexual Abusive Behavior Prevention and Intervention Program (PREA)*
3. Letter from Maine Medical Center
4. Memorandum of Understanding with Sexual Assault Response Services of Southern Maine (SARSSM)

Interviews:

1. Pharos House PREA Coordinator

Site Review Observations:

1. PREA posters within the facility

Pharos House policy *Staff and Resident Sexual Abuse and Sexual Harassment (PREA) states* (*p.30-31*):

Ongoing Medical and Mental Health Care for Sexual Abuse Victims and Abusers

(1) The program shall offer medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse in any criminal justice setting.

(2) The evaluation and treatment of such victims shall 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.

(3) The program shall provide such victims with medical and mental health services consistent with the community level of care.

(4) Female residents who have been victims of sexually abusive vaginal penetration while in the program shall be offered pregnancy testing to be completed by local medical treatment agencies.

(5) If pregnancy results from conduct specified in paragraph (4) of this section, such victims shall receive timely and comprehensive information about and timely access to all lawful pregnancy related medical services.

(6) Resident victims of sexual abuse while incarcerated shall be offered tests for sexually transmitted infections as medically appropriate.

(7) On-going treatment services shall be 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.

(8) The program shall 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.

Pharos House does not provide any medical or mental health services onsite, with the exception of telehealth via remote video conferencing that has been implemented during the pandemic. All such services are delivered by providers in the community. There were no medical or mental health staff who worked at the facility for the auditor to interview regarding the provision of medical or mental health services onsite.

Interview with the PREA Coordinator confirmed that there were no residents placed on a treatment plan during the audit period. The auditor's review of records identified 3 incidents of either sexual abuse or sexual harassment during the audit period, 1 Substantiated Resident-on-Resident incident of Sexual Abuse which included Sexual Harassment and 1 Unfounded incident of Staff-on-Resident Sexual Harassment in 2019. In 2020 there was 1 Unsubstantiated case of Resident-on-Resident Sexual Harassment. The facility documented their offer of medical and mental health services to the victims and included this in the incident case file. One resident who was a victim was still at the facility and was interviewed during the onsite audit. The resident confirmed that mental health services were offered immediately, which the resident declined (Note: incident involved Sexual Harassment only and medical care was not applicable). Review of the investigation of the other Sexual Abuse incident revealed that it involved inappropriate touching outside of the facility where both residents were working at the same location and Sexual Harassment inside of the facility. Mental health services were offered during the facility's initial meeting with the resident; however, medical care was not applicable. The resident declined services and the facility documented their offer.

Pharos House policy requires that services be offered without cost to the victim. The MOU with SARSSM states that services will be offered without cost. The facility has secured a letter from the Maine Medical Center, a local hospital with Level One Trauma Center designation [highest level of emergency and trauma care available onsite], which also confirms that medical treatment, to include testing for sexually transmitted diseases, as clinically appropriate. Services are provided without consideration of whether the victim names the abuser or cooperates with the investigation of the incident. In the one incident involving inappropriate touching, the Federal Bureau of Prisons removed the subject from the facility prior to the facility having the opportunity to attempt to offer a mental health evaluation and follow-up treatment as identified by the provider.

Based upon this analysis, the auditor finds the facility is substantially compliant with this standard.

DATA COLLECTION AND REVIEW

Standard 115.286: Sexual abuse incident reviews

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

115.286 (a)

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

115.286 (b)

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

115.286 (c)

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

115.286 (d)

- Does the review team: Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse? ☒ Yes ☐ No
- Does the review team: Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; gang affiliation; or other group dynamics at the facility? ☒ Yes ☐ No
- Does the review team: Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse? ☒ Yes ☐ No
- Does the review team: Assess the adequacy of staffing levels in that area during different shifts? ☒ Yes ☐ No
- Does the review team: Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff? ☒ Yes ☐ No

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

115.286 (e)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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 following evidence was analyzed in making the compliance determination:

Documents:

1. Pharos House Pre-Audit Questionnaire (PAQ)
2. Pharos House policy *Staff and Resident Sexual Abuse and Sexual Harassment (PREA)*
3. Incident Review Documentation

Interviews:

1. Executive Director
2. PREA Coordinator
3. Case Manager (member of Incident Review Team)

Pharos House policy *Staff and Resident Sexual Abuse and Sexual Harassment (PREA)* states (*p.32*):

9.Sexual Abuse Incident Reviews
a. The facility shall conduct a sexual abuse or sexual harassment incident review at the conclusion of every sexual abuse/harassment investigation, including where the allegation has not been substantiated (Attachment N)
b. Such review shall ordinarily occur within 30 days of the conclusion of the investigation.
c. The review team shall include upper-level management officials, with input from line supervisors, investigators, local law enforcement and medical or mental health practitioners.
d. The review team shall:
(1) Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual

abuse;
(2) Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; or gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility;
(3) Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse; assess the adequacy of staffing levels in that area during different shifts.
(4) Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff and current camera systems; and
(5) Prepare a report of its' findings, including but not necessarily limited to determinations made pursuant to sections a. – e. (above) and any recommendations for improvement, and submit such report to the director and the PREA Compliance Manager.
e. The facility shall implement the recommendations for improvement, or shall document its' reasons for non-compliance.

The facility responded in the PAQ and the PREA Coordinator confirmed that there was 1 Substantiated Resident-on-Resident incident of Sexual Abuse which included Sexual Harassment and 1 Unfounded incident of Staff-on-Resident Sexual Harassment in 2019. In 2020 there was 1 Unsubstantiated case of Resident-on-Resident Sexual Harassment. The facility conducted two Incident Reviews (Unfounded incidents do not require an Incident Review), one review was within 30 days and one was not. The auditor spoke with the PREA Coordinator and reviewed the standard and the expectation that reviews occur within 30 days. The incident review team met to consider the following criteria during their review:

1. Whether the incident requires a change to policy or practice to better prevent, detect, or respond to sexual abuse;
2. Whether the incident was motivated by race, ethnicity, gender identity, LGBTI status or perceived status, gang affiliation or other group dynamics at the facility;
3. Examination of the area in the facility where the incident occurred to identify physical barriers that may enable abuse;
4. Adequacy of facility staffing levels;
5. Whether existing monitoring technology is sufficient, or it needs to be augmented;

The Incident Review Team is required to prepare a report of its findings and submit it to the Executive Director. As a result of the review in 2020, two additional cameras were recommended and approved by the Executive Director. At the time of this report, the cameras are on order and will be installed when the camera vendor receives them. If the Incident Review Team's recommendations are not implemented, the facility generates a report detailing the reason(s) why not.

Based upon this analysis, the auditor finds the facility is substantially compliant with this standard.

Standard 115.287: Data collection

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

115.287 (a)

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

115.287 (b)

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

115.287 (c)

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

115.287 (d)

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

115.287 (e)

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

115.287 (f)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making the compliance determination:

Documents:

1. Pharos House Pre-Audit Questionnaire (PAQ)
2. Pharos House policy *Staff and Resident Sexual Abuse and Sexual Harassment (PREA)*
3. Pharos House Website (www.pharoshouse.org)

Interviews:

1. Executive Director
2. PREA Coordinator

Pharos House policy *Staff and Resident Sexual Abuse and Sexual Harassment (PREA)* states (*p.7*):

4. Data Collection

a. The PREA Compliance Manager shall collect accurate, uniform data for every allegation of sexual abuse and sexual harassment at all facilities under its direct control using a standardized instrument and set of definitions (Attachment E).

b. The PREA Compliance Manager shall aggregate the incident-based sexual abuse data.

c. The incident-based data collected shall 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. (Attachment D).

d. Pharos House shall maintain, review, and collect data as needed from all available incident-based documents including reports, investigation files, and sexual abuse incident reviews.

e. The Executive Director will be responsible for compiling the number of reports of sexual abuse and sexual harassment at a minimum of once a month.

f. The Executive Director shall provide documentation on the website of his/her review of the most current aggregated incident-based sexual abuse data annually.

g. Upon request, Pharos House shall provide all such data from the previous calendar year to the Department of Justice no later than June 30.

The Pharos House Annual PREA Report is published on their website. The interview with the Executive Director and the PREA Coordinator confirmed that Pharos House aggregates incident-based sexual abuse data annually. Pharos House does not contract out to other facilities to house residents. Pharos House was not requested to provide previous calendar year data by the Department of Justice.

Based upon this analysis, the auditor finds the facility is substantially compliant with this standard.

Standard 115.288: Data review for corrective action

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

115.288 (a)

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

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

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

115.288 (b)

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

115.288 (c)

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

115.288 (d)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making the compliance determination:

Documents:

1. Pharos House Pre-Audit Questionnaire (PAQ)
2. Pharos House policy *Staff and Resident Sexual Abuse and Sexual Harassment (PREA)*
3. Pharos House Website (www.pharoshouse.org)

Interviews:

1. Executive Director
2. PREA Coordinator

Pharos House policy *Staff and Resident Sexual Abuse and Sexual Harassment (PREA)* states (*p.7-8*):

5.Data Review for Corrective Action
a. Pharos House shall review data collected and aggregated to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including:
(1) Identifying problem areas;
(2) Taking corrective action on an ongoing basis; and

b. Preparing an annual report of its findings and corrective actions for Pharos House.
c. Such report shall include a comparison of the current year's data and corrective actions with those from prior years and shall provide an assessment of the agency's progress in addressing sexual abuse.
d. Pharos House may redact specific material from the reports when publication would present a clear and specific threat to the safety and security of a program but must indicate the nature of the material redacted.

PREA incident data is collected and evaluated by the Executive Director and the PREA Coordinator to determine if policy, operational, staffing or program changes are warranted. The Facility Director also conducts an Annual Review to evaluate incidents of Sexual Abuse and Sexual Harassment that occurred during the year to determine root causes and to identify policy, operational or physical plant modifications that are necessary to improve the sexual safety of residents at the facility. The auditor visited the agency's website and reviewed the 2019 and 2020 PREA Annual Reports. The Reports provide the required information and do not contain any personally identifiable information (PII). Data for three years is provided to allow for a comparison.

Based upon this analysis, the auditor finds the facility substantially compliant with the requirements of this standard.

Standard 115.289: Data storage, publication, and destruction

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

115.289 (a)

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

115.289 (b)

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

115.289 (c)

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

115.289 (d)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making the compliance determination:

Documents:

1. Pharos House Pre-Audit Questionnaire (PAQ)
2. Pharos House Website (http://pharoshouse.org)
3. Pharos House Final Audit Report (December 2017)

http://pharoshouse.org/wp-content/uploads/2017/06/Pharos-House-Final-Report.pdf

Interviews:

1. Executive Director
2. PREA Coordinator

Pharos House policy *Staff and Resident Sexual Abuse and Sexual Harassment (PREA)* states (*p.8*):

6. Data Storage, Publication, and Destruction
a. Pharos House shall ensure that data collected is securely retained.
b. Pharos House shall make all aggregated sexual abuse data, from programs under its direct control, readily available to the public at least annually (Attachment E).
c. The most current aggregated sexual abuse data shall be posted on the Pharos House website.
d. Before making aggregated sexual abuse data publicly available, Pharos House shall remove all personal identifiers.
e. Pharos House shall maintain sexual abuse data collected for at least 10 years after the date of the initial collection unless Federal, State, or local law requires otherwise.

The auditor interviewed the PREA Coordinator, who confirmed that the facility is required to maintain data for at least 10 years after the date of the initial collection as required by this standard. The Facility Director conducts an Annual Review to evaluate incidents of Sexual Abuse and Sexual Harassment that occurred during the year to determine root causes and to identify policy, operational or physical plant modifications that are necessary to improve the sexual safety of residents at the facility. The auditor visited the Pharos House website and reviewed the 2019 and the 2020 PREA Annual Reports. The Reports did not contain any personally identifiable information (PII), while providing the required data.

Based upon this analysis, the auditor finds the facility substantially compliant with the requirements of this standard.

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 (i)

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

115.401 (m)

- Was the auditor permitted to conduct private interviews with 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 following evidence was analyzed in making the compliance determination:

Documents:

1. Pharos House Pre-Audit Questionnaire (PAQ)
2. Pharos House Final Audit Report (December 2017)

http://pharoshouse.org/wp-content/uploads/2017/06/Pharos-House-Final-Report.pdf

The auditor reviewed the Pharos House website as part of the audit process and confirmed that the Pharos House was audited, and a Final Report issued and posted to its website in December of 2017. As detailed in the Audit Narrative of this audit, the auditor was provided access to all areas of the facility, provided access to or a photocopy (when requested) of all relevant documents from the facility and the auditor was allowed access to the video monitoring system. The auditor was provided a private conference room to conduct staff and resident interviews. The facility posted notices of the audit six weeks in advance, which provided the auditor's name and mailing address. These Notices also identified communication with the auditor as confidential. The auditor contacted community-based organizations to gain insight into relevant conditions in the facility. No concerns were noted.

Based upon this analysis, the auditor finds the facility is substantially compliant with this standard.

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. 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 following evidence was analyzed in making the compliance determination:

Documents:

1. Pharos House Pre-Audit Questionnaire (PAQ)
2. Pharos House Final Audit Report (December 2017)

http://pharoshouse.org/wp-content/uploads/2017/06/Pharos-House-Final-Report.pdf

The auditor reviewed the Pharos House website as part of the audit process and confirmed that the Pharos House was audited, and a Final Report issued and posted to its website in December of 2017. The auditor will verify that the Final Report for this audit is posted to the Pharos House website as required by this Standard.

Based upon this analysis, the auditor finds the facility is substantially compliant with this standard.

AUDITOR CERTIFICATION

I certify that:

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

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

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

Auditor Instructions:

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

Michael B. Vitiello June 09, 2021

Auditor Signature **Date**

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

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