My name's Bob Dumond. I'm a licensed clinical mental health counselor. I've been involved in mental health, criminal justice, and correction since 1970. I've served primarily in commonwealth of Massachusetts, I've served in juvenile corrections. I directed a prosecutor-based victim witness assistance program where I served rape victims, battered women, children who were physically and sexually abused.

Most of my career then was with the Massachusetts Department of Corrections in seven different facilities as a psychologist and as a mental health director and finally as the director of research and planning. In addition, I've been researching and writing about prisoner sexual violence for over twenty years. I served on the committee that actually put together the Prison Rape Elimination Act.

I contributed language to the law and since its implementation, I've worked with the National Institute of Corrections, the National Prison Rape Elimination Commission, Just Detention International, the Moss Group. I've had the opportunity to do consultation and training in forty different states and various jails and prisons. So, I bring with [me] a variety of experiences and what I want to do is talk about some of the agency responsibilities. I mean we're going to be looking at: what are the reporting requirements? The justice PREA standards have very specific reporting requirements. We're going to talk about that.

There are also some you... it's important that all of you understand your state specific requirements for mandatory reporting. Every state has a child abuse law. Most states and some states have specific vulnerable person statutes.

You've heard a lot about, you know, we've had a very good discussion, very rich with all of our experts with Jaye, with Karla, with Kim, with Jayne. I mean they've given you a lot of information.

We're going to look at, you know, "how do you access some of these outside support services that we've been talking about?" We're going to look at "how do you implement a coordinated response?"

And finally, I think that the process is we want to encourage people to come forward and report. We want reporting institutions because our goal in correction is what? Care, custody, control, safety, security, and rehabilitation. That's what we're committed to, that's what we do.

Now, why PREA? Why now? Why are we dealing with this?

I have to tell you when we first started talking about sexual victimization and sexual abuse in jails and prisons, everyone said "this is anecdotal."

We now know the Bureau of Justice Statistics has actually determined through very carefully, well-constructed studies, studies of correctional administrators, anonymous studies of inmates who are in custody, anonymous studies of inmates

who are on parole, we know that sexual abuse occurs with great regularity in jails, prisons and youth facilities. It's real. And the two most common forms of sexual misconduct in all the studies that have been done, are staff sexual misconduct and inmate-on-inmate non-consensual acts, sexual acts, basically those acts which are penetrative, which in most jurisdictions would be considered rape.

I have to give you and I want to start with two scenarios and two vignettes.

The most serious sexual assault case that I had in the Commonwealth of Massachusetts was a young man in 1987 who had been sexually assaulted.

Referring to a photo on the screen This isn't the young man and I apologize. We're going to see Rodney in a second.

He'd been sexually assaulted. He was a homosexual, he appeared to be homosexual, people identified him. He was raped by four different inmates. His injuries were so severe that he was sent to the hospital and it took 120 stitches to repair his anus.

When he returned, we put him in protective custody and the protective custody unit at the institution I served was one hallway here, one hallway here, with rows of primary cells connected by a hallway in the back.

Three of the individuals who had been responsible for his victimization were identified. We failed to do something very important. We physically separated the young man from the persons who had harmed him but we left him over the weekend in the same protective custody unit where he endured, "Faggot, we're gonna kill you the next time we see you." We failed to recognize that protection is more than just physical separation. That was 1987.

The story I'm about to tell you now I had the honor to testify before the Senate Judiciary Committee in 2002 on behalf of the Prison Rape Elimination Act. One of the people who testified before me was a woman by the name of Linda Bruntmyer and she told the story of her son, Rodney Hulin, Jr. At sixteen years eight months he was arrested for lighting, basically, an environment on fire. It was a waste area and he was charged with two felonies. He was tried, convicted, and sentenced as an adult. He was placed in the Texas Department of Criminal Justice for eight years. When he was sent to the Clemens Unit, he basically said, "please!" He was repeatedly raped over a two-and-a-half year period. The results were catastrophic. But I want you to see the story for yourself 'cause I think that, you know, this is why we're here. Why we're doing this? We're doing this for all the Rodneys in the world.

VIDEO
A prisoner speaks
We got all kinda stuff. People beatin' up people for commissary. You got people beatin' up people for their tennis shoes... you got people just, just sodomizing

people, just, you know, just goin' rambunctious. Someone comes in and is kinda scared or hesitant and stuff like that, shy, you know? He's gonna get turned out, you know, chances are real high that you're gonna get turned out. They rape 'em. You know, they go in there and rape 'em. Guys sometimes, you know, commit suicide because of that.

A letter is read aloud
To all my family that I ever knew:
I can't live life being mistreated, lied, and stolen from and most of all, being hurt. I most of all mean being behind bars when I say "being hurt."

Rodney's Mom, Linda
We had about a two minute long conversation and he was crying. He said, "Mom, I'm emotionally and mentally destroyed." That's the last time I ever really heard his voice.

An anonymous Texas prison social worker, "Stella"
The physical exam in the records did document that there were tears in the anus at certain times, they usually call it at ten o'clock or two o'clock, given as a diagram of a clock. Even though it was documented, it was just covered over as if it never happened.

Back to Rodney's letter
I have found forgiveness for those who have hurt me in my life, which has been a very short one, only seventeen years.

Stella
Well Rodney, he was a really small statured person, he probably didn't way 105 lbs. at the most. I'll never forget his face and his eyes. He had the sweetest face. And he smiled. I remember he smiled a lot.

Unfortunately in the prison there's a hierarchy or a pecking order. There are those that they call the have and the have-nots. Rodney would be considered a have-not.

Rodney's letter
I'm very sorry to end my life this way, but if I don't do this, someone will. I'm saying I'd rather die of my own free will than be killed. That's why I must do this.

Rodney's brother, Rynell, speaks, also with Linda
-If I remember correctly this trash can
-was right here.
-it was
-it mighta been right there but I think it's been moved.
-it has been

Rynell: I think it was a little closer up. Well I mean we had flames coming out of that trash can and I would say at least 10, 15 feet high from different chemicals poured in and us lighting it. And I barely even burnt it, in a matter of minutes they had it out. But it's the fact that what little things you can do that can still have you put to prison, you know? Misdemeanor arson. Where did it get us? You know it was funny at the time being, but where did it get him today? I mean it's just hard to sit here and look at this and realize that this is probably one of the last spots I actually seen him at was in that yard.

Selden Hale, the Former Chairman of the Texas Board of Corrections
A kid like that shouldn't have been in prison but because of the judicial system we're sendin' a lot of young, troubled kids to the joint because we don't know what else to do with 'em. The classification system, if it'd been running appropriately, should have kept him out of a cell or out of an environment where a guy was sodomizing him.

Stella
I think he was desperate and unfortunately in this case there were people in this department I was in that were less than professional, to say the least. The psychologist said, "he's just another fuckin' inmate." And I rebuttled, I said, "but he's being raped and they're beating him," and he said, "he probably likes it."

Fred Becker, a Texas prison warden from the Carol S. Vance Unit
Frankly in my own experience, it has almost never happened that we came up and verified that the offense did take place or if the offense, or if there was some sexual activity, there wasn't some consensual agreement involved. Now I'm not saying that rape doesn't take place in the penitentiary because it does.

Donna Brorby, a lawyer for Texas prisoners
You know you'd see this pattern in some of the investigations that express this disbelief that a guy who did not want to have anal sex could be the victim of a rape. You know, that somehow if it happened, it was because the guy wanted it.

A new letter from Rodney
State Grievance: 12/21/95.

I have been sexually and physically assaulted several times by several inmates. I'm afraid to go to sleep, to shower, and just about everything else. I'm afraid that when I'm doing these things I may die in any minute. Please sir, help me.

The response to the letter
You were seen by the unit classification committee on December 18th, 1995 and your request for protection was denied unanimously. Unless you have new information to support your case for protection, your grievance is denied.

An inmate grievance form of Rodney's is read aloud
1/13/96: I fear that my life is in danger. I have been threatened, jumped, and nearly stabbed many times. I request to be placed on protective custody.

Another response
You have been reviewed twice by the unit classification committee. Both times, your request for protection was denied. Unless you have information to present, your request is still denied.

Linda
I called the ward. I asked the warden what was going on, what was he doing about it. And he wasn't doin' nothin.' He told me, he even told Rodney, "Learn to grow up. You're just a little boy. Learn to grow up. This happens every day, learn how to deal with it, it's no big deal." And I've been told that so many times.

Stella
Even when I would ask him, I said, "I'm tryin' really, really hard to get you some help, can you hang on?" And he'd say, "I'll try, I'll try real hard."

The end of Rodney's letter
PS I love you all. I wish I could be with you all... spiritually I am.

Signed, Rodney Hulin. I love you Mom and Dad.

END VIDEO

Bob
Now what happened in this case? A young man went to prison for a crime he committed.

Our goal is care, custody, control, safety, security, and rehabilitation.

He did everything he possibly could to get the help he needed from all the people who are supposed to do that. He went to administration, he went to classification, he told the warden. It's for Rodney Hulin and the thousands of Rodney Hulins across the country that we're doing the Prison Rape Elimination Act.

And make no mistake, you heard some of the characteristics of people who are vulnerable: young, new to prison or jail, look/appear weak... I mean he had all of these characteristics. Now, I don't want to bore you with statistics, but remember: every one of these numbers represents a human being.

Ok in 2008, this was an anonymous survey using a very sophisticated piece of equipment which you heard from Karla called the audio CASI (Audio Computer-Assisted Self Interview.) And it was really done over in both adult facilities, juvenile facilities, and in jails and it is estimated that in the period, in the year 2008, over

209,000 people anonymously reported some kind of sexual abuse that took place in jail or prison or in a juvenile facility.

Now we've also heard sexual abuse is the most under-reported crime in the United States and we know why. There's guilt, there's shame, there's having to expose yourself to being, inviting people into your most personal, negative experience that you could possibly have.

Now the formal reports in this particular case in 2008, 7,700 plus inmates had the courage to come forward and report they'd been sexually abused. But pay attention to this number: 13% or about a thousand inmates- we know that they were sexually abused, its proven, it's not anecdotal, the evidence supported the fact that they were sexually abused.

Now you might say "well, with the other people I know, the most common reported finding in investigations is what?" Unsubstantiated. Because we have neither the ability to have sufficient evidence to prove or disprove that something took place. But remember this happens; it happens at regularity. So as a result of this we have a very important duty to do.

You heard Dr. Anno and her husband were key players in creating care for medical and mental health care for inmates nationwide. The National Commission on Correctional Health Care is dedicated to this process. We are partners with administration in responding to sexual victimization. We have a very unique perspective that really we have the obligation ethically to enhance quality of care for any victim, any inmate who has been victimized. And really, our commitment is to community safety and improving public health. We know all too well the prevalence of sexually transmitted infections in jails and prisons is much higher than the community. If individuals are sexually assaulted while incarcerated, does that not transfer to possible contamination in the community? We know that to be true. That is one of the reasons we have to pay attention to this.

In addition, we have a really unique role. Now, it's somewhat sad. If you look at the statistics you've heard, only about 40% of the reported incidents actually come to medical and mental health practitioners and one has to question, "well what does that mean?" Is it because they didn't feel comfortable? We are the people that provide the hands-on care to people every single day. As a result, it's important that every inmate, detainee, juvenile, resident who discloses a sexual victimization, we in our role must have been the ability to know, to understand, and to be able to implement our agency and institution policy and protocol.

I also want to go on record as saying I know all too well that sometimes agencies create protocols and procedures that I've had nothing to do with. I think it's incumbent upon each one of you. You have expert power. You are clinicians, you are licensed in your state to provide care. You should review your agency institution protocols and procedures. You should identify the specific roles that have been

crafted for you or the duties you must perform. You must insure that these are consistent and valid. Are these really capable? Can you really do these effectively? And you should recommend changes and modifications as may be necessary.

Now, the specialized training you've heard. This is one of the initial periods here of providing specialized training to medical and mental health practitioners and that specialized training should involve the following: sexual abuse detection and assessment, physical evidence protection, effective, professional response to victims, how and to whom to report. The reason we're doing this is because we want to create the opportunity to keep inmates safe or residents or detainees. If they're being victimized by staff or inmates, we have an obligation to change that. So, what can we do?

You should review the agencies' current sexual abuse staff training and also the inmate education training that's being provided. You should assess knowledge gaps among your staff regarding whatever kind of physician, nursing, mental health, PA, whoever they are... you should try to assess: What do they know? What do they not know? As you well know, I'm trained as a mental health practitioner. I'm licensed in two states. I had to get specialized training for trauma and sexual abuse response. That was not part of my graduate training. And that's something that you really need to educate yourself on. And you should also identify the local resources- the rape crisis programs, the trauma specialists who can provide the specialty training.

Another observation you may want to consider is to plan and execute mock drills to test the knowledge among staff. When people were asked "how many people have actually had this experience?" a handful of people put up their hand.

This is not something that you're necessarily going to have some experience with so you have to be able to understand what you would be required to do and that would be the case. And finally, you have to prepare pocket cards with key roles that are identified.

(Bob sees something on the computer)
And Dr Lomburg? It's saying that we need to plug in the computer because it's going to run out of juice in a moment... Not a good thing here...

Dr. Lomburg: Just keep going. I'll fix it.

(Back to speech)
Now one of the things... these are examples of an innovative project that's being done by Just Detention International with the California Department of Correctional Rehabilitation. I was part of the opportunity to do that. And these are examples of pocket cards that they put together.

As you probably know, correctional staff like to have things very clearly identified. These two or one card that's laminated, it's the custody super by the checklist and it

talks about [what to do] while in a dedicated medical location, what do you do upon return to the institution? Ensure the victim/suspect, to the best of your ability, does not shower or remove clothing, all those things you heard Kim talk about... Understand the initial contact with staff, so this is one example.

This is a second example of, again, the same type of approach for custody response to a victim post-trauma. Be sensitive to the signs. Victims should not be blamed for being attacked, all those kind of things. So this is again something that you can take advantage of and we will have these available as an option to give to you to possibly emulate.

The standards talk about a coordinated response. Now that coordinated response, as you've heard, requires a written institutional plan to coordinate actions which are taken in direct response to an incident of sexual abuse. It should articulate the actions that staff first responders must do in conjunction with medical and mental health practitioners, with investigators, and facility leadership.

Toward that goal, again, you should all be reviewing periodically your written response plan. You should ensure that the specific roles are clear and appropriate. You should also identify the lines of communication and reporting, who needs to be notified, when, by what means, you should specify the required documentation, and you should also recommend necessary changes to the plan. As you have had experience with an incident of this nature, you may see that one of the articulated roles or duties or protocols is not appropriate or is insufficient. You should then be able to really rectify that through this process.

Staffers first responder duties- you heard a lot about this. Require specific actions that the first staff member take in responding. Separate the alleged victim and abuser. Let me also share with you that I've had the experience, unfortunately, of having an institution send out a victim and a perpetrator in the same van to the hospital because they wanted to save money and they didn't have staff time. And I am appalled to say that to you; but those are the kind of things that we've got to pay attention to. We need to preserve and protect the crime scenes, now again, in our role as the medical and mental health provider we wouldn't be doing that but we have to ensure that someone on the security team is doing that. And also all that we request the alleged victim not take any actions that could destroy physical evidence.

Again, when a person comes forward, they're taking a great risk- that risk is palpable. And actually what we know from the research on sexual assault victims, the first interactions that victim has with anyone is going to determine the future outcome of both treatment involvement, their treatment engagement, and their involvement in investigation. Simons calls it the second injury because in a sense you're opening yourself up in the most vital of ways- I'm telling someone that someone has done something that's unimaginable. We need to provide safety in support of/to the victim.

We really, again, all of you, I have to tell you I've done counseling outside of a protective housing unit with two doors and I've been talking through the door. That's not the optimal time or place to be doing this kind of discussion. You need to provide confidential space and a setting that's going to really be optimal and consider that.

The other thing I've had and some of you have are seriously persistently mentally ill inmates who are on my case log. If those people are now going to have to talk with an investigator, one of the choices that you may want to consider is having them come to your office… sitting there, again, you in your role as a practitioner cannot and should not be part of the investigation or part of the inquiry, but being there and having the support of presence when the investigators question that individual and then having the opportunity after the investigator leaves to pick up the pieces- it may be a real critical way to help a person function in dealing with it.

Now we spent a lot of time and this is something different for most of us- the staff and agency reporting duties.

It requires- and I want you to pay attention to the slides (I'm going to read it for a specific reason) that all staff immediately report according to agency policy any knowledge, suspicion, or information regarding an incident of sexual abuse and harassment that occurred in the facility, whether or not it was part of the agency. Any knowledge, suspicion, or information. That's something very different than most of us are used to doing. Now reporting is not optional and it's required at all times.

And then the other thing staff must report, according to the standards, is whether there's been retaliation against any intimate, detainee, juvenile, resident, or staff has reported such an incident.

And this is even more troublesome to some degree: staff must also report any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation.

Now I've been in corrections a long-time. I know about the blue wall, I know that brothers have to take care of their brothers and sisters in uniform. I have to also remind you we are there because we are given responsibilities under the government that we serve and under the state; and anyone that's allowing this to go on is actually tacitly approving and participating in a criminal act.

Now, given this, one of the things that's different in corrections (and this is very different,) as you've heard from Karla and from Kim and from Jane: if a victim in the community goes to the hospital, he or she can elect not to involve law enforcement in any way, shape, or form. They can get services, they can get treatment and don't have to call the police.

Now, one of the reasons that we have to do this and one of the reasons that I think the physician had a very good question, "Is this not a violation the 'do no harm' reporting?" Understand that because an inmate is in custody, the agency is responsible for that person and their body and their soul, if you will. If the agency fails to protect that person over the long term, that agency now becomes culpable, which is why we have to make that report.

So what do we need to do? Well we need to do two things. We need to understand: what are the implications if a victim does or does not report? If they don't report, they're going to continue to get abused. And I have to tell you when I worked at the community and prosecutor's office, you could have one event of a sexual assault that could change a person's life. Can you imagine what it would be like to see the person that has assaulted you every single day or undergoing continued assaults by another inmate or staff? 'Cause that's essentially what happens in jails and prisons.

And also understand: if they do report what's going to happen? It is likely they may be put in what? Protective custody, at least for a period of time. You need to be honest with people about that.

Now, as you've heard, the standards are very clear. That should not be the default position and you also should move that person out of protective custody when and as soon as possible because that's not the appropriate… it is not a punishment for reporting. On the other hand, there are certain things that will happen.

In addition, if an inmate reports a staff, is that inmate going to be at risk with other staff that may like this particular staff? That has to be considered.

Now, what we do as mental health and medical practitioners? We need to clearly articulate, verbally and in writing, the limits of confidentiality and the duty to report requirements for patients or clients. That has to be done before the service delivery occurs. We need to discuss that in very clear language and we also have to discuss the duty to report with patients and regularly review these.

And then again, well you say, "Well, nobody's gonna report." I beg to differ. To be honest with you, if they feel that the institution will respond appropriately, inmates will come forward. They want this to stop. They don't want to be victimized and if they believe that you're going to take it seriously, they will do something about that.

So this is something that we need to do on a regular basis. We need to continue to do that as we see clients in whatever intervention that we have, and you also (and we know this but it bears repeating) information is on a need to know basis. If you are the person that receives a report, you have to report according to your chain of command as outlined in your institution.

Now each state, as you know, has a very specific requirement for reporting incidents of sexual abuse, including mandatory child abuse reporting statutes and also reporting abuse for certain identified vulnerable populations.

And you need to understand: what are the specific laws and mandatory reporting in your jurisdiction?

Now on these powerpoint slides you're going to see some hyperlinks. As Dr. Longwood has suggested, we will be sending every participant in this room a list of the hyperlinks that are noted here. Okay? So you will have this resource available to you.

And the National District Attorney's Association, for example, has a specific identification of mandatory reporting of domestic violence and sexual assault statutes which are available at their website.

The Child Welfare League has an information gateway that also provides specific information for reporting of child abuse and child sex abuse in your jurisdiction.

The Center for Adolescent Health Laws has a listing of minor consent laws.
As you probably know, the age of consent varies state to state. You need to understand when or (rather) what that is.

And another very important resource is Professor Brenda Smith, who was also a Commissioner of the National Prison Rape Elimination Commission. On her website at the American University Washington College of Law, they have a fifty state survey of mandatory reporting laws and also correctional staff as mandatory reporters.

And it's important to note like, for example, that in the state of Maine, a correctional officer who fails to report sexual abuse can actually be held legally culpable for not doing so. And that's a state specific statute, so you need to know your agency and your state.

So what do you need to do for this?
-We need to review the resources and consult with appropriate legal, child abuse, and administrative agencies in your jurisdiction. All of you can certainly consult your own agencies' legal team to get some clarification on this. You can also consult your board of registration for your various disciplines. They will give you some consultation on that.
-You also need to determine the specific requirements for your agency and institution. You should prepare and post listings of agencies with the address, phone numbers, and specific contact information.
-And you should also identify the specific information that will be required. And in fact many states have specific forms that you will use in your contact with the reporting agencies.

One of the standards of 115.53 also identifies that facilities shall provide detainees, inmates, and residents access to outside victim advocates- you've heard about that. So how do you get those people? How do you know what they are?

You need to identify local, state, and national victim advocacy resources and with their mailing addresses and telephone numbers- we're going to give you some of that in a moment- you should post that contact information so that patients and clients can see and consider contacting those agencies. You may also want to provide a safe environment where an inmate, resident, or detainee can come in and call those particular agencies if need be when appropriate.

And really I think one of the things, and this is a big change for us in corrections, we were very insulated. When I started, we were out of sight, out of mind. These individuals, these agencies are support resources for us. They help us do a better job to serve the clients that we need.

And some examples you may wish to contact (and again you will get these in a separate e-mail):
-You'll want to contact or look at the Office of Victims of Crime. They've got actually a map of all the agencies available.
-RAIIN, or the Rape, Abuse, and Incest National Network has a national on-line hotline.
-Just Detention International also has very excellent resources.
-And, of course, Kim's group, the International Association of Forensic Nurses. The SANE actually has a lot of resources as well. So these resources are available and you should and can take advantage of them.

When you're dealing with youth, as you've heard, the standards often articulate some specific, additional things and in this particular case a resident must have access to outside support services and legal representation. So the standards specifically say that juveniles and residents of juvenile facilities must have reasonable and confidential access to their attorneys and other legal representatives, parents and other legal guardians. And really, health-care professionals, particularly in mental health, can often facilitate and support juvenile offenders in getting these additional services.

Also, making reporting possible. One of the things that we know are: should there be multiple ways that an inmate, detainee, or resident can come forward? That multiple way can we what? It can be the sick hall slip, it could be a box, it could be a 1-800 hotline, it could be a hotline to an external agency. Agencies must make every reasonable effort to assist individuals to be safe, to be free from sexual abuse, and also to report victimization.

In addition, when a person comes to the facility they've got to know, "How do you report? To whom do you report? What are the choices and options that you have?"

And really, part of our responsibility should be we should be making our facilities safe for individuals to come forward. We are seen as reliable, hopefully, and able to assist in times of crisis.

You should work with your agencies on improving the reporting procedures- be creative. You should create and encourage a reporting culture. And we do that by what? Taking people seriously when they come forward, responding with the proper safety and treatment that's required and really make sure the message is "We will do something if someone comes forward. We're not gonna blow you off, we're not gonna kick you to the curb, we're not gonna just stick you in isolation. We are going to treat this and treat this appropriately."

There's also- the standards stipulate what's called third party reporting and it essentially means you can receive phone calls or communication from family and friends about sexual abuse. Other patients may also express concerns and as the staff you need to be prepared to respond.

Reporting to other confinement agencies- we talked about that. If you receive a report in the course of your work you need to be able to identify that and report to the proper person.

We've talked a little bit about this but just to remind all of you that have had, for example, a successful suicide or has been to a suicide autopsy, the standard stipulates sex abuse incident reports individuals will include medical and mental health team as part of that because basically this is a quality control process and they're going to look at things like race, gangs, gender identities, gender orientation... it's really an opportunity to improve care.

And in summary, I mean basically, the reporting requirements are key to service. They protect the agency and practitioners in reducing risk and liability, they require specific actions in your roles, they help agencies promote quality, effective care, and they really assist agencies to improve safety, and they save lives. Thank you.