

Comments Submitted to the Department of Justice Notice of Proposed Rulemaking on National Standards to Prevent, Detect, and Respond to Prison Rape

Docket No. OAG-131; AG Order No. 3244-2011

April 4, 2011

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The Department solicits comments regarding the application of this definition to those States that operate "unified systems"—i.e., States with direct authority over all adult correctional facilities, as opposed to the more common practice of jails being operated by counties, cities, or other municipalities. States that operate unified systems may be less likely to adhere to the traditional distinctions between prisons and jails, and may operate facilities that are essentially a mixture of the two. Do the respective definitions of jail and prison, and the manner in which the terms are used in the proposed standards, adequately cover facilities in States with unified systems? If not, how should the definitions or standards be modified? Should the Department modify the full-time coordinator requirement to allow additional flexibility, such as by requiring only that PREA be the coordinator's primary responsibility, or by allowing the coordinator also to work on other related issues, such as inmate safety more generally? Question 3.....19 Should the final rule provide greater guidance as to how agencies should conduct such *monitoring?* If so, what guidance should be provided? Should the standard require that facilities actually provide a certain level of staffing, whether determined qualitatively, such as by reference to "adequacy," or quantitatively, by setting forth more concrete requirements? If so, how? If a level such as "adequacy" were mandated, how would compliance be measured? Various States have regulations that require correctional agencies to set or abide by minimum staffing requirements. To what extent, if any, should the standard take into account such State regulations? Some States mandate specific staff-to-resident ratios for certain types of juvenile facilities. Should the standard mandate specific ratios for juvenile facilities? If a level of staffing were mandated, should the standard allow agencies a longer time frame, such as a specified number of years, in order to reach that level? If so, what time frame would be appropriate?

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Question 26
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scope of treatment that subsequently must be offered to such abusers? If not, how should it be revised?

Should audits be conducted at set intervals, or should audits be conducted only for cause, based upon a reason to believe that a particular facility or agency is materially out of compliance with the standards? If the latter, how should such a for-cause determination be structured? If audits are conducted for cause, what entity should be authorized to determine that there is reason to believe an audit is appropriate, and then to call for an audit to be conducted? What would be the appropriate standard to trigger such an audit requirement? Should all facilities be audited or should random sampling be allowed for some or all categories of facilities in order to reduce burdens while ensuring that all facilities could be subject to an audit? Is there a better approach to audits other than the approaches discussed above? To what extent, if any, should agencies be able to combine a PREA audit with an audit performed by an accrediting body or with other types of audits? Question 33......101 To what extent, if any, should the wording of any of the substantive standards be revised in order to facilitate a determination of whether a jurisdiction is in compliance with that standard? Question 34......101 How should "full compliance" be defined in keeping with the considerations set forth in the above discussion? To what extent, if any, should audits bear on determining whether a State is in full *compliance with PREA?* Should the final rule include a standard that governs the placement of juveniles in adult facilities?

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Question 38
Has the Department appropriately determined the baseline level of sexual abuse in correctional settings for purposes of assessing the benefit and cost of the proposed PREA standards?
Question 39
Are there any reliable, empirical sources of data, other than the BJ studies referenced in the IRIA, that would be appropriate to use in determining the baseline level of prison sexual abuse? If so, please cite such sources and explain whether and why they should be used to supplement or replace the BJS data.
Question 40
Are there reliable methods for measuring the extent of underreporting and overreporting in connection with BJS's inmate surveys?
Question 41
Are there sources of data that would allow the Department to assess the prevalence of sexual abuse in lockups and community confinement facilities? If so, please supply such data. In the absence of such data, are there available methodologies for including sexual abuse in such settings in the overall estimate of baseline prevalence?
Question 42
Has the Department appropriately adjusted the conclusions of studies on the value of rape and sexual abuse generally to account for the differing circumstances posed by sexual abuse in confinement settings?
Question 43
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Question 44
Has the Department correctly identified the quantifiable costs of rape and sexual abuse? Are there other costs of rape and sexual abuse that are capable of quantification, but are not

included in the Department's analysis?

Should the Department adjust the "willingness to pay" figures on which it relies (developed by Professor Mark Cohen for purposes of valuing the benefit to society of an avoided rape10) to account for the possibility that some people may believe sexual abuse in confinement facilities is a less pressing problem than it is in society as a whole, and might therefore think that the value of avoiding such an incident in the confinement setting is less than the value of avoiding a similar incident in the non-confinement setting? Likewise, should the Department adjust these figures to take into account the fact that in the general population the vast majority of sexual abuse victims are female, whereas in the confinement setting the victims are overwhelmingly male? Are such differences even relevant for purposes of using the contingent valuation method to monetize the cost of an incident of sexual abuse? If either adjustment were appropriate, how (or on the basis of what empirical data) would the Department go about determining the amount of the adjustment? Ouestion 46......111 Has the Department appropriately accounted for the increased costs to the victim and to society when the victim is a juvenile? Why or why not? Are there available methodologies, or available data from which a methodology can be developed, to assess the unit value of avoiding a nonconsensual sexual act involving pressure or coercion? If so, please supply them. Is the Department's estimate of this unit value (i.e., 20% of the value of a forcible rape) appropriately conservative? Are there available methodologies, or available data from which a methodology can be developed, to assess the unit value of avoiding an "abusive sexual contact between inmates," as defined in the IRIA? If so, please supply them. Is the Department's estimate of this unit value (i.e., \$375 for adult inmates and \$500 for juveniles) appropriately conservative? *Would a higher figure be more appropriate? Why or why not?* Are there any additional nonmonetary benefits of implementing the PREA standards not mentioned in the IRIA? Are any of the nonmonetary benefits set forth in the IRIA actually capable of quantification? If so, are there available methodologies for quantifying such benefits or sources of data from which such quantification can be drawn? Are there available sources of data relating to the compliance costs associated with the proposed standards, other than the sources cited and relied upon in the IRIA? If so, please provide them.

Are there available data as to the number of lockups that will be affected by the proposed standards, the number of individuals who are detained in lockups on an annual basis, and/or the anticipated compliance costs for lockups? If so, please provide them. Are there available data as to the number of community confinement facilities that will be affected by the proposed standards, the number of individuals who reside or are detained in such facilities on an annual basis, or the anticipated compliance costs for community confinement facilities? If so, please provide them. Has the Department appropriately differentiated the estimated compliance costs with regard to the different types of confinement facilities (prisons, jails, juvenile facilities, community confinement facilities, and lockups)? If not, why and to what extent should compliance costs be expected to be higher or lower for one type or another? Are there additional methodologies for conducting an assessment of the costs of compliance with the proposed standards? If so, please propose them. With respect to §§ 115.12, 115.112, 115.212, and 115.312, are there other methods of estimating the extent to which contract renewals and renegotiations over the 15-year period will lead to costs for agencies that adopt the proposed standards? Do agencies expect to incur costs associated with proposed §§ 115.13, 115.113, 115.213, and 115.313, notwithstanding the fact that it does not mandate any particular level of staffing or the use of video monitoring? Why or why not? If so, what are the potential cost implications of this standard under various alternative scenarios concerning staffing mandates or video monitoring mandates? What decisions do agencies anticipate making in light of the assessments called for by this standard, and what will it cost to implement those decisions? With respect to §§ 115.14, 115.114, 115.214, and 115.314, will the limitations on crossgender viewing (and any associated retrofitting and construction of privacy panels) impose any costs on agencies? If so, please provide any data from which a cost estimate can be developed for such measures.

Will the requirement in §§ 115.31, 115.231, and 115.331 that agencies train staff on how to communicate effectively and professionally with lesbian, gay, bisexual, transgender, or intersex residents lead to additional costs for correctional facilities, over and above the costs of other training requirements in the standards? If so, please provide any data from which a cost estimate can be developed for such training.

Has the Department accounted for all of the costs associated with §§ 115.52, 115.252, and 115.352, dealing with exhaustion of administrative remedies? If not, what additional costs might be incurred, and what data exist from which an estimate of those costs can be developed?

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Are the expectations as to the effectiveness of the proposed standards that are subsumed within the breakeven analysis (e.g., 0.7%-1.7% reduction in baseline prevalence needed to justify startup costs and 2.06%-3.13% reduction required for ongoing costs) reasonable? Why or why not? Are there available data from which reasonable predictions can be made as to the extent to which these proposed standards will be effective in reducing the prevalence of rape and sexual abuse in prisons? If so, please supply them.

A. INTRODUCTION

Just Detention International (JDI) respectfully submits these comments regarding the Department of Justice's proposed standards addressing sexual abuse in detention. In its proposal, the Department has clarified or strengthened several of the provisions recommended by the National Prison Rape Elimination Commission (the Commission) and JDI applauds the Department for those accomplishments. Unfortunately, in its 20 months of review, the Department has also substantially weakened or removed measures that are urgently needed to keep men, women, and children in detention safe from sexual abuse.

This submission highlights what JDI has identified as areas of improvement and areas of concern in the Department's proposed standards. It also responds to the questions the Department posed in its Notice of Proposed Rulemaking. In addition to JDI's in-house expertise, these comments rely heavily on the expertise of dozens of prisoner rape survivors, service providers, and other advocates with whom JDI collaborates.

I. About Just Detention International

The only organization in the country exclusively dedicated to ending sexual violence in detention, JDI has three core goals for its work: to hold government officials accountable for prisoner rape; to change ill-informed public attitudes about sexual violence behind bars; and to ensure that those who have survived this type of abuse get the help they need. Founded in 1980 by a prisoner rape survivor, JDI's work is driven by the experiences of men, women, and children who have refused to remain silent about the sexual violence they endured while in the government's custody.

Working with Congressional sponsors on both sides of the aisle and a broad coalition of advocates, faith-based leaders, corrections experts, and prisoner rape survivors, JDI played a central role in securing passage of the Prison Rape Elimination Act (PREA). Since the law's enactment, JDI has been involved in all aspects of PREA implementation. In addition to monitoring and disseminating information about the law's progress, JDI has connected federal

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agencies that have mandates under PREA with survivor advocates, and has provided these agencies with policy analysis and technical expertise related to all aspects of sexual violence behind bars.

For the past several years, JDI has also collaborated with state and local corrections agencies in their implementation efforts, including three jurisdictions – the California Department of Corrections and Rehabilitation, the Oregon Department of Corrections, and the Macomb County (Michigan) Sheriff's Office – that have agreed to become "early adopters" of the Commission's recommended standards. Through its Raising the Bar Coalition, JDI has mobilized more than 60 organizations – including victim service providers; faith-based groups; advocates for immigrant populations, youth, and lesbian, gay bisexual and transgender (LGBT) individuals; and other civil rights organizations – to be engaged in the standards ratification process.

II. The Problem of Prisoner Rape

The Department's own data confirm the pervasiveness of sexual abuse behind bars, with an estimated 200,000 prison and jail inmates and more than 17,000 juvenile detainees sexually abused in U.S. facilities in 2008 alone.¹ These shocking numbers only begin to illustrate the problem. Survivors are often abused relentlessly, and marked as fair game for attacks by other detainees. In the aftermath of an assault, incarcerated survivors experience the same emotional pain as other victims, which may be exacerbated by prior trauma and the inability to control their daily surroundings. In addition to physical injuries that are often inflicted during an assault, prisoner rape survivors are at grave risk of contracting HIV and other sexually transmitted infections.²

¹ U.S. Department of Justice, PREA Notice of Proposed Rulemaking, 76 FED. REG. 6249 (Feb. 3, 2011) (hereinafter "NPRM").

² HIV and other sexually transmitted infections are significantly more prevalent in corrections settings than in the general population. *See, e.g.,* Laura Maruschak, Bureau of Justice Statistics, HIV in Prisons, 2007-08 3 (2010) (estimating HIV rate in U.S. prisons to be 2.4 times the rate in society); Scott A. Allen et al., *Hepatitis C Among Offenders—Correctional Challenge and Public Health Opportunity*, 67 Fed. Probation 22 (Sept. 2003) (finding that Hepatitis C rates were 8 to 20 times higher in prisons than on the outside, with 12 to 35 percent of prison cases involving chronic infection); *see also* Centers for Disease Control & Prevention, U.S. Dep't Health & Hum. Svcs., Sexually Transmitted Disease Surveillance 2007 89 (2008), *available at http://www.cdc.gov/std/stats07/Surv2007-SpecialFocusProfiles.pdf*.

As the leading advocates addressing the problem of sexual violence in detention, JDI hears from prisoner rape survivors across the country on a daily basis. JDI does not solicit such correspondence, and does not conduct outreach to prisoners. Rather, survivors tend to hear about JDI through word-of-mouth and contact the organization simply because they feel they have nowhere else to turn.

The following is a small sampling of survivors who have been brave enough to write to JDI (and who have authorized the organization to share their story publicly):

- Scott Hill was repeatedly physically and sexually assaulted by his cellmate in protective custody at USP Victorville. A gay man who had been raped during a prior federal prison term, Hill was a clear target for abuse. He reported the assaults after he was transferred to another federal facility, where he was again placed in a protective custody unit. The Bureau of Prisons (BOP) took more than two weeks to provide Hill with the address for the FBI so that he could report his assault to them. The BOP also opened his legal mail and denied him legal calls. At the time of this writing, both BOP and FBI investigations are ongoing.
- **Kimberly Yates** was serving time at FDC-Philadelphia on drug charges when she was sexually assaulted in the prison warehouse by Officer Theodore Woodson. Yates was badly injured during the rape and spoke with a captain at the facility, after which she was taken to the emergency room. A year before Yates' rape, the family of another prisoner had contacted the facility to report Officer Woodson's sexual abuse of another woman, but the BOP never investigated that report. The officer went on to sexually assault at least four other women, including Yates. Eventually, Officer Woodson pled guilty to engaging in sexual acts with three women inmates and received a four-month jail sentence and three years of probation.³
- **Ivory Mitchell** was repeatedly sexually assaulted by a female corrections officer at L.C. Poweldge Unit, a Texas state prison. The officer groped him and forced him to perform oral sex on her while he was working as a porter. The officer threatened Mitchell that if he did not do what she demanded, she would report him for inappropriately touching her. Despite his fears, Mitchell reported the abuse, but was told that there was nothing that could be done. Eventually, the officer confessed, was terminated from her position, and

³ Further details about Kimberly Yates's experience are available in her submission to the Department during its public comment period on the Commission's recommended standards (ID: DOJ-OAG-2010-0001-0190), in a testimony she prepared for JDI's website, www.justdetention.org/en/survivortestimony/stories/kimberly_ky.aspx, and on two news programs: *Survivors speak out after DOJ misses deadline for prisoner rape standards* (WUSA News 9 broadcast, June 25, 2010), *available at:* http://www.justdetention.org/en/jdinews/2010/06_25_10.aspx (last accessed April 4, 2011); ; *L.I.F.E. After Lockup* (WKCTC broadcast, July 10, 2009), *available at:* http://tv.westkentucky.kctcs.edu/videoclips/life/16938_kim_yates/video.shtml (last accessed April 4, 2011). She also participated in the Department's listening session with survivors and victim service providers.

charged with improper sexual activity with a person in custody. The officer claimed that the abuse was consensual, so Mitchell was punished with a disciplinary infraction, which halted his parole and resulted in him being transferred to a more dangerous unit where he was assaulted by gang members.⁴

- Valjean Royal has been sexually abused repeatedly in federal, state, and county custody. A transgender woman, Royal was only 17 years old when she was gang-raped by more than 20 inmates in a county jail. She continued to be sexually abused while in prison and was transferred into federal custody for her protection. Royal was again sexually abused in two different BOP facilities before being returned to Indiana. She has mostly been targeted by inmates, but officers often contributed to the sexual abuse by looking the other way while inmates assaulted her, and sometimes by assisting perpetrators in gaining access to her. Royal contracted hepatitis C and syphilis as a result of the sexual abuse and describes herself as mentally and emotionally numb from the repeated trauma.⁵
- Linda Lamb was raped by her bunkmate and another female inmate in a "blind spot" at the Plain State Jail in Texas. Other inmates watched the abuse and did nothing to help her. As a self-identified lesbian, Lamb did not feel safe reporting the assault; she was afraid no one would believe that she could be raped by another woman. Lamb was transferred to prison shortly after the assault, and never received medical attention or mental health counseling. ⁶
- **Scott Howard** was repeatedly raped, assaulted, extorted, and forced into prostitution by a large, notorious white supremacist prison gang while serving time in Colorado. Because he is openly gay, officials blamed Howard for the assaults and refused to protect him. Howard repeatedly requested safe housing but was told that he could enter administrative segregation only if he named the assailants. On the day he was released from state custody, Howard was placed in a holding cell with one of his assailants, who beat him and forced him to perform oral sex. While he was being abused in prison, Howard was too afraid to leave his cell and considered suicide.⁷

⁴ Further details about Ivory Mitchell's experience are available in his submission to the Department during the first comment period (ID: DOJ-OAG-2010-0001-478) and in a written testimony he prepared for JDI's website, http://www.justdetention.org/en/survivortestimony/stories/ivory_tx.aspx.

⁵ Valjean Royal submitted comment during the Department's first comment period in 2010 (ID: DOJ-OAG-2010-0001-0286), and prepared a written testimony that is available on JDI's website at www.justdetention.org/en/survivortestimony/stories/valjean in.aspx.

⁶ Linda Lamb submitted comment during the Department's first public comment period (ID: DOJ-OAG-2010-0001-0276), and prepared a testimony under her Native American name, Soaring Eagle, which is available on JDI's website at http://www.justdetention.org/en/survivortestimony/stories/soaring_tx.aspx

⁷ Howard's story was recently featured in the Denver Westword News. Alan Prendergast, *Raped and extorted by a prison gang, Scott Howard was called a "drama queen" by corrections officials,* WESTWORD NEWS, Feb. 2, 2011, *available at*

http://www.westword.com/2011-02-03/news/211-crew-rapes-extorts-scott-howard-colorado-prison (last accessed March 31, 2011); Alan Prendergast, *Scott Howard: Inmate's history of obtaining bogus refunds tip of prison-tax-fraud iceberg*, WESTWORD NEWS BLOG, Feb. 3, 2011, *available at*

http://blogs.westword.com/latestword/2011/02/scott_howard_prison_tax_fraud.php (last accessed March 31, 2011); Alan Prendergast, *Scott Howard: Does "smoking gun" memo prove he was targeted by prison gang?*, WESTWORD

- **Troy Isaac** was sexually abused repeatedly in California youth and adult facilities throughout more than two decades. The first attack occurred when he was 12 years old and detained in a California Youth Authority facility for vandalism. Within days, he was propositioned for oral sex by a gang member in the showers and was later raped in the middle of the night by his 16-year-old cellmate. Too scared and confused to report the abuse, Isaac told staff he was suicidal, hoping to be placed in solitary confinement, but they ignored him and the sexual abuse continued. For the next twenty years, Isaac was in and out of youth and adult facilities, where he was repeatedly sexually assaulted.⁸
- **Frank Mendoza** was detained for a non-violent public order offense in the Los Angeles County Jail. There, he was persistently harassed by corrections officers for being openly gay. After a particularly intense verbal attack, an officer beat and raped Mendoza, leaving him naked and bloodied in his cell in the middle of the night. Mendoza reported the abuse the next morning, but rather than being provided with a forensic exam, he was given a shower. The officer he told about the abuse did not write a report about the incident, nor was Mendoza provided with medical or mental health care. He was released a few days later and filed a formal complaint with the Los Angeles Police Department. The police conducted a video interview with Mendoza, but because there was no physical evidence, the police told him that the officer received a verbal warning and nothing else could be done.⁹
- Allison Mitchell was forced to perform oral sex on a male officer while she was detained at the Rappahannock Regional Jail in Virginia. The officer stalked Mitchell and threatened to harm her family if she reported the abuse. Other officials knew about the abuse and stalking, but did nothing to protect Mitchell. Approximately a month after the abuse began, Mitchell reported the abuse to an officer, who did nothing except ask her what she expected for him to do. She told a lieutenant a few days later, and was taken to Internal Affairs, where one of the investigating officers told her that the assault was

www.justdetention.org/en/actionupdates/JDIActionUpdateOct10vM.pdf and has provided a verbal statement that is featured in JDI's *Portraits of Courage*, at www.justdetention.org/en/survivortestimony/portraits_of_courage.aspx.

NEWS BLOG, Feb. 4, 2011, available at

http://blogs.westword.com/latestword/2011/02/scott_howard_prison_gang_smoking_gun.php (last accessed March 31, 2011). He also submitted comment during the Department's first public comment period (ID: DOJ-OAG-2010-0001-0024), participated in the Department's listening session with survivors, and prepared a written statement that is on JDI's website, http://www.justdetention.org/en/survivortestimony/stories/scott_co.aspx.

⁸ In addition to participating in the Department's listening session and submitting comment during the first public comment period (ID DOJ-OAG-2010-0001-0063), Troy Isaac's experience has been featured in the following news stories: Editorial, *Locked Up and Vulnerable*, WASHINGTON POST, Feb. 21, 2010, *available at*

http://www.washingtonpost.com/wp-dyn/content/article/2010/02/20/AR2010022002950.html (last accessed April 4, 2011); *Juvenile Inmates Report Sexual Abuse At Detention Centers* (NPR broadcast, Jan. 19, 2010), *available at* http://www.npr.org/templates/story/story.php?storyId=122725085 (last accessed April 4, 2011); David Kaiser & Lovisa Stannow, *The Crisis of Juvenile Prison Rape: A New Report*, NEW YORK REVIEW OF BOOKS BLOG, Jan. 7, 2010, *available at* http://blogs.nybooks.com/post/321666354/the-crisis-of-juvenile-prison-rape-a-new-report (last accessed April 4, 2011).

⁹ Frank Mendoza submitted comment during the Department's first public comment period (DOJ-OAG-2010-0001-0083). He was also featured in JDI's newsletter, *Action Update, available at*

consensual. Mitchell was then transferred to another jail where she was retaliated against by inmates and staff and denied protective custody. She developed severe anxiety/panic attacks and suffered from nightmares, flashbacks, and chest pains. Mitchell received six mental health sessions after reporting the abuse; her subsequent requests to meet with a counselor were denied.¹⁰

- **Michelle Branch** is a 62-year-old, transgender woman who was arrested in late 2006 and placed in the men's wing of the Los Angeles County Jail. At the time of her arrest, she had very limited mobility. During Branch's confinement, she was denied the use of her wheelchair. Other detainees were prohibited from helping Branch and she was forced to move about without assistance, falling on multiple occasions. One day while in the shower, she was surrounded and threatened with rape by four other inmates. The attempted sexual assault was interrupted when another inmate entered the shower and was able to fend off the would-be assailants.¹¹
- **Brian Lee Nestor** was raped by another inmate at Fort Dix Federal Correctional Institution and contracted syphilis as a result of the attack. Immediately following the sexual assault, Nestor was devastated and in shock and was reluctant to report the rape for fear of retaliation by inmates and staff. When he finally told a lieutenant, the officer told Nestor that if he filed any paperwork or otherwise complained he would be transferred to a prison in the south. After being transferred to New York Medical Detention Center, Nestor reported the rape to the BOP's Special Investigative Services (SIS). The BOP eventually placed Nestor in administrative segregation for six months. Nestor has suffered from anxiety and depression, and has attempted suicide, but the BOP has not responded to his repeated requests for psychological help. Nestor was recently informed that he cannot file a lawsuit since he did not file a grievance within 20 days of the incident.

JDI maintains a database that compiles aggregate data from the many letters it receives from inmates. While JDI's database of letters does not permit statistical conclusions about prevalence, it does provide rare, first-person insights from survivors of horrifying sexual abuse.

In calendar year 2010, JDI received letters from 534 survivors of sexual violence. More than half (277) of these survivors stated that they reported the assault to prison officials, but an investigation was undertaken less than half the time (112). Eighty-eight survivors stated that they were placed in segregation as a result of reporting, more than half of whom (46) were placed

¹⁰ A full account of Allison Mitchell's abuse, under the name Loretta Mitchell, is available in a written testimony she provided for JDI's website, www.justdetention.org/en/survivortestimony/stories/loretta_va.aspx, and was featured in JDI's newsletter, *Action Update*, www.justdetention.org/en/actionupdates/AU1009_web.pdf. ¹¹ Michelle Branch provided a verbal testimony that is featured in JDI's *Portraits of Courage* at

www.justdetention.org/en/survivortestimony/audio/Michelle.mp3.

there involuntarily. Twenty-nine survivors reported having trouble with the grievance system. (Additional information from JDI's 2010 aggregate data is provided in Appendix A.)

III. Sexual Violence in Federal Detention

While the standards will apply to all corrections agencies, the Department in its Notice of Proposed Rulemaking pays special attention to its own prison system, the Bureau of Prisons (BOP). BOP financial data – which has not been disclosed publicly – is relied upon in the Department's cost benefit analysis, and the BOP is held up as a model to justify some of the Department's most drastic revisions. Unfortunately, however, despite being part of the Department, the BOP has not been a leader in PREA implementation and sexual abuse remains a significant problem in BOP facilities. Reliance on current BOP policies and practices for national PREA standards is misguided and dangerous.

Although JDI has not worked directly with Bureau of Prisons facilities, approximately eight percent (110) of the survivors who have written to the organization since 2003 were raped in a BOP facility. These incidents occurred in facilities that spanned 30 states and Puerto Rico. Of the survivors who identified the type of person who abused them, 60 percent stated that they were abused by an inmate, and approximately 10 percent of these victims were assaulted by more than one inmate at a time. Thirty percent were abused by a corrections officer and seven percent were abused by non-custody staff members, including a physician's assistant and work supervisor. One BOP survivor who wrote to JDI was abused by both inmates and staff.

Nearly two-thirds (68) of survivors from federal facilities who contacted JDI stated that they reported the assault to prison officials, but an investigation was undertaken less than half of those cases (28 cases). A mere ten percent (11) of survivors reported that they were protected following the assault and only 13 of these men and women reported that a forensic medical exam was conducted following the assault. Only four survivors (or less than three percent) received adequate medical or mental health care in the aftermath of the sexual assault(s). HIV tests were given to survivors in only 11 cases; five survivors reported contracting HIV as a result of the sexual assault(s), and five reported contracting some other sexually transmitted infection.

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(Additional information from JDI's aggregate data from survivors in BOP custody is provided in Appendix B.)

Confirming the dire picture that emerges in inmates' letters to JDI, the Office of the Inspector General has likewise noted that staff sexual misconduct is a serious problem in BOP facilities. Following up on a 2005 report, which found that staff sexual abuse in federal prisons was a serious problem and that many perpetrators were not held accountable for such abuse, the Inspector General released a 2009 report that highlighted serious deficiencies in BOP policy and practice regarding staff sexual misconduct.¹² Specifically, the Inspector General found that staff sexual abuse and misconduct allegations in BOP facilities more than doubled from FY2001 to FY2008, with nearly two-thirds of these allegations involving criminal sexual abuse.¹³ The majority of allegations were cross-gender – male staff abusing female inmates and female staff abusing male inmates – with female staff committing a disproportionate amount of sexual abuse and misconduct and male staff most often accused of misconduct stemming from pat searches.¹⁴ The Inspector General identified deficiencies in several key areas, including staff training, the use of alternatives to isolating victims, victims' access to psychological and medical services, the extent to which allegations were reported to the Office of the Inspector General and the Office of Internal Affairs, and oversight of the BOP's sexual abuse program.¹⁵

While the BOP has not been a leader in PREA implementation, several state and county systems across the country have chosen to make the effort to end sexual abuse in detention a high priority. The Commission's final report includes a chart of PREA initiatives in state and county systems nationwide.¹⁶ In the nearly two years since that report was released, several state and local systems have launched new and innovative PREA programs. For example, the California

¹² OFFICE OF THE INSPECTOR GENERAL, U.S. DEPARTMENT OF JUSTICE, THE DEPARTMENT'S EFFORTS TO PREVENT STAFF SEXUAL ABUSE OF FEDERAL INMATES (2009) (hereinafter "OIG 2009 REPORT"). *See also* OFFICE OF THE INSPECTOR GENERAL, U.S. DEPARTMENT OF JUSTICE, DETERRING STAFF SEXUAL ABUSE OF INMATES (2005) (recommending changes to 18 U.S.C. § 2243(b) (sexual abuse of a ward) and 18 U.S.C. § 2244(a) (abusive sexual contact) to provide for increased penalties and to 18 U.S.C. Chapter 109A to extend federal criminal jurisdiction to facilities under contract with the Department).

¹³ OIG 2009 REPORT, *supra* note 12, at 19.

¹⁴ *Id.* at 26, 30-31

¹⁵ *Id.* at 33-49.

¹⁶ See NATIONAL PRISON RAPE ELIMINATION COMMISSION, FINAL REPORT 251-59 (2009).

Department of Corrections and Rehabilitation has established an inmate peer education program in two of its facilities, in which carefully selected and trained inmates provide information to other inmates about the right to be free from sexual abuse and the resources available in the aftermath of an assault. In addition, the Macomb County Sheriff's Office, in Michigan, has incorporated a section labeled "sexual assault in the jail" into its policy for investigations of sexual assault in the community, acknowledging that jail is another place in their jurisdiction where assaults occur and that such abuse should be treated in accordance with community standards.

In short, several state and county corrections systems have emerged as leaders in PREA implementation and the critically important effort to end sexual abuse in detention. The BOP is not one of those leaders. JDI urges the Department to reconsider its reliance on BOP's current policies and practices as models. Instead, it should encourage the BOP to embrace best practices that have been implemented in state and county systems nationwide.

B. DISCUSSION OF PROPOSED STANDARDS

As noted above, JDI believes that the Department has made some positive clarifications and improvements to several of the Commission's proposed standards but is deeply concerned about the substantial weakening of many provisions. This section discusses JDI's consideration of each standard and answers the questions posed by the Department. Unless otherwise noted, JDI's recommendations refer to the corresponding standards for each type of facility - prisons and jails, lockups, community confinement, and juvenile facilities. For ease of discussion, the term *inmate* is used to describe an individual held in any facility; in the recommended language, *inmate* should be replaced by *detainee* in the lockup provisions and by *resident* in the community confinement and juvenile facility provisions.

I. Definitions

Facilities excluded from the proposed standards

Excluding immigration detention and nonresidential probation and parole officers from the standards contradicts the explicit intent and language of PREA, as well as the Department's own statement that "[p]rotection from sexual abuse should not depend on where an individual is incarcerated: It must be universal."¹⁷

Just Detention International strongly urges the Department to restore the definition of "prison" relied upon by Congress so that - consistent with all other aspects of PREA implementation - the standards apply to all forms of detention in the U.S.¹⁸

Recommendation: Adopt the definition of "prison" that is in PREA: any confinement facility of a Federal, State, or local government, whether administered by such government or by a private organization on behalf of such government.¹⁹

¹⁷ NRPM, 76 FED. REG. at 6250.

¹⁸ While this discussion focuses on immigration detention, for the same reasons, the proposed standards should apply to domestic military facilities and tribal facilities. Inmates in these facilities are just as vulnerable to sexual abuse as other inmates, and these institutions are generally even more isolated and less regulated than corrections facilities. Be it federal, state or tribal, when the government removes someone's liberty, it bears a duty to protect that person from abuse, no matter what type of detention he or she is in. 19 42 U.S.C. § 15609 (7).

In accordance with the law's definition of "prison," the legislative history of PREA recognized the law's application to both criminal and civil detainees.²⁰ With respect to immigration detention, Senator Kennedy, a lead co-sponsor of PREA, explicitly noted his satisfaction that the law would protect immigration detainees, in his remarks at the first hearing of the National Prison Rape Elimination Commission.²¹

Consistent with this history, federal entities charged with implementing PREA – in particular the National Prison Rape Elimination Commission and the Bureau of Justice Statistics - have included civil detention in their mandate. The Commission held a public hearing that focused on immigration detention, convened an expert working group on immigration detention, included a section on immigration detention in its final report, and proposed supplemental standards for facilities housing immigration detainees in its recommended adult prison and jail standards.²² The Bureau of Justice Statistics similarly included facilities run by Immigration and Customs Enforcement (ICE) in its collection of statistics on prisoner rape mandated by PREA. Beyond the urgent need for the standards in immigration detention facilities, where sexual abuse is rife, the Department's dangerous statement that these facilities are beyond the scope of PREA will likely preclude further collection of vital data from these neglected facilities.

Notably, when PREA was first drafted (in 2002), there was no Department of Homeland Security (DHS); the Immigration and Naturalization Service, which did then still exist, was a division of the Department of Justice. While DHS was established by the time PREA passed, the transition of authority and scope of power were still being defined; even if they had foreseen this issue, the law's drafters would not realistically have been able to amend the statutory language in time.

²⁰ U.S. House Committee on the Judiciary, *Report on the Prison Rape Reduction Act of 2003*, 108th Cong., 1st sess., 2003, H. Rept. 108-219, at 14, 115, available at http://frwebgate.access.gpo.gov/cgibin/getdoc.cgi?dbname=108 cong reports&docid=f:hr219.108.pdf (last accessed February 3, 2011).

²¹ The Cost of Victimization: Why Our Nation Must Confront Prison Rape, Hearing of the National Prison Rape Elimination Commission (June 14, 2005) (testimony of Senator Edward M. Kennedy), available on-line at http://www.cybercemetery.unt.edu/archive/nprec/20090820160727/http://nprec.us/ docs/SenatorEdwardKennedyRemarks Vol 1.pdf (last accessed February 3, 2011).

² NATIONAL PRISON RAPE ELIMINATION COMMISSION, *supra* note 16, at 174-188.

The Department's decision to exclude immigration detention also undermines the Administration's own efforts to reform the immigration detention system.²³ Notably, in response to sexual abuse perpetrated by a transportation officer at Hutto Detention Center – a Corrections Corporation of America (CCA) facility contracted exclusively with Immigration and Customs Enforcement (ICE) – ICE requested a "PREA audit" of its CCA-contracted facilities. To assess these facilities' PREA readiness, the recommended standards were a key tool relied upon by the monitor who conducted those audits.²⁴

If immigration facilities are excluded from the PREA standards, an immigration detainee in a local jail would be protected by PREA but would lose that protection if transferred to an ICE facility. It is inconceivable that Congress intended PREA protection for detainees to be a matter of luck, depending on the facility that happens to confine them.

Efforts by ICE to address sexual assault through its own detention standards are important steps, but do not obviate the need for its facilities (as well as the Office of Refugee Resettlement facilities for unaccompanied minors) to be bound by the PREA regulations. ICE's performance-based national detention standards are unenforceable, subject to modification through collective bargaining, and lack the force of law. These provisions also do not include all of the measures that the Department and the Commission have deemed necessary in the proposed standards, including a means to ensure oversight and accountability.²⁵

²³ See, e.g., Dr. Dora Schriro, Immigration and Customs Enforcement, *Immigration Detention Overview and Recommendations* 22 (2009), *available at* <u>http://www.ice.gov/doclib/about/offices/odpp/pdf/ice-detention-rpt.pdf</u> (last accessed February 3, 2011) ("The system must make better use of sound practices such as ... practices that comply with the Prisoner [sic] Rape Elimination Act."); Nina Bernstein, *U.S. to Reform Policy on Detention for Immigrants*, N.Y. TIMES, Aug. 5, 2009 (quoting Assistant Secretary for ICE John Morton as seeking to work toward a "truly civil detention system" that would demonstrate greater respect for the dignity of individuals held in the agency's custody).

²⁴ This audit was conducted in the fall of 2010, and therefore the Department's proposed standards were not yet available. The auditors relied on the Commission's recommendations.

²⁵ For example, the ICE Sexual Abuse and Assault Prevention and Intervention Standard does not require that law enforcement be informed of a reported rape, that a criminal investigation occur, or that a criminal investigation be coordinated with any administrative investigation. As ICE's standards are nonbinding, they also do not include the internal and external oversight mechanisms found within the PREA standards. Appendix C, *infra*, is a list, compiled by JDI, of major differences between the 2010 PBNDS' sexual assault provision and the Department's proposed standards.

<u>Recommendation</u>: Restore the supplemental standards for facilities housing immigration detainees.

Whether housed in facilities exclusively used for immigration custody or in jails with criminal detainees, immigration detainees are especially vulnerable to abuse. Language and cultural barriers, histories of state-sanctioned abuse in their home countries, and a fear that reporting abuse will result in deportation all increase the likelihood that a non-citizen will not feel safe reporting sexual abuse and that perpetrators will not be held accountable. Unlike criminal defendants, immigration detainees have no right to an attorney, and as a result may not be aware of their right to be free from sexual abuse, nor whom to contact if they are sexually assaulted.

The Commission's supplemental standards addressed these disparities in an efficient and streamlined way. They included basic measures with minimal cost implications, such as requiring that staff receive cultural sensitivity training, that detainees are informed about how to contact the DHS Office of the Inspector General and the Office on Civil Rights and Civil Liberties, and that detainee victims and witnesses are not transferred or deported involuntarily during the course of a sexual abuse investigation. The Department's proposed standards for jails and other facilities that often house immigration detainees do not include these protections.

<u>Recommendation</u>: Apply relevant community confinement standards to parole and probation officers.

Excluding non-residential probation and parole officers from the standards is equally problematic, albeit for different reasons. These officers wield as much, if not more, authority as other corrections officials do, as they literally have power over the freedom of their probationers and parolees. Sadly, many probation and parole officers abuse that extraordinary power to extort sex. Moreover, many people who are victimized while incarcerated will wait to tell someone until they are released, with their parole or probation officer being an obvious first responder. By excluding these corrections players, the Department would dramatically limit the standards' overall effectiveness, even in residential settings.

Clearly, not all of the standards could, or should, apply to non-residential community corrections. However, at a minimum, training and education, investigation and response, and

data collection are urgently needed in these settings. Probation and parole officers are instrumental in ensuring a consistent and continuous response to sexual abuse in detention throughout the U.S. criminal justice system. Failing to include them in the scope of the standards will dangerously and unnecessarily interrupt such urgently needed continuity.

§ 115.5 General definitions

Overall the Department provides sensible and straightforward definitions. However, in addition to restoring the definitions of *prison* and *community corrections* to include immigration detention facilities and parole and probation officers, respectively, within the scope of the standards, the definition of *juvenile* should be modified to include all youth. Also, consistent with the Department's commendable protections for transgender and intersex inmates, these terms should be defined – and gender non-conformance should be included in relevant protections.

<u>Recommendation</u>: Modify the definition of "juvenile" to: any person under the age of 18, <u>unless otherwise defined by state law or a person</u> <u>who is under the jurisdiction of the juvenile justice system</u>," and modify the definition of "juvenile detention facility" to specify that it is "a facility primarily used for the confinement of juveniles, <u>including secure</u>, <u>non-secure</u>, <u>and community</u> <u>confinement facilities</u>.

All detained youth under the age of 18 are at grave risk of sexual assault by virtue of their stage of adolescent development and relative vulnerability to adults. According to the most recent BJS survey of residents in juvenile facilities, a shocking one in eight was sexually assaulted in the preceding year alone.²⁶ The prisons and jails survey results do not specify the rates of abuse for youth in adult facilities; however, in a survey of reports lodged with corrections officials, 42 percent of victims of inmate-on-inmate sexual abuse were under the age of 25.²⁷ All youth need the protections of the provisions for juvenile detention facilities, even if they are deemed adults by the criminal justice system.

²⁶ ALLEN J. BECK, PAUL GUERINO & PAIGE M. HARRISON, BUREAU OF JUSTICE STATISTICS, SEXUAL VICTIMIZATION IN JUVENILE FACILITIES REPORTED BY YOUTH, 2008-09 (2010) (hereinafter "YOUTH SURVEY").

²⁷ PAUL GUERINO & ALLEN J. BECK, BUREAU OF JUSTICE STATISTICS, SEXUAL VICTIMIZATION REPORTED BY ADULT CORRECTIONAL AUTHORITIES, 2007-2008 6 (2011).

The Department's proposed definition for *juvenile*, which relies on state law definitions, will create unnecessary confusion. State laws do not define adulthood consistently; a child may be considered an adult for some purposes, but not others. For example, parental consent laws for medical treatment may differ from the age of majority established for juvenile justice purposes. Further, state laws vary considerably on the age at which a youth may be prosecuted in the adult criminal justice system. More than half the states permit children under the age of 12 to be treated as adults for certain criminal offenses

The standards' definition of *juvenile* should include all youth under age 18, regardless of whether they are legally considered adults and prosecuted in the adult criminal justice system. This definition should also include people over the age of 18 who are currently in the custody of the juvenile justice system, as many state juvenile justice systems hold people until they reach the age of 21 or 25 if they were adjudicated as juvenile delinquents. Finally, the definition for *juvenile detention facilities* should be clarified to make clear that it concerns all facilities used for persons under the age of 18, including juvenile community corrections facilities.

Recommendation: Add the following definitions to § 115.5:

- Transgender: A term describing a person whose gender identity (internal, deeply felt sense of being male or female) is different from his or her assigned sex at birth.
- Intersex: A term describing a person whose has a sexual or reproductive anatomy and/or chromosomal pattern that does not fit typical definitions of male or female. Intersex medical conditions may also be called Disorders of Sex Development ("DSD").
- Gender non-conforming: A term describing a person whose gender expression does not conform to traditional societal gender-role expectations.

The terms *transgender* and *intersex* are used throughout the regulations, but are not defined. Many corrections staff members lack a clear understanding of these terms and therefore, without further guidance, are likely to misapply the strong protections intended by the Department. As discussed below (in § 115.41/241/341 and § 115.113), JDI urges that *gender non-conformance* be included in the definitions and added to the screening provisions.

Question 1: The Department solicits comments regarding the application of this definition to those States that operate "unified systems"—i.e., States with direct authority

over all adult correctional facilities, as opposed to the more common practice of jails being operated by counties, cities, or other municipalities. States that operate unified systems may be less likely to adhere to the traditional distinctions between prisons and jails, and may operate facilities that are essentially a mixture of the two. Do the respective definitions of jail and prison, and the manner in which the terms are used in the proposed standards, adequately cover facilities in States with unified systems? If not, how should the definitions or standards be modified?

JDI does not anticipate that the current definitions would pose any problems for unified systems. If the Department adopts the definition of *prison* that is used in PREA,²⁸ this term would encompass both prisons and jails. Regardless of the definitions used, the proposed Adult Prisons and Jails Standards have only one provision that differentiates based purely on facility type, rather than rated capacity. Section 115.81 requires that prisons ask inmates about prior sexual victimization and abusiveness, but requires jails to only ask about victimization. The Department's justification for the reduced requirement for jails is based on a "disproportional cost burden on smaller jails." While JDI does not support this revision (see discussion below), even if it remains, the Department could also limit this provision – as it does § 115.11(c),(d) and § 115.13(d) – based on rated capacity.

<u>Recommendation</u>: Clarify that co-located facilities need to implement the appropriate set of PREA standards at each unit in the co-located complex.

While unified systems should be able to adopt the Department's standards without further guidance, co-located facilities (such as a lockup and a jail or an adult jail and a juvenile unit in the same building or complex) may not know which standards should apply. In these situations, officials may choose to apply the standards that impose the least requirements or that apply to the largest set of their population. While JDI believes that all juveniles should be removed from adult facilities, to the extent that juveniles remain in adult systems, those youth need the protections of the juvenile standards. To address these concerns, the Department should clarify that, while each unit or ward is only bound to one set of standards, a co-located facility may need to implement more than one set of standards as appropriate. Thus, for example, a juvenile wing in an adult facility would be bound by the provisions for juvenile facilities, while the rest of the facility follows the prison and jail provisions.

²⁸ 42 U.S.C. § 15609 (7).

§ 115.6 Definitions related to sexual abuse

JDI applauds the Department for recognizing the importance of distinguishing sexual abuse, which is covered by PREA, from consensual sexual activity between inmates. Corrections agencies remain free to establish disciplinary rules and regulations as they see fit, but conflating consensual sexual activity between inmates with the crime of sexual abuse serves no legitimate purpose and thwarts many of PREA's goals. Indeed, doing so discourages survivors from reporting abuse or seeking medical assistance, out of fear that the sexual abuse they endured will be misconstrued as prohibited consensual sexual activity and that they will face punishment if they file a report.

<u>Recommendation</u>: Remove the subjective intent element in the sexual abuse definitions by modifying paragraph (4) in the definition for sexual abuse by another inmate, detainee or resident to:

"Any other intentional touching, either directly or through the clothing, of the genitalia, anus, groin, breast, inner thigh, or the buttocks of any person, excluding <u>contact incidental to a physical altercation</u> incidents in which the intent of the <u>sexual contact is solely to harm or debilitate rather than to sexually exploit</u>."
And modify paragraph (4) in the definition for sexual abuse by staff to:
"Any other intentional touching <u>that is unrelated to official duties</u>, either directly or through the clothing, of the genitalia, anus, groin, breast, inner thigh, or the buttocks of any person, with the intent to abuse, arouse or gratify sexual desire.

The Department's definition of sexual abuse requires considering the subjective intent of inmates and staff who perpetrate sexual abuse. For inmate-on-inmate sexual abuse, the standard excludes "incidents in which the intent of the sexual contact is solely to harm or debilitate rather than to sexually exploit." For abuse by staff, contractors or volunteers, the standard requires those individuals to have "the intent to abuse, arouse or gratify sexual desire." It is unclear why these distinctions matter, particularly given that this language will require agencies to engage in a complicated time- and labor-intensive inquiry into the intent of the perpetrator. The standards themselves do not include any guidelines that would clarify these difficult inquiries.

Requiring proof of intent to establish sexual abuse contradicts the victim-centered approach that the standards and PREA appropriately have maintained. Unwanted sexual touching is unacceptable, regardless of the perpetrator's motive. However, the current standards would deprive a victim of protections under the standards, even if an incident is particularly traumatic,

so long as the perpetrator did not intend to sexually exploit the inmate. The definition of inmateon-inmate sexual abuse already properly excludes consensual contact; the Department should not further limit the definition.

With respect to staff-on-resident abuse, the Department may have concerns regarding situations in which staff members intentionally make contact with inmates in accordance with an agency's policies and procedures, such as during a search. However, this concern can be addressed by excluding touching that is related to official duties.

<u>Recommendation</u>: Amend the definition of voyeurism as follows: Voyeurism by a staff member, contractor, or volunteer means an invasion of an inmate's privacy by staff for reasons unrelated to official duties, such as peering at an inmate who is using a toilet in his or her cell to perform bodily functions; requiring an inmate to expose his or her buttocks, genitals or breasts; or taking images of all or part of an inmate's naked body or of an inmate performing bodily functions, and distributing or publishing them.

As written, the definition of voyeurism does not address when a staff member takes pictures of an inmate performing bodily functions, so long as the staff member does not distribute or publish those images. Whether or not staff chooses to distribute or publish those types of images is immaterial; taking such images has no legitimate purpose and clearly constitutes sexual abuse.

II. Prevention Planning

<u>§ 115.11/111/211/311 Zero tolerance of sexual abuse and sexual harassment</u>

JDI commends the Department for requiring that the PREA policy outlines the agency's approach to preventing, detecting, and responding to sexual abuse and sexual harassment. A mere statement of zero-tolerance is not enough to provide the leadership and guidance needed for safe facility practices and culture.

<u>Question 2</u>: Should the Department modify the full-time coordinator requirement to allow additional flexibility, such as by requiring only that PREA be the coordinator's primary responsibility, or by allowing the coordinator also to work on other related issues, such as inmate safety more generally?

The Department may allow for the PREA coordinator to have other responsibilities, as long as addressing sexual violence remains the highest priority and that other responsibilities address

related issues. The PREA coordinator must be able to provide sufficient focus and attention to make sexual abuse prevention, detection, and response a high priority in each facility. Larger agencies and facilities will need a full-time coordinator to implement the standards fully and meaningfully; smaller facilities may find that a part-time employee is sufficient. Either way, these responsibilities should not be marginalized from the broader safety concerns to which they relate. Administrators who fail to recognize that sexual violence, physical violence, corruption, and other security breaches are all related will fail to address the root causes of these problems, such as deficiencies in staff training, hiring practices, screening and classification of inmates, and in investigation and response systems. The PREA coordinator should be able to operate within that larger framework in a manner that maintains a focus on sexual violence, as he or she assists with related concerns.

§ 115.12/112/212/312 Contracting with other entities

<u>Question 3</u>: Should the final rule provide greater guidance as to how agencies should conduct such monitoring? If so, what guidance should be provided?

Inmates and residents need the full protections of the PREA standards, whether they are housed in public or privately-run facilities. Private agencies may conceal or minimize incidents or risk factors that could subject them to contractual penalties, result in the cancellation or non-renewal of contracts, or have an adverse impact on their stock performance or other contract opportunities.²⁹ Moreover, as private facilities are often outside of the jurisdiction where detention was imposed, victimized inmates and residents in these facilities are likely to be especially isolated and conditions in the facility subject to less scrutiny. At a minimum, private facilities should be monitored for compliance with the standards to the same extent as public facilities, in accordance with the audit provision.

²⁹ In 2008, for example, a former manager with the Corrections Corporation of America (CCA) revealed that the company kept two sets of internal audit reports – a detailed version with auditors' notes that was for in-house use only, and another version without the detailed notes, which was provided to government contracting agencies. The latter audit reports were reportedly "doctored' for public consumption, to limit bad publicity, litigation or fines that could derail CCA's multimillion-dollar contracts with federal, state or local agencies." Adam Zagorin, *Scrutiny for a Bush Judicial Nominee*, TIME, Mar. 13, 2008, *available at*

http://www.time.com/time/nation/article/0,8599,1722065,00.html#ixzz1GnQP4EQm (last accessed March 21, 2011).

<u>Recommendation</u>: Add the following paragraphs to this provision: (c) Private agencies or other entities responsible for the confinement of youth shall be audited by qualified and independent monitoring entities, in accordance with the criteria in § 115.93 and related criteria established by the Department of Justice. The reports and action plans arising from these audits shall be made publicly available.

(d) Any new contracts or contract renewals with private agencies or other entities for the confinement of inmates shall include enforcement provisions to ensure that the private agencies or entities are in compliance with the PREA standards. Such enforcement provisions shall include but not be limited to financial sanctions for non-compliance with the standards, as determined by the contracting public agency.

Sections 115.12, 115.112, 115.212 and 115.312 should include specific guidance on how government agencies should monitor compliance with the standards in private contract facilities. While states and counties generally monitor contracts with private agencies, the scope and expertise involved in the monitoring of the PREA standards is dramatically different from the audits required by Standard § 115.93 and the corresponding provisions for other facilities. Such monitoring is not conducted by an independent entity that is qualified to detect sexual abuse and provide relevant recommendations. It also may not include private communications with inmates and staff, nor result in any publicly available report or recommendations. Comprehensive reviews and transparency are as necessary in contracted facilities as they are in facilities run by the government agency itself.

Worse still, the Department's proposed standards do not provide mechanisms for government agencies to sanction private contractors that fail to comply with the standards. Given the profit incentives underlying private corrections agencies, this is a dangerous omission indeed; the standard should make clear that government agencies must enforce non-compliance with the PREA standards through remedies that include financial sanctions.

<u>§ 115.13/113/213/313 Supervision and monitoring</u>

The Department's decision to combine the Commission's standards on supervision and technology has some merit, as the necessary levels of staffing and of surveillance technology needed are interrelated. Likewise, the additional standard requiring agencies to take sexual abuse

prevention into account when designing or expanding facilities or installing or updating technology (Std. § 115.17/117/217/317) should improve the ability of agencies to deploy staff and technology appropriately moving forward.

However, to reiterate concerns raised with the Commission's standards and with regard to the Booz Allen Hamilton cost projection study, adequacy in staffing and surveillance technology must be defined, and agencies must be provided with guidance on how to conduct staffing and technology analyses – the Department's proposed standards do not do these things. Without such definitions and guidance, concerns about the workability of the standard remain, and the standard's potential to ensure that resources are available and allocated appropriately becomes significantly weakened. Moreover, the proposed standards allow agencies to subvert this critical requirement by allowing them to implement a plan for how to conduct staffing and video monitoring when adequate levels are not attained, without specifying consequences for agencies that fail to create and/or adhere to such plans.

<u>Recommendation</u>: Remove paragraph (b) and modify the first sentence of paragraph (a) as follows:

For each facility, the agency shall determine the develop and adhere to a plan to ensure that facilities establish adequate levels of staffing and, where applicable video monitoring, to protect inmates against sexual abuse.

The proposed standard lacks sufficient means to ensure that facilities are staffed adequately to keep inmates safe from abuse. By suggesting that agencies determine their own adequate levels of staffing and video monitoring and then create a plan for what to do if they fail to achieve those levels, the Department essentially permits facilities to operate at sub-optimal staffing levels indefinitely. While creation of a back-up plan is essential, it is not, in itself, enough. At a minimum, clear accountability measures must be built into this structure, whereby PREA auditors (see § 115.93/193/293/393 below) have the authority to declare agencies non-compliant if they fail to create sufficient back-up plans, to adhere to such back-up plans, and/or to work toward achieving adequate staffing and monitoring levels. The standards should not offer blanket exemptions from basic constitutional requirements to employ enough personnel to keep inmates and residents safe from harm. Rather, the standards should help agencies to examine seriously their deficiencies and, if necessary, engage their legislators in adopting a feasible solution.

Whether by re-examining sentencing schemes and incarceration rates, or by re-appropriating funds, states and counties in such circumstances can often identify workable solutions.

<u>Recommendation</u>: Amend the second sentence of paragraph (a) as follows: In calculating such levels, agencies shall take into consideration (<u>1</u>) the physical layout of each facility, (<u>2</u>) the composition of the inmate population, (<u>3</u>) blind spots, including blind spots in areas not designated for inmates (e.g. closets, rooms and hallways where staff perpetrators of sexual abuse could bring an inmate); (<u>4</u>) hightraffic locations and busy times, such as when there is movement of a large number of inmates within the facility and during shift changes; (<u>5</u>) identified "hot spots" for abuse; (<u>6</u>) the ease with which individual staff members are able to be alone with individual inmates for extended periods of time; (7) the need to ensure that known perpetrators are directly observed when interacting with other inmates; (<u>8</u>) the need to ensure that inmates identified by facility staff as especially vulnerable receive additional protection without being subject to extended isolation or other forms of punishment; (<u>9</u>) the ability to establish and retain video and other evidence of sexual misconduct; (<u>10</u>) compliance with any applicable laws and regulations on staffing requirements; and (<u>11</u>) any other relevant factors.

As the Department notes, "determining adequate staffing levels is a complicated, facility-specific enterprise [that depends on a] variety of factors."³⁰ Nonetheless, there are factors that should always be taken into account when assessing staffing adequacy and that should be incorporated into the standard. For example, facility blind spots, hot spots for abuse, high traffic areas, and the ease with which individual staff members can be alone with individual inmates create conditions that contribute to sexual abuse. Likewise, staffing levels must ensure that known perpetrators are directly supervised when interacting with other inmates and that victims are not unduly isolated.

Requiring consideration of these factors, which are known to contribute to the levels of sexual abuse, will help agencies with limited resources figure out how to supervise inmates. JDI's suggested amendments to the standard would also provide auditors with concrete factors to be taken into account when monitoring compliance with this provision. Agencies should be required to devise plans for staffing and electronic surveillance that include an assessment of relevant factors and a plan for redistributing or securing needed funds. Auditors would then review the sufficiency and feasibility of these plans. The aforementioned considerations would also increase

³⁰ NPRM, 76 FED. REG. at 6252.

the likelihood of securing evidence of abuse, leading to greater agency accountability as well as protecting staff against false reports.

Recommendation: In § 115.313, the standard should mandate that technology only be used as a supplement to direct supervision, not as a substitute.

In any facility in which youth are held, they need direct supervision by adults who are attuned to youth interactions and potential conflicts. Continuous, direct, engaged supervision provides one of the best forms of protection from abuse, as staff is more likely to identify signs of developing problems among youth when they interact with them regularly.

Video surveillance cannot create the rehabilitative environment and personal relationships between youth and staff that are seen as best practice within the juvenile justice system. To achieve that goal, facilities must deploy trained staff to work directly with youth. The Department recognized this need in its Notice of Proposed Rulemaking, stating that "[a]dministrators of juvenile facilities ... are typically more reluctant to rely heavily on video monitoring given the staff-intensive needs of their residents." Limiting its value, video surveillance systems rarely capture live audio, which severely diminishes their effectiveness as surveillance tools. Staff who directly supervise youth rely on what they hear to help prevent dangerous situations from developing, taking cues from residents' conversations and changes in tone or inflection. Because video surveillance systems usually lack this feature, facilities that rely too much on such tools are compromised in anticipating and responding to events.

Questions 4-5:

- Should the standard require that facilities actually provide a certain level of staffing, whether determined qualitatively, such as by reference to "adequacy," or quantitatively, by setting forth more concrete requirements? If so, how?
- If a level such as "adequacy" were mandated, how would compliance be measured?

A quantitative blanket requirement for staffing at all facilities would not be feasible, given the wide array of facility-specific factors affecting staffing needs, such as population size, security levels, and building architecture. However, providing no requirements makes this provision virtually unenforceable. With proper guidance, a qualitative standard can be established in a realistic, measureable way.

As detailed above, many of the factors that contribute to high levels of abuse are known, and can be accounted for in assessing appropriate staffing levels. The data developed by the Bureau of Justice Statistics provides some information about when and where abuse is most prevalent. For example, of the incidents reported in the prisons and jails survey, more than half of all inmate-on-inmate assaults occurred in cells between 6:00 p.m. and midnight, while staff sexual misconduct most often took place in a closet or locked office.³¹ In juvenile facilities, both resident-on-resident and staff-on-resident assaults were most prevalent in common areas, and between 6:00 p.m. and midnight.³² Agencies should be encouraged to consider such data when assessing the needs in their facilities.

Questions 6-8:

- Various States have regulations that require correctional agencies to set or abide by minimum staffing requirements. To what extent, if any, should the standard take into account such State regulations?
- Some States mandate specific staff-to-resident ratios for certain types of juvenile facilities. Should the standard mandate specific ratios for juvenile facilities?
- If a level of staffing were mandated, should the standard allow agencies a longer time frame, such as a specified number of years, in order to reach that level? If so, what time frame would be appropriate?

The Department need not require that one state's regulation become the standard for the nation. Rather, if as JDI suggests, the Department specifies factors that must be considered in each agency's annual assessment, applicable state regulations should be a part of that analysis.

The Department should not provide a lengthened time frame for compliance with this standard. As discussed above, appropriate staffing to keep inmates safe is a basic function of all corrections settings and a constitutional requirement. Agencies that cannot adequately supervise the people in their charge must address that problem as a matter of urgency and must be held accountable to ensure that solutions are implemented. A time frame determined by the Department would also fail to account for the significant differences between facilities and agencies. Establishing one time frame to fit all circumstances would set the bar disturbingly low.

³¹ ALLEN J. BECK & PAIGE M. HARRISON, BUREAU OF JUSTICE STATISTICS, SEXUAL VICTIMIZATION IN PRISONS AND JAILS REPORTED BY INMATES, 2008-09 21-23 (2010) (hereinafter "ADULT SURVEY").

³² YOUTH SURVEY, *supra* note 26, at 12-14.

To the extent that facilities are unable to provide adequate staffing, such a failure should be addressed the same way as other forms of noncompliance: requiring the agency to establish a clear action plan as soon as possible, and having that plan approved and monitored by the PREA auditor.

Questions 9-11:

- Should the standard require the establishment of priority posts, and if so, how should such a requirement be structured and assessed?
- To what extent can staffing deficiencies be addressed by redistributing existing staff assignments? Should the standard include additional language to encourage such redistribution?
- If the Department does not mandate the provision of a certain level of staffing, are there other ways to supplement or replace the Department's proposed standard in order to foster appropriate staffing?

Areas of a facility where it is known that sexual abuse is likely to occur must be monitored by staff, not just cameras. Where known perpetrators are interacting with other inmates, for example, an officer must be present who can respond immediately to any problems. Given that a substantial proportion of sexual assaults take place in cells and dormitories, these are also areas that must be monitored by staff, and not primarily by cameras. Further, cameras should not be used to monitor areas where inmates are in states of undress (showers, toilets, etc.), unless there are privacy screens to ensure that cameras do not film an inmate's intimate body parts. It may be helpful for the Department to identify such priority posts – however, agencies should also be required to do so themselves, and to incorporate this information into their assessment plans, to account for different cultures and needs of each institution.

In some facilities, redistribution of staff may be the most cost-effective way to ensure adequate supervision. The Department should encourage the incorporation of such redistribution into assessments and plans, as appropriate. However, the Department must be clear that agencies are required to ensure that staff are appropriately trained and qualified for whatever new posts are created or assigned.

As discussed above, JDI urges the Department to include factors that must be considered in assessing whether the level of staffing is appropriate. Rather than providing strict formulas, or no

substantive guidance, the inclusion of such factors will help agencies remain focused on what is needed to keep inmates and residents safe from sexual abuse.

Questions 12-13:

- Should the Department mandate the use of technology to supplement sexual abuse prevention, detection, and response efforts?
- Should the Department craft the standard so that compliance is measured by ensuring that the facility has developed a plan for securing technology as funds become available?

There is no one quick fix for agencies to improve their supervision efforts. Technology is an invaluable supplement to direct supervision when used appropriately in the proper settings. In juvenile institutions, the Department should emphasize the value and importance of direct supervision.

In all facilities, the use of technology should be part of the PREA-related supervision assessments and plans, as deemed appropriate by the agency and the auditor. In addition to mandating that a plan be developed for adequate supervision generally, the Department should ensure that the plan is feasible. Limited resources unquestionably create challenges, but states should be pressured to prioritize these needs in their decision-making. Costs cannot justify any dereliction of the core duty of corrections agencies to keep inmates safe.³³

Question 14: Are there other ways not mentioned above in which the Department can improve the proposed standard?

As discussed above, the Department must provide criteria for assessing the adequacy of supervision and the use of technology, including concrete measurable factors, and require agencies to take steps to achieve these goals.

³³ Courts have long rejected insufficient funding as an excuse for unconstitutional conditions of incarceration. *See*, *e.g., Rufo v. Inmates of Suffolk County Jail*, 502 U.S. 367, 392 (1992); *Harris v. Thigben*, 941 F.2d 1495, 1509 (11th Cir. 1991); *Monmouth County Correctional Institution Inmates v. Lanzarro*, 834 F.2d 326, 336-337 (3rd Cir. 1987); *Williams v. Edwards*, 547 F.2d 1206, 1212-13 (5th Cir. 1977); *Detainees of Brooklyn House of Detention v. Malcolm*, 520 F.2d 392, 399 (2d Cir. 1975); *Finney v. Ark. Bd. of Correction*, 505 F.2d 194, 202 (8th Cir. 1974); *Rozecki v. Gaughan*, 459 F.2d 6, 8 (1st Cir. 1972).

<u>Recommendation</u>: All facilities should have a policy and practice of having intermediate-level or high-level supervisors conduct and document unannounced rounds on a regular basis, regardless of rated capacity.

Unannounced rounds are an essential part of institutional management and oversight. They provide a low-cost, high-impact way for agencies to identify problems within their facilities and to ensure that policies are properly implemented. While the appropriate frequency of such rounds may vary by facility size and structure, they must be conducted on a regular basis in order to be effective. There is simply no reason why this form of surveillance should not be required everywhere as part of a comprehensive plan for ensuring inmate safety.

<u>Question 15</u>: Should this standard mandate a minimum frequency for the conduct of such rounds, and if so, what should it be?

The practice of conducting unannounced inspections should be normalized through frequent rounds, and be required in all facilities – regardless of population count. The frequency may vary by facility size, but even the smallest facility will benefit by having a high-level supervisor conduct rounds on a regular basis. The diversity among institutions makes it difficult for the Department to specify a minimum frequency of rounds. Providing a specific frequency may also take away from the value of having them be unannounced, as regular frequency rounds will allow staff and inmates to estimate when the next round is likely to occur. Rather, the Department should require that rounds be staggered (so there is no set time between rounds) and that they occur often enough to prevent abuse.

<u>Recommendation</u>: Lockups provision § 115.113(d) should identify known vulnerability factors by adding the following sentence to this paragraph: <u>Law enforcement staff treat the following as indicators of vulnerability to sexual</u> <u>abuse: mental or physical disability; young age; slight build; nonviolent history;</u> <u>identification as lesbian, gay, bisexual, transgender, or intersex; gender non-</u>

conforming appearance; prior sexual victimization; and the detainee's own perception of vulnerability.

Not all lockup facilities will be able to conduct systematic risk screening for all detainees, or will need to if they generally have more cells than detainees. Nonetheless, the Department rightly requires those that do intake screenings to address vulnerabilities to sexual abuse. However, to be effective, this provision must inform facility staff of what they need to consider in making this

assessment. Accordingly, the standard should list the known indicators of vulnerability that can be determined by asking the detainee or through observation.

§ 115.14/114/214/314 Limits to cross-gender viewing and searches

The Department recognizes that, ideally, officers supervising inmates of the opposite sex would not conduct pat searches or view them in states of undress. Nonetheless, the proposed standard makes no meaningful effort to limit these dangerous practices.

The BJS surveys confirm that sexual abuse of inmates and residents by staff members of the opposite sex is pervasive in prisons, jails, and juvenile facilities.³⁴ Authorizing officers to touch inmates of the opposite gender and to view them in states of undress is simply bad policy, often leading to abuse and a sexualized institutional culture. As the Ninth Circuit recently noted, "[i]t is not surprising that a connection has been made between cross-gender searches and the level of sexual impropriety between inmates and corrections personnel."³⁵ In addition to inciting sexual abuse, the lack of bodily privacy and integrity that stem from cross-gender searches can be especially problematic to someone with a history of abuse, often triggering prior trauma.³⁶

<u>Recommendation</u>: Limit cross-gender pat searches to emergency situations, by adding it to the list of searches in paragraph (a), and deleting paragraph (e).

The Department's revisions to the limitations on cross-gender searches conform to BOP policy, but disregard the progression of state agencies toward the best practice of significantly limiting cross-gender pat searches.³⁷ In relying on the BOP as a model, the Department also ignores

³⁴ ADULT SURVEY, *supra* note 31, at 5; YOUTH SURVEY, *supra* note 26 at 1.

³⁵ Byrd v. Maricopa County Sheriff's Department, ______F.3d 365, 379 (9th Cir. 2011) (en banc), pet. for cert. pending (citing Nicholas D. Kristof, Op-Ed., Kids in Crisis (Behind Bars), N.Y. TIMES, Jan. 28, 2010, at A33; Connie Rice and Pat Nolan, Op-Ed, Policing Prisons, L.A. TIMES, Apr. 5, 2010, at A13). JDI served as amicus curiae in Byrd. ³⁶ In a 1999 BJS survey, just under half of incarcerated women and one-tenth of incarcerated men indicated past abuse. The survey did not define physical and sexual abuse, instead relying on the definitions of the respondents; the total number is likely much higher. CAROLINE WOLF HARLOW, BUREAU OF JUSTICE STATISTICS, PRIOR ABUSE REPORTED BY INMATES AND PROBATIONERS 1 (1999), available at http://bjs.ojp.usdoj.gov/content/pub/pdf/parip.pdf (last accessed March 27, 2011).

³⁷ In a 1999 prison survey by the National Institute of Corrections, only seven systems reported a policy allowing routine cross-gender pat-downs in female facilities. By 2001, four of those states began prohibiting male pat searches of women prisoners, leaving the federal system and two states in the extreme minority. Half of the states reported prohibiting cross-gender searches in male facilities. National Institute of Corrections Prisons Division and Information Center, *Cross-Sex Pat Search Practices: Findings from NIC Telephone Research* (January 6, 1999).

known problems with the BOP's pat search policy. According to a 2009 report by the Inspector General, "BOP officials believed that male staff members were most often accused of sexual misconduct stemming from pat searches."³⁸ The BJS prisons and jails survey confirm a similar link between pat searches and sexual touching by staff³⁹ – indeed, a significant proportion of sexual abuse in detention begins during pat searches, before escalating into more severe forms of sexual violence.

As acknowledged in the Notice of Proposed Rulemaking, juvenile systems have largely restricted cross-gender pat searches and viewing to emergency situations. While adult facilities face different challenges and generally have more significant security needs than youth facilities, with proper incentives, they could establish similar solutions to those that have worked for juvenile agencies.

Outside of the federal system, many women's facilities have also limited cross-gender supervision. When confronted with these issues, judges are increasingly recognizing that limiting cross-gender viewing and searches may be constitutionally necessary.⁴⁰ In some jurisdictions such limitations have been imposed, either as injunctive relief in civil rights litigation or upon the Department's recommendations pursuant to a CRIPA investigation.⁴¹ A recent case decided *en banc* by the Ninth Circuit Court of Appeals held that the search of a male jail inmate by a female cadet, who touched his thighs, buttocks, and genital areas over a thin pair of boxer shorts, amounted to an unreasonable search in violation of the Fourth Amendment.⁴² Many of these precedents acknowledge the link between cross-gender supervision and sexual abuse.⁴³

³⁸ OIG 2009 REPORT, *supra* note 12.

³⁹ ADULT SURVEY, *supra* note 31, at 24 (finding that 42.7 percent of inmates who reported sexual touching by a staff member said that it happened at least once as part of a strip or pat search).

⁴⁰ See, e.g., Everson v. Mich. Dep't of Corrections, 391 F.3d 737 (6th Cir. 2004) (holding that gender was a bona fide occupational qualification for certain positions in Michigan's women's prisons, based in part on "the endemic problem of sexual abuse in Michigan's female facilities"); *Tharp v. Iowa Dep't of Corrections*, 68 F.3d 223 (8th Cir. 1995) (upholding facility's decision to exclude male employees from posts in female housing unit).

⁴¹ See, e.g., Letter from Thomas Perez, Assistant Attorney General, Department of Justice, to Hon. Mitch Davis, Governor of Indiana 43 (Jan. 29, 2010) (recommending, among other things, that cross-gender strip searches be prohibited in non-emergencies); *Women Prisoners v. District of Columbia*, 877 F. Supp. 634, 679-81 (D.D.C. 1994), *vacated in part, modified in part*, 899 F. Supp. 659 (D.D.C. 1995).

⁴² Byrd, _____ F.3d 365. Although the Court deemed the search to be a strip search, in light of the minimal amount of clothing worn by the inmate, neither of the parties had characterized it as such. The Department defines pat searches

The models and precedents created in juvenile institutions and women's prisons should apply to all facilities. Contrary to widespread misperceptions, the Department itself has found that staff sexual abuse is even more prevalent in men's and boy's facilities than in facilities for women and girls, making clear that these basic measures are urgently needed everywhere.⁴⁴

The Commission, in its work, was aware of recent judicial precedent (both with respect to inmates' privacy rights and officers' employment opportunities) and of the financial and legal concerns of corrections officials. While it initially sought to limit cross-gender supervision in any area of a facility where inmates disrobe or perform bodily functions – which, consistent with international human rights standards,⁴⁵ is the norm in most Western countries – the Commission consulted with officials about their concerns and ultimately limited its recommendations to searches and the actual viewing of inmates who are nude or performing bodily functions. This compromise is consistent with professional standards and emerging best practices.⁴⁶

The dangers of cross-gender pat-down searches are not sufficiently mitigated by creating an exception for inmates who can demonstrate that they have suffered "documented prior cross-gender sexual abuse while incarcerated."⁴⁷ Indeed, this proposal makes a mockery of the realities of sexual abuse in detention. One drawback of this exception is that it places the burden on previously victimized inmates to provide documentation and to ensure that officers conducting searches are aware that they meet the exception, negating any proper checks in place that limit such information to a need-to-know basis. The Department's standards should instead give such

as "a running of the hands over the clothed body of an inmate, detainee or resident by an employee to determine whether the individual possesses contraband," NPRM, 76 FED. REG. at 6277, precisely what occurred in *Byrd*. ⁴³ See, e.g., *Byrd*, ____ F.3d at 379 (citing NATIONAL PRISON RAPE ELIMINATION COMMISSION, *supra* note 16); *Everson*, 391 F. 3d 737 (upholding same sex supervision in the housing units based in part on Michigan's long history of sexual abuse of women in custody).

⁴⁴ ADULT SURVEY, *supra* note 31, at 12; YOUTH SURVEY, *supra* note 26, at 10. In all types of facilities, victimized inmates and residents reported that the majority of staff sexual abuse was perpetrated by an employee of the opposite gender. ADULT SURVEY, *supra* note 31, at 24; YOUTH SURVEY, *supra* note 26, at 13.

⁴⁵ See Standard Minimum Rules for the Treatment of Prisoners, ECOSOC Res. 2076 (LXII), P 95, U.N. Doc. E/RES/2076 ¶ 53 (May 13, 1977).

⁴⁶ American Bar Association, Criminal Justice Standards on the Treatment of Prisoners, Standard 23-7.9, *available at* http://www.americanbar.org/publications/criminal_justice_section_archive/crimjust_standards_treatmentprisoners.html#23-7.9 (last accessed March 27, 2011).

⁴⁷ Dep't of Justice, Proposed Standard § 115.14/214 (e).

responsibility to corrections agencies, which have a duty to keep inmates safe from abuse. This exception also requires inmates to have filed and had substantiated a report of abuse, even though the vast majority of sexual abuse survivors are too afraid to file a report and the vast majority of those who do so find that their reports are not substantiated. This is especially true in cases of abusive searches, where there is rarely physical evidence of the abuse. Moreover, this exception ignores the traumatic and devastating impact of these searches on inmates who were sexually victimized in the community, as well as the prevalence of staff abuse of inmates who were not previously assaulted in detention.

In its Initial Regulatory Impact Assessment, the Department justifies its substantial weakening of the Commission's standard by claiming that "a number of facilities interpreted [this provision] as requiring them either to hire significant numbers of additional male staff or to lay off significant numbers of female staff, due to the overwhelmingly male inmate population and substantial percentage of female staff," which could violate equal employment opportunity laws.⁴⁸ This justification underscores serious problems with the data relied upon by the Department. Booz Allen Hamilton asked officials to estimate what it would cost to comply with the standards, without providing any incentive for them to think creatively or identify the most cost-effective way of doing so. Not surprisingly, administrators (who ultimately need to defend their budgets to appropriators and therefore have no reason to minimize estimated costs) offered what they saw as the easiest solutions.

However, contrary to the assertions of some corrections officials, these requirements can be met with low-cost solutions that conform to employment law and do not require significant additional hiring. For example, "roving officer" positions can be established to ensure that an officer of the same gender as the inmates is available to conduct searches without requiring significant changes in personnel.⁴⁹ In non-emergency situations, intrusive searches that require bodily exposure or physical contact can be limited to areas that serve as potential entry-points for contraband. While

⁴⁸ Dep't of Justice, Initial Regulatory Impact Analysis for Notice of Proposed Rulemaking, Proposed National Standards to Prevent, Detect, and Respond to Prison Rape Under the Prison Rape Elimination Act (PREA) 45 (2011) (hereinafter "IRIA").

⁴⁹ While the gender breakdown of staff may not match the gender breakdown of inmates, facilities generally have enough officers of each gender to employ roving officers. JDI has been told that such a practice has been accepted in collective bargaining agreements.

many agencies conduct frequent cursory pat searches throughout their facilities, focusing staff efforts by emphasizing thorough searches at key places will aid in the confiscation of contraband at its point of entry into the facility, reduce complaints about harassing searches, and free up staff resources for other safety and security measures.

<u>Question 16</u>: Should the final rule contain any additional measures regarding oversight and supervision to ensure that pat-down searches, whether cross-gender or same-gender, are conducted professionally?

Regardless of whether cross-gender pat searches are limited, the proposed standard's requirement that security staff receive training in how to conduct cross-gender pat searches professionally, respectfully, and in the least intrusive manner possible consistent with security needs remains important – and should be incorporated into the staff training provision. Staff should also be educated on how to conduct a proper same-gender pat search, as these searches can also be violating and abusive if performed improperly. Consistent with the government findings that staff sexual misconduct is often linked to pat searches, ⁵⁰ JDI regularly hears from inmates who have endured abusive pat searches – both cross-gender and same sex, at men's and women's facilities.

<u>Recommendation</u>: Require cross-gender pat searches to be documented, in the same manner as strip and body cavity searches, by removing the word "such" from paragraph (b).

The Department should also require documentation of all cross-gender searches. Documenting these searches can be useful in monitoring staff sexual misconduct, particularly when it arises from a pat search. Through documentation, supervisors will be able to assess whether officers accused of sexual misconduct are conducting these searches unnecessarily, and whether there is a link between the performance of cross-gender pat searches and complaints of sexual misconduct. Moreover, this procedural step will help dissuade the overuse of such searches, encouraging the use of same gender officers for pat searches when possible to minimize paperwork.

<u>Recommendation</u>: Do not allow staff to view inmates and residents of the opposite gender in states of undress "incidental to routine cell checks."

⁵⁰ See, e.g., OIG 2009 REPORT, *supra* note 12, at 26.

The Department's authorization of cross-gender viewing of inmates and residents in states of undress "incidental to routine cell checks" negates any practical limitation on cross-gender viewing and any incentives for agencies to limit this dangerous practice. In many facilities, inmates and residents undress, use the toilet, and sometimes wash in their cells. Officers should be prohibited from viewing inmates and residents of the opposite sex at these times in non-emergency situations.

As with cross-gender pat searches, low and no-cost measures can provide a base level of bodily privacy in detention. For example, officers of the opposite gender can be required to announce themselves prior to entering the cell block. Alternately, inmates or residents can be provided with tools to shield their body – e.g. with towels or privacy screens – while performing these functions.

<u>Recommendation</u>: Do not allow for searches of transgender inmates solely to determine genital status, by replacing paragraph (d) with the following: <u>The facility shall not search or physically examine a transgender or intersex inmate</u> for the sole purpose of determining genital status. If an inmate's genital status is <u>unknown, it may be determined during routine intake medical examinations that all</u> inmates are required to undergo, by reviewing medical records, or by speaking with <u>the inmate.</u>

The proposed standard rightly recognizes that transgender and intersex inmates are at acute risk for sexually abusive searches, and that determining an inmate's genital status frequently is a pretext for abuse. Strip searching transgender or intersex inmates (or touching their genitals) for the sole purpose of determining their genital status is emotionally and sexually abusive, even if the search is called an examination and is conducted by a medical practitioner in private. Permitting medical practitioners to touch a transgender or intersex resident's genitals or requiring an inmate to undress in front of a medical practitioner solely so that the practitioner can look at his or her genitals is an unnecessary and inherently traumatic experience and presents serious potential for abuse.

The standard should prohibit searches or medical examinations for the sole purpose of determining genital status. In the very limited circumstances where this information is needed by a facility, it should be determined during routine medical examinations at intake or from the resident, from medical records, or from other reliable sources.

<u>Recommendation</u>: Specify what a cross-gender search means in the context of transgender and intersex inmates, but adding the following provision to this standard: <u>For purposes of determining what constitutes a same-gender search of a</u> transgender or intersex inmate, the facility shall ask the inmate to specify whether <u>he or she would feel safest being searched by male or female staff and shall</u> <u>accommodate such requests except in the case of emergency or other unforeseen</u> <u>circumstances.</u>

With no formal guidance stating who shall administer routine searches of transgender and intersex inmates, these inmates are likely to be subjected to cross-gender searches from which the proposed regulations protect other residents. Transgender and intersex inmates are known to be especially targeted for harassment and abuse, ⁵¹ and also have particular privacy and safety needs that are compromised by cross-gender searches. In order to address the safety concerns of transgender and intersex inmates and protect their privacy and dignity, the Department should specify how the restrictions on cross-gender searches and supervision apply to transgender and intersex inmates.

The best practice for doing so is to ask transgender and intersex individuals by which gender they would feel most safe being searched, and accommodating this preference whenever possible. This pragmatic approach is currently used by the New York State Office of Children and Family Services in its juvenile facilities, and by the Cumberland County Sherriff's Office in

⁵¹ See, e.g., SYLVIA RIVERA LAW PROJECT, "IT'S WAR IN HERE": A REPORT ON THE TREATMENT OF TRANSGENDER & INTERSEX PEOPLE IN NEW YORK STATE MEN'S PRISONS 29-31 (2007), available at <u>http://srlp.org/resources/pubs/warinhere</u>; AMNESTY INTERNATIONAL USA, STONEWALLED: POLICE ABUSE AND MISCONDUCT AGAINST LESBIAN, GAY, BISEXUAL AND TRANSGENDER PEOPLE IN THE US 54-58 (2005), available at <u>http://www.amnestyusa.org/outfront/stonewalled/report.pdf</u>; At Risk: Sexual Abuse and Vulnerable Groups Behind Bars, Hearing Before the National Prison Rape Elimination Commission (August 13, 2005) (testimonies of Christopher Daley & Dean Spade). Maine.⁵² A similar approach has recently been adopted by the UK government for searches by police and corrections officers.⁵³

However, if a general presumption is needed about who should conduct searches of transgender and intersex individuals, all such searches should be conducted by female staff. Transgender and intersex individuals, regardless of gender identities, are often perceived as female and/or feminine and are at considerably higher risk of being targeted for abuse and harassment by male staff.

<u>§ 115.15/115/215/315 Accommodating inmates with special needs</u>

As the Department acknowledges, federal civil rights laws require agencies receiving federal assistance to provide inmates with disabilities or limited English proficiency (LEP) with meaningful access to programs and services.⁵⁴ The proposed standards provide LEP inmates, deaf inmates, and inmates with a disability with education about PREA-related policies. However, they fall short on ensuring that these inmates have sufficient access to reporting, and necessary assistance during investigations and response efforts.

<u>Recommendation</u>: Amend paragraph (a) to require agencies: to ensure that inmates who are limited English proficient, <u>or</u> deaf, or <u>have a</u> <u>disability</u> disabled are able to report sexual abuse and sexual harassment to staff directly <u>and through at least one other established reporting mechanism</u>.

Inmates with disabilities and LEP inmates are among the most vulnerable to abuse, in part because they often contend with barriers to effective communication with facility staff. Ensuring that special needs inmates can report to staff is an important first step, but accommodations should be made to ensure that inmates with disabilities, deaf inmates, and LEP inmates have multiple reporting options. Like other victimized inmates, inmates with disabilities and other

⁵² It is also used in other settings in the United States, such as by the District of Columbia Police Department. Police departments in several Canadian jurisdictions, including Toronto, Vancouver, and Edmonton, have adopted a similar policy following a 2006 ruling by the Ontario Human Rights Commission.

⁵³ Code of Practice for the Exercise by Police Officers of Statutory Powers of Stop and Search (PACE Code A), Annex F (2010), *available at* <u>http://www.homeoffice.gov.uk/publications/police/operational-policing/pace-code-a-2011</u>; Prison Service Instruction 48/2010, Search of the Person, Annex H (2010), *available at* <u>http://psi.hmprisonservice.gov.uk/psi_2010_48_searching_of_the_person.doc</u>.

⁵⁴ NPRM, 76 FED. REG. at 26-27 (citing the Americans with Disabilities Act, 42 U.S.C. § 12132, and Title VI of the Civil Rights Act of 1964, 42 U.S.C. § 2000d *et seq.*).

special needs are unlikely to feel safe reporting staff sexual misconduct if their only option for reporting is to the perpetrating staff member or a colleague of the perpetrator. Disabilities that impair an inmate's vision, hearing or mobility, for example, may make it particularly difficult to report sexual abuse or harassment and to comply with administrative exhaustion requirements. Ideally, all reporting mechanisms would be available to all inmates; at a minimum, however, the proposed standard should require at least one alternate reporting mechanism to be fully accessible to inmates with disabilities and LEP inmates.

<u>Recommendation</u>: Only allow inmate translators in adult facilities in "exigent circumstances <u>and with the expressed voluntary consent of the inmate victim</u>." In § 115.315(a), never allow resident translators to be used in juvenile facilities.

Unlike the Commission's recommendation, the proposed standard allows for inmate translators in exigent circumstances. There may be instances in which an inmate translator is the only, and best, available option. However, inmate translators should only be used upon the expressed voluntary consent of the complaining inmate.

Translation is a sensitive task that requires significant skills. The private information contained in a sexual abuse report is generally not appropriate to share with other inmates; the lack of a professional translator who speaks the inmate's language is not, on its own, sufficient grounds to justify a breach in confidentiality. Thus, an inmate translator must be subject to the same guidelines on confidentiality as the formal members of the investigative team.

Moreover, inmate translators may not provide accurate translations – either intentionally in retaliation for the abuse reported or inadvertently because of limited language skills. There will inevitably be some level of interpretation on the part of the translator, particularly if the translator is not a trained professional. Additionally, there is a strong likelihood that inmate survivors and witnesses will self-censor if the translator is another inmate – due to fear of retaliation and further victimization, the survivor or witness many not wish to disclose information about abuse to other inmates.

If a professional translator is not available, then the victimized inmate is in the best position to assess the likelihood of retaliation and his or her own level of English fluency in order to determine whether an inmate translator is a good option. In juvenile facilities, resident translators should never be allowed: beyond the heightened concerns about sharing sensitive information among youth in the facility, the likelihood of inaccurate translations is simply too great.

<u>Question 17</u>: Should the final rule include a requirement that inmates with disabilities and LEP inmates be able to communicate with staff throughout the entire investigation and response process? If such a requirement is included, how should agencies ensure communication throughout the process?

<u>Recommendation</u>: Add the following paragraph to the standard on accommodating inmates with special needs:

(c) The agency shall make accommodations to ensure that inmates who are limited English proficient, deaf, or have a disability can communicate with facility staff and supportive service providers throughout the investigative process, when requesting and receiving medical and mental health care, and during the provision of other services that may be necessary after an inmate is victimized or witnesses an abusive event. Agencies shall make such accommodations by utilizing bilingual staff, providing translation by qualified interpreters, entering into agreements with community service providers with capabilities in or services to residents with disabilities, or by other means.

Without effective means to communicate with staff during the investigations and response processes, inmates who are LEP, deaf or have a disability will not be able to access lifesaving support services that respond to their changing needs in the weeks and months after an assault. Moreover, they will be less effective witnesses, decreasing the likelihood that perpetrators are held accountable. Further, inmates who are LEP, deaf or have a disability will have less reason to trust these processes, as they will lack any assurance that their complaints are being handled swiftly and comprehensively. Staff and inmate perpetrators disproportionately target individuals who are unlikely to report or have their reports credited. By failing to ensure that survivors with disabilities or LEP are engaged to the same extent as other victimized inmates, the Department in effect makes these individuals more vulnerable to abuse.

The costs for providing these accommodations should be minimal, particularly relative to the tremendous benefits for these highly vulnerable inmates. As discussed below (with proposed

Standard § 115.22/222/322), memoranda of understanding with agencies that serve LEP inmates can ensure professional translation without diverting corrections staff resources. Moreover, many state and county systems have access to language translation phone services,⁵⁵ but often fail to train officers sufficiently on how to use them. Providing key staff with information about how to access these services is a low-cost, high-gain way of ensuring that all inmates can communicate effectively throughout the reporting, investigation, and response processes.

§ 115.16/116/216/316 Hiring and promotion decisions

<u>*Recommendation:*</u> Amend paragraph (a) as follows:

The agency shall not hire or promote anyone who has engaged in sexual abuse <u>or</u> <u>sexual harassment</u> in an institutional setting; who has been convicted of engaging in sexual activity in the community facilitated by force, the threat of force, or coercion <u>or has otherwise been adjudicated</u>, including civilly or administratively, <u>as</u> <u>having engaged in sexual abuse</u>; or who has been the subject of a civil protection order or protection from abuse order granted on the basis of such activity; or who has been convicted of domestic violence or stalking.

Domestic violence, stalking, and sexual abuse convictions and adjudications provide useful information regarding a staff member's history of or propensity to engage in sexual abuse. The Department's 2000 survey of violence against women concluded that domestic violence "is often accompanied by emotionally abusive and controlling behavior" and that battering "is often part of a systematic pattern of dominance and control."⁵⁶ The connection between these behaviors and further abuse is particularly well-established in the juvenile context: studies have found that between 30 and 60 percent of men who batter their partners also abuse their children.⁵⁷ Moreover, sexual abuse adjudications of any kind (not just those involving use of force or coercion) and the imposition of civil protective orders should serve as a clear red flag for agencies charged with ensuring the safety of others.

⁵⁵ For localities without current access to language translation services, Language Line Services (<u>www.languageline.com</u>) provides fee-for-usage access to over-the-phone interpreters 24 hours a day/365 days per year for more than 100 languages.

⁵⁶ Patricia Tjaden & Nancy Thoennes, *Extent, Nature, and Consequences of Intimate Partner Violence: Findings from the National Violence Against Women Survey* iv (2000), *available at*

http://www.ncjrs.gov/pdffiles1/nij/181867.pdf (last accessed April 4, 2011).

⁵⁷ See Janet E. Findlater & Susan Kelly, *Child Protective Services and Domestic Violence*, 9 FUTURE OF CHILDREN 84 (1999).

<u>Recommendation</u>: Require background checks whenever a staff member is considered for a promotion.

The proposed standard correctly puts parameters on who can be promoted based on past behavior, but does not require criminal background checks when individuals are being considered for promotion. Promotions are intended to reward leadership, work performance, and professional behavior of individuals who set a worthy example for more junior staff. Agencies must make every effort to avoid promoting individuals found to have engaged in abusive behavior.

<u>§ 115.17/117/217/317 Upgrades to facilities and technologies</u>

As noted above (with § 115.13/113/213/313), this new provision will improve the ability of agency administrators to maintain adequate supervision, and remain current with technological advancements. JDI commends the Department for adding this standard.

III. Response Planning

§ 115.21/121/221/321 Evidence protocol and forensic medical exams

In general, JDI applauds the Department for retaining key provisions from the Commission's recommendations in its evidence protocol and forensic exams standard – including ensuring that these exams are performed by a qualified medical practitioner, free of charge – and for strengthening this provision to provide for exams whenever "evidentiarily or medically appropriate."

<u>Recommendation</u>: To ensure that pre-pubescent youth receive an appropriate exam, modify § 115.321(b) as follows:

(b) The protocol shall be <u>developmentally appropriate for all youth – providing for a</u> <u>pediatric examination for female victims who have not experienced the onset of</u> <u>menarche and for male victims who have not yet reached puberty, and a medical</u> <u>forensic examination in accordance with adapted from or otherwise based on</u> the 2004 U.S. Department of Justice's Office on Violence Against Women publication "A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents," subsequent updated editions, or similarly comprehensive and authoritative protocols developed after 2010 <u>for youth who have reached puberty</u>. <u>The protocol shall detail policies and procedures for mandatory reporting, consent</u>

to treatment, parental notification, and scope of confidentiality in accordance with applicable laws.

For adults and adolescents, the Department's *National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents* is recognized as the definitive guide to conducting forensic exams. At the time of this writing, that protocol is being revised and a protocol for confinement facilities is being created. All corrections agencies should be encouraged to familiarize themselves with the new protocol once it is finalized.

However, this protocol was not intended to be used when examining pre-pubescent youth. As noted in the *National Protocol*, it does not address the legal issues regarding child sexual abuse, mandatory reporting, a child's ability to consent to medical treatment and evidence collection without parental/guardian involvement, and the scope of confidentiality afforded to minors.⁵⁸Abused children require a pediatric exam, which is not addressed in the *National Protocol*. Currently, there is no national protocol appropriate for use with children, and JDI urges the Department to develop one. In the interim, several jurisdictions have protocols that appropriately address the legal and developmental issues unique to forensic examinations of children.

<u>Recommendation</u>: Require facilities to enter into cooperative agreements with community sexual assault response teams (SARTs), and allow facility staff to conduct the examinations only as a last resort, by amending paragraph (c) as follows: (c) The agency shall offer all victims of sexual abuse access to forensic medical exams performed by qualified medical practitioners, whether onsite or at an outside facility, without financial cost, where evidentiarily and medically appropriate. <u>Agencies shall enter into cooperative agreements with community sexual assault</u> response teams (SARTs), and when a local SART is not available, explore other options such as contracting with a mobile SART. Agencies shall conduct examinations with facility medical personnel only as a last resort.

The community Sexual Assault Response Team (SART) model, in which a multidisciplinary team meets at a designated, fully equipped site to conduct interviews and complete the sexual assault forensic exam, is an established best practice across the country. Every state has a sexual

⁵⁸ Office on Violence Against Women, U.S. Dep't of Justice, A National Protocol for Sexual Assault Medical Forensic Examinations Adults/Adolescents 1 (2004), available at <u>http://www.ncjrs.gov/pdffiles1/ovw/206554.pdf</u>. (last accessed March 27, 2011)

assault coalition or organizing body or state agency that supervises and funds the state's sexual assault response that could provide an agency with information about how to locate local service providers.

In most cases, joining the community SART and utilizing the community SART facilities will be the most efficient and cost-effective option for corrections agencies. Beyond minimizing inhouse costs for forensic examinations and ensuring that corrections staff maintain proper training and certification, partnering with an experienced community SART will: provide increased expertise and access to the most recent developments in the field; improve the quality of care offered; eliminate potential concerns regarding conflicts of interest for facility staff; and increase the likelihood of successful prosecutions.

Some communities do not have a functioning SART, and some facilities may be located a prohibitive distance from the nearest certified site. In such cases, having community organizations come into the facility to conduct medical examinations, interviews, and crisis counseling and advocacy may be the second best option. In such cases, facilities must be prepared to: provide an examination room that is private, available on demand, can be sterilized to prevent cross contamination of evidence, and is large enough to accommodate the forensic nurse, advocate, and survivor; clear community personnel in advance for entry into the facility and facilitate their getting to the examination room in a timely manner; and enter into contracts with Sexual Assault Nurse Examiners (SANEs) or Sexual Assault Forensic Examiners (SAFEs) and rape crisis programs to provide this service on-site.

If there is no opportunity to make use of either an off-site or a mobile SART, allowing facility medical staff members to conduct sexual assault examinations should be permitted as a last resort only. However, the lack of transparency, challenges of maintaining certified staff, and chilling effect involving facility staff would have on reporting are contrary to the spirit of the standards and far outweigh the benefits when other options are available. As discussed further with the specialized training provision for medical and mental health care (§ 115.35/135/235/335), if staff are charged to perform these duties, they should undergo the same level of training that is required of forensic examiners in the community, in accordance

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with the Department's National Training Standards for Sexual Assault Medical Forensic Examiners.⁵⁹

<u>Recommendation</u>: Require that outside victim advocates be used, and only allow properly screened and trained agency staff members to serve in this role when community advocates are unavailable, by amending paragraph (d) as follows: (d) The agency shall make available to the victim qualified staff member or a victim advocate from a community-based organization that provides services to sexual abuse victims. <u>If a community-based organization is not able to provide victim</u> <u>advocate services, the agency shall make qualified staff members who have been</u> <u>screened and trained in accordance with community standards available to provide</u> <u>these services.</u>

Outside victim advocates serve a vital role in the investigation and response process, which is significantly weakened when they are replaced by a corrections staff member. Victimized inmates may have legitimate concerns of retaliation and other reasons not to trust a staff member advocate, particularly if the designated staff member and/or the staff members' colleagues participated or acquiesced in the assault. They also may not understand the limits to confidentiality when speaking with an agency staff member.

Even the most well-qualified, committed staff members work within the agency and, particularly if they are sworn officers, will inevitably experience a conflict between their security obligation to respond to all disciplinary violations and the requirement to retain certain information confidentially in their victim advocate role. Staff members also are not likely to be able to spend sufficient time with an inmate before, during, and after the lengthy (and intrusive) medical forensic examination process while still performing other required duties. Reliance on staff member advocates further may not ensure that there is the necessary 24-hour coverage of this role.

Moreover, allowing a staff member to provide this crucial service is inconsistent with proposed Standard § 115.22/222/322, which requires agencies to "maintain or attempt to enter into memoranda of understanding or other agreements with community service providers that are able

⁵⁹ Office on Violence Against Women, U.S. Dep't of Justice, *National Training Standards for Sexual Assault Medical Forensic Examiners* (2006), *available at* <u>http://www.ncjrs.gov/pdffiles1/ovw/213827.pdf</u> (last visited March 27, 2011).

to provide inmates with confidential emotional support services related to sexual abuse." If agencies are allowed to assign a staff member to provide support services, agencies will have little incentive to form these agreements with outside organizations, making it even less likely that incarcerated victims will have access to appropriate services.

As with community SARTs, some facilities may be in areas where there are no available rape crisis agencies, and in those locations, having a qualified staff member available to provide support services may be the best option. However, staff should be allowed to serve this role only as a last resort, in locations where the agency is unable to develop an agreement with a community-based agency that would cover these services in accordance with standard § 115.22/222/322.

The Department's requirements for a staff member to be qualified are wholly inadequate for providing support services to a victim of sexual abuse. Serving as a victim advocate is a specialized skill that requires training, screening, and sensitivity. Agencies must ensure that staff members chosen for this important role are carefully screened, to ensure that they are not likely to be perpetrators of abuse, that they will interact in a professional manner that is respectful of inmates regardless of sexual orientation or gender identity, and that they are emotionally prepared to provide support in this very demanding context. The Department details no requirements for qualification, except for estimating that an eight-hour training course would be needed.⁶⁰ Most community-based agencies require that advocates receive a minimum of 40 hours of training. Staff members should not be considered qualified until they have completed training similar to that required for advocates in the community.

<u>Recommendation:</u> Require agencies to document their efforts to collaborate with outside service providers by replacing paragraph (h) with the following: (h) <u>Agencies shall document their efforts to secure services from a community-based</u> <u>organization. If relying on staff members to serve as victim advocates, the agency</u> <u>shall also document that sufficient screening and training were provided to establish</u> <u>that staff are qualified to perform this role.</u>

⁶⁰ IRIA, *supra* note 48, at 47.

Agencies should be required to collaborate with community providers in conducting forensic examinations and serving as victim advocates, and only be allowed to rely on facility staff to perform these sensitive and skilled functions when outside providers are not available. To ensure that this requirement can be monitored, the Department should require documentation establishing the agency's efforts to enter into relevant agreements and, if agency staff members are used, showing that they have been properly screened and trained, and are available to provide sufficient round-the-clock coverage.

<u>Question 18</u>: Do the standards adequately provide support for victims of sexual abuse in lockups upon transfer to other facilities, and if not, how should the standards be modified?

The evidence protocol and forensic exam provision for lockups (§ 115.121) do not provide for a victim advocate to be part of the investigation and response process. Nor are lockups required even to attempt to enter into agreements with outside public entities and community service providers, despite the fact that many law enforcement entities with lockups already have such agreements for investigating sex crimes in the community. These services play an important role regardless of where an assault occurs. The Department should restore these provisions to the lockups standards, as the Commission had recommended.

<u>Recommendation</u>: Require lockups to provide an outside victim advocate, just as other facilities are required to do.

Victims need and deserve an advocate during the investigation process regardless of where they are held. Lockups should be required to provide the same range of services as other types of facilities. Notably, as lockups are often run by sheriffs' and police departments, they should be able to utilize the same resources for this purpose that they employ in other sex-crime cases. Thus, at a minimum, the proposed standard should require lockups to provide for an outside victim advocate whenever one can be made available. Lockups should be required to establish memoranda of understanding with outside service providers, when possible. At a minimum, the proposed standard should require larger law enforcement agencies that have lockup facilities to modify their contracts and agreements with providers who serve on community response teams to ensure that victims in lockups receive their services.

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Victims who report abuse after they have been transferred to another facility should be afforded access to the same protections and services that are required when the report is made at the site of the abuse. Such a practice should be explicitly incorporated into the standards, whether the transfer is intra-agency (e.g. from one prison to another prison in the same state) or between agencies (e.g. from lockup to jail; from jail to prison; from prison to community corrections).

§ 115.22/222/322 Agreements with outside public entities and community service providers

Collaborating with outside entities and service providers is a low or no-cost way for facilities to: maximize their use of limited personnel and resources; dramatically enhance their relevant expertise; encourage the sharing of information that is not likely to be disclosed to officials; ensure that they are providing victim-centered care that is similar to what is available in the community; and provide accountability and integrity to the process. While the Department recognizes the value of corrections-community partnerships, the standards should be stronger in requiring these relationships.

<u>Recommendation</u>: Only allow for an internal, operationally independent entity to serve as the outside reporting mechanism when there is no outside entity available, by modifying paragraph (a) as follows:

The agency shall maintain or attempt to enter into memoranda of understanding or other agreements with an outside public entity or office that is able to receive and immediately forward inmate reports of sexual abuse and sexual harassment to agency officials pursuant to § 115.51. If no outside entity is available, unless the agency shall enables inmates to make such reports to an internal entity that is operationally independent from the agency's chain of command

With respect to reporting entities, the proposed standard allows for agencies to forgo even attempting to establish an agreement with an outside entity if it "enables inmates to make reports to an internal entity that is operationally independent from the agency's chain of comment."⁶¹ This is very problematic. Regardless of how officials view internal entities, inmates are unlikely to understand or trust the distinction between an operationally independent entity and a more traditionally internal one. A reporting entity that answers to the same agency head will be seen as part of the system that failed to protect the inmate in the first place. This perception is legitimate;

⁶¹ Dep't of Justice, Proposed Standard § 115.22(a).

internal entities are rarely as effective in detecting and responding to sexual abuse as, for example, outside inspector general offices.⁶²

<u>Recommendation</u>: Require lockups to attempt to enter into agreements with outside service providers, or to modify current agreements with community providers, by applying § 115.22(b) and (c) to § 115.122.

As discussed above, lockups should be required to enter into agreements with outside service providers.⁶³ At a minimum, law enforcement entities that run lockups should be required to modify any agreements they have with community providers to respond to sexual assaults in the community, so that survivors of sexual violence in lockups receive the same coordinated response.

<u>Recommendation</u>: Add sexual harassment to § 155.22/222/322 (b).

Sexual harassment is often a precursor to sexually abusive behavior, particularly if it remains unchecked. Community service providers are skilled in assisting individuals who are facing a broad range of unwanted sexual activity. When an inmate is sexually harassed, confidential emotional support services may provide him or her with the information and safety-planning tools necessary to end harassment before it escalates into sexual abuse.

<u>Question 19</u>: Should this standard expressly mandate that agencies attempt to enter into memoranda of understanding that provide specific assistance for LEP inmates?

<u>Recommendation</u>: Add the following paragraph to this standard: <u>Agencies shall maintain or attempt to enter into memoranda of understanding for</u> <u>assistance in communicating with LEP inmates in languages commonly spoken</u> <u>within the facility.</u>

⁶² In this context, the Department's Office of the Inspector General would be considered wholly independent, because it does not report directly to the head of the Bureau of Prisons. The Attorney General, who oversees both entities, is analogous to a state governor, who would likewise have the ultimate authority over the state corrections department and a public oversight entity.

⁶³ While ideally all agencies would collaborate with an outside reporting entity, given the short period of time that individuals generally spend in lockups, the cost of establishing an outside reporting entity may outweigh the benefits of doing so. People are generally in lockups only for a matter of hours. As a result, someone victimized in a lockup facility should be able to report to another entity within the same day (or at least within the 96 hour time period that generally would allow for a forensic exam).

As discussed above (addressing standard § 115.15/115/215/315), all inmates need to have effective means of communication throughout the reporting, investigation, and response processes. Reliance on inmate translators for LEP inmates is an ineffective and dangerous practice. Agencies should be required to secure professional translation services for the full range of languages present at the facility. In facilities with a large number of LEP inmates who speak the same language, efforts should also be made to enter into agreements with agencies that can provide assistance directly in those languages. As with the other provisions in this proposed standard, JDI recommends that the Department require documentation of these efforts.

§ 115.23/123/223/323 Policies to ensure investigations of allegations

<u>Recommendation</u>: Ensure that multiple investigations pertaining to the same incident of sexual abuse are coordinated by adding the following provision: <u>The agency shall coordinate internal investigations of alleged sexual abuse and</u> <u>sexual harassment with any external investigations by law enforcement, child</u> <u>protective services, or other entities charged with investigating alleged abuse. The</u> <u>agency shall establish an understanding between investigative bodies with</u> <u>overlapping responsibilities so that staff have a clear understanding of their roles in</u> <u>evidence collection, interviewing, taking statements, preserving crime scenes, and</u> other investigative responsibilities that require clarification.

Beyond identifying the entity with the legal authority to conduct criminal investigations of sexual misconduct, the agency must ensure that criminal and administrative investigations each occur in a timely manner, and that they are coordinated. When the victim is a minor, whether in a juvenile or adult facility, allegations of sexual abuse may also trigger a child abuse investigation by a state or local entity. Without clearly defined roles and procedures, internal investigations are often unduly delayed, child abuse allegations are not always investigated, and one entity's approach to the collection of evidence or statements can hinder another entity's investigation. The standard should require that facilities establish clear responsibilities when overlapping investigations occur, so that staff members understand the actions they should take and on which they can collaborate with other agencies to ensure timely resolution of all investigations. This type of coordination is essential to ensuring full and timely investigations of alleged misconduct.

<u>Recommendation</u>: Add sexual harassment to paragraphs (c) and (d).

Paragraph (a) appropriately requires that allegations of both sexual abuse and sexual harassment be investigated. As a result, state entities and Department of Justice components conducting administrative investigations should ensure that their policies encompass sexual harassment as well as sexual abuse.

IV. Training and Education

§ 115.31/131/231/331 Employee training

<u>Recommendation</u>: Add the following topics to employee training, paragraph (a): <u>how to handle disclosures of victimization sensitively</u>; and <u>how to distinguish consensual/voluntary sexual activity between inmates from</u> <u>sexual abuse</u>.

JDI applauds the Department for recognizing the vital importance of sufficient staff training on critical topics, such as how to maintain appropriate professional boundaries and how to communicate effectively and professionally with lesbian, gay, bisexual, transgender, and intersex inmates. However, some additional training topics are warranted. These areas directly respond to issues identified in the BJS surveys, namely, that a large percentage of all abuse is committed by staff of the opposite sex to those victimized, without force, and that LGBTI inmates are disproportionately targeted for abuse.

The proposed standards properly empower all staff to receive reports of sexual abuse and, as a result, all staff must learn how to respond appropriately. Information about sexual abuse must be shared discretely and professionally, to protect victims as well as the integrity of investigations.

The Department correctly recognizes that there is a difference between sexual abuse and consensual sexual activity between inmates. However, employees need to be educated about how to make this distinction. Coercion tactics can be subtle, making it difficult to recognize when an inmate is being forced, pressured or threatened into engaging in sexual activity. "Protective pairing" – in which an inmate provides sex in exchange for protection from other inmates – is exceptionally common in confinement settings and on the surface often appears consensual when

it is in fact exploitive and abusive. Staff members need to learn about these dynamics so that they can distinguish between consensual activity and abusive behavior.

<u>Recommendation</u>: Amend paragraph (a)(9) to require training on: How to communicate effectively and professionally with inmates, including lesbian, gay, bisexual, transgender, or intersex, or gender non-conforming inmates.

Individuals who do not self-identify as lesbian, gay, bisexual, transgender or intersex (LGBTI) but are gender non-conforming in appearance and/or mannerisms are often perceived by others as LGBTI and are frequently targets of sexual abuse. Staff training on effective and professional communication with gender non-conforming inmates will encourage greater reporting and help decrease the levels of harassment and abuse that these vulnerable individuals endure.

<u>Recommendation</u>: Add sexual harassment to paragraphs (a)(4) and (a)(5).

As noted in the recommendation for § 115.22/222/322 (b), sexual harassment is often a precursor to sexual abuse. Therefore, it is important to include sexual harassment in all relevant areas of employee training. In addition to the zero-tolerance policy and the right of all people to be free from abuse and harassment, staff should be informed about the dynamics of sexual harassment, particularly as it relates to sexual abuse, and that retaliation based on reports of sexual harassment is prohibited.

<u>Recommendation</u>: Add the following provision to ensure that all staff members receive basic information about sexual abuse in detention: <u>Agency employees who do not have contact with inmates shall receive information</u> <u>about the agency's zero-tolerance policy, employee reporting options, and the</u> <u>prohibition on retaliation.</u>

Though agency employees who do not have contact with inmates do not need full training about PREA, they should still receive basic information about sexual violence in detention. Specifically, all employees should receive information about the agency's zero-tolerance policy regarding sexual abuse so they understand that the agency -- in all of its functions -- will not tolerate sexual abuse and sexual harassment. All employees also need to understand reporting options (in some instances non-contact employees may be made aware of sexual abuse) and the prohibition on retaliation. This basic information will engage all employees, even those who do

not come into regular contact with inmates, in the agency's commitment to addressing sexual abuse.

<u>Question 20</u>: Should the Department further specify training requirements for lockups and if so, how? Would lockups be able to implement such training in a cost-effective manner via in-person training, videos, or web-based seminars?

<u>Recommendation</u>: Amend § 115.131(a) as follows:

The agency shall train all employees and volunteers who may have contact with lockup detainees to be able to fulfill their responsibilities under agency sexual abuse prevention, detection, and response policies and procedures, <u>including: the agency's</u> <u>zero-tolerance policy; inmates' right to be free from sexual abuse and sexual</u> <u>harassment; the dynamics of sexual abuse and harassment in confinement settings,</u> <u>including which inmates are most vulnerable in lockup settings; the right of inmates</u> <u>and employees to be free from retaliation for reporting sexual abuse or harassment;</u> <u>how to detect and respond to signs of threatened and actual abuse;</u> and <u>how</u> to communicate effectively and professionally with all detainees.

The lockup standard should specify topics that must be included in employee training. In order for training about how to "fulfill [employees'] responsibilities" and "communicate effectively and professionally" to be meaningful, lockup employees and volunteers must receive training on: the agency's zero-tolerance policy; inmates' right to be free from sexual abuse and sexual harassment; the dynamics of sexual abuse and harassment in confinement settings, including which inmates are most vulnerable in lockup settings; the right of inmates and employees to be free from retaliation for reporting sexual abuse or harassment; and how to detect and respond to signs of threatened and actual abuse. Given the prevalence of staff sexual misconduct in detention settings generally, training on professional boundaries should also be required.

Since the proposed standard already requires that lockup employees receive training on agency policies, adding the topics detailed above should not add a significant amount of training time or expense.⁶⁴ The minimal amount of additional training time would be outweighed by the substantial benefit of ensuring that employees understand which lockup inmates may be the most vulnerable to sexual abuse and how to prevent and respond to potential abuse.

⁶⁴ The National Institute of Corrections training "Your Role: Responding to Sexual Abuse," available on-line at <u>http://nicic.gov/Training/PREA</u>, is a free, two-hour online training designed to enhance corrections professionals' skills in responding to allegations of sexual abuse. One portion of this training involves a review of the dynamics of sexual violence in confinement and could be used to provide training to lockup employees.

§ 115.32/232/332 Volunteer and contractor training

<u>Recommendation</u>: Modify paragraph (a) to ensure that "all volunteers and contractors who have <u>substantial</u> contact with inmates have been trained <u>in accordance with the</u> <u>employee training</u>" and modify paragraph (b) such that "all volunteers and contractors who have contact with inmates shall be notified of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report abuse."

In some agencies, contractors and volunteers serve essential corrections functions with substantial inmate contact. Contracted medical and mental health personnel, religious leaders, and work supervisors, for example, are at least as likely to receive disclosures about sexual abuse as corrections staff, and face similar issues with respect to professional boundaries. Thus, these individuals should receive the full training required for employees who have contact with inmates. Additionally, all volunteers and contractors – even those who do not have contact with inmates – should be informed about the agency's zero-tolerance policy and the right to be free from retaliation for reporting sexual abuse.

§ 115.33/233/333 Inmate/resident education

<u>Recommendation</u>: Require that sexual violence education be accessible to all inmates and residents.

A basic tool for preventing and responding to sexual abuse is to educate inmates about sexual violence. Sadly, a significant number of individuals in confinement settings have experienced past sexual or physical abuse, neglect or marginalization. Some inmates have been so traumatized from past experiences that they may not fully understand their right to bodily integrity and safety. Many individuals, especially those first entering detention, have an expectation that sexual abuse is an inevitable part of life behind bars. As such, it is imperative that all inmates and residents receive clear, age-appropriate, and understandable education about sexual violence.

Inmate education should be appropriate not just with regard to age, but also to cognitive level. The language used in adult inmate education sessions and printed materials should be at a fifthgrade reading level, and material for youth should be age-appropriate. Agencies should also be

required to ensure that inmates and residents with cognitive disabilities, limited literacy skills, limited English proficiency or other challenges receive and understand the information provided.

JDI suggests that agencies be encouraged to work with outside professionals who can advise them about the development of appropriate and accessible information.JDI also recommends that the PREA Resource Center be tasked with developing accessible materials that can be used by agencies for inmate and resident education.

§ 113.34/134/234/334 Specialized training: investigations

<u>Recommendation</u>: Require investigative staff to receive training on how to access and use available translation services.

As discussed previously (in § 115.15/115/215/315 and § 115.22/222/322), ensuring that LEP inmates have sufficient means to communicate throughout the investigation process is critical. Ideally, each facility would have investigators who are fluent in the languages spoken by inmates. However, there will inevitably be times when the investigator assigned to a sexual abuse allegation does not speak the language of a victim or witness. Per § 115.22/222/322, facilities should enter into agreements with translation services for such these occasions. Such agreements are only effective, however, if investigative staff know how to access the services. Providing this basic information is a low-cost, high-gain way of ensuring that all inmates are able to communicate throughout the reporting, investigation, and response processes.

<u>Recommendation</u>: In prisons, jails, lockups, and community confinement facilities, amend paragraph (b) to include <u>guidance on determining whether sexual activity</u> <u>between inmates is consensual</u>. In juvenile facilities, require investigators to receive <u>guidance on how to apply age of consent laws to distinguish between sexual abuse and</u> <u>voluntary sexual contact between similarly aged residents.</u>

In its definition of sexual abuse, the Department appropriately made clear that consensual sexual conduct between inmates does not constitute sexual abuse. To ensure that this translates into appropriate practices, investigators should be trained on how to distinguish between consensual sexual activity between inmates and sexual abuse. The current standard requires facility staff to report any suspicion of sexual abuse, leaving it to investigators to determine whether the conduct

constituted sexual abuse for purposes of PREA-mandated responses. Providing investigators with appropriate training will help ensure that PREA is properly invoked to prevent and respond to the serious harms and trauma of sexual abuse, and that abuse is not minimized or mistaken for consensual activity. This training will also lessen the frequency with which LGBTI and other inmates who engage in consensual sexual activity are labeled as perpetrators of sexual abuse and penalized as a result.

In juvenile facilities, investigators should also receive specialized training on age of consent laws to ensure a thorough understanding of the limited circumstances under which juvenile facilities can treat voluntary sexual contact between residents as abuse, in order to prevent facilities from using PREA to target LGBTI and other youth for engaging in voluntary sexual contact with similarly aged residents. Many residents of juvenile facilities are old enough to consent to sexual activity with other similarly aged youth. ⁶⁵ With a solid understanding of age of consent laws, investigators will be less likely to apply the standards incorrectly to voluntary sexual contact between minors who, under the laws of that state, can legally consent to engage in such contact.

§ 115.35/235/335 Specialized training: medical and mental health care

<u>Recommendation</u>: Amend paragraph (a) to include: <u>In addition to the general training provided to all employees pursuant to § 115.31</u>, the agency shall ensure that...

Whether employed directly by the corrections agency or through a contracted provider, medical and mental health staff has extensive contact with inmates. As such, they are among the most likely to receive reports of abuse -- and they may also perpetrate abuse. Similar to investigative staff, all medical and mental health professionals need to receive the full employee training, as well as specialized information appropriate for their field.

⁶⁵ In most states the age of consent is 16, and in more than half of states, minors 14 or older can consent to sexual contact with others who are close to them in age. In addition, some facilities house residents as old as 25. *See* ASAPH GLOVER, KAREN GARDINER & MIKE FISHMAN, THE LEWIN GROUP, STATUTORY RAPE: A GUIDE TO STATE LAWS AND REPORTING REQUIREMENTS, PREPARED FOR THE OFFICE OF ASSISTANT SECRETARY FOR PLANNING & EVALUATION, DEP'T OF HEALTH & HUM SVCS. (2004), *available at*

http://www.4parents.gov/sexrisky/statutoryrapelaws.pdf (last accessed April 1, 2011).

<u>Recommendation</u>: Modify paragraph (b) to read: If medical staff employed by the agency conduct forensic examinations, such medical staff shall receive the <u>appropriate</u> training <u>that meets or exceeds the</u> <u>recommendations in the Department of Justice's National Training Standards for</u> Sexual Assault Medical Forensic Examiners to <u>conduct such examinations</u>.

As discussed above (with § 115.21/121/221/321), forensic examinations should only be performed by facility medical staff as a last resort. Corrections agencies are not likely to have sufficient in-house expertise to provide the high-level, comprehensive medical education needed to qualify facility medical staff to conduct a medical forensic exam. When medical staff employed by the agency are charged with performing these duties, they need the same level of training and qualifications as community-based sexual assault forensic examiners (SAFEs). To meet this standard, the Department should require that the training provided to medical staff conducting forensic examinations meets or exceeds the recommendations found in the Department's *National Training Standards for Sexual Assault Medical Forensic Examiners*.⁶⁶

The *National Training Standards for Sexual Assault Medical Forensic Examiners* is a companion to the *National Protocol for Sexual Assault Medical Forensic Examinations: Adults/Adolescents*, which the Department already relies upon for evidence protocol and forensic medical examinations.⁶⁷ The training standards offer a framework for the specialized education necessary to ensure that providers conducting forensic examinations are able to validate and address victims' health concerns, minimize their trauma, promote their healing, and maximize the detection, collection, preservation, and documentation of physical evidence related to the assault.

V. Screening for Risk of Sexual Victimization and Abusiveness

<u>§ 115.41/241 Screening for risk of victimization and abusiveness</u> <u>§ 115.341 Obtaining information from residents</u>

JDI commends the Department for insisting that the full range of known vulnerability factors be considered in screenings of all inmates and residents – including those in women's prisons and

⁶⁶ Office on Violence Against Women, *National Training Standards for Sexual Assault Medical Forensic Examiners, supra* note 59.

⁶⁷ See Dep't of Justice, Proposed Standard § 115.21/121/221/321.

jails and in juvenile facilities. Many of the factors that make someone especially vulnerable to sexual abuse behind bars are known. While most research on the question has been conducted in men's prisons, the same characteristics are known to place someone at risk in facilities for women and girls. An individual's self-perception of vulnerability is likewise as important a consideration in juvenile facilities as it is in adult institutions. The Department's application of these key risk factors to all inmates and residents is an important improvement to the standards.

The explicit prohibition on punishing an inmate for failing to disclose this sensitive information is also essential. Vulnerable inmates – particularly LGBTI inmates – are understandably apprehensive about revealing information that might place them at heightened risk for abuse. Pressuring inmates to answer screening questions related to their identity or past victimization, and then punishing them if they refuse to provide such information, would further undermine trust between inmates and corrections staff, making it more difficult for inmates to report abuse.

<u>Recommendation</u>: To ensure that individuals perceived as LGBTI are adequately protected, regardless of their sexual orientation and gender identity, amend § 115.41/241(c)(7) as follows: "Whether the inmate is gay, lesbian, bisexual, transgender, or gender <u>non-conforming."</u> and amend § 115.341 (c)(2) as follows: "Sexual orientation, transgender or intersex status, or gender non-conformance."

Inmates and residents who are gender non-conforming are often targeted for sexual abuse and harassment based solely on the fact that other inmates or staff perceive them to be LGBTI, regardless of how they self-identify. As a result, gender non-conforming individuals are at just as high risk of sexual abuse as LGBTI inmates and residents. Including gender non-conformance as one of the screening criteria for risk of sexual victimization will help ensure that inmates and residents who are vulnerable to sexual abuse because they are perceived to be LGBTI are adequately protected.

<u>Recommendation</u>: In light of the lack of a validated screening instrument for juvenile facilities, modify § 115.341(b) to require the use of <u>a standardized information</u> gathering tool.

The current standard instructs agencies to attempt to gather a host of different information about youth during the intake process using "an objective screening instrument." However, among professionals familiar with assessment and screening, the term "objective screening instrument" means a tool that has been validated and that differentiates between different levels of risk of being victimized or engaging in sexual abuse. While youth should be asked a standardized set of questions during the intake process, JDI (and the juvenile experts with whom it collaborates) know of no validated objective screening instrument that assesses a resident's risk of victimization or abusive behavior.

<u>*Recommendation:*</u> Amend § 115.341(d) as follows:

This information shall be ascertained through conversations with residents during the intake process and medical and mental health screenings; during classification assessments; and by reviewing court records, case files, facility behavioral records, and other relevant documentation from the residents' files. <u>In facilities where</u> <u>medical and mental health practitioners conduct medical and mental health</u> <u>screenings during the intake process, these practitioners, and not other facility staff, should ask residents information about their sexual orientation or gender identity, prior sexual victimization, mental health status, intersex condition, and mental or physical disabilities.</u>

As currently drafted, the proposed standards allows intake and security staff to gather information about sensitive issues from residents, regardless of whether these staff have the appropriate level of training to do so effectively, safely, and respectfully. Only sufficiently trained professionals should be asking residents such sensitive questions, both to increase the likelihood that residents will share this important information and to decrease the risk that they will be traumatized in the process. Medical and mental health practitioners are in the best position to gather this information while conducting health assessments during the intake and classification process.

<u>Question 21</u>: Recognizing that lockup detention is usually measured in hours, and that lockups often have limited placement options, should the final rule mandate rudimentary screening requirements for lockups, and if so, in what form?

<u>Recommendation:</u> Add the following provision as § 115.141: (a) Before detainees are placed together in a cell, they must be screened to ensure that those at high risk of being sexually abused are not held with those who are likely to be sexually abusive.

(b) Facility staff shall make reasonable efforts to gather information about and consider, at a minimum, the following criteria: (1) the age of the detainee, including whether the detainee is a juvenile; (2) the physical build of the detainee; (3) whether the detainee has a mental, physical, or developmental disability; (4) whether the detainee is gay, lesbian, bisexual, transgender, intersex, or gender non-conforming; (5) the detainee's criminal history; and (6) the detainee's own perception of vulnerability.

Sexual violence does not require days in detention to occur. Indeed, if a vulnerable inmate is left alone with a likely predator, abuse can occur quickly. To prevent this, lockups should do basic screening to ensure that highly vulnerable inmates are not left alone with likely perpetrators even for short periods of time. While a full classification process may not be necessary, lockups should be required to collect information similar to what the standards require longer-term facilities to gather, especially if lockups hold multiple inmates in the same cell. Indeed, many police lockups already employ basic measures aimed at protecting inmates from sexual abuse.⁶⁸ The Department would be remiss if it did not require that police lockups employ at least a rudimentary screening.

The shorter time that people generally spend in lockups may justify a more liberal use of isolation than is appropriate in other types of facilities. As discussed below (in § 115.43), JDI believes that segregation in prisons and jails needs to be curtailed beyond the limits in the Department's proposed standards. However, in a lockup, keeping someone separated for a few hours may be the most effective solution and is unlikely to have the traumatizing impact that arises from extended isolation.

<u>Question 22</u>: Should the final rule provide greater guidance regarding the required scope of the intake screening, and if so, how?

The proposed standard encourages some consideration of the risk of victimization and abusiveness at the initial screening, but without additional guidance, agencies may not know how

⁶⁸ See, e.g., Lockups, Native American Detention Facilities, and Conditions in Texas Penal and Youth Institutions, Hearing before the National Prison Rape Elimination Commission (March 26, 2007) (Ronald Ruecker, Interim Police Chief, Sherwood (OR) Police Department, International Association of Chiefs of Police, testifying before that "where possible, rival gang members should be held separately, as should other persons accused of particularly vile crimes, such as pedophilia, or any others who by virtue of their criminal charge, physical condition, or lifestyle are more likely to be victimized by fellow prisoners").

to comply with that provision effectively. As discussed below, the intake screening should attempt to gather all of the information required for the initial classification.

<u>Recommendation:</u> Modify paragraphs (c) and (d) to each begin "The <u>intake screening</u> and initial classification process shall consider..."

The final rule should require agencies to attempt to gather all information related to risk of victimization and risk of abusiveness as early as the intake screening. Agencies need to have as much screening information as possible in order to make safe housing and bed decisions for an inmate's first days in the facility, since vulnerable inmates are often abused sexually soon after intake. Not all information may be immediately available, but the agency should attempt to gather this information as expeditiously as possible. Information about an individual's physical build, age, gender non-conformance, criminal history, and immigration status should be readily available even at this early point, and factored into inmates' initial housing assignments. At a minimum, inmates should also be asked about their own perception of vulnerability, whether they identify as LGBTI, and whether they have a disability. While some vulnerable individuals may not feel comfortable answering these questions soon after arriving at a facility, many others will. In addition, the inclusion of these factors from the moment someone enters the facility will have a positive impact on the zero-tolerance culture.

§ 115.42/242 Use of screening information

JDI applauds the Department's requirement of an individualized assessment to determine whether a transgender or intersex inmate should be housed in a men's or women's facility. Transgender women, who tend to be housed in men's facilities in accordance with their birth gender and/or genitalia, are unquestionably among the most vulnerable to sexual abuse.⁶⁹ The standards for adult facilities recognize that, for many transgender and intersex individuals, housing in a facility aligned with their gender identity may be the safest and most appropriate option.

⁶⁹ VALERIE JENNESS ET AL., CENTER FOR EVIDENCE-BASED CORRECTIONS, VIOLENCE IN CALIFORNIA CORRECTIONAL FACILITIES: AN EMPIRICAL EXAMINATION OF SEXUAL ASSAULT (2007), *available at* <u>http://www.justdetention.org/pdf/VJReport2007.pdf</u>.

On the other hand, JDI disagrees with the Department's decision to allow housing determinations to be based solely on sexual orientation or gender identity. All too often, agencies that have housed LGBTI inmates based solely on these factors have subjected them to punitive conditions, typically in isolation. Separate housing also encourages the misperception that LGBTI inmates are worthy of stigmatization. Furthermore, such separate housing tends inadvertently to house vulnerable and predatory inmates together, by placing higher importance on LGBTI status.

<u>Recommendation</u>: Prohibit agencies from relying exclusively on sexual orientation and gender identity to make housing determinations, by adding the following paragraph to this standard:

"The agency shall not place lesbian, gay, bisexual, transgender, or intersex inmates in particular facilities, units, or wings solely on the basis of their sexual orientation, genital status, or gender identity, unless such placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement or judgment for the purpose of protecting inmates."

Determining safe housing for inmates requires consideration of the full range of relevant screening criteria. While sexual orientation and gender identity are strong vulnerability factors, LGBTI inmates need to be housed based on a full assessment of their risks. Even facilities with a large population of gay and transgender inmates have found that housing based solely on this status is problematic. Both the San Francisco Sheriff's Department and the New York City Department of Correction have closed the "gay unit" in their facilities in favor of a more comprehensive strategy for protecting vulnerable inmates, in part due to concerns about security and abuse in these units. At Fluvanna Correctional Institution in Virginia – which the BJS identified as having the highest rate of inmate-on-inmate abuse for all prisons and jails and the second highest rate of staff sexual misconduct among women's prisons⁷⁰ – the previous warden had purportedly established a "butch ward," where women who identified as or were perceived to be lesbian or gender non-conforming were subject to ongoing harassment and punitive conditions.⁷¹

If the Department seeks to preserve the "K6G unit" at the Men's County Jail of the Los Angeles Sheriff's Department, it can do so while still protecting against the likelihood that other agencies

⁷⁰ See ADULT SURVEY, supra note 31.

⁷¹ Va. women's prison segregated lesbians, others, ASSOCIATED PRESS, June 11, 2009.

will segregate LGBTI inmates or otherwise place them unnecessarily in punitive conditions. The K6G unit is unique, in that people housed there retain access to substantial programming—often more than what is available in the general population—and the jail has a large enough identified gay and transgender population to fill multiple wings, so that inmates are not isolated and staff can separate LGBTI inmates from each other when needed. This is not the norm.

Maintaining a unit based solely on sexual orientation or gender identity requires a demonstrated need, sufficient facility size and LGBTI inmate population, a basic level of cultural competence among staff, and an institutional commitment to safety and fairness toward these populations. Notably, such a separate, protective unit has never been successfully implemented in a women's facility. JDI recommends that placing adult inmates in particular beds, wings or units solely on the basis of sexual orientation, gender identity, genital status or birth gender be permitted only when, as in Los Angeles County, such placement is based on a finding, made by a judge or outside expert, that these inmate groups cannot be housed safely by other means.

<u>§ 115.342</u> Placement of residents in housing, bed, program, education, and work assignments JDI commends the Department for prohibiting agencies from placing LGBTI residents in particular housing, bed or other assignments solely on the basis of such identification or status. Unfortunately, many juvenile facilities segregate or isolate LGBTI youth, ostensibly for their own protection, sometimes by placing these residents in sex offender units. While presumably intended to keep LGBTI youth safer than they would be in general population, this practice essentially punishes LGBTI youth and denies them access to the same privileges and programs as other residents. As discussed above, a modified version of this prohibition should be instituted for adult facilities as well.

<u>Recommendation:</u> Limit the extent to which vulnerable residents are isolated by amending paragraph (c) as follows:

Residents may be isolated from others only as a last resort when less restrictive measures are inadequate to keep them and other residents safe, and then only until an alternative means of keeping all residents safe can be arranged. (1) If isolation is unavoidable, the agency shall review the use of isolation every 24 hours and document the reason for continued isolation. (2) The agency shall not hold youth in isolation conditions for a continuous period of more than 72 hours.

(3) Residents placed in isolation shall have access to education, recreation, counseling, and other programming.

The proposed standards appropriately require individualized placements, but should be strengthened to ensure placements are appropriate and to avoid isolating LGBTI and other vulnerable residents unnecessarily. Recent research confirms the serious dangers associated with isolation of youth, including increased suicide risk and long-term psychiatric problems.⁷² Additionally, isolation deprives youth of programming designed to support their rehabilitation, such as educational services.⁷³ Isolating residents who may be at risk of victimization has the effect of singling those youth out for punishment based solely on safety concerns.

The Department should do more to minimize the isolation of vulnerable youth. By limiting isolation to a maximum of 72 hours, the Department can reduce the negative consequences of this practice for youth in secure facilities, while providing adequate time for facilities to find appropriate housing without extended isolation. By requiring that isolated youth enjoy the same privileges as other residents, the standards will also avoid punishing youth based on their risk of victimization.

The use of isolation in juvenile facilities should also be subject to oversight and review mandates similar to those required for the use of protective custody in adult facilities, with shorter time frames to account for the increased harm of isolating youth. Specifically, juvenile agencies should review the use of isolation daily, to ensure that it remains the only safe option and is used purely as a last resort. Juvenile facilities should also be required to document its use of protective isolation. In addition to creating a record should a youth or his/her legal guardian wish to

⁷² LINDSAY M. HAYES, NATIONAL CENTER ON INSTITUTIONS AND ALTERNATIVES, OFFICE OF JUVENILE JUSTICE AND DELINQUENCY PREVENTION REPORT, JUVENILE SUICIDE IN CONFINEMENT: A NATIONAL SURVEY (2009), *available at* <u>http://www.ncjrs.gov/pdffiles1/ojjdp/213691.pdf</u> (noting a "strong relationship between juvenile suicide and room confinement"); American Psychiatric Association, Press Release, Incarcerated Juveniles Belong in Juvenile Facilities (Feb. 27, 2009), *available at*

http://www.psych.org/MainMenu/Newsroom/NewsReleases/2009NewsReleases/IncarceratedJuveniles.aspx ("Children should not be subjected to isolation, which is a form of punishment that is likely to produce lasting psychiatric symptoms."); *see also* Linda M. Finke, *Use of Seclusion Is Not Evidence-Based Practice*, 14 J. CHILD & ADOLESCENT PSYCHIATRIC NURSING 186 (2007).

⁷³MICHAEL PUISIS, ED., CLINICAL PRACTICE IN CORRECTIONAL MEDICINE 139 (2006) (noting that "[v]arious activities, positive relationships between staff and youth, individual attention, and accessible counseling are all aspects of the general program that help stabilize youth....").

challenge such isolation, the documentation will help track the use of protective isolation and identify whether facilities are employing isolation too readily. Such data may also assist the Department and other organizations in providing guidance and technical assistance to jurisdictions on reducing the use of isolation.

<u>Recommendation:</u> Provide greater guidance on how to determine whether a transgender or intersex resident should be housed in a boys' or girls' facility or unit with the following changes:

(e) The agency shall make an individualized determination about whether a transgender <u>or intersex</u> resident should be housed with males or with females. <u>Such a determination shall not be based solely on the resident's genital status or birth gender. In deciding whether to assign a transgender or intersex resident to a facility or unit for male or female residents, and in making other housing and programming assignments, the agency shall consider on a case-by-case basis whether the placement would ensure the resident's health and safety. Transgender and intersex residents' own views with respect to their own safety shall be given serious consideration.
(f) Placement and programming assignments for transgender and intersex residents shall be reassessed at least twice each year to review any threats to safety experienced by these residents.
</u>

Many juvenile facilities struggle with appropriate housing options for transgender and intersex residents and will base this determination solely on the resident's genital status. These residents are especially vulnerable to sexual abuse. The standard on this topic for adult prisons and jails provides better guidance for agencies and better protections for transgender and intersex individuals than do the juvenile standards. Because inappropriate placements of transgender and intersex residents greatly increase their risk of victimization, this standard should provide additional guidance to agencies on what to consider when determining whether a transgender or intersex resident will be housed in a boys' or girls' facility or living unit. Considering that many officials lack experience in working with transgender and intersex residents, it is especially important that a transgender or intersex resident's own views with respect to his or her own safety be considered seriously in all placement determinations for that resident.

§ 115.43/243 Protective custody

As is true for juvenile detainees, extended isolation of vulnerable adult inmates is psychologically harmful and rarely an appropriate means of protection. Protective custody is

punitive by default, as it results in a loss of services and programs, can brand someone as a victim and/or a snitch, and often leaves the inmate with less access to outside support. Relying on isolation to protect inmates who are vulnerable or have been victimized discourages inmates generally from informing officials about their vulnerabilities and from reporting abuse. As a result, involuntary segregated housing must be used for protection only as a last resort.

Ironically, while the Department justified many of its revisions to the Commission's recommendations as a means to reduce costs, it neglected to consider the substantial costs of segregated housing. In a 2009 report, the California Inspector General estimated that, based on needs for increased staffing and greater physical space, the annual costs per inmate in administrative segregation average at least \$14,600 more than the annual costs per inmate in the general population.⁷⁴ In light of these increased costs, the California Inspector General found that the overuse of administrative segregation cost the California Department of Corrections and Rehabilitation nearly \$11 million every year.⁷⁵

While the Department states that the use of protective custody authorized by the proposed standards will not impose new costs on the BOP, since the proposed standard is consistent with current BOP policy,⁷⁶ the BOP and other agencies can, like the CDCR, save millions of dollars by limiting their use of involuntary segregation, thereby preserving additional funds for more effective prevention and response measures.

<u>Recommendation:</u> Require further restrictions and documentation requirements on protective custody by amending paragraphs (c) and (d) as follows: (c) The agency shall not ordinarily assign such an inmate to segregated housing involuntarily for a period exceeding 90 ten days.

(d) If an extension is necessary Whenever an inmate is involuntarily placed in protective custody, the agency shall clearly document:

(1) The basis for the agency's concern for the inmate's safety; and

(2) The reason why no alternative means of separation can be arranged:

⁷⁴ CALIFORNIA OFFICE OF THE INSPECTOR GENERAL, MANAGEMENT OF THE CALIFORNIA DEP'T OF CORRECTIONS AND REHABILITATION'S ADMINISTRATIVE SEGREGATION POPULATION 21-22 (2009), *available at* <u>http://www.oig.ca.gov/media/reports/BOA/reviews/Management%20of%20the%20California%20Department%20o</u> <u>f%20Corrections%20and%20Rehabilitation's%20Administrative%20Segregation%20Unit%20Population.pdf</u> (last visited March 26, 2011).

 $^{^{75}}$ *Id.* at 22.

⁷⁶ IRIA, *supra* note 48, at 47 (discussing § 115.43). There is no comparable discussion for § 115.66/366

(3) The extent to which access to programs, privileges, education and work opportunities have been limited; and

 (4) The plan for providing safe, less restrictive housing for the inmate in the future.
 (e) Every 90 10 days, the agency shall afford each such inmate a review to determine whether there is a continuing need for separation from the general population. Each review that results in continued segregation should be documented in accordance with (d).

While the Department specifies some restrictions on the use of involuntary protective custody, its proposed standard here still allows the indefinite placement of vulnerable inmates in involuntary segregation, without sufficient access to programming and work assignments – or sufficient means to challenge this designation. Shorter deadlines are needed to discourage prolonged isolation. Moreover, agencies must fully document the use of involuntary protective custody – to allow inmates to challenge this involuntary status; to track the extent to which it is relied upon by facilities as a means of protecting vulnerable populations; and to enable monitors to review whether it is overused.

<u>Recommendation:</u> Add the following paragraph to this provision: <u>(f) When an inmate identified as vulnerable to sexual victimization requests to be</u> <u>placed in protective custody, the agency shall make a decision as to the individual's</u> <u>request within 24 hours. During the period in which the agency makes its decision,</u> <u>the individual shall be placed in segregation. Should the agency deny the</u> <u>individual's request, the agency shall (1) document the grounds for the denial; and</u> <u>(2) provide for an expedited appeal by the individual requesting protective custody.</u>

While many inmates are involuntarily segregated, some vulnerable individuals do request housing in protective custody for their own safety. The proposed standards provide no guidance for agencies on how to handle requests for segregation. Inmates are often in the best position to assess their safety in general population, but far too often their requests are not seriously considered until after they have been assaulted. The Department should encourage agencies to review these requests promptly, as a prevention measure.

VI. Reporting

§ 115.51/151/251/351 Inmate reporting

JDI commends the Department for recognizing the need for both inmates and staff to be able to report abuse privately.⁷⁷ Whether as victims or witnesses, inmates need reporting options that they feel are safe and trustworthy, which for some individuals will only occur with anonymity. Allowing staff to report the abuse privately will likewise increase a staff member's willingness to address sexual abuse. Corrections culture too often includes a willingness on the part of staff to "turn a blind eye" when a colleague or powerful inmate behaves inappropriately. A private reporting option, partnered with zero-tolerance for sexual abuse, may encourage staff who would otherwise remain silent to report sexual abuse and sexual harassment.

<u>Recommendation</u>: Require agencies to make their best efforts to establish an external reporting option, and to allow reporting to external entities to be anonymous by amending paragraph (b) as follows:

Pursuant to § 115.22, the agency shall also make its best efforts to provide at least one way for inmates to report abuse or harassment to an outside governmental entity that is not affiliated with the agency or that is operationally independent from agency leadership, such as an inspector general or ombudsperson, and that is able to receive and immediately forward inmate reports of sexual abuse and sexual harassment to agency officials, allowing the reporting inmate to remain anonymous upon request. If there is no outside entity able to accept such reports, the agency shall establish a reporting mechanism that is operationally independent from agency leadership.

For the reasons discussed above (addressing standard § 115.22/222/322), the Department's elimination of the requirement that inmates have access to an external, confidential reporting option is very problematic. Victimized inmates often have legitimate reasons for not trusting members of the agency that failed to protect them from sexual abuse in the first instance, and an "operationally independent" entity remains part of the agency for these purposes. Moreover, an

⁷⁷ The term "confidentially" is used throughout the standards, in a few different contexts. Presumably any report would trigger an investigation and the disclosure of some information. Confidentiality generally precludes sharing any information provided by a client in the course of requesting or receiving services, except in limited circumstances such as imminent harm, knowledge of child abuse or with the client's explicit, written permission. For clarity, the Department may want to use the word "anonymous" when referring to an inmates' ability to report abuse to a staff member, administrator, ombudsperson or outside entity without revealing their own identity. When staff members responding to an allegation of sexual abuse are required to safeguard information, including the identity of the victim and alleged perpetrator, and provide information only to those individuals who need it to complete an investigation, a more accurate description would be "report privately."

anonymous reporting option may be the only way for an inmate to feel safe reporting sexual abuse. Despite the fact that an anonymous report will not allow for a full investigation into the incident, it will provide facility staff with important information about sexual violence within the facility, including information that may help officials track trends and become aware of areas in the facility that are not safe.

In § 115.351, the Department's requirement that youth have access to the tools necessary to make a written report is an important improvement to the Commission's recommendations. The lesser capacity and greater developmental needs of youth are often cited to justify giving them less access to legal resources than adults have. Nonetheless, the legal system imposes the same procedural hurdles on juvenile residents as it does on adult inmates. Youth need to be provided with these basic materials to document their concerns.

<u>Question 23</u>: Should the final rule mandate that agencies provide inmates with the option of making a similarly restricted report to an outside public entity? To what extent, if any, would such an option conflict with applicable State or local law?

Though the intention behind the military's "restricted reporting" system is good, in practice, it often creates unnecessary confusion and provides victims with false promises of privacy. For example, if a survivor in the military system reports sexual abuse to the wrong person, that person will still have to report the abuse. Commanders who receive reports of sexual abuse are also free to pursue an investigation, even if that goes against the wishes of the survivor. While the "restricted reporting" option allows some military personnel to receive medical care following a sexual abuse to authorities. Similar concerns are likely to arise in the corrections context, without survivors understanding the consequences of their reports becoming "unrestricted" until after the fact.

In order to model the intention and most positive aspects of the military's "restricted reporting" option without succumbing to its shortcomings, JDI recommends that the Department allow for anonymity whenever requested by the inmate, as allowed by federal and state law.

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§ 115.52/252/352 Exhaustion of administrative remedies

<u>Question 24</u>: Because the Department's proposed standard addressing administrative remedies differs significantly from the Commission's draft, the Department specifically encourages comments on all aspects of this proposed standard.

As the Department acknowledges, there is "strong evidence that victims of sexual abuse are often constrained in their ability to pursue grievances," due to unrealistic and arbitrary deadlines and requirements.⁷⁸ As scores of cases have shown, even where sexual abuse committed by officials is not controverted, adult prisoners and juvenile residents are often denied legal redress because of hyper-technical requirements.⁷⁹ Still more cases are never brought to the attention of officials because, having missed a deadline or other requirement, survivors know that filing a grievance will yield no positive benefit but may subject them to further abuse and other retaliation.

Requiring that harsh grievance policies be loosened for complaints of sexual abuse in detention is not inconsistent with the Prison Litigation Reform Act (PLRA).⁸⁰ The PLRA created various barriers to redress by the courts that are unique to inmates, including a requirement that inmates fully navigate the grievance procedures at their facilities.⁸¹ The law provides no mandates on the content of these grievance procedures. However, in response to the law, agencies nationwide have avoided responsibility for abuses by erecting harsh requirements for substantive review of complaints, including unrealistically short deadlines, multiple levels of appeal, and confusing distinctions between who can receive a report of sexual abuse generally and which reports will be deemed grievances.

⁷⁸ NPRM, 76 FED. REG. at 6259.

⁷⁹ See, e.g., Tracy v. Coover et al., No. 0-778/09-0931 (Iowa Ct. App. Jan. 20, 2011) (dismissing a prisoner's complaint of sexual abuse because, as suggested in orientation materials provided by the Iowa Department of Corrections, she complained to a counselor rather than filing an official grievance); *Baker v. Chapman*, 2010 WL 1258021 (M.D. Ga. 2010) (dismissing allegations of a staff-on-inmate sexual assault for failure to exhaust official grievance procedures); *B, N & G v. Duff*, 2009 WL 2147936 at *7-9 (N.D. Ill. 2009) (dismissing a juvenile plaintiff's claim that adult staff had sexually abused her because she had not appealed an adverse determination on her grievance); *Delaney v. Tilton*, 2009 WL 1405008 at *4 (E.D. Cal. 2009) (dismissing from the lawsuit a supervisory defendant because, although the plaintiff had filed a complaint enumerating "allegations of sexual assault, battery and misconduct" by the perpetrating officer, she did not write in her grievance that she had previously complained about the assailant's behavior and that prison officials had failed to help her).
⁸⁰ Prison Litigation Reform Act, P.L. No. 104-134, 110 Stat. 1321-73 (1996).

⁸¹ 42 U.S.C. § 1997e(a).

The PLRA was intended to weed out frivolous prisoner lawsuits, not to bar legitimate cases of sexual abuse and harassment from judicial review. Effective grievance systems and access to court when officials fail to prevent and respond to sexual violence are important internal monitoring and external oversight mechanisms – allowing victims to seek redress and encouraging officials to make the changes necessary to prevent such abuses in the future.

As proposed, the Department's standard does not ensure that legitimate claims of sexual abuse and harassment are substantively reviewed, rather than being derailed by confusing and unrealistic technical requirements.

Recommendation: Remove the grievance filing deadline by replacing paragraph (a) with the following: Under agency policy, an inmate has exhausted his or her administrative remedies with regard to a claim of sexual abuse or sexual harassment either: (1) When the agency makes a final decision on the merits of the report of abuse or harassment, regardless of whether the report was made by the inmate, made by a third party, or forwarded from an outside official or office; or (2) When 90 days have passed since the report was made, whichever occurs sooner.

JDI strongly believes that no survivor of sexual abuse or harassment should be subject to harsh and arbitrary grievance deadlines. Fear, shame, and the prospect of enduring further abuse and retaliation are powerful disincentives to filing a grievance, particularly for the many victimized inmates who have brought prior reports that were ignored or, worse, caused them to be subjected to punitive and/or more dangerous conditions. Limited education, lack of sufficient support services, and the triggering of prior trauma further preclude victims from being able to overcome these barriers within the Department's proposed 20-day deadline.

Even if the Department takes the unfortunate position of creating deadlines for adult inmates, it should not do so for young survivors. Children are especially hesitant to report abuse or to use a facility's grievance system, and their limited cognitive and emotional development may make it particularly hard for them to do so. It is often difficult for young people to understand their rights as entitlements that they can exercise without adverse consequences; they are more likely than

adults to acquiesce to authority figures rather than assert those rights.⁸² Abusers often convince young victims that if they reveal the abuse, they will get in trouble or other harm might come to them or someone they care about. Moreover, youth are generally not held in juvenile facilities for extended periods of time, further reducing the need for short deadlines.

<u>Recommendation</u>: JDI explicitly opposes the use of filing deadlines. However, if the Department insists on retaining such requirements, it must provide a more realistic timeframe by amending paragraph (a) as follows:

(1) The agency shall provide an inmate a minimum of 20 <u>180</u> days following the occurrence of an alleged incident of sexual abuse or sexual harassment to file a grievance regarding such incident.

(2) The agency shall grant an extension of no less than 90 days from the deadline for filing such a grievance when the inmate provides documentation, such as from a medical or mental health provider or counselor, that filing a grievance within the normal time limit was or would likely be impractical, whether due to physical or psychological trauma arising out of an incident of sexual abuse, the resident having been held for periods of time outside of the facility, or other circumstances indicating impracticality. Such an extension shall be afforded retroactively to an inmate whose grievance is filed subsequent to the normal filing deadline.

The Department relies on the BOP grievance policy as the benchmark for its proposed filing deadline. Such a baseline will not, however, improve survivors' ability to pursue grievances or access the courts. Worse still, in many systems it may result in grievance requirements becoming more stringent. In particular, the 20-day deadline for a rape victim to file a grievance, with an exception only for those who can provide "documentation … that filing a grievance within the normal time limit was or would not be practical," is unacceptable.

Like survivors in the community, victimized inmates are typically in shock for months after an assault. Most incarcerated survivors will ultimately be diagnosed with Rape Trauma Syndrome (RTS) or Posttraumatic Stress Disorder (PTSD).⁸³ Both conditions include an initial crisis period

⁸² Barry C. Feld, *Police Interrogation of Juveniles: An Empirical Study of Policy and Practice*, 97 J. CRIM. L. & CRIMINOLOGY 219, 229-30 (2006).

⁸³ AMERICAN PSYCHIATRIC ASSOCIATION. *DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS* (4th ed. text revised 2000) ("DSM-IV-TR"); MARY P KOSS & MARY R. HARVEY, THE RAPE VICTIM: CLINICAL AND COMMUNITY INTERVENTIONS (1991); Ann Wolbert Burgess & Lynda Lytle Holmstrom, *Rape Trauma Syndrome*, 131 AM J. PSYCHIATRY 981 (1974). Because of the high level of distress immediately after an assault, these diagnoses generally are not made until individuals have experienced the full range of symptoms for a period of time.

– known as the "acute phase" – during which survivors experience significant distress that disrupts all major spheres of life. One of the defining characteristics of acute RTS and acute PTSD is avoidant behavior – persistent avoidance of thoughts, emotions, and physical sensations that cause the survivor to recollect the traumatic event. Filing a report and entering into the grievance process are actions that a survivor would typically avoid while in the acute period.

The duration and severity of the symptoms will vary depending on factors such as prior trauma, perceived level of helplessness during the traumatic event, relationship to the abuser, and level of support received after the abuse. However, the most severe symptoms often last for three months, while many people experience symptoms for longer than twelve months after the traumatic event.⁸⁴ These timeframes are based on experiences of victims in the free world and assume that there are no subsequent traumatic events. As the Department's surveys indicate, however, prisoner rape survivors are likely to be victimized repeatedly. Moreover, people with prior victimization or mental illnesses (both of which are dramatically more prevalent among inmates than in the community) also commonly experience unusually severe symptoms. In light of these considerations, a deadline of 20 days to file a grievance is woefully inadequate.

The 90-day extension for victims who can document trauma does not negate the inadequacies of that unrealistic deadline. All survivors of sexual assault can be expected to experience a level of distress that prevents them from accessing grievance procedures and medical or mental health care well past the 20-day deadline, and most can be expected to experience severe symptoms until at least 90 days after the assault. A traumatized prisoner, and especially one who fears retaliation, is as unlikely to be able to secure timely medical or mental health assistance as she or he is to be able to file a timely grievance. In the worst systems, even victims who have the wherewithal to request help still may not be able to access competent services in a timely manner. In fact, sexual abuse grievances often include complaints that sufficient response services were not provided. Thus, the ability to file a grievance becomes contingent upon the ability to access timely assistance.

⁸⁴ DSM-IV-TR, *supra* note 83 at 426; KOSS & HARVEY, *supra* note 83.

Moreover, creating an evidence-based extension to the harsh 20-day deadline will result in administrative challenges, and ultimately litigation, focused on the sufficiency of such evidence. Issues will inevitably arise with respect to a range of questions, including: when must the documentation be obtained; who is qualified to provide it; what recourse there is for an inmate who cannot access a qualified provider in time; and how the credibility of the documentation is established. Rather than creating a system that would generate such issues, a more effective use of resources would be to recognize that any inmate who has been sexually victimized is likely to have experienced some trauma. Therefore, at the very minimum, inmates should be provided with six months to file sexual abuse claims.

<u>Recommendation</u>: Ensure that all timely reports are considered grievances by adding the following paragraph to this standard:

<u>A complaint lodged with any established reporting entity, including any staff</u> <u>member or established outside reporting body, shall trigger the highest-level</u> <u>grievance process in the facility.</u>

While the proposed standard allows for a third-party complaint to begin the grievance process (if the victimized inmate takes subsequent steps to establish that he or she wants the complaint pursued), the Department does not make clear that an inmate's complaint to any staff member or established outside reporting entity, in accordance with proposed Standard § 115.51/251/351, must be treated as a grievance. Nor does the proposed standard ensure that sexual abuse and harassment grievances will be kept private and afforded the highest level of review.

As the Department recognizes, multiple avenues for reporting are vitally important to maximizing the information provided to officials and ensuring that survivors have safe and effective ways of complaining.⁸⁵ Failing to allow for each reporting mechanism to trigger a grievance will add further confusion to already complex exhaustion requirements and further disenfranchise sexually victimized inmates from judicial relief. Recent cases in Iowa and New York make clear the need for this requirement to be explicit. In both states, female prisoners relied upon agency materials encouraging them to complain to trusted entities (in Iowa a case manager, in New York the Inspector General), which they did. In subsequent court action, the

⁸⁵ See Dep't of Justice, Proposed Standard § 115.51/151/251/351.

agencies successfully argued that because these reporters were not part of the official grievance system, judicial review was procedurally barred.⁸⁶

The sensitive information contained in a sexual abuse or harassment grievance needs to be shared discretely, due to the same safety considerations at issue during an administrative and/or criminal investigation. While many agencies have grievance systems with multiple levels – starting with a complaint to an officer, which must be followed by additional filings for review up the chain of command – complaints pertaining to sexual abuse or harassment, particularly if staff members are implicated, should go directly to the warden or other high-level official with final authority over such complaints. Such a practice would help ensure that sexual abuse and harassment grievances are treated with the appropriate level of seriousness and attention, consistent with the requirements for investigations.

<u>Recommendation</u>: Do not allow for inmates or residents to be disciplined for filing an emergency grievance in good faith, by amending paragraph (d)(5) as follows: An agency may <u>only</u> discipline an inmate for intentionally filing an emergency grievance where no emergency exists <u>and the agency establishes that the inmate had</u> <u>no basis to believe that an emergency existed and that such grievance was filed with</u> <u>the intent to deceive. Such findings must be documented in writing in the inmate's file.</u>

As written, the proposed standard authorizes agencies to punish victimized inmates who reasonably believe that an emergency exists, if the agency ultimately disagrees with the victim's assessment. Such a policy will serve as a significant disincentive to reporting. Inmates are often hesitant to report legitimate claims of abuse because they think no one will believe them, particularly when it is their word against a staff member's. While the agency should be able to sanction inmates who misuse the emergency grievance process, it should only be permitted do so when the inmate is found to have acted in bad faith.

⁸⁶See Amador v. Andrews, No. 03 Civ. 0650, 2007 U.S. Dist. LEXIS 89648 (S.D.N.Y. Dec. 5, 2007), pending on appeal sub nom. Amador v. Superintendents of the Department of Correctional Services, 08-2079 (2d Cir.); Tracy v. Coover, No. 0-778/09-0931 (Iowa Ct. App. Jan. 20, 2011).

§ 115.53/253/353 Inmate access to outside confidential support services

Providing inmates with access to trained advocates who can maintain confidentiality helps ensure that inmates receive compassionate, skilled support services. This, in turn, encourages victimized inmates to report sexual abuse to officials. Confidential counseling provides survivors with a safe and trusted way to discuss the sexual violence they have experienced, deal with their fears, develop appropriate coping skills, and understand that the abuse was not their fault. Confidential support may also improve a survivor's ability to participate in an investigation and will enhance institutional safety. A survivor who receives quality mental health care services also is likely to encourage other victimized inmates to come forward.

<u>Recommendation</u>: Modify paragraph (a) to require: access to outside victim advocates ..., and by enabling reasonable communication between inmates and these organizations, as confidential as possible, <u>to the extent</u> <u>allowed by law</u> consistent with agency needs.

While the standard here recognizes the benefit of providing access to outside victim advocates for emotional support services, allowing this communication to be only "as confidential as possible, consistent with agency security needs," will dramatically reduce the effectiveness of this provision and make it difficult for auditors to measure compliance. Worse still, this provision will enable particularly troubled facilities that are acting in bad faith to refer to 'agency needs' whenever seeking to prevent information about abuse from reaching outside the facility.

Confidential counseling is one of the most important best practices in the community, and it is the norm in professional and ethical standards for mental health professionals. Nonetheless, some corrections agencies refuse to allow service providers to offer confidential counseling based on the mistaken belief that confidential counseling will limit officials' ability to learn about (and therefore address) crimes within the facility. In practice, however, survivors who are able to share their ordeal confidentially generally feel safe and supported and, as such, are much more likely to report abuse and be able to fully cooperate with investigations and prosecution.⁸⁷

⁸⁷ See Special Topics in Preventing and Responding to Prison Rape: Medical and Mental Health Care, Community Corrections Settings, and Oversight, Hearing of the National Prison Rape Elimination Commission (Dec. 5, 2007) (testimony of Wendy Still, Associate Director, Female Offender Programs and Services, California Dep't of Corrections and Rehabilitation).

Agencies should not be able to limit these life-saving services based on the common misperception that confidentiality conflicts with their 'agency needs.'

Limitations on confidentiality that have been identified and defined by the relevant legislature are the result of deliberation that has balanced the benefits of providing safe services, even for victims who do not want to initiate an investigation, with the value of providing law enforcement with timely information about ongoing crimes. 'Agency security needs,' in contrast, is a vague and broad measure. Officials may define this need differently from one another, and health care professionals are likely to define it differently than officials. On the one hand, any instance of wrongdoing relates to security and could therefore justify barring any confidentiality. On the other hand, absolute confidentiality can be justified as a good security measure, as information provided confidentially is unlikely otherwise to be shared at all. If the standard continues to limit confidentiality based on 'agency security needs,' how to determine these needs must be explicitly defined, in advance, both to ensure that service providers (and officials) have sufficient guidance in providing services and for auditors to be able to monitor compliance with the standard. Ultimately, given the proven benefits of confidentiality should be considered sufficient for agency security needs.

<u>Recommendation</u>: Add sexual harassment to § 155.53(a).

As discussed above (addressing § 155.22/222/322), sexual harassment frequently escalates into sexual abuse, and community service providers are skilled in assisting victims who have endured all forms of unwanted sexual activity. Adding sexual harassment to this provision would help provide inmates with the information and safety planning tools they need to address sexual harassment.

§ 115.54/154/254/354 Third-party reporting

JDI commends the Department for recognizing the value of third-party reporting. Some inmates may be too afraid to report abuse directly to officials, but will tell a trusted family member or other loved one about their victimization. Allowing third parties to express their concern and

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report sexual abuse on behalf of an inmate is an important way that officials can learn about sexual abuse in their facilities.

VII. Official Response Following Inmate Report

§ 115.61/161/261/361 Staff and agency reporting duties

The Department makes a commendable effort to balance competing claims here, accommodating staff's need to share knowledge, suspicions, and information about sexual abuse with their superiors and colleagues while also maintaining some protections against unnecessarily disclosing sensitive information. Additional protections limiting the amount of information shared among staff and preserving the confidential relationship between medical and mental health staff and patients would greatly improve this standard.

<u>Recommendation</u>: Clarify the extent of information provided to staff who "need to know" about a sexual report by modifying paragraph (b) as follows: Apart from reporting to designated supervisors or officials, staff shall not reveal any information related to a sexual abuse report to anyone other than those who need to know, as specified in agency policy, to make treatment, investigation, and other security and management decisions. <u>Such personnel shall receive only the</u> <u>information necessary for them to perform their job functions safely and effectively.</u>

The Department rightly limits the sharing of information about sexual abuse reports to staff who need this information in order to make treatment, investigation, and other security decisions. However, the fact that a staff member needs some information about a sexual abuse report does not mean that all such information must, or should, be shared. Rather, to maintain privacy about this highly sensitive matter to the fullest extent possible, staff should only receive the information necessary for them to perform their job functions.

<u>Recommendation</u>: Align medical and mental health staff reporting obligations to the obligations of analogous professionals in the community by modifying paragraph (c) as follows:

Unless otherwise precluded by <u>In accordance with</u> Federal, State, or local law, <u>as</u> well as legal and ethical standards of their professions, medical and mental health practitioners shall be <u>determine whether they are</u> required to report sexual abuse pursuant to paragraph(a) of this section and to inform inmates of the practitioner's duty to report, <u>and the limits of confidentiality</u>, at the initiation of <u>services and each</u> <u>time that the practitioner makes the determination that he or she is required or</u> <u>permitted to breach confidentiality</u>. The agency shall specify as a matter or written

policy the extent of health providers obligation to report sexual abuse, relying on existing professional standards and an ethics-based decision model.

JDI commends the Department for requiring medical and mental health practitioners to inform inmates at the commencement of services of any duty to report they may have, thereby securing informed consent before inmates disclose any information. However, the standard should allow for greater confidentiality between inmates and medical and mental health staff, rather than holding health professionals to reporting obligations that are similar to those of other staff.

In the community, confidentiality is recognized as an important health care practice, as it encourages full disclosure of information that may be relevant to treatment. While confidentiality can be breached to share information that places the patient or others at risk of serious harm, information about prior crimes is generally not disclosed, except when the local law requires certain injuries resulting from criminal activity, such as gun or knife wounds, to be disclosed to law enforcement.

The issue of whether medical and mental health practitioners in corrections settings should be required to report sexual abuse (apart from when such reports are required by law) is a complex one that remains unresolved in the field.⁸⁸ Corrections health practitioners have to consider safety and security issues beyond those facing practitioners in the community, but such considerations should not preclude treating information confidentially simply because officials may prefer to receive it. If the confidentiality of medical and mental health communications is not protected, victimized inmates will be far less likely to seek treatment.

The leading standards for corrections health care recommend confidentiality in prison counseling sessions, unless the disclosed information concerns a contemplated crime, indicates clear and imminent danger or is required to be shared by court order.⁸⁹ While some sexual abuse of

 ⁸⁸ See, e.g., Emil R. Pinta, Decisions to Breach Confidentiality When Prisoners Report Violations of Institutional Rules, 37 J. AM. ACAD. PSYCH. L. 150 (2009), available at <u>http://www.jaapl.org/cgi/content/full/37/2/150</u> (considering whether to disclose information about an inmate having sex with a staff member to be a "grayer area").
 ⁸⁹ See National Commission on Correctional Health Care, Standards for Mental Health Services in Correctional Facilities (2008); American Psychiatric Association, Task Force to Revise the APA Guidelines on Psychiatric Services in Jails and Prisons: Psychiatric Services in Jails and Prisons (2000); see also American Bar Association, supra note 46, Standard 23-6.8.

prisoners may create a clear and imminent danger, in light of the frequent targeting of prior victims, far from all disclosures of abuse will fall into this category. Agencies should be required to create appropriate policies that balance these concerns, in accordance with relevant state law and local practices.

<u>§ 115.62/162/262/362 Reporting to other confinement facilities</u>

Many victimized inmates will wait until they have been transferred to another facility before reporting that they have been sexually abused by a staff member or another inmate. The Department wisely requires the facility receiving the report to transmit this information to the facility where the abuse occurred. However, the time frame given for providing the information conflicts with the requirements of § 115.71/171/271/371, to conduct prompt investigations, and with those of paragraph (b) of this provision, to ensure that an allegation is investigated in accordance with the standards.

<u>Recommendation</u>: Ensure that prompt investigations occur by amending paragraph (a) as follows:

Within 14 days of <u>Immediately upon</u> receiving an allegation that an inmate was sexually abused while confined at another facility, the head of the facility that received the allegation shall notify in writing the head of the facility or appropriate central office of the agency where the alleged abuse occurred. <u>Verbal notice shall be</u> provided within one business day, followed by notice in writing within three business days.

Law enforcement agencies in the community often have to cross-report information because a crime occurred in multiple jurisdictions or because of considerable distance between the place where the crime occurred and where the victim currently resides. Such reporting is generally required to happen immediately, to allow for prompt investigations.⁹⁰ Placing similar time restrictions on cross-reporting among corrections facilities will help ensure that all sexual abuse reports are treated with the same level of urgency regardless of whether the abuse occurred at the reporting facility.

⁹⁰ See, e.g., CAL. PENAL CODE § 11165.9 (requiring verbal notification immediately and written notification within three days).

<u>§ 115.63/163/263/363 Staff first responder duties</u>

As the Department acknowledges, first responders need specific guidance on what actions to take to assist in the subsequent investigation and to secure any potential evidence. In most instances, however, these individuals are not equipped to determine whether the report was made "within a time period that still allows for the collection of physical evidence."

<u>Recommendation</u>: Amend paragraph (a) as follows:

Upon learning that an inmate was sexually abused within a time period that still allows for the collection of physical evidence, regardless of when the abuse occurred, the first security staff member to respond to the report shall be required to:

 (1) Separate the alleged victim and perpetrator;
 (2) Seal and preserve any crime scene, <u>keeping in mind the possibility of multiple</u> <u>crime scenes, until a trained investigator can determine if physical evidence may</u> <u>be present;</u> and
 (3) Request the victim not to take any actions that could destroy physical evidence, including washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating, <u>until a trained forensic medical professional has</u> <u>been consulted</u>.

The science of collecting sexual assault evidence is ever-changing and advancing, extending timeframes in which evidence can still be collected. Many reports of prisoner rape are delayed disclosures, requiring agencies to take a proactive approach to sexual assault investigations. Physical evidence might be in the form of clothing, documentable injuries, or notes written between the perpetrator and victim that persist well after 120 hours. JDI has heard from survivors who have preserved physical evidence in their cells for months or years.⁹¹ Regardless of how much time has passed, the initial assumption must always be that evidence might be available.

§ 115.64/164/264/364 Coordinated response

Coordinated responses to sexual abuse in detention, such as institution-based sexual assault response teams (SARTs), ensure that all relevant corrections staff is seamlessly engaged.

⁹¹ See, e.g., The Cost of Victimization: Why Our Nation Must Confront Prison Rape, Hearing of the National Prison Rape Elimination Commission (June 14, 2005) (testimony of Marilyn Shirley).

Leading researchers have consistently found that a coordinated response is beneficial to survivors.⁹² The Department wisely encourages this best practice.

<u>Recommendation:</u> Require agencies to develop an institutional plan for a coordinated response by amending this provision as follows:

The facility shall <u>develop an institutional plan to</u> coordinate actions taken in response to an incident of sexual abuse, among staff first responders, medical and mental health practitioners, investigators, and facility leadership, <u>using community-based sexual assault response teams (SARTs) as a model</u>.

The presence of a coordinated team that responds immediately and professionally following a report of sexual assault is a proven mechanism for encouraging reports and securing the victim's cooperation with an investigation. A number of state corrections departments, including those in California, Oregon, and Pennsylvania, have developed institution-based SARTs and have seen first-hand the value of this model for staff and inmates alike. SART members report that they feel more empowered to respond to sexual abuse reports because they are well trained and work as a team. Their timely and seamless responses to sexual abuse reports allow them to serve incarcerated survivors effectively and to fulfill their facilities' zero-tolerance policy on sexual abuse.

<u>Question 25</u>: Does this standard provide sufficient guidance as to how compliance would be measured? If not, how should it be revised?</u>

In addition to helping in the formalization of a best practice, requiring a written institutional plan will create a measurable deliverable that can assist with compliance monitoring. This plan should include a list of staff positions that make up the response team and the duties of response team members, which the monitor can confirm upon visits to the facility and/or in conversation with relevant staff.

⁹² PATRICIA YANCEY MARTIN, RAPE WORK: VICTIMS, GENDER, AND EMOTIONS IN ORGANIZATIONAL AND COMMUNITY CONTEXT (2005); Rebecca Campbell, *The Community Response to Rape: Victims' Experiences with the Legal, Medical, and Mental Health Systems*, 26 AM. J. COMMUNITY PSYCH. 355 (1998).

Standard 115.65/165/265/365 Agency protection against retaliation

<u>Recommendation</u>: Require a policy detailing who should conduct the monitoring and how monitoring will take place by amending paragraph (a) as follows: The agency shall protect all inmates and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other inmates or staff <u>by establishing a policy that prohibits</u> <u>retaliation, designates which staff members or departments are charged with</u> <u>monitoring retaliation, and requires that the inmate or staff member at risk of</u> <u>retaliation be interviewed regularly during the monitoring period.</u>

The Department laudably requires agencies to address retaliation through concrete measures and ongoing monitoring. By formalizing this practice into a written policy that specifies who will conduct the monitoring and mandates that these individuals gather information from the person at risk of retaliation, the Department can increase the likelihood that this monitoring is conducted effectively. A written policy will also assist the auditor in measuring compliance with this provision.

<u>Question 26</u>: Should the standard be further refined to provide additional guidance regarding when continuing monitoring is warranted, or is the current language sufficient?

Monitoring should continue until no new incidents of retaliation have occurred for 90 days. Retaliation may take many forms, some subtle and some that would constitute new criminal acts. If retaliation rises to the level of additional abuse, or if the inmate or staff member expresses a fear for her or his safety, that should be considered a new event, and a new 90-day monitoring period should commence after corrective actions have been taken.

§ 115.66/366 Post-allegation protective custody

Post-allegation protective custody is just as problematic as involuntary protective custody – it isolates, and essentially punishes, individuals based on their vulnerability to, and willingness to report, abuse. This provision mandates that post-allegation protective custody meet the requirements of § 115.43/115.342. The modifications recommended for that standard above are equally applicable here.

VIII. Investigations

§ 115.71/171/271/371 Criminal and administrative agency investigations

Investigations are a critical component of preventing and responding to sexual abuse. Sound investigative policies and practices ensure that perpetrators are held accountable, assure victims that their complaints will be taken seriously, and set a tone that underscores the zero-tolerance policy to deter further abuse. While the Department's standards includes key provisions regarding the collection and assessment of evidence, the coordination of criminal and administrative investigations, and the creation and retention of records, further guidance is needed to ensure that agencies conduct investigations in a thorough and timely manner.

<u>Recommendation:</u> Amend paragraph (a) as follows:

When the agency conducts its own investigations into allegations of sexual abuse, it shall <u>initiate a preliminary investigation immediately</u>, by assessing the availability of <u>physical evidence and determining what crime is alleged</u>, where it occurred, and <u>who was involved or a witness</u>. The agency shall complete the investigation do so promptly, thoroughly and objectively, using investigators who have received special training in sexual abuse investigations pursuant to 115.34, and shall investigate all allegations of sexual abuse, including third-party and anonymous reports.

Given the nature of physical evidence, the potential for further trauma to the victim, and the cost to facilities of separating witnesses prior to their interviews, it is essential that an investigation begins immediately and is completed promptly. The precise speed with which this must occur will depend on the circumstances of the case, such as the length of time between the assault and the report, and the number of inmate and staff witnesses. Conducting a preliminary investigation right away, to determine the specific allegations and what evidence may be available, will also allow subsequent investigations and actions to be undertaken as urgently as necessary.

<u>Recommendation</u>: Add the following sentence to paragraph (b): <u>The agency shall base its investigation protocol on available, accepted sexual assault</u> <u>investigation protocols developed by law enforcement agencies within its state</u> <u>and/or jurisdiction.</u>

In the evidence protocol and forensic medical exams provision (§ 115.21/112/212), the Department rightly requires agencies to rely upon the *National Protocol for Sexual Assault*

Medical Forensic Examinations, Adults/Adolescents when conducting forensic exams.⁹³ Similarly, the Department should require agencies to rely on established guidelines for their investigations protocols. While there is no comparable federal protocol for investigations, as there is for forensic examinations, many states have models that can be relied upon and require only slight modifications to account for the detention setting.⁹⁴

<u>Recommendation:</u> Amend paragraph (c) as follows: <u>When the quality of evidence appears to support criminal prosecution, t</u><u>T</u>he agency shall <u>conduct compelled interviews only after</u> consulting with prosecutors <u>as (1)</u> to determine whether <u>or not the quality of evidence appears to support criminal</u> <u>prosecution; and (2) prior to conducting compelled interviews, to determine if</u> compelled interviews may be an obstacle for subsequent criminal prosecution. <u>All</u> <u>investigations must be completed and documented, and a case summary submitted to</u> <u>the prosecuting attorney for review.</u>

The Department is correct to stipulate that agency investigators must consult with prosecutors prior to conducting compelled interviews. While facility investigators should be qualified to gather and assess information to determine whether the alleged abuse occurred, they generally do not have the qualifications to determine whether the quality of evidence meets the threshold needed for prosecution. Investigators should consult with prosecutors to determine whether the quality of evidence appears to support criminal prosecution. In addition, the data and conclusion of the investigation should be provided to prosecutors for review – both to make a final determination about criminal action in that case and as quality assurance to ensure that in-house investigations are conducted in a manner that encourages criminal prosecution where appropriate.

<u>Recommendation</u>: Amend paragraph (d) to add the following sentence: <u>Polygraph testing for inmates who report sexual harassment and abuse is</u> <u>prohibited.</u>

Polygraph testing often yields inaccurate results and can be traumatizing to a survivor, crippling the effectiveness of an investigation, and damaging the rapport between an investigator and a

⁹³ As discussed in the section on that provision, this protocol is not appropriate for pre-pubescent youth and therefore should not be relied upon exclusively in juvenile facilities.

⁹⁴ See, e.g., Executive Office of Public Safety and Security, Commonwealth of Massachusetts, Adult Sexual Assault Law Enforcement Guidelines (2009), *available at* <u>http://www.mass.gov/Eeops/docs/mptc/2009 SA Final 6-9-09.pdf</u>.

survivor. Given their significant flaws, it is not surprising that polygraph test results are often deemed inadmissible in court, and that the Department prohibits states receiving grants under the STOP (Services, Training, Officers, Prosecutors) Violence Against Women Formula Grant Program (VAWA STOP Program) from using polygraph testing for victims of sexual violence.⁹⁵ The PREA standards should conform to the limitations imposed for VAWA STOP grants.

<u>Recommendation</u>: modify paragraph (k) to require a written plan for coordinating investigations related to the same abuse:

(k) When outside agencies investigate sexual abuse, the facility shall cooperate with outside investigators and shall endeavor to remain informed about the progress of the investigation develop a comprehensive, written plan, including a memorandum of understanding, to guide the coordination of administrative and criminal investigations. The plan shall outline how the two entities' investigators will cooperate around timing, communication, and information sharing throughout and at the conclusion of both investigations.

Administrative investigations and criminal investigations may need to take place within the same timeframes and, in such cases, require careful coordination. By developing a plan with outside police agencies, where applicable, around timing, communication, and information sharing, both the administrative and criminal investigations will be more effective. Formalizing this plan in policy and/or a memorandum of understanding with the police agency responsible for investigations will ensure that both agencies have a thorough understanding of their respective roles. Such clarity is particularly important as an administrative investigation might conclude before a decision has been made about whether to prosecute, and the outcome of either investigation could have an impact on determinations made in the other.

<u>Recommendation</u>: Add sexual harassment to this standard.

This standard should include investigations into allegations of sexual harassment, to ensure that such claims are taken seriously and to conform to § 115.23/123/223/323.

§ 115.72/172/272/372 Evidentiary standard for administrative investigations

JDI strongly supports establishing that the evidentiary standard for substantiating administrative investigations shall not be higher than the preponderance of the evidence.

⁹⁵ 42 U.S.C. § 3796gg-8.

§ 115.73/273/373 Reporting to inmates

JDI commends the Department for requiring that certain information be shared with incarcerated survivors when the investigation into their report of sexual abuse has been concluded. Notification of the outcome of an investigation provides victims with closure and peace of mind, and the knowledge that their allegations were taken seriously and investigated thoroughly. The standard should be further strengthened by requiring similar notifications when the perpetrator is another inmate.

<u>Recommendation</u>: Add paragraph (d) to this provision, with the following language:
<u>Following an inmate's allegation that another inmate(s) has committed sexual</u>
<u>abuse, the agency shall subsequently inform the inmate whenever:</u>

(1) The inmate perpetrator(s) is no longer housed in the inmate's unit or serving
<u>on the inmate perpetrator(s) has been transferred to another facility;</u>
(2) The inmate perpetrator(s) has been indicted on a charge related to the sexual
<u>abuse;</u>
(4) The inmate perpetrator(s) has been convicted on a charge related to the sexual abuse.</u>

Like victims of staff sexual misconduct, inmates who have been sexually abused by other inmates will benefit greatly from knowing that the perpetrator is no longer at the facility and that the abuse is seriously addressed through criminal prosecution. While agencies have legitimate reasons for not providing inmates with many details about the housing and status of other individuals, sharing this basic information will not negatively impact security and may be crucial to a victim's ability to heal and feel safe in the facility.

IX. Discipline

§ 115.76/176/276/376 Disciplinary sanctions for staff

<u>Recommendation:</u> Amend paragraph (b) such that: Termination shall be the presumptive disciplinary sanction for staff who have engaged in sexual <u>abuse</u> touching.

Any type of sexual abuse by staff is serious, harmful, and inexcusable. The Department's proposed standard creates a presumptive sanction for some forms of staff sexual abuse, but not

for indecent exposure or voyeurism. Employees found to have committed these forms of abuse should also be subject to a presumption of termination, however. In addition to the potential security breaches, triggering of trauma, and other harm that may result from staff exposing themselves or forcing others to expose themselves, indecent exposure and voyeurism are known precursors to acts of sexually abusive touching or rape. Retaining employees found to have committed these forms of sexual abuse puts inmates at risk of further and escalating victimization, and sends a message that the agency condones such abusive behavior—it is completely contrary to the requirement that facilities must have zero-tolerance of sexual abuse.

§ 115.77/277/377 Disciplinary sanctions for inmates

The Department rightly prohibits facilities from treating unsubstantiated good faith allegations of sexual abuse as false reports or lies. Gathering sufficient evidence to substantiate a report is exceptionally challenging and, as a result, the majority of allegations end up unsubstantiated.⁹⁶ Physical evidence may not exist, inmate witnesses may be released, transferred, or uncooperative and, in instances of staff sexual misconduct, officials may withhold information to protect themselves or their colleagues. As the standard acknowledges, inmates should not be punished for these evidentiary barriers if their allegations are made in good faith.

JDI also commends the Department for recognizing that inmates cannot consent to sexual activity with staff, but that consensual sexual activity between inmates is not sexual abuse. Too often, inmates suffer disciplinary action as a result of staff-on-inmate sexual abuse, when in fact staff members need to be the ones held accountable for such professional breaches. Punishing inmates for sexual contact with staff sends a dangerous message that staff-on-inmate sexual abuse is not taken seriously. It also serves as a serious deterrent to reporting abuse and suggests to inmates who are sexually abused by staff that it is their fault, disregarding the inherent power differential between staff and inmates. While inmates cannot legally consent to sexual contact with staff, consensual sexual activity between inmates is possible. Regardless of whether disciplinary action is taken in response to such activity, facilities should not waste limited

⁹⁶ GUERINO & BECK, *supra* note 27.

resources to investigate and file reports of abuse in response to consensual sexual activity between inmates that would not be considered sexual abuse in any other setting.

<u>Recommendation</u>: Prevent staff perpetrators of sexual abuse from retaliating against reporting inmates by amending paragraph (e) as follows: The agency may discipline an inmate for sexual contact with staff only upon a finding that the staff member did not consent to such contact <u>and that the inmate</u> used force or threat of force against the staff member.

While sexual assaults against staff members by inmates always should be taken seriously, as written this standard allows a staff perpetrator to threaten an inmate or otherwise retaliate against a legitimate report of staff sexual misconduct by claiming that she or he did not consent to the activity. Requiring a finding of force or threat of force before an inmate is punished recognizes the limited situations in which an inmate can manipulate the power dynamic to force staff to engage in sexual activity and provides a clear evidentiary standard for determining staff victimization.

<u>Recommendation</u>: Add the following paragraph to § 115.377: <u>In cases involving residents who engage in voluntary, though legally non-</u> <u>consensual, sexual conduct with other residents, the disciplinary process shall take</u> <u>into account the voluntary nature of this conduct as a mitigating factor when</u> <u>determining what type of sanction, if any, should be imposed.</u>

Facilities need specific guidance on how to handle the disciplining of residents who engage in voluntary sexual conduct with other residents that, due to the ages of those involved, is not legally consensual. Without such guidance, facilities may fail to consider the voluntary nature of such conduct and harshly discipline these residents, often based on homophobia or bias. Specifically, officials may use the standards to target LGBTI youth for harsh sanctions and even prosecution for engaging in sexual contact with similarly aged residents that is voluntary, but technically nonconsensual under state law. Unlike sexual activity between inmates and staff – in which there is an inherent power differential between the person locked up and the person supervising him or her – residents who are similar in age, but one or both are younger than the legal age of consent, are not faced with a power differential such that sexual conduct between two willing youth would be inherently abusive.

When sexual contact between similarly aged youth is voluntary but legally non-consensual due to a state's age of consent laws, the voluntary nature of the contact should be taken into account in any disciplinary process. Unfortunately, many facilities fail to consider this. According to a report by the BJS, in substantiated cases of reported sexual abuse, youth designated as perpetrators of *voluntary* sexual contacts with other youth often received harsher sanctions than those found to be perpetrators of *abusive* sexual contacts.⁹⁷ Facilities need additional guidance to discourage the use of harsh sanctions to punish youth who engage in voluntary, but legally non-consensual, sexual contact. Specifically, facilities should not treat these youth as sexually aggressive, violent or deviant, or attempt to "change" their sexual orientation. In addition, interventions for "victims" and "perpetrators" of voluntary sexual contact should not be more punitive than those for sexual contact that is forced, aggressive, or violent.

X. Medical and Mental Health Care

§ 115.81/381 Medical and mental health screenings

While this standard is entitled "medical and mental health screening," the Department has greatly weakened the Commission's recommendations, removing the requirement that these screenings be conducted by medical and mental health staff. As a result, this provision is, at best, redundant and, at least in the jail context, contradictory to the screening provision (§ 115.41/341).

<u>Recommendation:</u> Require that medical or mental health practitioners ask about sexual victimization and abusiveness by replacing paragraph (a) with the following: <u>In facilities where medical or mental health practitioners conduct medical and</u> <u>mental health screenings as part of the intake or classification process, these</u> <u>practitioners shall ask inmates about prior sexual victimization and abusiveness</u> <u>during intake or classification screenings.</u>

The prisons and jails standard on screening for risk of victimization and abusiveness (§ 115.41) and the juvenile standard on obtaining information from residents (§ 115.341) already require facilities to ask during intake and screening processes about the factors known to heighten the risk of vulnerability and sexual abusiveness, including history of sexual victimization and

⁹⁷ Allen J. Beck et al., Bureau of Justice Statistics, Sexual Violence Reported by Juvenile Correctional Authorities, 2005-06 11 (July 2008), *available at*

<u>http://bjs.ojp.usdoj.gov/content/pub/pdf/svrjca0506.pdf</u>. For example, "perpetrators" of *voluntary* sexual contact were more than twice as likely to be placed in solitary confinement (25 percent) or referred for prosecution (27 percent) than perpetrators of *abusive* sexual contact (12 percent and 13 percent respectively). *Id.*

abusiveness. Reiterating those two factors here, without any specification about who should be asking these questions, invites confusion as to why these factors, and not the others in the earlier provision, are emphasized in this way.

Medical and mental health professionals are the best equipped to ask sensitive but necessary questions about past victimization and abusiveness. These practitioners are accustomed to obtaining personal information from patients, are able to identify physical or emotional injuries that may accompany such disclosures, and are in the best position to assess what treatment services may be needed.

The tremendous value of having medical and mental health practitioners conduct these inquiries should outweigh any marginal costs incurred by this obligation.⁹⁸ This is particularly true for prisons and large jails that employ or contract with full-time health practitioners. Agencies that regularly conduct medical and mental health screenings as part of their classification process have no legitimate basis to exclude these questions from that process.

<u>Recommendation:</u> Require that medical and mental health screenings in jails, like those in prisons, ask about sexual abusiveness and sexual victimization. In addition to adopting the language for paragraph (a) as detailed above, ⁹⁹ by deleting paragraphs (c) and (d), and amending paragraph (b) as follows:

(b) If a<u>n</u> prisoner-inmate discloses sexual victimization or abusiveness, whether it occurred in the an institutional setting or in the community, staff shall ensure that the inmate is offered a follow-up reception with a medical or mental health practitioner within 14 days of the intake screening.

The need for officials to know about an inmate's history of abusiveness is as important in the jail setting as it is in prisons. To house people awaiting trial and serving shorter sentences safely, jail administrators need to separate likely victims from likely perpetrators. Such determinations can only be made if information about victimization and abusiveness is obtained. The Department's decision to limit the inquiry that jails must make is dangerous and arbitrary. As noted above,

⁹⁸ IRIA, *supra* note 48, at 59. Notably, while relying on cost to justify this change, the Department also acknowledges that the Booz Allen Hamilton study considered the costs for this provision to be negligible. *Id.*

⁹⁹ If the Department does not adopt JDI's proposed language, then paragraph (a) should be amended to read "All <u>facilities prisons</u>-shall ask inmates about prior sexual victimization and abusiveness during intake or classification screenings."

removing any inquiry about abusiveness for jails, while retaining it for prisons, is particularly hard to reconcile with § 115.41, which rightly requires both types of facilities to screen for these and other factors.

§ 115.82/282/382 Access to emergency medical and mental health services

JDI applauds the Department for preserving the requirement that timely, unimpeded access to emergency treatment and crisis intervention services be made available free of charge to victims of sexual abuse in detention, regardless of whether the victim names the abuser, and for further requiring that victims be given timely information about and access to pregnancy-related medical services and prophylaxis for sexually transmitted infections.

These basic measures will ensure the well-being of prisoner rape survivors and address the significant public health concerns that arise from: untreated medical and psychiatric conditions; inability to access pregnancy-related services; and the spread of sexually transmitted infections.

<u>§ 115.83/283/383 Ongoing medical and mental health care</u>

As with the preceding standard, JDI applauds the Department for ensuring that female survivors of rape in detention receive access to pregnancy tests and timely information and access to pregnancy-related services. Requiring a mental health evaluation of known abusers is also commendable, although this assessment and treatment should not be delayed for 60 days.

<u>Recommendation</u>: Reduce the time period for evaluation and treatment of known inmate abusers in adult facilities by amending § 115.83/283(d) as follows: All prisons shall conduct a mental health evaluation of all known inmate abusers within 60 14 days of learning of such abuse history and offer treatment when deemed appropriate by qualified mental health practitioners. Reduce the time period for evaluation and treatment of known resident abusers in

juvenile facilities by amending § 115.383(d) as follows:

The facility shall conduct a mental health evaluation of all known resident abusers within 60 7 days of learning of such abuse history and offer treatment when deemed appropriate by qualified mental health practitioners.

In standard § 115.81/381 (b), agencies are given up to 14 days to provide inmates and residents who disclose sexual abusiveness access to a mental health practitioner. There is no justification for such a lengthy delay in this provision. In response to a recent incident of sexual assault in

particular, abusiveness needs to be addressed promptly, with appropriate treatment offered as soon as possible.

In juvenile facilities, the timeframe for conducting an assessment should be even shorter. The juvenile justice system was designed to provide a rehabilitative and therapeutic environment for youth; this mandate cannot be met if youth must wait two months for follow-up evaluations after disclosures of abusiveness, and even longer for treatment. Furthermore, juvenile residents are usually held in a facility for a significantly shorter period of time than adult inmates. The National Commission on Correctional Healthcare (NCCHC) recommends that mental health assessments be conducted for new residents as soon as possible, but no later than seven calendar days after admission to a facility.¹⁰⁰ A seven-day window for assessing known resident abusers in juvenile facilities would be comparable to the NCCHC standards and more appropriate than the 60-day window proposed in the Department's draft standard.

<u>Question 27</u>: Does the standard that requires known abusers to receive a mental health evaluation within 60 days of learning the abuse has occurred provide adequate guidance regarding the scope of treatment that subsequently must be offered to such abusers? If not, how should it be revised?

The proposed standard appropriately leaves open the scope of treatment to be offered to abusers. Currently, there is no validated treatment program for abusers that is uniformly recognized as a best practice. Sex offender treatment programs in the community have had limited success rates and minimal proof of effectiveness. Given the state of the field, treatment for known incarcerated abusers will have to be based on an individualized assessment and treatment plan that conforms to local practices. Therefore, JDI believes that the Department appropriately defers to the expertise of the practitioners at the facility.

¹⁰⁰ National Commission on Correctional Healthcare, Standards for Health Services in Juvenile Detention and Confinement Facilities, § Y-E-03 (2004); *see also id.* at § Y-G-09 ("Immediate response to an act of sexual assault is of the utmost importance.").

XI. Data Collection

§ 115.86/186/286/386 Sexual abuse incident reviews

The Department laudably requires incident review teams to use information from past sexual abuse investigations in order to propose ways of preventing future incidents. The proposed standard requires these teams to consider many important issues, including policies and procedures, staffing levels, monitoring technology, and limitations of the facility's physical plant. Specifying additional issues to be considered would further strengthen this provision.

<u>Recommendation</u>: Add "gender identity" to (c)(2), and the following provisions to that paragraph:

(6) <u>Consider how additional or enhanced staff training opportunities could have</u> <u>prevented abuse and how it can prevent future abuse;</u>
(7) <u>Examine any barriers to reporting or filing grievances;</u>
(8) Incorporate input from inmate victims and witnesses on how to improve the investigation and response processes; and
(9) Prepare a report of its findings and any recommendations for improvement and submit such report to the facility head and PREA coordinator, if any.

The Department's draft standard requires facilities to consider a number of factors related to the perpetrator and victim, including sexual orientation. The final standard should also include consideration of gender identity in this list. In addition, facilities should learn from serious incidents such as sexual misconduct, and incorporate lessons learned to enhance or add trainings aimed at preventing, detecting, and responding to incidents. Barriers to reporting or filing grievances should also be considered. Finally, the incident review should include input from victims and witnesses on how to improve the investigation and response processes, as they may have particularly valuable insights as to how to prevent future misconduct.

<u>Recommendation</u>: Add the following as paragraph (d): <u>After receiving the report, the facility head and PREA coordinator must determine</u> <u>which of the recommendations to carry out, and document benchmarks and a</u> <u>timeline for doing so as an addendum to the report.</u>

To ensure that the results of an incident review translate into action, and to assist the auditor in measuring compliance with this provision, a plan of action should be documented that includes measurable benchmarks and a timeline.

<u>Recommendation</u>: Add sexual harassment to paragraphs (a) and (c)(1).

As noted previously, sexual harassment often serves as a precursor to sexual abuse. Agencies should review incidents of harassment as part of their quality assurance process.

§ 115.87/187/287/387 Data collection

JDI commends the Department for retaining the data collection provisions recommended by the Commission and requiring agencies to provide the prior year's data to the Department upon request. Data collection should also encompass sexual harassment allegations.

§ 115.88/188/288/388 Data review for corrective action

Collectively, the data collection provisions ensure that agencies gather the information necessary to learn about problems. The draft standards also recognize that agencies must take appropriate action based on that information. As written, though, the draft standard on corrective action only requires agencies to review aggregate data.

<u>Recommendation</u>: Require corrective action based on data incident reviews by amending paragraph (a) as follows:

(a) <u>Annually and after significant incidents</u>, <u>T</u>the agency shall review data <u>and</u> <u>analyses</u> collected and aggregated pursuant to § 115.86 and § 115.87 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including: ...

If agencies are only required to compile aggregate data on an annual basis, they may miss critical opportunities to implement changes to practices, policies, staffing, training or monitoring. Indeed, it is difficult to imagine how facilities could "tak[e] corrective action on an ongoing basis," as the proposed standard currently requires, without reviewing individual incidents as they arise. The revised language ensures that facilities take corrective action on an ongoing basis, reviewing both individual and aggregate data.

§ 115.89 Data storage, publication, and destruction

JDI supports the retention of the provisions regarding data storage, publication, and destruction.

XII. Audits

<u>§ 115.93/193/293/393 Audits</u>

External scrutiny, and the transparency and accountability it brings, are vitally important to the strength of any public institution – and corrections facilities are no exception. Sound oversight, conducted by a qualified independent entity, can identify systemic problems and offer solutions. The Department faces the challenge of establishing regulations that will successfully translate the oversight function of the standards into policy and practice across the country. Recognizing this important challenge, a number of advocacy organizations with experience in prison oversight, investigations of sexual abuse in detention, victims' rights, and community responses to sexual violence,¹⁰¹ came together during the Department's public comment period to study this issue and suggest a practical and effective model to the Department.

The principle guiding this group was that a realistic, cost-effective monitoring system is critical to the standards' overall effectiveness and impact. Outside audits are needed to provide a credible, objective assessment of a facility's safety, and to identify problems that may be more readily apparent to an outsider than to an official working within the corrections system. Thorough audits will help prevent abuse and lead to safe facilities, more effective prison management, and, ultimately, lower fiscal and human costs to the community.

<u>Recommendation:</u> Amend the audit provision as follows: (a) <u>Agencies shall ensure that all facilities are audited on a triennial basis by an</u> <u>independent and qualified auditing body.</u>

(1) An audit shall be considered independent if it is conducted by:(1) A <u>a</u> correctional monitoring body that is not part of the agency but that is part of, or authorized by, the relevant State or local government; or (2) An auditing entity that is within the agency but separate from its normal chain of command, such as an inspector general or ombudsperson who reports directly to the agency head or to the agency's governing board; or (3) O other outside individuals with relevant experience.

¹⁰¹ The following organizations, all members of JDI's Raising the Bar Coalition, formed the coalition's oversight working group to develop these recommendations: JDI; the ACLU National Prison Project; the Correctional Association of New York; Pennsylvania Coalition Against Rape; Prison Legal News; and the Washington Lawyers Committee for Civil and Urban Affairs. The Raising the Bar Coalition advocates for the U.S. Attorney General's full and swift adoption of the recommended national standards for the prevention, detection, response, and monitoring of sexual abuse in U.S. detention facilities, as proposed by the National Prison Rape Elimination Commission.

(2) To be qualified, the auditing entity must have experience and/or adequate training in corrections, the dynamics of sexual violence, and the investigation of sexual abuse, including interviewing victims.

(b) No audit may be conducted by an auditor who has received financial compensation from the agency being audited within the three years prior to the agency's retention of the auditor.

(c) The agency shall not employ, contract with, or otherwise financially compensate the auditor for three years subsequent to the agency's retention of the auditor, with the exception of contracting for subsequent audits.

(d) All auditors shall be certified by the Department of Justice to conduct such audits, and shall be re-certified every three years.

(e) The Department of Justice shall prescribe methods governing the conduct of such audits, including provisions for reasonable inspections of facilities, review of documents, and interviews of staff and inmates. The Department of Justice also shall prescribe the minimum qualifications for auditors <u>that incorporate sufficient</u> training and/or expertise in corrections, the dynamics of sexual violence in <u>detention, and the investigation of sexual abuse, including interviewing traumatized individuals</u>.

(f) The agency shall enable the auditor to <u>make unannounced visits</u>; enter and tour <u>all areas of all facilities</u>, <u>including contract facilities</u>; review documents; and <u>conduct private</u>, <u>confidential</u> interviews <u>with staff</u> and inmates, <u>as deemed</u> <u>appropriate by the auditor</u>, to conduct a comprehensive audit. <u>The auditor must</u> <u>have access to all documents and any staff member or inmate</u>, <u>including inmates</u> held in protective custody or solitary confinement.

(g) During each triennial auditing cycle, every facility shall be visited and have its policies, records, data, and other documents assessed for compliance with the standards; however, the auditor may conduct more frequent audits of any facility when the auditor determines that a visit is necessary as follow-up to a previous audit, has concerns about compliance with the standards, or based upon a request for assistance from the facility. All facilities must ensure that staff and inmates are aware of the audit process and have reasonable means to contact the auditor confidentially.

(h) The agency shall ensure that the auditor's final report is <u>provided to the</u> <u>Department of Justice, made available to staff and inmates, and</u> published on the agency's website if it has one or is otherwise made readily available to the public.

This model places central importance on realistic, cost-effective strategies to ensure that every facility is monitored. The Department should endorse triennial audits of every facility as proposed by the Commission. Site visits are essential for an auditor meaningfully to assess whether complaints of sexual abuse are being appropriately filed and facilities are properly documenting, investigating, and responding to acts of sexual abuse. JDI feels strongly that the Department must mandate triennial site visits to all facilities. If, however, the Department chooses to disregard that recommendation, it should at the very least establish a tiered system by

which at least every three years all facilities are assessed for compliance with the standards through a review of policies, records, data and other documents, and contacts with facility administrators, staff, and inmates. Then the standard should also require that a select number of facilities – chosen by the auditor for cause and also by random selection – are visited for more comprehensive auditing in an ongoing manner.

These basic reviews and visits must be performed by an entity that is structurally external to the corrections agency being audited, and by individuals who have no recent relationship with the agency. The auditors must also have a victim-centered approach that incorporates expertise in both corrections and sexual violence.

Aside from suggesting that the Department will eventually establish guidelines for determining who may become a certified auditor and how PREA audits should be conducted, the proposed standard does not address these issues in any detail. Auditor certification and recertification must ensure that the monitors are sufficiently qualified and independent. Government entities should only be considered independent if they are truly separate from the agency being audited – and do not answer to the agency head for funding or other resources. Expertise in addressing sexual violence, and especially in working with survivors of sexual victimization, is just as important as expertise in corrections and, similarly, cannot be fully learned in a brief training course. Audit teams should include a community member, to add to the integrity and accountability of the audits. This could be a professional from a partnering organization (such as the local rape crisis center or state sexual assault coalition) or a volunteer with appropriate background and commitment. Further, members of the audit teams must be aware of relevant legal requirements, including civil rights law.

PREA monitors must have free and unfettered access to all facilities. Such access must include the right to make unannounced visits and to enter and tour all areas of any facility, including contract facilities.¹⁰² Unannounced visits are the cornerstone of effective corrections monitoring. Such access does not mean that visits will be inconsistent with security needs or that a very brief

¹⁰² These requirements are also required in the ABA's external monitoring standards. *See* American Bar Association, *supra* note 46, at Standard 23-11(b).

wait for auditors to comply with security demands, such as facility counts, may not occur. However, as the American Bar Association's Standards for the Treatment of Prisoners note: "security concerns do not provide a justification for disallowing unannounced inspections, nor do rationales related to convenience of correctional staff."¹⁰³ Auditors must also be permitted to review all documents, be able to copy any documents (including documents related to pending investigations), and take those copies off-site for review. Similarly, they should be able to conduct private, confidential interviews with staff and prisoners, including prisoners in protective custody or solitary confinement.¹⁰⁴

The agency must ensure that there are accessible mechanisms for inmates and staff to engage in confidential communication with the auditor (both on-site and via mail/telephone), and that mechanisms are in place to ward off retaliation for contacting or communicating with the auditor. In addition to making themselves available to staff and inmates, auditors must publicly advertise their work and solicit input from the community before and after facility visits as well as in response to their reports.

In each audit, the monitor should be responsible for independently verifying that the facility is making reasonable progress toward achieving compliance with the PREA standards and thereafter maintaining such compliance. Each monitor's report shall describe the steps taken to analyze conditions and assess compliance with the standards, including documents reviewed and individuals interviewed (unless confidentiality is requested), and the factual basis for each of the monitor's findings. The monitor's reports should also include specific recommendations for actions needed to bring the facility into compliance with the PREA standards.

The monitor's findings should be publicly available – except for private information (such as victims' names) – to fulfill the transparency and accountability expectations of such oversight. In addition to providing hard copies to the facility law libraries and to any inmate who requests one, the reports should be posted on the websites of the auditor, the agency, the Department, and the

¹⁰³ *Id.* at Standard 23-11, Commentary, subdivision (b).

¹⁰⁴ These requirements are further supported in the ABA's standards. *See id.* at Standard 23-11.3(b) (external monitoring and inspection).

PREA Resource Center, so that they appear in places where stakeholders and other interested parties are likely to look for them.

Recognizing the enforcement role the Department will play in any audit scheme and the need to determine the meaning of "full compliance" with the standards, JDI believes that the Department should use the multi-tiered approach that it employs in other contexts, whereby *substantial compliance* means compliance with most components of all of the provisions, *partial compliance* is established when the monitor identifies gaps in compliance that go beyond anecdotal incidents, technicalities, or temporary factors, and *non-compliance* is a designation of last resort when a facility refuses to establish and/or implement an action plan to address gaps that have been previously identified.

Questions 28-31:

- Should audits be conducted at set intervals, or should audits be conducted only for cause, based upon a reason to believe that a particular facility or agency is materially out of compliance with the standards? If the latter, how should such a for-cause determination be structured?
- If audits are conducted for cause, what entity should be authorized to determine that there is reason to believe an audit is appropriate, and then to call for an audit to be conducted? What would be the appropriate standard to trigger such an audit requirement?
- Should all facilities be audited or should random sampling be allowed for some or all categories of facilities in order to reduce burdens while ensuring that all facilities could be subject to an audit?
- Is there a better approach to audits other than the approaches discussed above?

While "for cause" audits have some value, oversight cannot rely exclusively on this method. Audits based on cause do not serve the important preventative role of identifying problems before they become serious – one of the greatest cost savings potentially derived from the standards. Moreover, while criteria for establishing cause can be developed (and suggestions are provided below), no standard is fool proof. Reporting is inherently unreliable;¹⁰⁵ some facilities may suppress information, such as grievances and other reports, to avoid audits, and facilities may have systemic problems that directly affect the potential for measuring cause (such as poor recordkeeping or insufficient access to reporting mechanisms and the auditor). Systems with

¹⁰⁵ *Compare* GUERINO & BECK, *supra* note 27, *with* ADULT SURVEY, *supra* note 31.

these types of deficiencies would benefit tremendously from random audits, but are unlikely to be identified as requiring for cause audits.

Despite the limitations of relying exclusively on cause to determine where to audit, for cause audits should be part of the auditing structure. Facilities with known problems are unquestionably in need of outside guidance. Mandatory audits of these facilities would help identify problems and realistic solutions while providing accountability.

A qualified and independent auditor is in the best position to determine when an audit is appropriate. As the value of audits comes from their external nature, allowing corrections administrators to choose which facilities to audit would undercut the important oversight role of the auditor. Officials who fear accountability in poorly performing facilities may avoid subjecting those facilities to audits. Even where officials seek outside monitoring to address known dangers, they are unlikely to be able to identify facilities that may have problems that are unnoticed by staff.

The appropriate standard for the auditor to use in determining when cause has been met depends on the oversight structure established – specifically, the extent to which this structure relies exclusively on cause in determining who to audit. If the Department adopts a hybrid structure that includes both random and for cause audits, then the standard for cause can be fairly lenient – affording the auditor sufficient discretion to assess what triggering events would amount to cause. However, if random audits are not being conducted, then the cause determination must be more inclusive.

Triggering events for determining that cause exists for a full audit should include a range of justifications, including but not limited to:

- (a) agency requests for assistance;
- (b) documentation of existing problems or incidents;
- (c) reasonable suspicion of any instance of staff-on-inmate abuse, as well as inmate-oninmate abuse that appears to be the result of a deficiency in staff efforts to prevent or respond to abuse;
- (d) follow-ups to previous audits to assess implementation of corrective action plans; and

(e) an auditor's review of documents at a facility or contacts from inmates or staff that indicates possible non-compliance with the standards.

In order to implement the for cause audit system effectively, the auditing entity must be able to gather information and intelligence from various sources, including: media reports; facility self-reports; prisoner complaints; family/friend/community concerns; contacts with advocacy groups and other citizen action efforts; and national reporting and research bodies.

While the Department requests information for establishing for cause audits, JDI and its partners urge it to mandate that every facility be visited by the auditor at least every three years. Site visits are vitally important because external reviews of documents concerning sexual abuse simply are not sufficient to assess compliance with the standards. As the Commission amply documented, many inmates and staff are extremely reluctant to report sexual abuse; if a complaint is not filed, there will be no documents for the auditor to review. Unfortunately, non-disclosure of sexual abuse may be greatest at the very facilities where non-compliance exists, due to intimidation or violence. Similarly, it is difficult to assess the adequacy of investigations without access to the complainants or witnesses. Finally, it is nearly impossible to determine whether there is a culture of abuse or intimidation at a facility without a site visit. Conditions within a system can vary dramatically from one facility to the next; only by visiting each facility can the monitor fully assess whether inmates are safe.

However, if full audits at every facility are not approved by the Department, JDI urges -- as a significantly less desirable alternative -- the Department to establish a tiered system that includes some external monitoring of all facilities with full audits at a selected number. At least every three years, all facilities should, at a minimum, be assessed for compliance with the standards through auditor reviews of their policies, records, data and other documents, and remote contacts with facility administrators, staff, and inmates. A hybrid of random and for cause audits would provide attention and accountability to the most deficient facilities while keeping all institutions 'on their toes' to maintain the most effective policies and practices.

Every facility should also submit a self-assessment of compliance with the standards to the auditing entity on a yearly basis. Doing so will ensure that corrections administrators are including the standards in their routine prison management exercises. It will also provide an ongoing source of information for the auditing entity.

<u>Question 32</u>: To what extent, if any, should agencies be able to combine a PREA audit with an audit performed by an accrediting body or with other types of audits?

PREA audits can be combined with other audits, but only if they are conducted by auditors who have sufficient independence from the agency and who are qualified with expertise both about corrections and sexual violence. Traditional audits – conducted solely by corrections practitioners and generally linked to voluntary fee-based accreditation – will not suffice.

The importance of independence cannot be overstated. Unless the review is conducted by an entity that is structurally external to the corrections agency being audited, and by individuals who have no recent relationship with the agency, the integrity of the audit will be compromised. To ensure sufficient autonomy, the auditing entity should be appointed or contracted for a fixed term by the governor/chief executive or the legislature – not the corrections agency. Some inspectors general and other public monitoring bodies are sufficiently independent, but entities that report to the head of the agency being audited (as permitted by subsection of \$ 115.93/193/293/393(a)(2)) are by default not qualified as PREA auditors.¹⁰⁶ Entities that ultimately answer to the head of the Department can easily be pressured to minimize or ignore certain concerns, or be prevented from fully examining conditions through the allocation of resources.

Ideally, audits would be conducted by teams that include at least one corrections practitioner (who may also be involved in other types of audits of corrections facilities) and at least one expert in sexual violence prevention and response from the community (who may be involved in other audits pertaining to federal funds, as required by VOCA and VAWA). An effective PREA

¹⁰⁶ This distinction is consistent with the ABA's oversight resolution and its Treatment of Prisoners Standards. *See* American Bar Association, *supra* note 46, at Standard 23-11.3(a) (external monitoring and inspection); AMERICAN BAR ASSOCIATION, RES. 104B KEY REQUIREMENTS FOR THE EFFECTIVE MONITORING OF CORRECTIONAL AND DETENTION FACILITIES (2008).

auditor must also have prior expertise and/or training in both sexual violence dynamics and the corrections environment. The balance between prior expertise and current training will vary, but being a retired corrections official, by itself, is not a sufficient qualification. Without state certification in rape crisis counseling, a corrections-only monitoring entity is unlikely to be aware of best practices in the community – many of which require only slight modification to account for the unique concerns in the corrections environment. More importantly, only a crisis counseling professional will have sufficient expertise in gathering information from traumatized individuals and picking up cues of possible concerns that inmates and others may not feel comfortable sharing.

Question 33: To what extent, if any, should the wording of any of the substantive standards be revised in order to facilitate a determination of whether a jurisdiction is in compliance with that standard?

The nature of the PREA standards, by necessity, is primarily qualitative. Quantitative indicators help measure compliance but will not sufficiently measure the overall effectiveness of prevention and response efforts. As a result, auditors must be provided with a fair amount of discretion to determine compliance based on overall effectiveness and ultimately, the safety of inmates at individual facilities.

The ability of the auditor to make these determinations, however, will be greatly enhanced by requiring further documentation of agency efforts. In particular, documenting facility efforts to collaborate with outside entities (§ 115.21/121/221/321 and § 115.22/222/322), to avoid cross-gender searches and viewing of inmates in states of undress (§ 115.14/114/214/314), to limit the use of involuntary segregation as a means to protect vulnerable and victimized individuals (§ 115.43/243 and § 115.66/366), and to follow-up on the recommendations arising from data incident reviews (§ 115. 86/186/286/386) will provide concrete deliverables that the auditors can measure and review.

Questions 34-35:

- How should "full compliance" be defined in keeping with the considerations set forth in the above discussion?
- To what extent, if any, should audits bear on determining whether a State is in full compliance with PREA?

Immediate and absolute compliance with all PREA standards is unlikely to be achieved by all systems at all times, and both the standards as a whole and the audit provisions in particular should be seen as a means of trouble-shooting problems and identifying solutions. As a result, the definition of "full compliance" deserves a nuanced approach. In other contexts, the Department uses a multi-tiered approach that would be equally effective here. This approach defines different types of compliance to be determined by the monitor, including the following: *substantial compliance,* meaning compliance with most components of all provisions; *partial compliance,* resulting when the monitor identifies gaps in compliance that go beyond anecdotal incidents, technicalities or temporary factors; and *non-compliance,* being a designation of last resort when a facility refuses to establish and/or implement an action plan to address gaps that have previously been identified.

The goal of the standards is to ensure the safety of inmates. Legitimate stakeholders would not want corrections agencies to lose federal funding except in extraordinary circumstances. Moreover, relying on the penalty of lost funding – without lesser sanctions available – would create a strong disincentive among auditors to make a finding of non-compliance. Through a multi-tiered system, agencies can have ample opportunity to correct deficiencies, with alternative sanctions providing pressure (and possibly assistance) for coming into compliance, and the loss of funds can be considered a last resort.

In line with the ABA's standards for external monitoring and inspection, corrections facilities should be required to respond in a public document (that redacts any confidential or security-related information) to the findings of the auditing entity, to develop corrective action plans to address identified problems, and periodically to document compliance with recommendations or explain non-compliance.¹⁰⁷ As mentioned above, follow-up for cause audits should assess and report on agency efforts to address identified problems and make suggestions for continuing facility improvement and compliance.

¹⁰⁷ See American Bar Association, supra note 46, at Standard 23-11.3(c) (external monitoring and inspection).

Auditors should be required to make their reports publicly available, and the agency, staff and inmates within the facility, and the general public should have an opportunity to respond. When a facility is found to be out of compliance (in full or in part), it must develop an action plan that sufficiently addresses the concerns raised in the report – after which compliance with the action plan must be at least as decisive as the initial audit in assessing full compliance with PREA.

Determining full compliance must incorporate the assessment of an outside monitor in order to have any meaning. In this respect, the audits should play a crucial role. However, they need not be the only indicia relied upon. While not conducting the reviews itself, the Department should verify that each inspection was properly conducted by a qualified monitor, and that corrective action plans are both implemented and monitored.

Additional suggested standard (youth in adult facilities)

Questions 36-37:

- Should the final rule include a standard that governs the placement of juveniles in adult facilities?
- If so, what should the standard require, and how should it interact with the current JJDPA requirements and penalties mentioned above?

The Department should create a standard that protects youth in adult facilities.¹⁰⁸ Because of the stage of development and cognitive and social immaturity of adolescents, they have characteristics that make them particularly vulnerable to abuse. Notably, the Commission stated that youth incarcerated with adults are at the highest risk for sexual abuse.¹⁰⁹ Adult facilities housing children and adolescents face a dangerous dilemma, as they have to choose between housing youth in the general adult population where they are at substantial risk of sexual abuse or housing youth in segregated settings that cause or exacerbate mental health problems. Neither option is safe and appropriate for youth, nor a good practice for corrections agencies that are ill-equipped to address the unique needs of minors.

¹⁰⁸ Specific language for such a standard has been developed by the Campaign for Youth Justice, and provided to the Department in a sign-on letter. JDI supports the language proposed in that letter.

¹⁰⁹NATIONAL PRISON RAPE ELIMINATION COMMISSION, *supra* note 16, at 18.

The Department should prohibit the placement of youth in adult jails and prisons as a way to reduce the sexual abuse of youth. At a minimum, the standards should require that jurisdictions create a presumption that all youth will be housed in juvenile facilities and can only be transferred to an adult facility after a hearing is conducted to determine whether the interests of justice require detention in a prison or jail.

These changes would protect all youth under the age of 18 held in adult facilities, and therefore go beyond the statutory requirements of the existing Juvenile Justice and Delinquency Prevention Act (JJDPA).¹¹⁰ To the extent that youth are currently housed in adult facilities in violation of the JJDPA, these facilities should be found out of compliance with both the JJDPA and the PREA standards. Facilities housing youth in adult facilities in violation of this recommended approach, but that are not in violation of the JJDPA, should be found out of compliance with PREA.

¹¹⁰See 42 U.S.C. §§ 5601-5681.

C. **REGULATORY QUESTIONS**

Questions 38-41:

- Has the Department appropriately determined the baseline level of sexual abuse in correctional settings for purposes of assessing the benefit and cost of the proposed *PREA* standards?
- Are there any reliable, empirical sources of data, other than the BJS studies referenced in the IRIA, that would be appropriate to use in determining the baseline level of prison sexual abuse? If so, please cite such sources and explain whether and why they should be used to supplement or replace the BJS data.
- Are there reliable methods for measuring the extent of underreporting and overreporting in connection with BJS's inmate surveys?
- Are there sources of data that would allow the Department to assess the prevalence of sexual abuse in lockups and community confinement facilities? If so, please supply such data. In the absence of such data, are there available methodologies for including sexual abuse in such settings in the overall estimate of baseline prevalence?

As the Department appears to recognize, assessing the prevalence of sexual abuse in detention facilities is remarkably difficult. As is also the case in the community, there are numerous reasons why a survivor of sexual abuse in detention is unlikely to disclose such abuse – including shame, guilt, fear of retaliation, fear of not being believed, and the interruption in cognitive functioning that is part of a normal trauma reaction. For incarcerated survivors, however, these concerns are magnified. People raped behind bars cannot escape their attackers and have legitimate fears about trusting officials who failed to protect them (and who, in many cases, are the perpetrators or colleagues of the perpetrators). Most prisoner rape survivors endure multiple attacks, and many of those who are brave enough to report sexual abuse end up in punitive conditions such as segregation, while their perpetrators are not held accountable.

The Bureau of Justice Statistics (BJS) is the foremost expert on corrections-related data collection and analysis, and the data from the BJS's inmate and resident surveys are the best available source for determining the baseline level of sexual abuse behind bars. Sexual violence is one of the least reported crimes, in the community and behind bars. In light of the shame and stigma associated with this crime, fear of retaliation, and other disincentives to reporting, reports lodged with officials simply do not capture the extent of sexual violence in detention. (This is also why multiple reporting mechanisms are necessary, including external reporting options.)

The BJS's inmate and resident surveys are the most comprehensive, credible studies to date that measure the prevalence of sexual abuse behind bars. However, as the Department notes, the snapshot nature of the BJS reports – reflecting only the inmates and residents detained on the given day that each survey was conducted – do not reflect the total number of inmates and residents incarcerated over the course of a year. While there are no absolute data on the total number of individuals in detention over the course of a year, the Department makes the best available flow adjustment based on the BJS calculations.

None of these data include lockups or community corrections, making even the best estimates by the Department too low. JDI knows of no credible accounting even of the number of such facilities or the number of inmates in lockups and community confinement, let alone a study of sexual violence against these individuals. The Department should gather such information, as a matter of urgency. In community confinement facilities, the BJS can conduct surveys similar to those already conducted in corrections facilities. Determining prevalence in lockups is especially difficult because of the rapid turnover of inmate populations there, but preliminary information could be gathered by incorporating questions about sexual assault while in police custody into both the prisons and jails surveys (to capture people who were ultimately incarcerated) and the National Crime Victimization Survey (to capture people who were released). Until these data are gathered, however, it is unclear how fully to account for these facilities' victims, except to note that the Department's estimate of victimization – like its other calculations – is overly conservative.

Furthermore, the Department's focus on the number of victims, rather than the number of incidents, minimizes the severity of the problem. In the BJS adult inmate survey, between one-half and two-thirds of those who reported being sexually abused reported that it happened more than once, with 15 to 40 percent citing six or more incidents.¹¹¹ In juvenile facilities, 81 percent of youth who reported sexual abuse by other residents and 88 percent of youth who reported staff sexual abuse said it happened more than once, with 46 and 49 percent, respectively, saying they

¹¹¹ ADULT SURVEY, *supra* note 31, at 21, 23.

experienced six or more incidents.¹¹² As each incident brings its own fiscal, health-related, and moral costs, as well as implications for institutional security, the Department's calculations should account for the substantially higher number of incidents than victims.

While the BJS data constitute the best available source of empirical data, several smaller studies confirm the BJS findings and provide useful additional qualitative analysis. Cindy Struckman-Johnson and David Struckman-Johnson surveyed Midwestern prisoners about their experience of sexual victimization over the entire course of their incarceration.¹¹³ In men's prisons, they found that nearly one in five inmates had been sexually assaulted while in prison. The rates varied dramatically in women's facilities, with one in four inmates being victimized at the worst institutions.

Researchers from the Center for Evidence-Based Corrections, in a study commissioned by the California Department of Corrections and Rehabilitation, surveyed inmates in California men's prisons about their experience of inmate-on-inmate sexual abuse.¹¹⁴ In addition to providing overall data about inmate-on-inmate abuse in these facilities, which conform to the BJS's findings, this study also surveyed all transgender women in the state's men's facilities, in an effort to gain insight into the prevalence and trends for this highly vulnerable population. In this survey, approximately 59 percent of transgender inmates reported having been sexually assaulted by another inmate during their incarceration, a rate that was more than 13 times higher than that of the inmate population overall. The BJS surveys did not ask about gender identity so they do not provide comparable data.

No survey can fully overcome the reality that victimized inmates will not report abuse out of shame, because it was too painful, or out of fear that the report will not remain anonymous. JDI believes that the BJS studies most likely undercount the victims of sexual abuse in detention, perhaps significantly. Nonetheless, JDI urges the Department to defer to the BJS in its approach

¹¹² YOUTH SURVEY, *supra* note 26, at 12, 14.

¹¹³ Cindy Struckman-Johnson & David Struckman-Johnson, A Comparison of Sexual Coercion Experiences Reported by Men and Women in Prison, 21 J. INTERPERSONAL VIOLENCE1591 (2006), available at http://www.justdetention.org/pdf/CoercionCSJ.pdf. ¹¹⁴ JENNESS ET AL., *supra* note 69.

to addressing under-reporting and over-reporting, both because no good ways have yet been discovered to establish by how much the surveys undercount the true prevalence of sexual abuse in detention, and because following the BJS's lead in this matter seems appropriately conservative. The surveys were designed to discourage false reporting, and took several precautionary measures to address over-reporting and under-reporting beyond those employed by government surveyors measuring sexual violence in the community.¹¹⁵ The anonymous nature of the survey, which was established to protect inmates who were too afraid to report abuse to officials, also precluded any possibility that they could secure a transfer or other personal gain from false reporting. Likewise, the BJS surveys provided no opportunity to name perpetrators or otherwise expect that an officer would be penalized in any way based on answers in the surveys. While some inmates may have fabricated their reports, as many officials fear, it is much more likely that people who were victimized decided not to disclose their abuse. In sum, relying on the BJS data without accounting for under-reporting and over-reporting will provide a conservative estimate of the overall number of victims, in line with the conservatism of the Department's other calculations.

Questions 42-44:

- Has the Department appropriately adjusted the conclusions of studies on the value of rape and sexual abuse generally to account for the differing circumstances posed by sexual abuse in confinement settings?
- Are there any academic studies, data compilations, or established methodologies that can be used to extrapolate from mental health costs associated with sexual abuse in community settings to such costs in confinement settings? Has the Department appropriately estimated that the cost of mental health treatment associated with

¹¹⁵ Three leading surveys are: the BJS's National Crime Victimization Survey (NCVS), *available at* http://bjs.ojp.usdoj.gov/index.cfm?ty=dcdetail&iid=245 (last accessed March 14, 2011); the National Institute of Justice's Prevalence, Incidence, and Consequences of Violence Against Women Report, *available at http://www.ncjrs.gov/pdffiles1/nij/183781.pdf* (last accessed March 27, 2011); and the FBI's Uniform Crime Report, *available at* http://www.fbi.gov/about-us/cjis/ucr/ucr (last accessed March 14, 2011). The NCVS asks about crimes at a particular household in the past six months and is able to compare the answers from the previous set of surveys to make sure that respondents are not reporting any incidents that occurred outside the six-month time frame. The NIJ report is generated by phone interviews with individuals at randomly chosen households, without any specific checks on under-reporting or over-reporting. The FBI report relies solely on crimes reported to law enforcement and therefore undoubtedly reflects under-reporting. In addition to being an anonymous computer-based survey without any means to name the perpetrator, the inmate and resident surveys include "latent class measures" to assess reliability. All interviews are also examined for interview error, interviews completed in too short a time, incomplete interviews, and inconsistent response patterns –any survey with any of these concerns is excluded from the data set. *See* ADULT SURVEY, *supra* note 31, at 11.

sexual abuse in confinement settings is twice as large as the corresponding costs in community settings?

• Has the Department correctly identified the quantifiable costs of rape and sexual abuse? Are there other costs of rape and sexual abuse that are capable of quantification, but are not included in the Department's analysis?

The Department relies on the best available research to calculate a unit of cost for rape, its first category of sexual abuse, and consistent with its general approach makes conservative adjustments to account for the confinement setting. (As discussed in questions 47-48, below, JDI believes that the Department's adjustments for other types of sexual abuse are more problematic and well below even conservative estimates.) As the Department notes, mental illness and sexually transmitted infections are more prevalent in detention than they are in the community and therefore will generate greater associated costs. While the Department chose to double the estimated costs in the community, prevalence rates in detention settings suggest a more dramatic multiplication: mental illness is estimated to be four to six times as prevalent in corrections settings as in the community,¹¹⁶ and HIV and other sexually transmitted infections are estimated at 2.4 to 20 times the rates in the community.¹¹⁷ Moreover, substance abuse and suicide acts are also more prevalent among detained populations, and these figures should likewise be adjusted upward. The repeated rapes that incarcerated victims often endure will also require higher treatment costs than would be suggested by general estimates from the community. In light of these distinctions, it is not surprising that, in the litigation context, much higher costs have already been estimated for detention settings. For example, Terry Kupers, MD, a leading psychiatric expert on sexual abuse in detention, estimates that, depending on the severity of emotional problems arising from an assault, the psychotherapy and group therapy sessions needed could total \$26,000 per year for two to three years.¹¹⁸

¹¹⁷ See, e.g., LAURA MARUSCHAK, BUREAU OF JUSTICE STATISTICS, HIV IN PRISONS, 2007-08 3 (2010) (estimating HIV rate in U.S. prisons to be 2.4 times the rate in society); Scott A. Allen et al., *Hepatitis C Among Offenders— Correctional Challenge and Public Health Opportunity*, 67 Fed. Probation 22 (Sept. 2003) (finding that Hepatitis C rates were 8 to 20 times higher in prisons than on the outside, with 12 to 35 percent of prison cases involving chronic infection); *see also* CENTERS FOR DISEASE CONTROL & PREVENTION, U.S. DEP'T HEALTH & HUM. SVCS., SEXUALLY TRANSMITTED DISEASE SURVEILLANCE 2007 89 (2008), available at

http://www.cdc.gov/std/stats07/Surv2007-SpecialFocusProfiles.pdf (last visited Jan. 22, 2009).

¹¹⁶ DORIS J. JAMES & LAUREN E. GLAZE, BUREAU OF JUSTICE STATISTICS, SPECIAL REPORT, MENTAL HEALTH PROBLEMS OF PRISON AND JAIL INMATES 3 (updated 2006), *available at* http://bjs.ojp.usdoj.gov/content/pub/pdf/mhppji.pdf.

¹¹⁸ According to Dr. Kupers, a victim may need psychotherapy three times per week for three years, with each session costing \$150, and group counseling for two years, at \$40-50 per session. In proposing these figures, Dr.

The Department also presumes that there will be no lost work/productivity for the victim or earning loss for the perpetrator. While prisoner rape survivors by and large do not generate any real income while incarcerated, the trauma of their abuse is likely to damage their reentry significantly, including their ability to secure and maintain employment. This expense may be lower than for currently employed members of society, but it is far from insignificant. The Department must also consider that a former inmate who is debilitated by the trauma of rape is likely to require assistance from public resources, such as community mental health providers, Medicaid, housing programs, or food stamps, which increase the long-term costs beyond incarceration. With respect to perpetrator earning loss, in the majority of cases, as the BJS has confirmed, perpetrators of sexual abuse in detention are staff member who should lose their jobs. Even in cases of inmate-on-inmate assaults, if the perpetrator is prosecuted and receives additional prison time, there will be further earning loss.

Consistent with available research, the Department only examined the costs of sexual abuse in detention to the victim – without factoring in expenses incurred by the agency and by society. In the free-world context, this makes sense: the government bears significantly fewer costs in responding to the abuse of someone who is not in its charge, and few law enforcement or other government officials would seriously suggest that efforts to combat sexual abuse in the community must be subjected to a cost-benefit analysis like the one here. There are, however, significant costs for the agency and society when a sexual assault happens in detention; these expenses can be quantified and should be factored into the analysis. For example, agencies incur costs related to security breaches, staff turnover, grievances and investigations, increased use of expensive single-celled beds (for victims or perpetrators), and increased security for transportation to the hospital and/or another facility. Society also incurs quantifiable costs with

Kupers emphasizes that damage from sexual abuse is long-term and more severe than generally imagined by courts or mental health professionals, and that these costs do not "erase" the damage but provide a starting-point for estimating dollar amounts. Email from Terry Kupers, MD, to Linda McFarlane, Deputy Executive Director, Just Detention International (March 9, 2011) (providing financial estimates); email from Terry Kupers, MD, to Melissa Rothstein, Senior Program Director, Just Detention International (March 22, 2011) (stating that he provided these estimates while serving as an expert witness in the following lawsuits: Testimony of Terry Kupers, MD, *Neal v. Michigan Dep't of Corrections*, Case No. 96-6986-CZ (Mich. Circ. Ct. Washtenaw Co. Jan. 30, 2008); Testimony of Terry Kupers, *Neal v. Michigan Dep't of Corrections*, Case No. 96-6986-CZ (second trial) (Mich. Circ. Ct. Washtenaw Co. Oct. 16, 2008); Deposition of Terry Kupers, *Doe v. Clark*, No. 07-2-01513-0 (Wash. Sup. Ct.).

respect to prosecutions for prisoner rape, increased reliance on public assistance by traumatized inmates upon release, and additional incarceration costs for sentenced perpetrators and for victims who are too traumatized to reintegrate successfully into the community. This last point deserves emphasis: former inmates are returned to prison every year in enormous numbers for technical violations of the terms of their parole – failing a drug test, for example, or missing an appointment with a parole officer, or failing to maintain employment. But all of these "failures" would, in fact, be entirely typical symptoms of Rape Trauma Syndrome (about which, however, the Department's proposed standards do not require that parole officers be trained).

Questions 45-46:

- Should the Department adjust the "willingness to pay" figures on which it relies (developed by Professor Mark Cohen for purposes of valuing the benefit to society of an avoided rape) to account for the possibility that some people may believe sexual abuse in confinement facilities is a less pressing problem than it is in society as a whole, and might therefore think that the value of avoiding such an incident in the confinement setting is less than the value of avoiding a similar incident in the non-confinement setting? Likewise, should the Department adjust these figures to take into account the fact that in the general population the vast majority of sexual abuse victims are female, whereas in the confinement setting the victims are overwhelmingly male? Are such differences even relevant for purposes of using the contingent valuation method to monetize the cost of an incident of sexual abuse? If either adjustment were appropriate, how (or on the basis of what empirical data) would the Department go about determining the amount of the adjustment?
- *Has the Department appropriately accounted for the increased costs to the victim and to society when the victim is a juvenile? Why or why not?*

Federal policy must recognize that all sexual abuse is equally unacceptable, regardless of the victim's gender, custody status or criminal history. If anything, the heightened responsibility of the government to protect people in its charge should warrant a higher "willingness to pay" figure for people in detention than for people in free society. Minimizing the cost of victimization of inmates due to a lack of public sympathy for incarcerated people is bad policy – and undermines the purpose of PREA, which is to ensure that prisoner rape is taken seriously. It is particularly problematic to do so when considering that 95 percent of inmates eventually return to their communities, and bring their trauma and abuse with them.

While all adult victims must be viewed equally, the longer life expectancy of juveniles and the impact of abuse on their healthy development do warrant increased cost estimates. Again, the Department's estimates are overly conservative here, as they do not clearly account for the impact that sexual abuse has on the long-term physical, emotional, and mental development and health of a child, nor any resulting social difficulties, cognitive dysfunction, or participation in high risk behaviors – outcomes that have been shown to affect children who experience sexual abuse.119

Increasing the National Institute of Justice's adult estimates by 33 percent to serve as the upper bound cost for youth victims is also too conservative. A recent study employing the willingnessto-pay (WTP) methodology found that society has a higher WTP for reducing child abuse than abuse of adults.¹²⁰ To calculate the costs, the researchers doubled the costs identified in the NIJ study after updating to 2007 dollars.¹²¹ The Department should do the same, and double the lower bound figure (which based on the current figure of \$275,000 would increase the upper bound from \$400,000 to \$550,000).

The decision to count all incidents of staff-on-youth contact as nonconsensual activity, given that all staff sexual activity with youth is inherently coerced or pressured and harmful to the youth and society as a whole, is sound but, as discussed below (in questions 47-48), the value assigned to sexual assault involving pressure/coercion is too low.

http://www.preventchildabuse.org/about us/media releases/pcaa pew economic impact study final.pdf. ¹²⁰ Mark A. Cohen et al, Estimating the Costs of Bad Outcomes for At-Risk Youth and the Benefits of Early Childhood Interventions to Reduce Them, 21 CRIM. JUST. POL'Y REV. 391, 415 (2010). ¹²¹ Id.

¹¹⁹ According to a 2007 study by Prevent Child Abuse America, children who have been sexually abused are more likely to experience: poor physical health (e.g., chronic fatigue, altered immune function, hypertension, sexually transmitted diseases, obesity); poor emotional and mental health (e.g., depression, anxiety, eating disorders, suicidal thoughts and attempts, post-traumatic stress disorder); social difficulties (e.g., insecure attachments to caregivers, which may lead to difficulties in developing trusting relationships with peers and adults later in life); cognitive dysfunction (e.g., deficits in attention, abstract reasoning, language development, and problem-solving skills, which ultimately may affect academic achievement and school performance); high-risk health behaviors (e.g., a higher number of lifetime sexual partners, younger age at first voluntary intercourse, teen pregnancy, alcohol and substance abuse); and behavioral problems (e.g., aggression, delinquency, and adult criminality). CHING-TUNG WANG & JOHN HOLTON, TOTAL ESTIMATED COST OF CHILD ABUSE AND NEGLECT IN THE UNITED STATES, PREVENT CHILD ABUSE AMERICA ECONOMIC IMPACT STUDY (2007), available at

Questions 47-48:

- Are there available methodologies, or available data from which a methodology can be developed, to assess the unit value of avoiding a nonconsensual sexual act involving pressure or coercion? If so, please supply them. Is the Department's estimate of this unit value (i.e., 20% of the value of a forcible rape) appropriately conservative?
- Are there available methodologies, or available data from which a methodology can be developed, to assess the unit value of avoiding an "abusive sexual contact between inmates," as defined in the IRIA? If so, please supply them. Is the Department's estimate of this unit value (i.e., \$375 for adult inmates and \$500 for juveniles) appropriately conservative? Would a higher figure be more appropriate? Why or why not?

In trying to extrapolate costs for sexual assault involving pressure/coercion, abusive sexual contacts, and willing sex with staff, the Department grossly underestimates the harm and resulting costs of these forms of abuse, well below even its other already conservative estimates. Beyond ignoring the costs to the agency and society that are not factored into the Department's analysis (detailed in our response to Questions 42-44), the Department estimates the unit value of avoiding nonconsensual sexual acts by relying on an arbitrary percentage of its estimated unit value for rape and it assigns a unit value for abusive sexual contact without explanation. These unit value determinations are dangerously low.

With respect to sexual assault involving pressure or coercion, the Department presumes that the cost is a mere one-fifth of the cost of a forcible rape because there is typically no physical injury. However, mental trauma and loss of quality of life account for 85 percent of the Department's estimate of the cost of forcible rape, and these expenses will be essentially the same in situations that do not involve force. Physical injury and level of violence are not the primary factors in determining the level of trauma; the perception of threat is also key.¹²² The nature of incarceration, the absence of confidential support services, and the complete lack of control over one's environment, including the people within it, cause incarcerated victims to feel especially helpless in the aftermath of any kind of assault. Moreover, regardless of the level of force used,

¹²² KOSS & HARVEY, *supra* note 83; *see also* ROBERT R. HAZELWOOD & ANN WOLBERT BURGESS, PRACTICAL ASPECTS OF RAPE INVESTIGATION: A MULTIDISCIPLINARY APPROACH (2009) (noting helplessness and loss of control are key contributors to trauma).

the pre-detention history of victimization prevalent among incarcerated victims¹²³ makes any incident of abuse likely to trigger prior trauma.¹²⁴

The values assigned by the Department for "abusive sexual contact" – \$375 for an adult and \$500 for a juvenile – are also unreasonably low. It is unclear how the Department arrived at these numbers, as its calculations in Table 3 place suffering and lost quality of life for sexual abuse at \$386. As is true for the estimate of costs associated with nonconsensual sexual acts, this estimate completely ignores the trauma resulting from these incidents, and the resulting mental health costs. It also presumes that victims endured one incident, when in fact abusive sexual contact often forms part of an ongoing and escalating pattern that results in increasing emotional harm. Likewise, agencies must be required fully to investigate, adjudicate, and sanction this form of abuse, and while the costs of so doing may not rise to the level appropriate for incidents requiring a full forensic medical examination, they are likely to be significant nonetheless.

Finally, while the Department appropriately treats willing sex with staff as nonconsensual sexual assault in youth facilities, its determination that in adult facilities the cost of this abuse is less than two percent of the costs estimated for rape is dangerously flawed. As with abusive sexual contact, these incidents should, at a minimum, trigger investigation/adjudication and sanctioning costs. Moreover, the earning loss while perpetrators are confined – which the Department excluded from its matrix – is unquestionably relevant here, as all corrections staff are employed and should be terminated upon a finding that they have engaged in sexual activity with an inmate.

Questions 49-50:

• Are there any additional nonmonetary benefits of implementing the PREA standards not mentioned in the IRIA?

¹²³ In its recent survey of prison and jail inmates, the BJS determined that history of victimization was the most statistically significant trait of inmates who were sexually victimized at their current facility. *See* ADULT SURVEY, *supra* note 31.

¹²⁴ Individuals who have experienced previous trauma are significantly more likely to develop Posttraumatic Stress Disorder than those who have not. *See* Naomi Breslau, *et al., Previous Exposure to Trauma and PTSD Effects of Subsequent Trauma: Results From the Detroit Area Survey of Trauma,* 156 AM. J. PSYCHIATRY 902 (1999).

• Are any of the nonmonetary benefits set forth in the IRIA actually capable of quantification? If so, are there available methodologies for quantifying such benefits or sources of data from which such quantification can be drawn?

The Department generally does a good job of laying out most of the key benefits of avoiding prisoner rape with respect to victims, other inmates, families, prison administrators and staff, and society at large. However, the Department fails to address the moral benefit to society of ending a form of torture that remains widespread in this country and the related improved standing that these efforts will confer on the U.S. in the international human rights community.¹²⁵

The Department also omits the benefits that would stem from the improved transparency, monitoring, and community collaboration called for by the standards. In addition to the agency benefit of outside expertise and perspectives – including access to best practices for addressing sexual abuse – increased transparency and accountability of corrections facilities is generally beneficial to a democratic society by providing greater access to information about these public institutions. In the long run, such transparency and accountability will make corrections facilities better-run and safer institutions.

Many of the benefits identified by the Department as non-monetary can be quantified. For example, the financial benefits to families and society of preventing former inmates from being unable to work due to the emotional trauma of sexual abuse can at least partially be measured by the cost of public assistance and other forms of governmental support that victims will need upon reentry. Similarly, the lost earning potential and income tax revenue could be estimated. The cost

¹²⁵ Sexual violence in U.S. detention facilities has been recognized internationally as a form of torture and ill-treatment, and U.N. bodies monitoring U.S. compliance with its international human rights obligations have repeatedly expressed concern about the nation's performance on this point. The U.N. Committee Against Torture recommended that the U.S. design and implement appropriate measures to prevent sexual violence in detention, and ensure that all allegations of prisoner rape be investigated promptly and independently. Committee Against Torture, 36th Session, Consideration of Reports Submitted by States Parties under Article 19 of the Convention, CAT/C/USA/CO/2, at ¶ 32 (2006). Similarly, the U.N. Human Rights Committee has expressed concern that male corrections officers have access to female inmates' housing areas. Human Rights Committee, 87th Session, Consideration of Reports Submitted by States Parties under Article 40 of the Covenant, CCPR/C/USA/CO/3/Rev.1, at ¶ 33 (2006). Recognizing the urgent need for increased external oversight of detention facilities in light of these and other pervasive human rights violations, a number of countries, as part of the U.N. Universal Periodic Review, have urged the U.S. to ratify the Optional Protocol to the Convention Against Torture. Human Rights Council, 16th Session, Agenda Item 6, Report of the Working Group on the Universal Periodic Review, A/HRC/16/11, at ¶¶ 59, 92.2, 92.4, 92.6, 92.16, 92.23 (2011).

of increased incarceration for perpetrators of sexual abuse in detention can be quantified based on the rates for housing a prisoner.¹²⁶

Finally, the Department makes no effort to quantify the benefits of avoiding investigations, grievances or litigation. Each of these processes requires the dedication of substantial resources that can be measured, including the cost of staff and attorney time, the development of documentation, and the likely fees and judgments imposed. Recently, for example, a class action lawsuit brought by female prisoners who had been sexually abused by corrections staff in Michigan settled for \$100 million, after several trials and more than ten years of active litigation.¹²⁷

<u>Question 51</u>: Are there available sources of data relating to the compliance costs associated with the proposed standards, other than the sources cited and relied upon in the IRIA? If so, please provide them.

As the Department's proposed standards were not publicly disclosed prior to the release of the Notice of Proposed Rulemaking, there are no data available about the overall compliance costs associated with these provisions, beyond the data compiled by the Department. While some agencies have estimated compliance costs for the Commission's recommended standards (with many of these estimates reflected in the surveys conducted by Booz Allen Hamilton), these anecdotal projections vary widely and are not reliable. Corrections officials charged with establishing and ultimately defending corrections cost estimates to their appropriators had every incentive to inflate costs and little motivation to think creatively and strategically about how to devise low-cost ways to comply with standards that are not yet in force.

The compliance cost data relied upon by the Department are in fact replete with problems. In addition to depending on estimates provided by corrections officials who had reason to inflate their projected costs, the Booz Allen Hamilton statistical analysis relies on the following inaccurate assumptions: (1) that its sample of correctional facilities was random, (2) that the

 ¹²⁶ The Department has already identified that, as of 2001, this cost would total \$22,600 per prisoner per year, or \$62 per day. IRIA, *supra* note 48, at 30.
 ¹²⁷ Class Settlement Agreement, *Neal v. Michigan Dep't of Corrections*, Case No. 96-6986-CZ (Mich. Circ. Ct

¹²⁷ Class Settlement Agreement, *Neal v. Michigan Dep't of Corrections*, Case No. 96-6986-CZ (Mich. Circ. Ct Washtenaw Co. July 15, 2009), *available on-line at* <u>http://www.clearinghouse.net/chDocs/public/PC-MI-0021-0003.pdf</u> (last accessed March 27, 2011).

sample came from a normal (bell curve) distribution, and (3) that the cost-per-inmate approach meant that the sample accurately represented the average costs per inmate for all facilities nationally. In fact, the 49 sites included in Booz Allen Hamilton's report were not randomly selected: many participating agencies volunteered, which makes it very unlikely that they accurately represent the range of PREA readiness. In fact, given that everyone participating knew that this information was being gathered to determine whether the Commission's recommended standards were too costly, facilities that were less compliant or otherwise resistant to the standards had the strongest incentives to participate, as they could skew the results to indicate higher costs than would otherwise be needed. Given the small sample size, there is also a risk of over-fitting the data by using them as primary cost-estimates rather than as a robustness check on other estimates.

In addition to the Booz Allen Hamilton data, the Department relied upon internal assessments provided by the Bureau of Prisons (BOP) and the U.S. Marshals Service (USMS). The Department has not disclosed these data publicly. However, even without seeing these assessments, it if fair to assume that reliance on them is problematic because the participating agencies have shown a consistent lack of leadership on the issue of preventing and addressing sexual abuse in detention. As discussed in Section I of this submission, BOP and USMS leaders have generally not embraced PREA, and federal inmates remain highly vulnerable to abuse.¹²⁸ Thus, relying on these systems sets a dangerously low bar that, in several cases, provides weaker protections than those already provided by other corrections agencies.

If the Department wants to establish a valid assessment of compliance costs, it should not rely on the speculative estimates of corrections administrators. Rather, it should have taken a structural approach that would have included developing reasonable assumptions about how different facilities would comply with the regulations and estimating the total costs of compliance over the entire country, using the statistical estimates as a robustness check. This would have provided more clarity about the cost of compliance and the assumptions made in developing these estimates.

¹²⁸ While Section I, *supra*, focuses on the BOP, the Inspector General's report also discusses the deficiencies in the USMS's efforts to address staff sexual abuse and misconduct. *See* OIG 2009 REPORT, *supra* note 12.

Questions 52-55:

- Are there available data as to the number of lockups that will be affected by the proposed standards, the number of individuals who are detained in lockups on an annual basis, and/or the anticipated compliance costs for lockups? If so, please provide them.
- Are there available data as to the number of community confinement facilities that will be affected by the proposed standards, the number of individuals who reside or are detained in such facilities on an annual basis, or the anticipated compliance costs for community confinement facilities? If so, please provide them.
- Has the Department appropriately differentiated the estimated compliance costs with regard to the different types of confinement facilities (prisons, jails, juvenile facilities, community confinement facilities, and lockups)? If not, why and to what extent should compliance costs be expected to be higher or lower for one type or another?
- Are there additional methodologies for conducting an assessment of the costs of compliance with the proposed standards? If so, please propose them.

As discussed above (in Questions 38-41), JDI knows of no relevant data regarding the number of lockups and community confinement facilities or the number of inmates or victims within these facilities. The BJS should compile data regarding the number of facilities and the number of people who pass through them on an annual basis, and victimization rates should be established through inmate surveys (in community confinement facilities) and targeted questions in the National Crime Victimization Survey.

Given its acknowledged lack of data regarding the number of lockups and community confinement facilities, it is unclear how the Department came up with its total costs for these types of facilities. Facility by facility, however, these costs should be lower than the Department has estimated, as lockups and community confinement facilities are often connected to jails and prisons that need to comply with the standards. The projected benefits associated with these facilities, however, should be as high as in a corrections facility or the community, as victims will experience the same level of suffering and debilitation that was factored into those analyses.

Even with the serious limitations of the Department's data in mind, however, it is clear that the PREA standards will pay for themselves quickly in all types of facilities. The Department consistently relied on overly conservative data in terms of benefits and generous estimates in terms of costs, and still found that a mere three percent reduction in abuse is needed for the

standards to break even in their costs and monetary benefits. As modest as the Department's proposals are, their impact will still easily surpass this low hurdle.

Questions 56-61:

- With respect to §§ 115.12, 115.112, 115.212, and 115.312, are there other methods of estimating the extent to which contract renewals and renegotiations over the 15-year period will lead to costs for agencies that adopt the proposed standards?
- Do agencies expect to incur costs associated with proposed §§ 115.13, 115.113, 115.213, and 115.313, notwithstanding the fact that it does not mandate any particular level of staffing or the use of video monitoring? Why or why not? If so, what are the potential cost implications of this standard under various alternative scenarios concerning staffing mandates or video monitoring mandates? What decisions do agencies anticipate making in light of the assessments called for by this standard, and what will it cost to implement those decisions?
- With respect to §§ 115.14, 115.114, 115.214, and 115.314, will the limitations on cross-gender viewing (and any associated retrofitting and construction of privacy panels) impose any costs on agencies? If so, please provide any data from which a cost estimate can be developed for such measures.
- Will the requirement in §§ 115.31, 115.231, and 115.331 that agencies train staff on how to communicate effectively and professionally with lesbian, gay, bisexual, transgender, or intersex residents lead to additional costs for correctional facilities, over and above the costs of other training requirements in the standards? If so, please provide any data from which a cost estimate can be developed for such training.
- Has the Department accounted for all of the costs associated with §§ 115.52, 115.252, and 115.352, dealing with exhaustion of administrative remedies? If not, what additional costs might be incurred, and what data exist from which an estimate of those costs can be developed?
- Is there any basis at this juncture to estimate the compliance costs associated with §§ 115.93, 115.193, 115.293, and 115.393, pertaining to audits? How much do agencies anticipate compliance with this standard is likely to cost on a per-facility basis, under various assumptions as to the type and frequency or breadth of audits?

In facilities that currently are not taking the measures necessary to protect inmates from abuse, meeting this basic expectation will undoubtedly require some expense. However, the Department's own analysis also confirms the enormous financial benefit of protecting inmates from abuse – and in any case, providing such basic protections to inmates is a constitutional and moral obligation, to which there may also be financial considerations.¹²⁹ By parsing out the individual costs of each standard, the Department loses this critical perspective.

¹²⁹ In this context, it is worth noting that the Supreme Court has unequivocally held that cost cannot be a factor in refusing to meet Constitutional obligations, such as preserving inmates' right to be free from sexual abuse. *See*, *e.g.*,

Nonetheless, as discussed further in the analysis of each of the provisions identified in these questions, the possible costs of these measures must be considered in relation to the benefits they will generate. Regarding § 115.12/112/212/312, in light of the conclusions of the Department's break-even analysis – which clearly show that the benefits of the standards will far outweigh their costs even though the Department used overly conservative assumptions to reach its conclusions – private prison corporations cannot justify imposing additional costs to implement these measures. Agencies must demand that all inmates from their jurisdiction are protected from abuse, whether they are in public or private facilities. Having the force of binding regulation from the federal government behind these demands should ease any negotiations on this point. Compliance with the standards cannot be used as a bargaining chip.

With respect to the staffing and technology requirements of § 115.13/113/213/313, it is hard to imagine how the Department's current provision would incur any costs as it lacks any specific requirements or guidance on what adequate staffing and technology would entail. If JDI's recommendations are adopted, agencies would still not be held to any specific levels of staffing or camera use. By suggesting a number of concrete and relevant factors in sexual abuse that must be taken into account when making staffing and technology decisions, agencies should be able to allocate staff time and cameras efficiently, without incurring undue expense.

Contrary to the claims of some officials, limiting cross-gender supervision to prevent the viewing or touching of inmates of the opposite gender need not require massive re-staffing. Basic measures such as installing privacy screens, designating roving officers, limiting pat searches to places where there is a likelihood of contraband being obtained (and conducting thorough searches at these locations), and requiring officers to announce themselves just prior to entering

Watson v. City of Memphis, 373 U. S. 526, 537 (1963) ("[I]t is obvious that vindication of conceded constitutional rights cannot be made dependent upon any theory that it is less expensive to deny than to afford them."); *Harris v. Thigpen*, 941 F.2d 1495, 1509 (11th Cir. 1991) ("[A] lack of funds allocated to prisons by the state legislature . . . will not excuse the failure of correctional systems to maintain a certain minimum level of medical service necessary to avoid the imposition of cruel and unusual punishment."); *Finney v. Arkansas Board of Corr.*, 505 F.2d 194, 201 (8th Cir. 1974) ("Lack of funds is not an acceptable excuse for unconstitutional conditions of incarceration."); Flynn v. Doyle, 630 F. Supp. 2d 987, 993 (E.D. Wis. 2009) ("Matters of administrative convenience must ultimately give way when constitutional rights are in jeopardy."); Laube v. Haley, 234 F. Supp. 2d 1227, 1250, 1252 (M.D. Ala. 2002) ("It is well-established that funding is not an excuse for constitutional violations.").

cell areas when inmates are likely to be changing or otherwise in states of undress would not result in significant costs. Doing so, however, would reduce the opportunities for staff sexual abuse and would help de-sexualize corrections culture – with all the financial benefits that would be associated with such improvements.

In its cost analysis of the Department's proposed standards, the researchers from Booz Allen Hamilton concluded that the training requirements collectively would not have any cost impact.¹³⁰ There is no reason for training on communicating with LGBTI inmates (§ 115.31/231/331) to be treated differently than any of the other training topics. Notably, even the marginal costs that could be incurred from the development of curricula and materials will be negated by federal efforts already under way to develop training materials on this topic.¹³¹ Moreover, given the consistent findings that LGBTI inmates are disproportionately targeted for sexual abuse, this training is clearly needed and will ultimately save money by reducing incidents of sexual abuse while increasing reporting of such abuse. The exhaustion provision, § 115.52/252/352, does not go far enough to allow for any meaningful cost savings or expenses. The Department revised the standard essentially to maintain the status quo within the BOP, whose grievance policy is more stringent than that of 18 states. Easing these procedural requirements for sexual abuse cases, and ensuring that all reports of sexual violence are afforded the highest level of review in the first instance, would minimize costs incurred by administrative and judicial review of whether a survivor complied with arbitrary requirements. It would also result in the tremendous benefits of encouraging the merits of these claims to be addressed swiftly and efficiently.

Finally, because most facilities currently are not subject to any relevant external oversight, audits will invariably require some expense. However, given the lack of specificity in § 115.93/193/293/393 about what a PREA audit would entail, the actual costs are impossible to determine. Booz Allen Hamilton estimated that the cost of triennial audits of every detention

¹³⁰See Booz Allen Hamilton, *Prison Rape Elimination Act (PREA) Regulatory Impact Analysis (RIA), Cost Impact of Revised Standards PP4, PP7, PP-2, TR-1, TR-2, TR-3, TR-4, TR-5, MM-3, SC-1, and SC-2, at 5 (prisons), 17 (jails), 29 (community corrections), 40 (juvenile detention).* ¹³¹See e.g., National Institute of Corrections & American University Washington College of Law, *Project on*

¹³¹See e.g., National Institute of Corrections & American University Washington College of Law, *Project on* Addressing Prison Rape: Preventing the Sexual Abuse of Individuals in Custody, Training Materials, available at http://www.wcl.american.edu/nic/training.cfm.

facility would total \$77.5 million per year – 14 percent of the compliance cost for the remaining standards.¹³² This estimate includes a significant "level of effort" on the part of corrections staff, assuming that a full-time employee would be needed to support four prison audits per year. This estimate is excessive, resulting in staffing costs for the audits exceeding the actual auditor costs. Staff will need to collect most of the necessary data pursuant to other provisions, and the remaining preparation and response required should not entail more than a week or two of effort. Moreover, quality audits will substantially improve safety and decrease costs within facilities, by identifying problems before they escalate and suggesting realistic, cost-effective solutions.

Questions 62-63:

- Has the Department used the correct assumptions (in particular the assumption of constant cost) in projecting ongoing costs in the out years? Should it adjust its projections for the possibility that the cost of compliance may decrease over time as correctional agencies adopt new innovations that will make their compliance more efficient? If such an adjustment is appropriate, please propose a methodology for doing so and a source of data from which valid predictions as to "learning" can be derived.
- Are there any data showing how the marginal cost of rape reduction is likely to change once various benchmarks of reduction have been achieved? If not, is it appropriate for the Department to assume, for purposes of its breakeven analysis, that the costs and benefits of reducing prison rape are linear, at least within the range relevant to the analysis? Why or why not?

Over time – as the standards become law of the land, best practices become normalized, the corrections culture becomes safer, incidents of abuse are reduced, and collateral safety concerns are addressed – the costs of implementing the standards should go down, while the benefits should go up. Additionally, several of the standards for which major or moderate ongoing costs have been estimated are also subject to Constitutional requirements. Screening, supervision, training, and provision of ongoing medical and mental health care are obligations independent of PREA and their costs should therefore not be associated only with the PREA standards.

Question 64: Are the expectations as to the effectiveness of the proposed standards that are subsumed within the breakeven analysis (e.g., 0.7%-1.7% reduction in baseline prevalence needed to justify startup costs and 2.06%-3.13% reduction required for ongoing costs) reasonable? Why or why not? Are there available data from which reasonable predictions can be made as to the extent to which these proposed standards

¹³² IRIA, *supra* note 48, at 30-31, 59.

will be effective in reducing the prevalence of rape and sexual abuse in prisons? If so, please supply them.

The assumptions and valuations the Department has made in estimating the benefits of preventing sexual abuse in detention are extremely conservative. By erring on the side of great caution in its projections of those benefits, and then showing that they would still outweigh costs even if the standards saved only three percent of all victims, the Department's analysis makes clear that, even with additional costs, the net result of the standards will be substantial savings. The goal of these provisions, as is made clear in the title and language of the Prison Rape Elimination Act, is not to reduce prison rape marginally, but to eliminate sexual abuse in detention. If the standards are strengthened in accordance with JDI's recommendations and then fully implemented, the shockingly high rates of abuse would decrease by far more than three percent.

The additional costs incurred by JDI's recommendations will be modest, and will be dramatically outweighed by the resulting benefits. Fewer incidents of abuse will reduce the costs of the investigations, grievances, and medical and mental health care required after an assault. Facilities that are run more safely will have fewer security breaches, less physical violence, greater staff retention, and ultimately, less litigation. Most importantly, by reducing the extent to which inmates and residents endure the trauma of sexual abuse in detention, these basic measures will decrease recidivism and increase the likelihood that detainees become law-abiding and contributing members of society.

Since the standards are an effort to codify innovations and best practices of facilities that have already had some success in reducing their rates of sexual abuse, examining the BJS data may allow for a conservative, but not arbitrary, basis for estimating the impact of the standards. Specifically, the estimate of possible gains can be based on what has already been accomplished across the country by taking the average rate of abuse in the best half of the surveyed facilities,

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and assuming that this rate could become the national average. The top half of all facilities have made their achievements without enforced standards, so there is still plenty of room for them to improve and every reason to expect that they will once the standards are in place, though probably not as dramatically as the bottom half of facilities. If the Department issues strong standards and enforces their compliance, it would not be unrealistic to expect that the national rate of abuse could be lowered to that of the top quarter or even the top tenth of all facilities.

According the latest BJS data, in adult prisons and jails, 4.4 percent of prisoners and 3.1 percent of jail inmates are sexually abused nationwide over the course of a year. But in the better half of all facilities, only 2.069 percent of prisoners are abused, and only 1.436 percent of jail inmates are sexually abused. ¹³³ Thus, if the standards allowed all facilities to do only as well as the top half do now, they would be sparing not 3 percent of the people sexually abused in detention, but more than 53 percent. This means that had the standards been in place in 2008, instead of the 199,500 people who the Department says were abused in adult prisons and jails, there would have been about 93,100. More than 100,000 adults (as well as many thousands of children) would have been saved an experience from which few recover emotionally.

¹³³ An explanation of the math behind this number is provided in Appendix D to this submission.

D. CONCLUSION

The national standards mandated by the Prison Rape Elimination Act (PREA) have the potential to become the most important tool so far in the effort to end sexual abuse in U.S. detention. Strong standards will help spare countless men, women, and children every year an experience from which few recover emotionally. Indeed, JDI believes that forceful PREA standards should be able to prevent more than half the sexual abuse that plagues American detention facilities today. The development of these standards represents a once-in-a-lifetime opportunity for the Attorney General to end a domestic human rights crisis.

As made clear in this submission, Just Detention International considers several of the Department's proposed standards too weak to offer the protections inmates need, and to which they have a legal and moral right. The Justice Department's own data, together with its preliminary cost-benefit analysis of the standards, make abundantly clear that much stronger standards would be warranted even from a purely financial perspective. Weaker standards would be arbitrary and capricious in their failure to protect inmates, detainees and residents, particularly in light of the Department's own data and cost analysis.

When the government removes someone's freedom, it takes on an absolute responsibility to protect that person's safety. No matter what crime someone might have committed, rape must not be part of the penalty.

E. APPENDICES

- Appendix A: Characteristics of Sexual Assault in U.S. Detention Facilities: Aggregate 2010 Figures from JDI's Survivor Database
- Appendix B: Characteristics of Sexual Assault in Bureau of Prisons (BOP) Detention Facilities: 2002-2010 Figures from JDI's Survivor Database
- Appendix C: List of Provisions in the Department of Justice's Proposed National Standards to Prevent, Detect, and Respond to Prison Rape that are Missing from Immigration and Customs Enforcement's Proposed 2010 Performance-Based National Detention Standards (PBNDS) Provision 2.11
- Appendix D: Just Detention International's Calculation of the Prevalence Rate of Sexual Abuse in the Top Half of Facilities in the BJS Adult Inmate Survey

Appendix A

Characteristics of Sexual Assault in U.S. Detention Facilities: Aggregate 2010 Figures from JDI's Survivor Database

In 2010, 524 survivors of prison rape from across the country wrote to Just Detention International (JDI), describing their harrowing experiences. Fifty-six percent of these survivors were abused while housed in a state corrections facility, while many others were victimized at a federal facility, jail, private prison or youth detention facility.

JDI does not solicit correspondence, nor does it require specific information from survivors. All information provided is voluntary and anecdotal. Most figures will not add up to the full number, as survivors rarely provide all of the information listed below. Percentages are based on the total number of survivors who provided such information.

Type of facility:

Men's facilities	
Women's facilities	

Survivor's Sexual Orientation and Gender Identity:

Heterosexual	174 (48%)
Gay, lesbian, bisexual or transgender	161 (42%)

Characteristics of the Assault:

Characteristics of the Assault.	
Sexually assaulted by an inmate	194 (55%)
Perpetrator was a cellmate	
Sexually assaulted by staff (including non-custody staff)	158 (45%)
Assaults carried out by more than one official	43 (12%)
Male perpetrator(s)	
Female perpetrator(s)	19 (6%)
Assault occurred in the survivor's cell	
Dorm	
Shower	
Work assignment	

Other (e.g. laundry room, warehouse, bathroom, clinic, yard, etc.)......44 (18%)

Impact of Assault on the Survivor:

Survivor experienced emotional trauma	185 (35%)
Survivor experienced physical injury	129 (24%)
Survivor experienced suicidal ideation	33 (6%)

Official Response to the Survivor's Report of Assault

Survivor reported assault to facility officials	277 (52%)
Investigation conducted	112 (40%) ^a
Survivor received forensic medical exam	
Survivor received adequate medical or mental healthcare	$20(7\%)^{a}$
Survivor denied medical and/or mental healthcare	
HIV test provided.	
HIV contracted	
Other STD contracted	
Survivor placed in segregation	$88(32\%)^{a}$
Steps taken to protect survivor's safety	
Demeter dissiplined	$21(110)^{a}$
Perpetrator disciplined Perpetrator charged with a crime	

^a Percentage based on the total number of survivors who reported the assault

Appendix B

Characteristics of Sexual Assault in Bureau of Prisons (BOP) Detention Facilities: 2002-2010 Figures from JDI's Survivor Database

One hundred and ten survivors of sexual abuse in Bureau of Prisons (BOP) detention facilities around the country reached out to JDI between 2002 and 2010.^b As with the 2010 aggregate data, the figures provided below are based on anecdotal information that is provided voluntarily and without any outreach by JDI. Percentages are based on the number who provided relevant information (typically totaling less than 110).

Type of Facility	(0.70/)
Men's prison	
women's prison	[4 (1370)
Survivor's Sexual Orientation and Gender Identity:	
Heterosexual	33 (52%)
Gay, lesbian, bisexual or transgender	31 (48%)
Characteristics of the Assault:	
Male perpetrator(s)	71 (93%)
Female perpetrator(s)	
Sexually assaulted by an inmate	54 (60%)
Perpetrator was a cellmate	18 (20%)
Sexually assaulted by staff (including non-custody personnel)	35 (39%)
Sexually assaulted by inmates and staff	1 (1%)
Assault occurred in the survivor's cell	24 (80%)
Other (e.g. work assignment, shower, warehouse)	
Impact of Assault on the Survivor:	
Survivor experienced emotional trauma	60 (50%)
Survivor experienced physical injury	
Survivor experienced suicidal ideation	

Official Response to the Survivor's Report of Sexual Assault:

Survivor reported assault to facility officials	68 (62%)
Investigation conducted	
Survivor received forensic medical exam	13 (19%) ^c

^b Nearly 20 percent of the survivors in JDI's database did not indicate in what type of facility they were held at the time of their assault(s), so it is quite likely that this number is, in fact, even higher.

^c Percentage based on the total number of survivors who reported the assault.

Survivor placed in segregation	29 (43%) ^d
Steps taken to protect survivor's safety	$\dots 11 (10\%)^d$
Survivor received adequate medical and mental healthcare	4 $(6\%)^d$
HIV test provided	$\dots 11 (10\%)^d$
HIV contracted	5
Other STD contracted	5

Perpetrator disciplined	$6(5\%)^{d}$
Perpetrator charged with a crime	$5(4\%)^{d}$

^d Percentage based on the total number of survivors who reported the assault.

Appendix C

List of Provisions in the Department of Justice's Proposed National Standards to Prevent, Detect, and Respond to Prison Rape that are Missing from Immigration and Customs Enforcement's Proposed 2010 Performance-Based National Detention Standards (PBNDS) Provision 2.11^e

- 1. PBNDS 2.11 does not detail how a detainee can report abuse. As a result, it is unclear whether there are multiple reporting options (§ 115.51) or if any of them accommodate inmates with special needs (§ 115.15). PBNDS 2.11 also does not provide for third party reporting (§ 115.54).
- 2. PBNDS 2.11 does not provide for agreements with outside public entities and community service providers (§ 115.22), nor do detainees have access to confidential support services (§ 115.53).
- 3. PBNDS 2.11 does not provide for confidential staff reporting (§ 115.51(d)), nor does it detail staff responsibilities in the aftermath of a report, other than to say staff should follow facility policies (§§ 115.61-115.63).
- 4. Aside from stating that retaliation will not be tolerated, PBNDS 2.11 does not detail any efforts that must be made to ensure that retaliation does not occur. (§ 115.65)
- 5. PBNDS 2.11 does not detail who conducts criminal investigations and, if facility officers are not empowered to do so, what the policy is for contacting the appropriate legal authority and ensuring that criminal and administrative investigations are coordinated. (§ 115.23 and § 115.71). The PBNDS also does not provide for detainees to be informed of key actions in an investigation/prosecution (§ 115.73).
- 6. There is no specialized training for investigative and medical/mental health staff in the PBNDS 2.11 (§ 115.34 and § 115.35).
- 7. The screening portion of PBNDS 2.11 does not include the risk factors delineated in § 115.41.
- 8. PBNDS 2.11 does not discuss how screening information would be used (§ 115.42), particularly (a) whether a detainee's own assessment of vulnerability will be given serious consideration and (b) whether there will be a case-by-case assessment for transgender or intersex detainees to consider whether placement in a facility for male or female detainees would best ensure the health and safety of the detainee without imposing undue management or security problems.

^e While ICE's 2010 Performance-Based National Detention Standards are not yet publicly available, they were leaked to the Houston Chronicle in October 2010 and temporarily made available on its webpage.

- 9. PBNDS 2.11 does not provide for incident reviews (§ 115.86) or outside audits (§ 115.93).
- 10. PBNDS 2.11 does not cover background checks for staff in hiring and promotion decisions (§ 115.16).
- 11. PBNDS 2.11 does not provide for unannounced rounds conducted by intermediate or higher supervisors in facilities with more than 500 inmates (§ 115.13(d)).
- 12. While the PBNDS states that there should be a sexual assault coordinator at each facility, it does not provide for an upper-level agency-wide PREA coordinator (§ 115.11(b)).
- 13. The use of protective custody as a means of protecting detainees (§§ 115.43, 115.66) is not sufficiently addressed in PBNDS 2.11.

Appendix D

Just Detention International's Calculation of the Prevalence Rate of Sexual Abuse in the Top Half of Facilities in the BJS Adult Inmate Survey

The BJS administered its adult inmate survey at 167 prisons and 286 jails. To calculate the prevalence rate of the top half of facilities, JDI took the rates of abuse from the better performing 84 prisons and 143 jails in the BJS study and averaged them. (The figures reached this way are not weighted averages: JDI did not try to account for the sizes of each different facility or the number of inmates who responded to the survey in each. With such large sample sizes, doing so would have made little difference.)

For both prisons and jails, JDI divided the average rate of abuse for the top half of facilities by the overall rate found by the BJS; then multiplied the numbers this produced by the Department's estimate of the numbers of victims in prisons and jails to reach the absolute numbers.

JDI did not attempt to perform the same calculation for juvenile facilities out of concern that the more limited data there might not support such an exercise; however, JDI is confident that strong standards could make a dramatic difference in juvenile facilities, perhaps an even greater difference than in adult prisons and jails given the higher overall rates of abuse in juvenile facilities.

Jails (rate of abuse multiplied by the number of facilities with that rate):

2.8 x 4 = 11.2 $2.7 \times 7 = 18.9$ $2.6 \ge 8 = 20.8$ $2.5 \ge 5 = 12.5$ $2.4 \ge 5 = 12.0$ $2.3 \ge 6 = 13.8$ $2.2 \ge 4 = 8.8$ 2.1 x 6 = 12.6 $2.0 \ge 5 = 10.0$ $1.9 \ge 7 = 13.3$ $1.8 \ge 4 = 7.2$ 1.7 x 8 = 13.6 $1.6 \ge 6 = 9.6$ $1.5 \ge 3 = 4.5$ $1.4 \ge 7 = 9.8$ $1.3 \ge 2 = 2.6$ $1.2 \ge 3 = 3.6$ $1.1 \ge 6 = 6.6$ $1.0 \ge 5 = 5.0$

.9 x 1 = .9 .8 x 2 = 1.6 .7 x 6 = 4.2 .5 x 3 = 1.5 .4 x 2 = .8 0 x 28 = 0.0

The products in that list all add up to 205.4. The average rate of abuse in these facilities, calculated by dividing the sum of the averages by the number of facilities (205.4/143), is 1.436. Dividing this rate of abuse by the rate of abuse in all jails (1.436/3.1) gives 0.46326 – meaning that the rate of abuse in the better performing half of all jails was only 46.326 percent of the national rate.

In this scenario, 53.674 percent of victims would be saved by the standards ($(1 - 0.46326) \times 100$). The number of victims in adult jails would be 50,078 (0.46326 x 108,100).

Prisons: $4.2 \ge 1 = 4.2$ $4.1 \ge 1 = 4.1$ $4.0 \ge 1 = 4.0$ $3.9 \ge 2 = 7.8$ $3.8 \ge 4 = 15.2$ $3.6 \ge 1 = 3.6$ $3.5 \ge 2 = 7$ $3.4 \ge 1 = 3.4$ $3.2 \times 1 = 3.2$ 3.1 x 4 = 12.4 $3.0 \ge 2 = 6$ $2.9 \ge 2 = 5.8$ $2.8 \times 3 = 8.4$ 2.7 x 1 = 2.7 $2.6 \ge 1 = 2.6$ $2.5 \ge 5 = 12.5$ $2.4 \ge 2 = 4.8$ $2.3 \times 3 = 6.9$ $2.2 \ge 2.4$ $2.1 \ge 1 = 2.1$ $2.0 \ge 2 = 4$ $1.9 \ge 4 = 7.6$ $1.8 \ge 4 = 7.2$ $1.7 \ge 3 = 5.1$ $1.6 \ge 3 = 4.8$ $1.5 \ge 1.5$ $1.4 \ge 6 = 8.4$ $1.3 \ge 2 = 2.6$ $1.2 \ge 2.4$

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1.1 x 1 = 1.11.0 x 3 = 3.9 x 2 = 1.8.8 x 1 = .8.7 x 2 = 1.4.6 x 1 = .6.4 x 1 = .40 x 6 = 0

The sum of the products is 173.8. Dividing this sum by the number of prisons (173.8/84) gives an average rate of abuse for these facilities of 2.069. Dividing this rate of abuse by the rate of abuse in all prisons (2.069/4.4) we get 0.47023. Multiplying this by the number of prisoners whom the BJS estimates were sexually assaulted in 2008 ($0.47023 \times 91,400$) gives, as the estimated number of victims of sexual abuse in prison in 2008 if the national rate of abuse had been as low as that of the better performing half of all prisons in the BJS study, 42,979.

Adding together the number of victims there would have been in jails and prisons if the national average had been the average rate of abuse of the better performing half of all facilities (50,078 + 42,979) would result in a total number of 93,057 victims. Rounding to the nearest hundred, as the Department does, this would be 93,100 victims.

Dividing this number of victims by the number of victims estimated in the Department's IRIA (93,100/199,500) results in a differential of 0.4666666667.

Based on these calculations, 53 1/3 percent of adult victims would have been saved (1-0.4666666667 x 100).