

19

(Off the record.)

20 CHAIRMAN KANEB:

21 Ladies and gentlemen, we're
22 11 minutes behind schedule. I see four
23 panelist -- or five. Good. I will now
24 ask general counsel to swear all of you
25 in together. Will you all please rise

1 and raise your right hands?

2 (Five witnesses sworn.)

3 CHAIRMAN KANEB:

4 This panel is entitled,
5 Confidentiality and Reporting: Medical
6 Ethics, Victim Safety, and Facility
7 Security.

8 Victims of sexual assault
9 need a safe and confidential way to
10 seek medical and mental health
11 services. Are there times when
12 reporting obligation and institutional
13 security considerations can -- or
14 should -- come before individual
15 victim's needs? Panelists will discuss
16 the tensions between preserving
17 patient/provider confidentiality and
18 trust, and ensuring safe and secure
19 functioning of correctional facility;
20 and option to address these tensions.

21 We have five panelists.
22 Mike Puisis, D.O., Consultant, former
23 Medical Director at the New Mexico
24 Department of Corrections, Cook
25 County -- and the Cook County Jail;

1 editor of Clinical Practice in
2 Correctional Medicine."

3 Art Beeler, the warden of
4 Federal Correctional Complex (Butner,
5 North Carolina).

6 Wendy Still, Associate
7 Director of Female Offender Program and
8 Services, California Department of
9 Corrections and Rehabilitation,
10 Sacramento.

11 Lynn Sander, M.D., NCCHC
12 Representative and Medical Director of
13 Denver Sheriff's Department Medical
14 Program, Immediate Past-President,
15 Society of Correctional Physicians,
16 Denver.

17 And Carrie Hill, Attorney,
18 Corrections Law and Criminal Justice
19 Consultant; Editor of Corrections
20 Manager's Report (Maple Grove,
21 Minnesota).

22 Thank you all. The format
23 we use is each expert witness presents
24 his testimony, which can either be the
25 whole statement you presented or if --

1 it's all up to you -- it may be a
2 shorten version thereof. And we will
3 go to, hopefully, an interactive
4 process, and questions will be posed to
5 you and -- by various members of the
6 Commission.

7 So Mr. PUISIS, would you --
8 am I pronouncing it correctly?

9 MR. PUISIS:

10 Close.

11 CHAIRMAN KANEB:

12 Okay. Well, actually,
13 that's -- I'll settle for that.

14 MR. PUISIS:

15 Thank you, Commissioner. I
16 appreciate the opportunity to speak to
17 the Commission and to help you develop
18 your recommendations to Congress. I
19 come from 23 years of experience in
20 correctional medicine. I've both taken
21 care of people, including patients who
22 have been raped, had managed
23 correctional facilities, and had
24 monitored facilities in a variety of
25 settings.

1 We've created, in the United
2 States, a large jail and prison system
3 with over 2.2 million people, the
4 largest per capita in the world. The
5 system is largely subterranean. No
6 reporters and cameras are allowed into
7 facilities to record what's going on as
8 would occur in a community setting.

9 The system is managed by
10 thousands of wardens, each of whom has
11 a unique style of management. And
12 security is the dominant function.
13 It's the purpose of a prison is to
14 securely hold people. There's no
15 mandatory oversight system over
16 security functions, except those that
17 occur under the auspices of the United
18 States Department of Justice or the
19 U.S. Federal Courts. And the U.S.
20 Federal Court system of oversight has
21 been significantly curtailed under
22 PLRA.

23 Within the system,
24 physicians and other health
25 professionals have to see patients, and

1 we are used to privacy and
2 confidentiality. But this conflicts
3 with the control mentality of security.
4 And security typically wins that --
5 that battle, because the Supreme Court
6 even has affirmed that a warden has the
7 responsibility to manage, in a secure
8 fashion, the facility. And that
9 includes obtaining reports of medical
10 records if the warden sees fit to
11 manage the facility.

12 Accrediting agencies for
13 medical care in prison, such as the
14 National Commission Correctional
15 Healthcare ACA, American Public Health
16 Association, have standards on privacy.
17 But, for example, the Commission
18 standard of privacy is a -- is a
19 standard that's important and not
20 essential. And in general, all
21 accrediting and correctional facilities
22 is voluntary and not mandatory. As a
23 result, these standards do not impact
24 practice as much as one would expect.

25 In relation to rape, there's

1 a large gap between the reports of
2 inmates, advocates, and the statistical
3 data that we have that demonstrate what
4 the prevalence of rape is. There's
5 also a gap between the NSO's reports
6 and what medical providers say they
7 report to their superiors. So even at
8 the level of the physicians and other
9 health professionals working in
10 correctional settings, those
11 individuals are not seeing rape at the
12 rates that even I believe are
13 occurring.

14 And the question is, is why
15 is this happening? Privacy and
16 confidentiality issues are rarely, I
17 believe, the reason why this gap exist.
18 Inmates are really in a position to
19 have to make choices. And the choice
20 they have to make is, if they report
21 rape, is their condition going to
22 improve. And I think lacking that
23 assurance, the reporting of rape will
24 not improve, regardless of
25 confidentiality matters.

1 And what I would like to do
2 is just close with some recommendations
3 that I would suggest that the
4 Commission consider as it reports to
5 Congress.

6 Number one, I would strongly
7 recommend a reduction in the prison
8 population, particularly for those
9 portions of the prison population that
10 are vulnerable or who's placement -- a
11 prison is not the placement or -- or
12 should not be the placement of choice,
13 specifically the mentally ill. Many of
14 the mentally ill belong in mental
15 health institutions, not in prison.
16 And we -- we heard earlier a
17 psychologist from the Georgia
18 Department of Corrections describe the
19 prevalence of rape in the mentally ill.
20 You can reduce rape by removing that
21 population into a setting that's more
22 appropriate for them. Other
23 populations could include the homeless
24 populations in jail settings, and
25 people who are so ill they don't really

1 even know that they're in prison any
2 longer.

3 Number two recommendation.
4 There should be some form of external
5 monitoring that is mandatory.
6 Currently, there is no -- no oversight.
7 And any agency that I can think of that
8 has any importance is monitored in some
9 aspect. There's the FDA that -- Jayco
10 for hospitals, there's a nuclear
11 regulatory agency. But prisoners have
12 no -- not advocates, but no one looking
13 over the shop. And so the decisions
14 that are made by these individual
15 wardens are -- can be unique, but are
16 the final say. And Federal laws have
17 diminished to the extent that very few
18 cases now are being filed in federal
19 court as class actions.

20 Regarding rape,
21 specifically, all inmates who are
22 suspected of rape should be presented
23 for medical evaluation when it's known.
24 The evaluation should be private to the
25 extent it can be. And I think unless

1 you've work in a correctional setting,
2 you may not know what can occur in many
3 of these facilities.

4 I have recently monitored a
5 facility in a state where the officer
6 who is guarding the inmate is sitting
7 next to the examination table as the
8 inmate is being examined. You can
9 believe that or not, but that's --
10 that's what occurs.

11 Medical professionals should
12 be required to report rape. Rape, to
13 me, is the equivalent of the laws in
14 most states that require the reporting
15 of child abuse. And it should be a
16 reportable issue. In my opinion,
17 medical ethics and patient safety are
18 the reasons that reporting rape should
19 be a professional obligation.
20 Hopefully, the reporting of rape will
21 result in the safety of the patient.

22 Medical treatment should be
23 consistent with community standards
24 regarding the management. Custody
25 policy and procedure should be

1 standardized so that the reporting and
2 the confidentiality are established in
3 policy and procedure, rather than
4 invented on the spot. Policy and
5 procedure should require automatic
6 transfer to a safe location that would,
7 hopefully, encourage people to report.
8 There should be confidentiality so that
9 only those who need to know that
10 someone has been raped know, and it
11 should not be something that is
12 discussed. And that should be in
13 policy.

14 Correctional staff are used
15 to a military style mentality in
16 control and policy and procedure in
17 post-orders. And I think to the extent
18 that those post-orders are standardized
19 and absolutely clear, I think they will
20 adhere to them.

21 The inmate patient should be
22 informed about how the rape would be
23 reported and to whom it will be
24 reported, in addition to being offered
25 counseling services. Officers who

1 interview inmates who have been raped
2 should receive training as to how to
3 conduct such interviews and how to
4 maintain confidentiality.

5 I hope these suggestions are
6 useful, and good luck on your work.

7 CHAIRMAN KANEB:

8 Thank you. Many of the
9 recommendations that you put before us,
10 as you might have -- might know, have
11 been placed before us. And we are
12 considering many of them very seriously
13 as we formulate standards and -- and
14 write our report.

15 But again, speaking for
16 myself, the very first thing you said
17 after your opening remark, are really
18 the dilemma of the prisoner who has
19 been the victim of sexual violence. By
20 violence, the way we define it, coerced
21 sex is violent sex. You put it so
22 well. And then the answer you pose to
23 your own question was, basically, no.
24 And that's very disturbing.

25 The question is, should I

1 report this rape? And one way or
2 another I then ask myself the question,
3 will I be better off if I report it?
4 And your answer to that question is,
5 most of the time, no.

6 Is that what I heard?

7 MR. PUISIS:

8 Not entirely. In principle,
9 I believe that all rape should be
10 reported. There's no question about
11 that. However, we work in abnormal
12 settings where some jurisdictions do
13 not function well. And if you reported
14 a rape, it would not be taken
15 seriously.

16 So under all considerations,
17 from my point of view as a physician, a
18 physician should take responsibility to
19 make sure that the patient is safely
20 cared for in the best manner that you
21 can do under the circumstances. In
22 some settings that may not include
23 reporting. If it is known that if you
24 report a rape, the patient will be
25 humiliated. Why would you do that?

1 However, under ideal settings, all rape
2 should be reported. And because
3 it's -- and typically it's the only way
4 that a -- an inmate can be transferred
5 to safe housing, is working through
6 custody.

7 So I think in answer to your
8 question, yes, all rape should be
9 reported. There will be circumstances
10 where I can understand why a clinician
11 would not do so.

12 CHAIRMAN KANEB:

13 If transportation or removal
14 to the safe housing situation is a
15 requirement of -- of your feeling that
16 it is best place to report the rape,
17 isn't there a question many times as to
18 whether or not reporting that rape will
19 result in the victim being put into
20 safe housing?

21 MR. PUISIS:

22 Well, that's a dilemma of
23 incarceration, isn't it? I mean, we
24 all understand that -- if you think of
25 a woman who is in a marriage where she

1 is abused and raped, or a child who's
2 beaten by a parent, you would want to
3 remove them from that situation. And
4 more often in so many settings you
5 could do that than you can in
6 correctional settings. And
7 unfortunately, that is our dilemma.
8 And that's why I believe your
9 Commission is -- has a -- a momentous
10 task. Because I believe it's the
11 conditions of incarceration, and that's
12 why I recommend external monitoring, to
13 try to improve those conditions.

14 Remember, the wardens and
15 the secretaries of corrections also
16 have what they have. They have the
17 funding that they have to run the --
18 this vast system of incarceration, and
19 often it's not enough. It just isn't.
20 And what are they to do? So I think
21 external monitoring points out those
22 deficiencies, and at least brings them
23 to the legislators and others so that
24 remedies can be taken. But it is a
25 dilemma.

1 CHAIRMAN KANEB:

2 Thank you.

3 Questions from other
4 commissioners?

5 Commissioner Smith.

6 COMMISSIONER SMITH:

7 Okay. Since this seems to
8 kind of be the area that I seem to be
9 spending a bit of time today --
10 hypothetical. You've recommended --
11 one of the things that you've said is
12 that, hopefully, the reporting of the
13 rape will result safety for the inmate.
14 And as I hear it, one of the things
15 that you're recommending, which I think
16 is an excellent recommendation, is some
17 degree of informed consent for the
18 offender, when you're counseling the
19 offender as a clinician. So if you
20 were doing an informed consent
21 interaction with the offender, what
22 would it sound like, given the
23 discussion that you and Commissioner
24 Kaneb had?

25 MR. PUISIS:

1 Well, I would tell the
2 person that it's my responsibility to
3 report this, and that I would be
4 reporting it. The purpose of that is
5 to try to get you into a housing
6 situation that is safe for you. I
7 would ask them their opinion. I would
8 ask them what are the issues
9 surrounding housing changes that --
10 that affect their safety. Because
11 inmates know, often better than we do,
12 where different gangs and affiliations
13 within a prison lie, and what risk
14 they're entering into.

15 I would allow a degree of
16 flexibility in talking with them. But
17 I think that the -- THE inmate needs to
18 be treated as a person, and they need
19 to be treated with respect as if they
20 were a civilian, in that situation.
21 And that's hard to do in custody.

22 COMMISSIONER SMITH:

23 And so under that set of
24 circumstances, if the inmate said to
25 you under an informed consent model

1 that, based on what you've told me, and
2 based on what I know about the
3 likelihood about being transferred or
4 that reporting will result in my
5 safety, I don't think that I want to
6 report this. What would be your
7 response?

8 MR. PUISIS:

9 Well, my response is that --
10 to the patient you're saying, or to
11 you?

12 COMMISSIONER SMITH:

13 To the patient.

14 MR. PUISIS:

15 I would still maintain to
16 the patient that the only way to break
17 the cycle within the prison is to make
18 sure that we bring this forward. And I
19 think in some states there may be a
20 legal responsibility to do so. If
21 there is, in those states, I would
22 acknowledge that. And -- but I would
23 discuss it. I would, frankly, discuss
24 it. And I know where you're coming
25 from.

1 I guess if I worked -- and I
2 won't name the prison. But if I worked
3 in certain prisons, I might not do
4 that. But places where I've worked, I
5 have always been able to have a
6 relationship with someone in the
7 organization of custody that would
8 allow for a safe transfer of the
9 inmate.

10 CHAIRMAN KANEB:

11 Thank you.

12 Other -- Commissioner Nolan.

13 COMMISSIONER NOLAN:

14 We had a hearing in South
15 Bend at Notre Dame, and there was an
16 inmate there who had been in two
17 different institutions.

18 At one institution, he was
19 being attacked and he went to the
20 lieutenant and said, I'd like to
21 transfer. The lieutenant understood
22 what was going on and said, is there a
23 place you'd like to go? And he told
24 him -- he moved him.

25 In the other institution, he

1 went and the lieutenant said, why are
2 you being beaten or raped? And Steve
3 said, no. And the reason he lied was
4 because there was a death sentence, if
5 you were a rat. And so the lieutenant
6 said, well, if you're not being beaten
7 or raped, you know, if you're not going
8 to report it, there's nothing I can do.
9 And Steve says, well, I just want to
10 transfer housing. The lieutenant,
11 knowing what was going on, said, well,
12 you don't get to choose where you
13 house. Get back in your cell. So he
14 condemned him to be beaten and raped.

15 Given that circumstance --
16 and in that the medical personnel
17 generally doesn't control the housing.
18 How -- how can we help in a situation
19 like that so that the lieutenants
20 give -- understands the situation, and
21 if Steve doesn't want to report it,
22 still put him in a safer place?

23 MR. PUISIS:

24 If there were national
25 standards that were externally

1 enforced, you could have a standard
2 that require that medical personnel
3 could -- could order a transfer of an
4 inmate to a certain housing unit, based
5 on a recommendation.

6 Typically, if you do that
7 now, you would be asked for a
8 rationale, and you would have to give
9 specifics. But if you were allowed to
10 do that -- now that -- you would have a
11 lot of people saying that that will
12 violate security rules. And I could
13 see where they would -- where they
14 would be coming from. But that could
15 be one way you could overcome that.

16 COMMISSIONER NOLAN:

17 Thank you.

18 MR. PUISIS:

19 You would have to give a
20 carte blanche ability.

21 COMMISSIONER FELLNER:

22 Could I just -- for
23 followup?

24 You had said in your -- that
25 one of the main reasons to require

1 medical personnel was to ensure safe
2 housing, so I was going to ask that
3 very question. Well, if medical
4 personnel themselves can ensure safe
5 housing, then the remaining reasons to
6 report wouldn't be safe housing, but
7 would be to enable the facility to
8 identify perpetrators, to take action
9 against the perpetrator, or to
10 otherwise enforce security.

11 If medical personnel were
12 given the authority to order housing --
13 so that's no longer the issue, the safe
14 housing -- how would you, as a medical
15 clinician, weigh the inmate's desire to
16 have a control of what's reported or
17 not in his or her assessment of what's
18 safe versus the facility's desire to be
19 able to prosecute, investigate, or take
20 other steps to ensure the safety and
21 security of the facility, but no longer
22 the specific individual's safety and
23 security? Did I phrase that --

24 MR. PUISIS:

25 No, I think I understand.

1 There's an assumption that safe housing
2 can be provided, which is, I think, a
3 question of assumption.

4 COMMISSIONER FELLNER:

5 Yes.

6 MR. PUISIS:

7 But I think in answer to
8 your question, at that point, it
9 wouldn't matter because, if you could
10 provide safe housing, I think that
11 inmates would not be reluctant to
12 report. And I think that the reason
13 they don't report is -- is twofold.
14 One, a lack of safe housing. But, two,
15 the fear and humiliation of
16 acknowledgment. It's a personal
17 acknowledgment that they have been
18 raped. Something they do not want to
19 do. But in addition, there's a safe
20 housing issue.

21 But if you can create safe
22 housing and you allow it, I think
23 that -- why would anyone not think that
24 that's a good thing to do? I think the
25 inmates would think it's a good thing

1 to do. I'm just speaking from
2 experience, but. I don't see why they
3 wouldn't think it's a good thing to do.
4 I have never in my 22 years offered
5 something that was good for an inmate
6 that they didn't accept. I just don't
7 see it. There are ordinary people like
8 you and I, and if you offer a good deal
9 to them, they'll take it. If you offer
10 them safety and protection, they'll
11 take it. I think the fact that we
12 can't offer it is why we have this
13 discussion about reporting and -- and
14 hiding and -- it's a subterranean
15 world.

16 CHAIRMAN KANEB:

17 Thank you.

18 Are there any other
19 questions?

20 Well, thank you.

21 We'll now move on to Art
22 Beeler, please.

23 MR. BEELER:

24 Thank you, sir.

25 Mr. Chairman and other

1 members of the Commission, let me
2 preface my remarks by saying that my --
3 I was asked to talk about absolute
4 confidentiality. That was the limit of
5 what I was asked to speak of today.
6 It's a very narrow topic, and I'm going
7 to try to restrain my testimony to that
8 very, very narrow topic. Because it is
9 a narrow topic against a whole -- of
10 issues that you guys are dealing with
11 in a most effective way.

12 By way of background, I've
13 been a warden for six federal
14 institutions, to include transportation
15 center, a federal jail, two medical
16 centers, and the largest federal prison
17 in the country. I've been a warden for
18 over 20 years. And I would like to say
19 that I haven't dealt with this subject,
20 but I have dealt with this subject.

21 Your task is critically
22 important to every prison administrator
23 in this country, and that's is how to
24 manage and protect offenders who have
25 been sexually abused or allegedly

1 sexually abused. And I want to regress
2 for a second and talk about what is
3 allegedly sexual abuse.

4 In the prison environment,
5 it doesn't matter if it's sexually
6 abusive or allegedly sexually abusive.
7 Because if the word gets out, it's just
8 as if it happened in the world of the
9 prison environment.

10 I doubt that you'll find one
11 prison administrator who will even say
12 one case of abuse by other inmates with
13 staff is acceptable. And we must deal
14 with, even the one case, in the most
15 expeditious manner we can, up and
16 including prosecution whenever
17 possible.

18 This discussion of today's
19 discussion comes from balancing the
20 needs of confidentiality in a prison
21 environment whether or not treatment
22 staff should be allowed or required to
23 maintain absolute confidentiality when
24 discussing the sexual abuse of an
25 offender. And I'm talking about

1 confidentiality you get here, and not a
2 legal concept of privilege. This
3 absolute confidentiality would allow
4 for treatment to be provided to the
5 offender who's been abused by qualified
6 staff or, in some cases, by contractors
7 or volunteers, without prison staff
8 becoming knowledgeable of the abuse or
9 involved in the process.

10 The ethical dilemma of whom
11 to share information with in a prison
12 environment is probably as old as
13 prisons are themselves. On the one
14 side, it is the desired that the
15 information not be shared with those
16 who do not have the sensitivity to
17 handle the information in a
18 professional manner. On the other
19 side, is the need to keep staff and
20 inmate safe and the institution secure.
21 Both of those are dynamic tensions, as
22 you have mentioned already.

23 And discussions with
24 professional and advocates the
25 suggestion was that nothing would be

1 told to prison staff. How about
2 information relating to a crime? As
3 law enforcement officials, we have a
4 duty, obligation to report a crime. In
5 fact, when I reviewed the monograph --
6 the recent review of the monograph,
7 Breaking the Code of Silence, the
8 correctional officers handbook for
9 identifying and address sexual
10 misconduct. It says that, misconduct
11 with offenders affects correctional
12 staff by jeopardizing staff safety,
13 threatening agency and facility safety,
14 creating the risk of legal action,
15 creating health risk, harming family
16 relationships, creating negative public
17 views, diminishing trust and morale,
18 and weakening the respect for in
19 authority of correctional staff among
20 offenders.

21 While this monograph was
22 written primarily looking at sexual
23 abuse of staff against inmates, I'm
24 here to tell you that it doesn't
25 matter, in my view, if staff or inmates

1 are perpetrating the sexual abuse. I
2 would argue that many of the same
3 factors facing correctional
4 administrators are both with staff and
5 inmates. If we do not attempt to
6 enforce the law and regulations,
7 because we know -- because we're not
8 told of the behavior. And quite
9 frankly, and this isn't my written
10 testimony, but if we do know and don't
11 do something, that's a crime. But if
12 we don't know about something of a
13 behavior, then how do you attempt to
14 deter the behavior?

15 In our system, when someone
16 comes forward with a statement that
17 they've been sexually abused, three
18 entities become immediately involved.
19 First, medical staff to determine if
20 there's any physical harm to the
21 offender. Also, if a crime has
22 occurred, it is either this medical
23 staff or community medical staff that
24 must act to preserve the evidence,
25 along with trained investigators.

1 Second, mental healthcare, to ensure
2 that someone is discussing the trauma
3 of the abuse with the offender as well
4 as the resources available to the
5 offender. And finally, the
6 investigative arm of the agency to
7 determine if there's a crime or rule
8 violation. And if action needs to be
9 taken -- and I say that on purpose with
10 a comma -- and if action is to be
11 taken, because sometimes those are
12 outside the hands of correctional
13 administrators, who like to action.

14 It is hoped this is
15 accomplished with professional
16 sensitivity. But each of the component
17 and parts is important to maintain the
18 safety and security of the offender and
19 the safety and security of the
20 institution.

21 California -- or the
22 University of California just published
23 a monograph called, Violence in
24 Correctional -- Correctional Facilities
25 and Empirical Examination of Sexual

1 Assault.

2 In this monograph, there's a
3 significant dialog going on regarding
4 housing assignment compatibility. Any
5 unit manager or correctional officer,
6 for that matter of fact, or
7 correctional administrator, knows that
8 this compatibility is essential in
9 maintaining safety inside your
10 institution. But again, if there's
11 absolute confidentiality regarding the
12 incident of sexual abuse, whether it's
13 real or perceived, administrators will
14 not know this information. Without it,
15 a correctional officer or unit staff
16 member may house the offender with the
17 perpetrator's best buddy. Or worse
18 yet, with the perpetrator themselves.
19 This is especially relevant when you
20 look at the issue against broad
21 spectrum of inmates cliques, ethnic
22 grouping and the like. And that's a
23 nice way of saying gangs. If this
24 information was not available to
25 correctional personnel, your decision

1 in housing an offender may be, in fact,
2 a death sentence.

3 Finally, much has been said
4 about the victim having to suffer when
5 information becomes noted about him or
6 her, and induced by either staff or
7 inmates.

8 The realities of prison life
9 are that these issues are very
10 difficult. And sometimes the victim
11 does end up in administrative
12 segregation until alternative
13 arrangements are made. I want to
14 underscore the word, alternative
15 arrangements are made.

16 However, as I once told a
17 mother on the phone, I would rather
18 your son come home alive in one piece,
19 even if that means I keep him locked
20 down, than come home in a coffin,
21 because I did not take steps to ensure
22 his safety.

23 Absolute confidentiality is
24 a nice idea. And in an ideal world, I
25 would concur wholeheartedly. However,

1 prison life and the practicality of the
2 correctional administrator maintaining
3 safe and secure confinement does not
4 allow for this in its totality.

5 I'll be happy to try to
6 answer any questions any of you may
7 have.

8 CHAIRMAN KANEB:

9 Commissioners?

10 Commissioner Puryear.

11 COMMISSIONER PURYEAR:

12 I just have a quick
13 question. Take it just a step beyond
14 the confidentiality context but along
15 with the lines when we were talking
16 about, if a inmate -- I'm talking about
17 from Notre Dame. If an inmate comes up
18 and says, I want to transfer, and won't
19 give reason. Does the BOP have a
20 policy about what to do there, or is it
21 left to the discretion of the warden?
22 And what would be your response in
23 either event?

24 MR. BEELER:

25 Well, generally, we're going

1 to try to -- to -- first of all, we're
2 not going to put the inmate on the hot
3 seat, meaning we're not going to make a
4 big deal out of it right then and
5 there. Are we going to try to find out
6 what's going on? The answer is yes.
7 If it's an unverified protection case,
8 meaning we've done -- the inmate says,
9 I want to a transfer. And if it's an
10 unverified protection case, meaning
11 that we cannot verify a reason for
12 protection, then we're going to treat
13 that as an unverified protection case,
14 and after a period of time, try to work
15 the person back into the general
16 population.

17 If it's a verified
18 protection case, then we're going to
19 move the offender.

20 COMMISSIONER PURYEAR:

21 I guess this gets a little
22 bit to the point that the first witness
23 was raising about medical staff being
24 involved in these decisions. Is there
25 any risk to that? And then secondly,

1 could you -- could the whole problem be
2 solved if inmates were allowed to make
3 a request for a transfer knowing that
4 request will be honored but not having
5 any idea where they might have be
6 transferred to? In other words, it
7 might get them out of the immediate
8 zone of danger where there's a stigma
9 against reporting what's happening, and
10 a great risk potentially.

11 MR. BEELER:

12 I could see that used very
13 quickly as a manipulative device by
14 inmates wanting to transfer to another
15 location, so I would give that as a
16 caution. And -- but I would also say
17 that I think medical staff should be
18 involved, and we do involve medical
19 staff in issues regarding these
20 situations, to include both mental
21 health and medical staff because they
22 are often two different entities
23 looking at two different aspects of the
24 problem. So I -- I encourage that --
25 that issue.

1 The one thing that the
2 doctor said that I wanted just to make
3 a comment upon, is sometimes medical
4 staff don't know what's going on inside
5 the cell blocks either. And you've got
6 to be careful there. That dynamic
7 development of tension going on has to
8 be -- that's why I -- I'm very reticent
9 to say that you can have the absolute
10 confidentiality.

11 I would love to tell you
12 that I would sit here and say that that
13 could be a possibility. But my job as
14 a prison administrator is to keep
15 people alive in my institution. My job
16 as a prison administrator is to keep
17 people safe inside my institution. My
18 job as a prison administrator is to
19 stop assaults inside my institution. I
20 take that very seriously. Whatever I
21 can do to make that happen, I'm going
22 to try to make it happen. But at the
23 same time, I've got to have the
24 information to make that happen.

25 CHAIRMAN KANEB:

1 Thank you.

2 Other questions?

3 COMMISSIONER AIKEN:

4 Just one question, sir.

5 And please correct me if I'm
6 wrong. In relationship to protective
7 custody, in that universe, you've got
8 all types of population going into a
9 protective custody setting. You've got
10 the ex-gang member that turned against
11 his gang and gave some valuable
12 information; however, that individual
13 still has traits of random as well as
14 systemic violence against other
15 inmates. The sexual predator that's
16 now tagged the wrong person and half
17 the institution is after him, and he's
18 on protective custody. And then on the
19 other end, you have a very vulnerable
20 population in protective custody.

21 What are some of the
22 protocols, some of the approaches, and
23 some of the criteria that you may use
24 in order to protect the people that are
25 in protective custody from each other?

1 MR. BEELER:

2 That's a very good question,
3 Commissioner. Many times you have to
4 protect them from each other, as you
5 say. And oftentimes, that means
6 three-men holds on staff having to take
7 them out, especially if the candidates
8 that you just mentioned that -- we
9 haven't talked about at all, but you
10 just mentioned it. The sexual predator
11 who then becomes a victim because of
12 the situation -- because of the
13 situation, whatever that situation
14 might be.

15 And I think the Commission
16 should remember that, as the
17 correctional administrator, I have to
18 provide care and custody to both of
19 these parties, not just the victim. I
20 have to provide care and custody for
21 the predator also in this situation.

22 The child pornographer, the
23 child molester. When the information
24 becomes known inside of an institution.
25 I'm fortunate that we've been able to

1 work most of those things out at my
2 facility, and we can work most of them
3 into the population. But I run a large
4 medical facility, as you know,
5 Commissioner. And I run a large mental
6 health facility, as you know. I'm not
7 sure that I could do the same things in
8 the penitentiary. In fact, I have run
9 a penitentiary and know that I can't --
10 not necessarily to do the same things
11 for the penitentiary.

12 So it's -- each case you
13 have to look at an individual. And you
14 have to take those safeguards that you
15 have to take against each case, each
16 individual inmate, to make sure that
17 you did the best you can to keep them
18 safe.

19 COMMISSIONER AIKEN:

20 So basically what you're
21 possibly implying is that each case has
22 to be, quote, unquote, custom case?

23 MR. BEELER:

24 Yes, sir.

25 COMMISSIONER AIKEN:

1 You've got to look at the
2 medical issue, the security issue, the
3 gang issue, of who he can get along
4 with, the mental health issue. All
5 those issues have to take a weight and
6 a value before a final decision is
7 made; is that correct?

8 MR. BEELER:

9 That is correct, sir.

10 COMMISSIONER AIKEN:

11 Thank you.

12 CHAIRMAN KANEB:

13 Commissioner Smith.

14 COMMISSIONER SMITH:

15 Thank you.

16 Warden Beeler, thank you --

17 MR. BEELER:

18 It's good to see you again.

19 COMMISSIONER SMITH:

20 You too. Thanks so much for

21 your testimony. And it's good to see

22 that some of the materials that we've

23 been working on is useful.

24 What I hear you saying,

25 and I think you responded to it in

1 Commissioner Aiken's, is that one of
2 the reasons that you're able to talk
3 with such certainty about this, is your
4 particular context being in a medical
5 and mental health facility. And I
6 think we have lots to learn from how to
7 do things at Butner. But you've also
8 been pretty explicit about, if you were
9 doing this in a penitentiary -- in a
10 penitentiary it wouldn't work.

11 And so going back to this
12 whole thing that you've been asked to
13 testify about, which is absolute
14 confidentiality. What I hear you
15 saying, or at least what I'm taking
16 from your testimony, is that you feel
17 like absolute -- absolute
18 confidentiality is not helpful in terms
19 of safety and security. But the
20 reality is, is that we end up having
21 absolute confidentiality anyway,
22 because inmates make an assessment
23 about that, and they create their own
24 sense -- they create that environment
25 by not report it.

1 Is that a fair assessment?

2 MR. BEELER:

3 Partially but not totally.

4 COMMISSIONER SMITH:

5 Okay.

6 MR. BEELER:

7 We often find out about

8 sexual assault or alleged sexual

9 assault without the inmates coming

10 forward.

11 COMMISSIONER SMITH:

12 Exactly. From a third party

13 of some kind.

14 MR. BEELER:

15 Through a drop note --

16 COMMISSIONER SMITH:

17 Right.

18 MR. BEELER:

19 -- through a 1-800 line.

20 Those kinds of avenues. And when we

21 find out those information, it's

22 not -- it's us going forward to deal

23 with that situation. So sometimes the

24 inmates create their own situation

25 around themselves, and I'm not going to

1 dismiss that. But oftentimes, it -- it
2 ends up coming to us anyway.

3 Prisoners typically want to
4 live in a pretty peaceful existence
5 inside institutions. And many times,
6 if there's something going on that we
7 need to know about, we find out about
8 it, and it's not necessarily from the
9 inmates themselves coming forth and
10 telling us. Many times it's from a
11 third party telling us. And then we
12 have to deal with that situation. And
13 then we have to protect not only the
14 victim, we have to protect the third
15 party who's come forth and told us, if
16 that knowledge is public. Thankfully,
17 most of the time that, and large
18 majority of the time, that information
19 doesn't become public.

20 COMMISSIONER SMITH:

21 And just one last comment.

22 I know that the Bureau has
23 been struggling and really doing some
24 reassessment in the aftermath of
25 incidents at Tallahassee. Because I

1 think that that was a real situation
2 where there was an impact, not only on
3 inmates, where information wasn't
4 coming up, but it also ultimately
5 resulted in a death of an OIG agent, I
6 believe. Is that correct?

7 MR. BEELER:

8 Yes, ma'am. And one of the
9 most tragic days of the Bureau's
10 history is when the OIG agent was
11 killed by a staff member who was under
12 investigation at Tallahassee. And
13 large parts of that are still in
14 litigation. Many of those people have
15 pled guilty already, but I don't know
16 if everybody has pled guilty. But it's
17 certainly a tragedy.

18 CHAIRMAN KANEB:

19 Any other questions?

20 COMMISSIONER SMITH:

21 John, one last question.

22 I guess -- not wanting to
23 take up a quick -- but what are the
24 lessons that the Bureau has learned or
25 is taking from that? And I think it

1 relates directly to issues around where
2 information comes from and how it
3 circulates up, because it creates kind
4 of a really explosive environment.

5 MR. BEELER:

6 You know -- and I don't mean
7 to speak for the director --

8 COMMISSIONER SMITH:

9 Right. I understand that.

10 MR. BEELER:

11 -- right now. But in being
12 a prison administrator and being a
13 warden for 22 years, I found
14 Tallahassee to be one of the blackest
15 mark in our history, because I'm not
16 going to sit here and tell you that I
17 don't think somebody didn't know about
18 it. There are very few secrets in
19 prison. And -- when I talk about
20 totality of secrets. And I am still
21 sitting here today saying that somebody
22 knew what was going on. Can I prove
23 that? The answer is no. My gut is
24 telling me somebody knew the
25 information was going on. What are we

1 doing about it? Well, we're doing a
2 number of things about it.

3 One of the thing is that we
4 are continually harping on training.
5 Not that that hadn't happened before,
6 but we've got to continue the training.
7 We've got to continue the training.
8 We've got to get people to understand
9 their responsibilities.

10 The other thing is swift
11 action against people, and I mean staff
12 in those situations. We've got to take
13 swift action against staff, and certain
14 action against staff up to prosecution.

15 One thing that has not been
16 asked of me, and I -- I will just
17 simply say this since, it is the
18 prosecution of these cases, whether
19 they're staff or inmates. Now, in the
20 inmate situation it's often not
21 prosecution because in many places it's
22 not a law. It's a regulation. But for
23 staff, sometimes it's very difficult to
24 move forward with the prosecution
25 because the -- there are prosecutorial

1 issues, whether it be -- people say,
2 hey, this is a prison case. You guys
3 handle this.

4 And I will tell you most
5 prison administrators -- and I'm not
6 going to speak for all prison
7 administrators. Most prison
8 administrators want to take these cases
9 forward. We need no stop these
10 behaviors, and that's one of the ways
11 to stop the behavior.

12 We could have a long
13 discussion on this, Brenda.

14 COMMISSIONER SMITH:

15 We surely could.

16 CHAIRMAN KANEB:

17 Thank you.

18 I think we'll now move on to
19 Ms. Still, please.

20 MS. STILL:

21 Thank you. My name Wendy
22 Still, and I serve as the associate
23 director for the California Department
24 of Corrections and Rehabilitation.

25 On behalf of Governor

1 Schwarzenegger and Secretary Tilton,
2 I'd like to thank the Commission for
3 inviting the speakers at CDCR to
4 testify today.

5 The CDCR is one of the
6 largest state corrections department in
7 the nation with over 173,000 offenders.
8 In 2005, the legislature put
9 rehabilitation back into the core
10 mission of the California Department of
11 Corrections to indicate and reflect its
12 strong commitment for CDCR to become a
13 place where offenders make positive
14 strides towards becoming productive
15 citizens of our state and nation. PREA
16 in the work of this Commission fits
17 clearly within that mission.

18 The State of California also
19 qualified its support of PREA and the
20 principles described therein when it
21 passed the Sexual Abuse and Detention
22 Elimination Act in 2005. I believe we
23 were the first state in the nation to
24 pass a state version of PREA. State
25 legislation requires, among other

1 things, that the CDCR works in
2 collaboration with the communities
3 partners to end sexual violence in its
4 prisons, and ensures that prisoners who
5 have been victims of abuse have access
6 to basic services.

7 Regarding confidentiality
8 and reporting, the CDCR policies and
9 law requires disclosure of the
10 information by all staff, including
11 healthcare, when the safety and
12 security of an inmate is at risk. And
13 we have formal reporting protocols that
14 must be followed. However, one
15 critical strategy that we've employed,
16 from the beginning of our work on PREA,
17 is to collaborate without fine
18 organization that have expertise in
19 sexual violence for victim services.
20 This collaboration has allowed us to
21 incorporate fresh ideas and to expand
22 the limits of what we are able to
23 accomplish.

24 One such example is the
25 pilot project called, Path to Recovery,

1 through which we are collaborating with
2 Stop Prison Rape, a national human
3 rights organization based in Los
4 Angeles, and two of California's
5 community rape crisis centers, Path to
6 Recovery, which brings independent rape
7 crisis counselors into CDCR facilities
8 to provided confidential counseling
9 survivors of sexual abuse. The
10 counselors work with inmates who have
11 been sexually assaulted, at any time of
12 their lives, not only those who are
13 victimized while incarcerated.

14 Drawing on the success of
15 this program, I'd like to address today
16 the issue of confidentiality in mental
17 healthcare and correctional facilities,
18 particularly for inmates who have been
19 sexually assaulted.

20 Prior to Path to Recovery,
21 there was no mechanisms for CDCR
22 inmates who have been sexually
23 assaulted to obtain counseling without,
24 in essence, making an official report.
25 We know that sexual assault is one of

1 the most under-reported crimes in
2 society and in prison. It only serves
3 to reason then that many inmates will
4 not ask for help if it means making a
5 report.

6 Focusing on the well-being
7 of inmates, who have endured sexual
8 abuse, we at CDCR decided to take this
9 full step forward and launch the Path
10 to Recovery at 200 institutions. One
11 men's facility housing nearly 6,000
12 inmates at all security levels, and a
13 women's facility with 2400 inmates at
14 secure levels one through three.

15 During the pilot stage,
16 staff members at each of the pilot
17 institutions expressed hesitation about
18 the project, citing security concerns.
19 Investigators were particularly
20 resistant stating that creating a venue
21 for inmates to discuss an assault that
22 have conceivably occurred within the
23 institution without initiating a
24 formalized report, would undermine
25 their roles and the ability to ensure

1 institutional safety.

2 While this concern certainly
3 has merit, we believe that this effort,
4 in fact, ultimately would lead to more,
5 not fewer, formal reports of sexual
6 abuse. If survivors of sexual assault
7 know that confidential support services
8 are available, if they see the
9 institution providing for their
10 emotional as well as medical needs,
11 they will be more likely to access the
12 services and to create an environment
13 where offenders feel safe enough to
14 file these formal complaints so that
15 proper action may be taken against the
16 perpetrator.

17 Initially, staff also raised
18 concern about the potential for
19 departmental liability. How can
20 someone such as a community rape crisis
21 counselor know about a crime that has
22 been committed or planned in a state
23 institution and did nothing with that
24 information? Rape crisis counselors
25 operate under ethical and legal

1 obligations to protect their clients'
2 confidentiality, except in those cases
3 where confidentiality is legally
4 limited, such as where the inmate poses
5 a danger to him or herself or others.
6 In other words, because the Path to
7 Recovery counselors provide services
8 under that auspices of the community
9 rape crisis program by which they're
10 certified, they're bound not to tell
11 CDCR officials about the content of
12 their counseling session.

13 I am pleased to report that
14 far from being a security risk, the
15 access to confidential counseling has,
16 in fact, improved security at the two
17 pilot prisons. The investigation --
18 investigators in both of the pilot
19 institutions have created, in no
20 uncertain terms, that both the
21 relationship with the services and the
22 services offered by the community
23 organizations are useful tools in
24 carrying out the CDC's mission of
25 maintaining safe, orderly facilities

1 and keeping, basically, the offender
2 safe. The project has progressed to
3 where the CDCR mental staff members
4 also view it as an important tool.

5 One of the Path to Recovery
6 counselor recently reported she's now
7 receiving referrals from the CDCR
8 Mental Health Department at the prison.

9 I want to acknowledge that
10 inviting counselors from community
11 groups to come into the institution and
12 maintain the same confidentiality that
13 they had in the community to careful
14 planning and a leap of faith on the
15 CDCR's part. We have to have build a
16 positive, mutually respectful
17 relationship with community groups or
18 investigators, and carefully review
19 safety, security, and legal concerns.
20 Path to Recovery has also increased our
21 awareness in situations in which many
22 inmates may be at risk for sexual
23 abuse, but not reporting.

24 At one of the pilot sites,
25 the counselors were providing services

1 to an inmate who had been sexually
2 abused as a child and never received
3 any counseling or support, and indeed,
4 he had never told anyone. During the
5 course of the counseling, the inmate
6 also revealed being pressured by other
7 inmates to perform sexual acts. The
8 inmate stated that under no
9 circumstances was reporting it an
10 option. He feared retaliation from the
11 inmates, from feeling a great deal of
12 shame relating to the acknowledgment
13 that he is gay. However, he committed
14 Path to Recovery counselor to discuss
15 the safety concerns with the
16 correctional counselor without
17 disclosing the details of the threat.
18 And as a result, correctional counselor
19 took the appropriate steps and was able
20 to decrease inmates' risk by moving to
21 new housing. Not only does this avert
22 more serious problems, but it also
23 helps to develop a more positive
24 working relationship between the inmate
25 and his correctional counselor. And

1 that word certainly gets out within the
2 population.

3 In terms of prevention, the
4 impact of a respectful and caring
5 response to sexual assault cannot be
6 underestimated. A good example can be
7 seen in the case of an inmate who
8 reported a sexual assault by another
9 inmate. While interviewing the inmate,
10 the investigator informed him that he
11 could have access to a confidential
12 rape crisis counseling. And the
13 inmate, prior to that, was unwilling to
14 provide the investigator with any
15 information regarding the nature of the
16 potential risk for assault. But just
17 by virtue of the investigator offering
18 that option, the inmate provided full
19 details to the investigator, and
20 appropriate steps were taken.

21 This is just one example,
22 but it's clearly indicative of progress
23 we've made through this program. And I
24 can tell you this is not the only
25 example.

1 At both institutions, the
2 rape crisis counselors and
3 investigators have developed
4 cooperative professional relationships
5 that are apparent to any inmate with
6 whom they interact.

7 The counselors trust in the
8 investigator's ability to handle cases
9 sensitively and respectfully, carries
10 over to the inmate with whom the team
11 works. Perhaps, most importantly with
12 respect to prevention is the change in
13 culture that my last example
14 illustrated.

15 We all know that information
16 and rumor spread quickly in detention
17 settings. If the survivor had not felt
18 supported, he would be telling not to
19 report sexual abuse, as it is of
20 inmates who have been targeted for
21 sexual assault. And potential
22 perpetrators will see that the prison
23 is a place where survivors are believed
24 and supported and sexual assault
25 allegations are taken very seriously.

1 The Path to Recovery program
2 is part of an overall shift in how we
3 respond to sexual assault by providing
4 confidentiality. And counseling
5 relationship is a vital component of
6 the shift. The collaboration will stop
7 prison rape and local crisis -- excuse
8 me, rape crisis centers have shifted
9 our institutional culture in other ways
10 as well.

11 Prison, by default, can be a
12 dehumanizing environment. Programs,
13 such as Path to Recovery exert humanity
14 influence by changing expectation,
15 increase in available support, and
16 bringing in the influence of people who
17 are not in the detention environment
18 every day. In short, it challenges us
19 to think more expansively about what is
20 possible.

21 The more safe avenues we can
22 create for offenders to report, the
23 more reports that will be made.
24 Another one of our goals is that
25 individuals who might never file a

1 report would still be able to receive
2 services. An inmate who has been
3 sexually assaulted is likely to
4 experience a variety of emotional and
5 behavioral problems, particularly if he
6 or she believes there is no option but
7 to stay silent. So we believe,
8 therefore, that an increase in the
9 number of survivors of sexual assault
10 receiving counseling services will have
11 a positive overall impact on
12 institutional stability, safety and
13 community safety, also. We also expect
14 that for those that have had the
15 opportunity to participate in the
16 program, we will see a decrease in
17 reentry difficulties.

18 We see Path to Recovery
19 Project is one of the ways in which the
20 CDCR is putting the intent of PREA into
21 practice. We also have accomplished
22 some myth by staying around the idea
23 that providing confidential counseling
24 for inmates who have been sexually
25 assaulted is inconsistent with sound

1 correctional management.

2 In some, the in-house of
3 operating confidential counseling with
4 a trained crisis -- rape crisis
5 counselor has been an increased
6 awareness and understanding of sexual
7 violence among staff and inmates, an
8 increased capacity to fulfill a
9 rehabilitative mission and create an
10 environment that is more conducive to
11 reporting incidents of sexual abuse, a
12 positive shift in corrections culture,
13 inmate culture, and the perception of
14 inmates and officer by service
15 organizations in the surrounding
16 communities.

17 In addition, the project's
18 team approach means that the pilot
19 institutions are accountable to the
20 community and vice versa. Ultimately,
21 we believe that Path to Recovery will
22 result in an overall decrease in sexual
23 assault in our institution.

24 It's been an honor to speak
25 before the Commission on this

1 groundbreaking effort. I appreciate
2 that opportunity, and welcome any
3 further questions or comments that you
4 have.

5 CHAIRMAN KANEB:

6 Thank you, Ms. Still.

7 So these counselors are not
8 under any legal obligation to report.
9 They've been told by somebody who
10 sought their advice was sexually
11 assaulted?

12 MS. STILL:

13 That is correct. They do
14 not work for us. They work for the
15 Rape Crisis Center and, therefore,
16 their mandatory reporting requirements
17 are much different than the
18 department's or any employee of the
19 department.

20 CHAIRMAN KANEB:

21 And presumably, inmates are
22 seeking them out even though -- I would
23 assume the fact that if I were an
24 inmate and I sought an appointment with
25 one of these counselors, it would

1 become known that I had sought such an
2 appointment?

3 MS. STILL:

4 That is correct. However,
5 they are offered in terms of the way
6 they conduct it and the way that they
7 can request the appointment. It
8 also -- just the way that they request
9 the appointment is treated in a very
10 confidential manner also.

11 CHAIRMAN KANEB:

12 Thank you.

13 Are there -- Commissioners,
14 questions?

15 Commissioner Smith.

16 COMMISSIONER SMITH:

17 Ms. Still, I wonder -- I
18 mean, in reading your testimony, does
19 the -- do the rape counselors also
20 offer -- following up on Commissioner
21 Kaneb's question. Do they also offer
22 sort of general education to inmates
23 regardless of whether it's related to
24 report? That was the impression that I
25 got. It was more general education for

1 anybody so that it was sort of
2 institutionalized, and the system is
3 sort of mass whether it might be
4 involving any individual incident.

5 MS. STILL:

6 That is correct. We have a
7 very formalized PREA program. We have
8 policies. We have training. We have
9 videos. And so PREA awareness and
10 safety, we have the whole program.
11 We've created a partnership with Stop
12 Prisoner Rape to come in as one
13 component of our program so that
14 education, that interaction, getting
15 used to see the counselors and knowing
16 that they'll maintain that
17 confidentiality, is all part of having
18 a program that the offenders really
19 think that you take it seriously. And
20 they trust that you're going to do the
21 right thing.

22 COMMISSIONER SMITH:

23 And so to some extent,
24 having that comprehensive program also
25 provide some cover so that it doesn't

1 seem as if, okay, the Pathway to
2 Recover people aren't showing up, so
3 somebody must have been raped?

4 MS. STILL:

5 That is correct. Because
6 they could also be receiving counseling
7 about any type of abuse in their prior
8 history, not necessarily about
9 something that's happened right now.

10 CHAIRMAN KANEB:

11 Any type of sexual abuse or
12 any type of abuse at all?

13 MS. STILL:

14 Sexual abuse.

15 CHAIRMAN KANEB:

16 Thank you.

17 MS. STILL:

18 And I also just want to
19 point out, we also have our -- you
20 know, our mental health program, a
21 mental health reporting. And we will
22 follow the normal protocols that you
23 hear in the other system. This just an
24 added component.

25 CHAIRMAN KANEB:

1 Yes, Commissioner Fellner.

2 COMMISSIONER FELLNER:

3 The Path to Recovery is both
4 at the men's facility and at a women's
5 facility?

6 MS. STILL:

7 That's correct.

8 COMMISSIONER FELLNER:

9 And I know you're a director
10 of Female Offender Program, but I
11 wonder can you -- has -- what have you
12 learned in terms of -- are there
13 differences in how it's worked at a
14 men's facility versus the women? Are
15 there certain problems or obstacles?
16 Can you shed any light on -- is there a
17 gender difference here?

18 MS. STILL:

19 Sure. I worked and managed
20 and provided oversight to both male and
21 female prison. I just happen to be,
22 right now, over the female prison. In
23 addition to that, I also chair the PREA
24 Commission. So we -- our program
25 focuses on both the male and female

1 population.

2 But what I can say is there
3 may be logistical challenges, of
4 course, because an institution that has
5 6,000 versus an institution that has
6 2400 offenders, whether it be male or
7 female, that in and of itself are going
8 to create logistical issues.

9 But in terms of -- I'd say
10 both have real reluctance in terms of
11 our investigators about the liability
12 of this type of program. Probably the
13 male prison more so, although our
14 female also have concerns within the
15 institution. But the first
16 investigative team that came forward
17 and say, this is really working, was
18 our male facility. And then
19 subsequently right behind that, we had
20 some really great experiences in our
21 women's facility. So we've been very
22 happy, as had the wardens of those
23 facilities been. They rave about the
24 program.

25 COMMISSIONER FELLNER:

1 And how do you respond in
2 your statement, both what you said in
3 writing and speaking, about how you
4 respond to some of the investigators'
5 concerns? How do you respond to the
6 questions that were -- how do you
7 handle housing? I mean, if somebody
8 is -- if a man is being threatened by
9 someone and you can't -- it's not
10 reported, it's not known, so he may
11 remain being double celled or -- with
12 the person who is victimizing him?
13 What's -- how are you handling that?

14 MS. STILL:

15 Well, I think look at the
16 purpose of the counseling in and of
17 itself. An offender may want to have
18 someone to talk to. If they're having
19 a housing concern, they are either
20 going to deal with it or not,
21 irregardless if that crisis counseling
22 is taking place. If they are serious
23 about wanting a housing move, they will
24 come forward, or they will try through
25 other ways -- I have to somewhat use

1 the word "manipulative" -- to try and
2 achieve that housing move.

3 If an incident is reported
4 to our mental health or healthcare
5 staff, they will work very closely with
6 our custody. The question came up
7 earlier about if you're a healthcare
8 staff, if something was reported, could
9 they facilitate a move.

10 We pay close attention. We
11 don't -- sometimes we need as much
12 detail, of course, as possible to
13 protect the inmate so that we don't
14 move them back in. But that inmate is
15 not telling that rape crisis counselor
16 because he or she wants a cell move.
17 They're wanting to download the
18 emotionalism and all -- all the
19 feelings that go along with that. They
20 don't tell them because of the safety
21 concerns. But what those counselors
22 will try and do is, even though they
23 belong to the Rape Crisis and outside
24 the department, try to convince them to
25 at least allow them to go forward with

1 enough information, as the example I
2 gave, so that a housing move could be
3 facilitated, or the safety could be
4 protected.

5 So there still is that
6 cooperation that goes between the
7 counselors. I just think it creates
8 more credibility to the program. And
9 again, the more that we can break down
10 the environment or the culture to where
11 the offenders really believe it's going
12 to be taken seriously, the more
13 effective we are going to be in terms
14 of maintaining their -- or protecting
15 their safety.

16 COMMISSIONER FELLNER:

17 Could I ask one follow-up to
18 that?

19 CHAIRMAN KANEB:

20 Yes.

21 COMMISSIONER FELLNER:

22 Could you do the same thing
23 and have the same impact and trust or
24 whatnot if the counseling was being
25 done by department staff? Does it have

1 to be an outside agency?

2 MS. STILL:

3 I think right now where our
4 system is at, and I think where many
5 systems are at, is it's about trust.
6 And so -- and I think that that's what
7 that outside crisis counseling
8 represents to them, objective,
9 independent. They're not CDCR.

10 I do believe as more
11 programs like that are rolled out and
12 the cultures are broken down and the
13 inmate see a change, I think it will
14 become more viable for our staff to
15 provide also that type of an
16 alternative. And our mental health
17 staff can and do now provide it when
18 asked for. But a lot of times the
19 inmates won't want to necessarily talk
20 to our mental health staff. And so
21 this is just another avenue for them.

22 COMMISSIONER FELLNER:

23 Because your mental health
24 staff would have to report it?

25 MS. STILL:

1 Exactly. Because of the
2 mandatory reporting.

3 CHAIRMAN KANEB:

4 Ms. Still, is this program
5 in compliance with your own PREA Act,
6 or is it something you're undertaking
7 just because you think it's a good
8 thing to do?

9 MS. STILL:

10 Well, it's really in
11 compliance with our own state PREA law,
12 which requires us to develop
13 partnerships and work with outside
14 entities, you know, to all of our
15 programs. We also have a PREA
16 commission that I chair, and the Stop
17 Prison Rape since this. It's a part of
18 our PREA commission. As you see,
19 Irvine was mentioned earlier. We've
20 done a lot of research in our system.
21 We're getting ready to do more
22 research.

23 CHAIRMAN KANEB:

24 So you're saying your Act
25 requires CDCR to cooperate with outside

1 entities to prevent -- to deal with
2 prison rape?

3 MS. STILL:

4 It requires us to work in
5 collaboration with community partners
6 to end prison rape.

7 CHAIRMAN KANEB:

8 Commissioner Puryear wants
9 to ask a question, but one last -- and
10 I assume, whether it's MOU or others,
11 they are being paid for the service?

12 MS. STILL:

13 They are. And how they're
14 being paid for their service in terms
15 of \$500 grants to the crisis center,
16 it's really nominal. They do that as
17 part of their charter.

18 CHAIRMAN KANEB:

19 Okay. So in order to work,
20 this program requires, at least from a
21 budgetary point of view, a low cost
22 availability of fairly skilled people
23 to make -- to make it function. I
24 guess I'm asking that as a question.

25 MS. STILL:

1 That is correct. And
2 depending upon the use of the services,
3 right now, I believe with our MOU
4 provides is the \$500 grant toward the
5 crisis center for their cost and
6 services for really establishing the
7 program and a little bit of travel.

8 CHAIRMAN KANEB:

9 This is very interesting.
10 Excuse me. commissioner Puryear has
11 questions for you.

12 COMMISSIONER PURYEAR:

13 Just one quick question.

14 Have you determined whether
15 there's been any impact on the
16 prosecution for sexual assaults, either
17 of staff, other inmates, in result of
18 paths to recovery?

19 MS. STILL:

20 No. We've seen no impact
21 quite -- in terms of the prosecutions.
22 The few -- the examples that I've given
23 to the two institutions, the
24 investigators are very pleased because
25 they're getting more information.

1 They're getting information that they
2 wouldn't have gotten before. And one
3 of the cases led directly to a
4 prosecution. So it's -- it's opening
5 up more information coming to the
6 investigators.

7 CHAIRMAN KANEB:

8 Other questions of
9 Ms. Still?

10 COMMISSIONER SMITH:

11 I just have one -- one
12 question.

13 Ms. Still, one of the thing
14 is that -- you know, and I raised this
15 question earlier. In California's
16 scheme, can rape crisis counselors
17 provide services to people in custody
18 to defendants? Because I know that
19 that's -- that in some jurisdictions
20 they're not able to provide those
21 services. So I'm wondering how you
22 guys are managing that, or sort of
23 getting around that barrier, if there
24 is one.

25 MS. STILL:

1 Well, that's why the \$500
2 grant to them, because there is a
3 barrier. Some of -- some of the crisis
4 centers will do that, and they have the
5 money to operate. But in reality, they
6 can't use any of their funds that they
7 get from the feds, as I understand it,
8 for that purpose we're talking about.

9 CHAIRMAN KANEB:

10 Well, thank you very much.
11 This has been an enlightening
12 presentation.

13 COMMISSIONER FELLNER:

14 Has our staff asked you or
15 gotten -- is it possible for us to get
16 your research results? You've done
17 research; the monograph was mentioned.
18 Have we got -- has the Commission's
19 staff contacted you to get copies of
20 it?

21 CHAIRMAN KANEB:

22 Yes. We have -- we have--
23 Professor Cooksbury (phonetic) is
24 raising his hands and putting his thumb
25 up to your --

1 COMMISSIONER FELLNER:

2 Okay. Thank you.

3 MS. STILL:

4 We have a subsequent
5 research project getting ready to
6 start. We will be happy to provide
7 that when it's finished.

8 CHAIRMAN KANEB:

9 Thank you again.

10 Ms. Sander.

11 MS. SANDER:

12 Hi, I'm Lynn Sander, and I'm
13 also going to be talking about
14 confidentiality reporting. I listened
15 in this morning, and I heard many
16 things and it brought stuff to my mind.
17 And so I'm not going to be reading from
18 my thing. I'm trying to -- some things
19 that came to mind --

20 CHAIRMAN KANEB:

21 Thank you.

22 MS. SANDER:

23 -- and I tried to rearrange,
24 but I did not have a computer where I
25 can cut and paste and put things in

1 that order. Hopefully, I will be able
2 to follow my arrows on my piece of
3 paper.

4 One thing that I wanted to
5 mention that I've heard over and over
6 again that people are talking about,
7 who are we talking about, and who are
8 we talking about. And we hear a lot
9 about male on male prisoner rape. I
10 have not heard any talk about female on
11 female prisoner rape, and that happens
12 as well. Obviously, there's not
13 necessarily a penetration, but there
14 can be a lot of sexual coercion amongst
15 female population, and I have females
16 report that to me. We also talked
17 about inmate and officer rape, and that
18 can go both direction. It can be
19 either heterosexual or homosexual. And
20 I just wanted these things stated.

21 CHAIRMAN KANEB:

22 Thank you.

23 MS. SANDER:

24 The other issue is the issue
25 of the victim who becomes a

1 perpetrator, or the perpetrator who
2 becomes a victim. And I think again,
3 we talked about -- touched on that a
4 little bit. And I think, again, that
5 we need -- all these things need to be
6 addressed.

7 I come from mostly a jail
8 background. And I think I am probably
9 half a little -- because I come from a
10 very progressive administration, and
11 the inmates in that facility trust most
12 medical -- most of the medical staff
13 and most of the custody staff and felt
14 very comfortable in reporting. As a
15 matter of fact, most cases brought to
16 my attention were brought by the
17 officers. The inmates report it to the
18 officers, and they brought the person
19 to medical to then get them evaluated.
20 So it's a very different situation.

21 I'm also here representing
22 NCCCH, which is the National Commission
23 of Correctional Healthcare, has asked
24 me to come and talk a little bit about
25 their standards. And I am the

1 immediate past-president of the Society
2 of Correctional Physicians, and I'm on
3 their board. And both of those
4 organizations, I'm sure, would be happy
5 to work with you in developing
6 standards. They have their own
7 standards and they also have policy,
8 and we'll be happy to work with you.

9 I think when you're talking
10 about confidentiality, the most
11 important thing confidentiality gives
12 you is trust. And without trust,
13 you're not going to get reporting. If
14 they don't trust that you're going to
15 use that information in a way that's
16 helpful to them and will not bring harm
17 to them, then they're not going to
18 report, and you're going to defeat your
19 purposes. The other thing that -- and
20 if you didn't get reporting to either
21 medical or security, you don't get
22 treatment.

23 We heard someone say just
24 this morning that most of these people
25 go back to the community. If you don't

1 get treatment, you're harming the
2 community in an additional way because
3 you're bringing it back to the
4 community, if there's no prophylactic
5 treatment. So we need to consider all
6 these factors.

7 And now I'm going to go in
8 the NCCH standards. There is a
9 standard on the procedural for sexual
10 assault. Their primary thing they
11 said -- the first recommendation is
12 that you send patients to a facility
13 that's equipped to do the proper
14 evaluation of the patient, both from
15 the medical and forensic point of view.
16 I personally think that there are a lot
17 of real benefits to that.

18 In-house -- the medical
19 staff has to take care both the victim
20 and the perpetrator as their primary
21 care physician and nursing staff. And
22 if you are taking sides in that case,
23 that really prevents you from doing
24 your mission of what you're really
25 there in a correctional institution to

1 do.

2 If you send them out to a
3 hospital or facility, first of all,
4 they're going to have people there with
5 the training to do that properly. Most
6 correctional institutions, especially
7 small jails, are not going to have
8 people with the experience and the
9 training. They're not going to have
10 the mental health staff and the proper
11 rape counselors there to follow-up with
12 those patients. So I think it's
13 really -- I take that as one ideal way
14 to do it.

15 The other thing that it does
16 is, in every state has a law, have --
17 have various reporting laws. Most of
18 them rape is a crime. Sexual assault
19 is a crime. And therefore, there is
20 mandatory reporting just as with child
21 abuse. If you bring them to a hospital
22 ER setting to manage them, they are
23 required to report that, and they will
24 call the police on it. The police will
25 start the investigation, but then the

1 police will report back to the
2 correctional institute. It really
3 takes your staff at the institution out
4 of the loop, which I think is very
5 helpful.

6 If you're in an institution
7 where you really have all this, you
8 have the rape kits, you have medical
9 staff who have gone through proper
10 training, then at the very least they
11 should be brought for medical
12 evaluation. They should get sexually
13 transmitted disease testing. They
14 should get mental health counseling.
15 And you should ensure the safe -- now
16 there's been a lot of talk. How do you
17 ensure safety? And what do you tell
18 the officers when you, as a medical
19 person, make a recommendation to move
20 them? Well, you can say, I'm concerned
21 for this person's safety. He has some
22 medical conditions that, probably if it
23 got out to the other inmates, would put
24 him in harm's way. And I think you
25 should put him in some kind of

1 protective custody.

2 In the institution I work
3 with, that would be enough. That may
4 not be true in all institutions, and
5 there's a lot of concern for
6 prosecution. And ideally, we all want
7 every perpetrator of every crime
8 prosecuted, investigated, and punished.

9 But the reality is, in the
10 outside world, if a woman is raped they
11 can report it but she doesn't have to
12 say, I want to prosecute for male
13 sexual assault. So why should an
14 inmate be treated differently? I mean,
15 if you look at the constitutional
16 standards, there's community standards.
17 A person has a choice whether they want
18 that perpetrator prosecuted. So even
19 though, you know -- especially in the
20 correctional environment, you really
21 want -- you know, your mentality is
22 more towards that. We need to remember
23 that they're under the same laws in
24 that regard as anybody else.

25 Now, whether the institution

1 then feels, well, we have our own
2 internal procedures that we want to go
3 through. That's fine. But a true
4 criminal prosecution really can't take
5 place without the victims' willingness
6 for that to take place, unless there's
7 a law, such as domestic violence, where
8 you can prosecute the partner without
9 the victim.

10 CHAIRMAN KANEB:

11 Excuse me, Ms. Sander.
12 Unfortunately, I have mismanaged the
13 clock here.

14 MS. SANDER:

15 Okay.

16 CHAIRMAN KANEB:

17 So I need to ask you to --
18 if you'll -- and I thank you for not
19 reading your statement. -- wrap up, and
20 we will have questions.

21 MS. SANDER:

22 Yeah. I think I really
23 pretty much said it all, so you came at
24 a perfect timing.

25 CHAIRMAN KANEB:

1 Well, thank you. I will now
2 take even greater advantage of my
3 mismanagement. Would I just be able to
4 ask you this.

5 What if the answer to your
6 question about why a victim should not
7 have to have his or her victimization
8 reported is that sex in prison is
9 illegal, and it's not a matter of you
10 not wanting your rape to be reported.
11 It's a matter that sex took place, and
12 that it's a crime. Is that an answer
13 to your -- would that suggestion be
14 optional on the part of the victim?

15 MS. SANDER:

16 Yes. But what I'm saying
17 is, for any crime, a victim has the
18 opportunity to say, I don't wish to
19 press charges. That's what I'm saying.
20 It's not that it's not a crime. It's
21 not that they don't acknowledge it as a
22 crime, 'cause they don't want to press
23 charges.

24 CHAIRMAN KANEB:

25 I'm out of my element. I'm

1 not a lawyer. Are there other
2 questions of Ms. Sanders?

3 All right. Thank you.

4 And, Ms. Hill, I give you
5 what time you -- you need here. I
6 apologize.

7 MS. HILL:

8 Should I talk really fast
9 then? Well, good afternoon. It is a
10 privilege for me to present to you on
11 PREA, specifically on issues of
12 confidentiality reporting from a legal
13 and corrections perspective.
14 Undoubtedly, this whole process of
15 eliminating rapes is an allottable one,
16 and it is heinous. And it is one we
17 should all unite in this amazing effort
18 to do that.

19 The United States Supreme
20 Court has recognized that such offenses
21 are not part of the penalty that
22 prisoners are sentenced to suffer. In
23 my 20 years in corrections field as a
24 former general counsel to the Utah
25 Department of Corrections and in my

1 training to the jails in -- nationally,
2 we teach them that it's not only the
3 inmates having Eighth Amendment rights
4 to be free from cruel and unusual
5 punishment, but we in corrections have
6 a duty, and it's a strong duty, to
7 protect these inmates from harm.

8 Exactly how corrections goes
9 about protecting their inmates,
10 especially from rape, is not so simple
11 as has been mentioned. Decisions
12 regarding prisoners require delicate
13 balancing between the prisoners' rights
14 and corrections' obligation to maintain
15 a safe and secure environment. But
16 also as the Supreme Court has
17 recognized, there is a need to defer to
18 corrections and how best to operate
19 their facilities on a day-to-day basis.

20 And as the Commission
21 mandates -- mandates on the issues of
22 confidentiality and reporting, I
23 respectfully request that you recommend
24 broad policies, which allow the
25 administrators in the trenches to best

1 determine how procedurally to implement
2 the mandate, recognizing that the
3 resources of a very small jail are
4 vastly different than that of a huge
5 prison. They are unique.

6 In addition, I also would
7 like to encourage the Commission to
8 consider the appropriation of monies
9 for much needed mental healthcare, and
10 also for training to make PREA a
11 reality. As progressions go with --
12 mandatory reporting goes, one critical
13 issue is to whom such report should be
14 made. We've heard so much about this.
15 There is no specific legal requirement
16 as to how an institution gathered --
17 gathered its information regarding
18 protecting its prisoners. What is key,
19 and as everyone has mentioned, is that
20 the prisoner reports, and then that
21 information somehow gets to security.

22 I speak generally that how
23 the prisoner -- or prisoners are more
24 likely to report when they feel
25 comfortable in telling; that has been

1 said. Requiring prisoners, however, to
2 report to one specific person or a type
3 of person may be too restrictive,
4 depending on resources available to
5 that particular institution. Again,
6 deference to correctional
7 administrators on how and to whom the
8 individuals should report, remembering
9 that very small jails have very limited
10 resources from community. At a minimum
11 though, corrections should make
12 reporting mechanisms part of every
13 prisoner's orientation. Second,
14 mandatory reporting should be required
15 of all staff, vendors, and visitors who
16 know of or suspect that a prisoner may
17 be a victim so that correctional staff
18 can respond.

19 Knowledge is essential in
20 our correctional system. Unlawful
21 conduct, such as rape, must be reported
22 to security staff so that they can
23 fulfill the objective of maintaining a
24 safe and secure environment.
25 Protecting the victim, once identified,

1 securing the crime scene, providing
2 necessary mental health treatment,
3 protecting other criminal -- or other
4 prisoners from possible future harm
5 from the alleged perpetrator,
6 reclassifying the prisoner, if
7 necessary, and disciplining both
8 administrative and criminally are
9 obligations that security, in fact,
10 has.

11 There has been mention of
12 housing, and I would like to touch on
13 that just real briefly. One of the
14 recommendations we do when we're
15 training is to encourage corrections to
16 triage with medical on all issues --
17 all cases involving inmates so that
18 housing decisions can be made together.
19 Maybe even without getting in all the
20 specifics, but clearly, corrections has
21 to be involved in that.

22 Decisions regarding
23 confidentiality require, again, that
24 balancing act between the victims'
25 desire to confidentiality and the

1 corrections' constitutional need to
2 protect not only the victims but all of
3 the other prisoners. The general
4 practice in corrections is that
5 security has access to all confidential
6 files, including medical on a need to
7 know basis for legitimate penological
8 purposes, specifically housing
9 decisions, classification decisions,
10 decisions as well as vulnerability and
11 protection issues, specifically on the
12 issue of rape.

13 The reporting of a rape,
14 including the identity of the alleged
15 perpetrator, cannot be kept
16 confidential from corrections, and must
17 be reported to security staff so that
18 they could take immediate action
19 against -- to protect the victim for
20 classification decisions, for
21 disciplinary issues, et cetera.

22 In addition, medical staff
23 should be required to report, and I
24 would ask that they be exempt from any
25 statutory liability for doing so. The

1 doctors who we work with and we talk
2 with, all want to protect that
3 particular inmate, and are all feeling
4 this tear between their privilege and
5 this confidential information and the
6 need to also share it with corrections.
7 So if this were to -- and how this
8 happens, I encourage you to look at
9 some statutory exemptions for them.

10 I applaud the Commission for
11 its goal. Eliminating rape in our
12 jails and prisons is one shared by
13 every correctional professional that I
14 work with. But I also encourage us to
15 look at broad policies in making these
16 mandates with specific procedurals
17 going to the individual institution,
18 again, recognizing that a very small
19 jail has very different resources and
20 allocation as that of a super max-type
21 of prison.

22 I thank you very much, and
23 I'm opened to your questions.

24 CHAIRMAN KANEB:

25 Thank you, Ms. Hill. So I

1 understand what you're asking in
2 respect to leaving the medical
3 professionals' liability, would you
4 please restate that again?

5 MS. HILL:

6 Some type of exemption. If
7 a doctor works within a facility --

8 CHAIRMAN KANEB:

9 A doctor or a nurse?

10 MS. HILL:

11 Correct. Let's call it
12 medical. The question is whether or
13 not there is a privilege between the
14 doctor and the inmate, and it's a
15 questionable one. The doctor will tell
16 you -- and everyone will recognize that
17 there's a doctor-patient privilege.
18 The question then becomes, if there is
19 a legitimate governmental interest,
20 does medical have -- or does security
21 have access to that information? And
22 the practice is, that they do.

23 They need to have access to
24 that medical information in making
25 determinations regarding

1 classification, regarding housing for
2 protection purposes, whatever it might
3 be. So many doctors, medical
4 profession, may feel conflicted
5 mandatory reporting. They have a
6 privilege that they see, and yet
7 security staff needs this information
8 for making decisions, again, on housing
9 classification, et cetera.

10 So I guess if they do
11 report, what I'm asking is that there
12 would be an exemption on them from
13 liability.

14 CHAIRMAN KANEB:

15 Against by a claim by the
16 victim that they had breached a
17 confidential patient-doctor
18 relationship?

19 MS. HILL:

20 Correct.

21 CHAIRMAN KANEB:

22 Do you think that medical
23 staff now feel they are exposed to such
24 liability?

25 MS. HILL:

1 I have several doctors who
2 have expressed the concern and asked
3 whether or not you would at least
4 consider it, depending upon how the
5 language and how reporting comes down.

6 CHAIRMAN KANEB:

7 Okay. Well, we are a
8 federal commission, and we are,
9 basically, going to develop standards
10 that are going to be meant for the
11 federal system. And their degree of --
12 of jurisdiction in non-federal systems
13 is --

14 MS. HILL:

15 I understand.

16 CHAIRMAN KANEB:

17 -- to be silenced, so. But
18 thank you.

19 Commissioner Fellner.

20 COMMISSIONER FELLNER:

21 I have a question from your
22 written statement about Broward County,
23 Florida.

24 MS. HILL:

25 Yes.

1 COMMISSIONER FELLNER:

2 You say that it requires all
3 staff, contractor, vendors, and
4 visitors who know or suspect that a
5 prisoner may be a victim must report.

6 By visitors, do you mean
7 family, friends are also under the
8 obligation to report, or do you mean
9 official -- what is the scope of the
10 mandatory reporting here?

11 MS. HILL:

12 And you're asking me a very
13 good question, and I can't specifically
14 answer 'cause it's general. It's not
15 defined. But the general policy is, as
16 I understand it, is that anyone --
17 anyone who has access to an inmate is
18 required to report any indication of
19 sexual abuse, whatever that might be,
20 and whether it be to any staff member
21 that they come into contact with.

22 COMMISSIONER FELLNER:

23 Do you think that it is
24 meant to extend to family, friends, not
25 officials, that that's a good idea?

1 MS. HILL:

2 And I don't think that's
3 generally who they were referring to.
4 I'm assuming they might have been
5 referring to people who are visiting.
6 And I don't have a specific definition
7 on that. And it's one that I'll be
8 absolutely more than willing to
9 followup with you.

10 The purpose, I think, behind
11 it is, is that all staff, vendors,
12 everyone tells -- anyone who comes in
13 contact with the visitor should be
14 required to report so that we can
15 immediately protect the victim and,
16 again, start looking whether there's a
17 crime scene and whether or not we have
18 to look at classification,
19 investigation, etc. But the idea is
20 mandatory reporting for anyone coming
21 into contact with an inmate for sexual
22 abuse.

23 CHAIRMAN KANEB:

24 That's certainly -- thank
25 you.

1 Are there other questions?

2 Yes, Commissioner

3 Struckman-Johnson.

4 COMMISSIONER STRUCKMAN-JOHNSON:

5 Mr. Beeler and Mr. Puisis,
6 would you respond to Ms. Still's idea
7 of recovering -- Pathway to Recovery?
8 If you could have a conversation about
9 what you think about that. I'll ask
10 either one of you. Does that sound
11 good?

12 MR. PUISIS:

13 I'm sorry. I didn't
14 understand your question.

15 COMMISSIONER STRUCKMAN-JOHNSON:

16 What do you think about the
17 Pathway to Recovery program? Does it
18 sound like a solution to either one of
19 you? Technically, you can have -- you
20 can have treatment without reporting,
21 so

22 DR. PUISIS:

23 Well, I -- I think the
24 strong part of it is that it's an
25 outside entity, so it removes the

1 problem outside of the prison where
2 there's likely to be more pressure on
3 staff to be seen as part of the
4 correctional machinery. And so by
5 getting -- it's very similar to -- I
6 agree very much with the
7 recommendation, that if someone's raped
8 to take them outside the prison for
9 medical evaluation. I think that's a
10 very sound principle.

11 In the same sense, I think
12 what that stands for is removing the
13 counseling piece to an outside entity.
14 And I think that's allottable. But
15 obviously, you cannot sustain a system
16 like that if it's a pro bono system.
17 And I think the Chair mentioned that --
18 he was talking about that, that there
19 has been mechanisms that can sustain.

20 But I think it's a good
21 system. It ensures counseling. It
22 ensures an inmate an avenue to talk to
23 someone who they feel is -- may not be
24 compromised, regardless of physicians
25 who work in corrections field

1 themselves relative to patients.
2 Inmates may not see it that way. I
3 think it's, overall, a good thing.

4 CHAIRMAN KANEB:

5 Mr. Beeler, did you have
6 something you want to say on this
7 subject?

8 MR. BEELER:

9 Certainly, sir. Thank you.
10 It boils down to a matter of trust.
11 And where is the trust laid? If the
12 trust is laid in an outside resource,
13 the only caveat I would put there --
14 and she made -- Ms. Still made this
15 caveat. Is there a danger to somebody
16 else, to themselves, or others? The
17 only question I raise to that is, how
18 do they know where the danger lies?
19 And that's my only concern there,
20 because they're not going to know all
21 the time where the danger lies. And
22 that's my biggest issue, making sure
23 that the safety of that individual
24 is -- I mean, it's a dynamic mentioned
25 with this all along. It's the safety

1 of that individual. It's not just all
2 about the prosecution of the
3 offender -- of the perpetrator. It's
4 about the safety of the individual too
5 and the safety of that institution and
6 the safety of other people who may be
7 victimized.

8 CHAIRMAN KANEB:

9 Thank you.

10 Commissioner Smith.

11 COMMISSIONER SMITH:

12 I thank the entire panel.

13 And I think one of the reason that we
14 wanted to do this panel is because all
15 of the issues around privilege,
16 reporting, HIPAA, other ethical -- I
17 mean, you guys have done a great job in
18 trying to make it clear. But I have to
19 still say that it's clear as mud to me.

20 Because I think -- Ms. Hill,
21 when you -- it sounds like in your
22 testimony you suggest that there's sort
23 of be a broader standard that would
24 kind of help deal with these privilege
25 issues. But as you also recognize,

1 privilege stuff is very much state
2 based, and it goes across clergy -- and
3 often these matters are reported to
4 clergy. -- physicians, drug counselors,
5 so on and so forth. So I think that
6 this is really something that the
7 Commission is going to have to struggle
8 with. But I think that you've added
9 tremendously, and also you as well as,
10 Ms. Sander, have added tremendously in
11 terms of identifying some resources
12 that are all in one place that we did
13 not know were available. So I
14 really -- I appreciate it, and will go
15 back and try to wade through. So thank
16 you.

17 CHAIRMAN KANEB:

18 Let me just finish by saying
19 the matter of reporting, the
20 effectiveness of reporting, the
21 availability of reporting, the trust in
22 reporting, we know is absolutely
23 essential to constructing a safe house
24 here for potential victims. This has
25 been helpful. We're putting a lot of

1 work in it.

2 I hope you know that we're
3 consulting with lots of different
4 people, you know, in several days a
5 week outside of the hearing process. I
6 know professionals in the industry
7 would know that, but. We are gathering
8 a lot of information and taking it very
9 seriously. So thank you so much.

10 Thank you. And now we're
11 going to have a brief recess. And
12 we'll come back at 2:30.

13 (Off the record.)

14 CHAIRMAN KANEB:

15 Ladies and gentlemen, we're
16 resuming. Our next panel is seated,
17 and I would ask that the other people
18 also seat themselves at this time.

19 At this point we swear in
20 our panelist. Unfortunately, my
21 general counsel and officer does that
22 is not here at the moment. Actually, I
23 might even do it myself.

24 COMMISSIONER FELLNER:

25 Go for it.

