PREA AUDIT REPORT ☐ **Interim** ☒ **Final**

ADULT PRISONS & JAILS

Date of report: April 25, 2016

Auditor Information			
Auditor name: Amy Fairbanks			
Address: P. O. Box 16054 Lansing, MI 48901			
Email: fairbaa@comcast.net			
Telephone number: (517) 303-4081			
Date of facility visit: March 23-25, 2016			
Facility Information			
Facility name: North Central Correctional Instituion			
Facility physical address: 500 Colony Rd. Gardner, MA 01440			
Facility mailing address: *(if different from above)* P. O. Box 466 Gardner, MA 01440			
Facility telephone number: (978) 630-6000			
The facility is:	☐ Federal	☒ State	☐ County
	☐ Military	☐ Municipal	☐ Private for profit
	☐ Private not for profit		
Facility type:	☒ Prison	☐ Jail	
Name of facility's Chief Executive Officer: Raymond Marchilli			
Number of staff assigned to the facility in the last 12 months: 356			
Designed facility capacity: 598			
Current population of facility: 973			
Facility security levels/inmate custody levels: Medium/minimum			
Age range of the population: 20-83			
Name of PREA Compliance Manager: Karen DiNardo		**Title:** Deputy Superintendent	
Email address: Karen.DiNardo@MassMail.State.MA.US		**Telephone number:** (978) 630-6000 Exxt.153	
Agency Information			
Name of agency: Massachusets Department of Correction			
Governing authority or parent agency: *(if applicable)* Commonwealth of Massachusetts			
Physical address: 50 Maple Street Suite 3, Milford, MA 01757			
Mailing address: *(if different from above)* Click here to enter text.			
Telephone number:			
Agency Chief Executive Officer			
Name: Carol Higgins O'Brien		**Title:** Commissioner	
Email address: Carol.Higgins.O'Brien@MassMail.State.US		**Telephone number:** (508) 422-3330	
Agency-Wide PREA Coordinator			

Name: Michael P. Donaher	**Title:** PREA Coordinator
Email address: Michael.P.Donaher@MassMail.State.US	**Telephone number:** (505) 541-5301 Ext. 12

AUDIT FINDINGS

NARRATIVE

On March 23-25, 2016, an audit was conducted at the North Central Correctional Institution to determine compliance with the Prison Rape Elimination Act standards finalized August 2012.

A complete tour of the facility was conducted on March 23, 2016 (medium custody) and March 25 (minimum custody). Areas and operations were observed during this tour that included the following:
Medium Custody
Inmate living areas:

- **Thompson 1, 2 & 3 including RTU double occupancy cells, a few single occupancy cells)**
- **Restrictive housing (one area operational with 12 beds, one closed)**
- **Medical housing unit (one four bed room, two mental health observation cells)**
- **F unit dorms (one area off line due to weather damage)**
- **G unit dorms**
- **H unit dorms**
- **I unit dorms**
- **A unit (one side receives orientation offenders, restrictive housing step down offenders and offenders moved from other housing areas due to lack of programming programs)**
- **B unit dorms**

Medical operations, booking operations, Programs building (classrooms, offices, barber shop) religious areas, laundry, gymnasium, weight lifting building, music building, maintenance, welding classroom, small engine repair classroom, optical labs (two areas), medication dispensing area, food service operations.
Minimum Custody – Inmate living areas, visiting areas, dining, programming and recreation areas.

Documents reviewed for this audit prior to and during the audit included the completed PREA questionnaire, policies, contracts, training curriculums, staff training records, documents from personnel files, contract/volunteer training records, documents printed from electronic logbooks (rounds, unannounced supervisory rounds), housing unit assignments, Intake risk assessments, 30 day risk assessments, PREA incident review meeting minutes, sexual abuse & harassment complaints, accreditation reports, staffing analysis, vulnerability assessment, and population reports for the previous twelve months. Cameras and monitoring operations were also examined.

The agency interview with Commissioner Higgins O'Brien was conducted on April 7, 2015. This interview confirmed strong support for compliance with the PREA standards by the Massachusetts Department of Correction. A follow up phone interview with the Commissioner on March 24, 2016 was also conducted. The support continues. Further information was conveyed regarding the use of the annual PREA report and how it is used with the annual staffing analysis and with the department wide initiative to continue to purchase cameras for monitoring based on needs identified in the report.

Twenty-one formal staff interviews were conducted through random selection of staff during the audit as well as scheduled interviews with specialized staff. They were conducted with the following: The Superintendent , PREA compliance manager (Deputy Superintendent), medical staff (Health Services Administrator, Mental Health Administrator, one mental health clinician, one afternoon shift RN), 11 corrections officers/supervisors from all areas of facility and shifts (including special management housing), three investigators (who also monitor for retaliation and participate in the PREA incident review team), two Correctional Program Officers (one who reviews grievances and one who assist offenders when they are ready to leave) and two programming staff – one barber shop instructor and one industry supervisor. Informal interviews were conducted with several staff throughout the tour addressing questions relevant to the operations and the standards.

A total of 23 formal interviews with offenders were held. Offender interviews were conducted in the attorney visiting room to afford privacy. One inmate from each housing unit was interviewed in addition to four who wrote letters, one with mobility issues, two with non-heterosexual orientations (one transgender inmate), one victim from a different facility, and one limited English offender. Two inmates housed in restrictive custody were asked if they would be willing

to be interviewed and both denied the request in the presence of the auditor. Four offenders were spontaneously questioned during the tour regarding female announcements, unannounced supervisor rounds and telephones.
A total of 22 hours was spent observing, touring, and interviewing at the facility during the dates noted. The auditor was allowed free access to all areas of the facility, access to interview offenders and staff and to see any documentation requested. Posters were visible throughout the facility announcing the audit. The auditor's name, address and dates of the audit were posted on the website several weeks before the audit. Offenders indicated they were aware that there was an audit.

Contact was made with Prison Legal Services in April 2015 as they were identified as an advocacy group that has acted upon the interests of inmates/offender housed in the Massachusetts Department of Correction. The auditor's contact information was provided along with an explanation of the role of the auditor certifying PREA compliance with the state agency. A meeting was held with Leslie Walker, Executive Director, Prisoners' Legal Services to discuss the audit process standards, and concerns from their organization on August 10, 2015. An email was sent March 2016 indicating what audits were being conducted in the coming weeks and where. An invitation to meet again was extended. To date no response has been received to the second contact.

DESCRIPTION OF FACILITY CHARACTERISTICS

North Central Correctional Institution is located approximately 58 miles west of Boston, Massachusetts. The facility was built in 1902 and used as a mental health operation, closed then re-opened when it was converted to a prison in 1981. There are 35 buildings in use for this facility. The average daily population is 973; the design capacity is 598.
There are 15 housing units, all unique in physical plant layout. One building is three levels and houses inmates in cells, typically with two beds. There are some multiple occupancy rooms and a few single cells as well. The Residential Treatment Unit is located in this building. There are two separate segregation units (restrictive housing) however one has not been utilized for several years and is therefore off line. The medical area has two secure mental health cells and a medical unit with one room and four beds. The remainder of the housing units are in either multi level buildings or single level buildings with dormitory settings. There is a minimum custody building outside the fenced perimeter which can house up to 30 inmates. All bathrooms and showers were observed in additional to all living areas. The physical plant affords female staff to conduct rounds and perform security functions but affords inmates the opportunity to shower, use the bathroom and change without having to be observed.

There are a variety of programming and recreation opportunities at this facility. They include small engine repair, welding, wood shop, optical program, education, sex offender treatment, music, barber instruction, culinary arts, two different dog handler programs and spacious areas for numerous religions to practice their faith. The inmate population consists of over 60% sex offenders, many long term offenders/lifers (approx. 20%) and other medium security offenders. Many inmates interviewed formally and informally want to reside at this facility. Many staff have significant correctional experience and also want to work at this facility.

One area of correction was required by the auditor although not specifically mandated by the standard. One unit had bathrooms that did not have privacy doors. Although the design of the housing area did not allow visibility to female staff, toilets are located across from the sinks/mirrors and may provide a potential uncomfortable situation for offenders when in use. This had not prompted any PREA investigations but in the interest of prevention, the auditor is requiring that doors be placed on bathroom stalls for this unit that provide privacy yet afford enough vision for security. An action plan was provided and given to the auditor prior to the end of the audit. Updates will be provided upon completion. Modifictions to bathroom doors is lo being addressed with the Director of Engineering Services.

SUMMARY OF AUDIT FINDINGS

As noted, the culture of this facility is reflected by the comments from staff and inmates of wanting to be at this facility to work and serve their sentence. Staff are keenly aware of the numerous blind spots provided in this facility from the age and unqie design of the buildings and are actively touring, inspecting and observing to enhance safety. There is a strong commitment to PREA and the practices in place that ensure compliance with the standards.

Number of standards exceeded: 8

Number of standards met: 33

Number of standards not met: 0

Number of standards not applicable: 2

Standard 115.11 Zero tolerance of sexual abuse and sexual harassment; PREA Coordinator

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

(a) Written policy
(b) Upper level agency wide PREA Coordinator
(c) PREA Compliance Manager at the facility

103 DOC 519 Sexually Abusive Behavior Prevention and Intervention Policy as well as the institutional procedural attachment supports a zero tolerance for sexual abuse and harassment as well as defines how the agency will prevent, detect and report this conduct (a). It ensures there is an agency wide PREA Coordinator and facility PREA Manager. The agency PREA Coordinator was available during the entire audit to provide documentation or clarification of questions the auditor posed. Interviews were conducted with the agency PREA coordinator who was officially named to the position (no longer in an acting capacity) as well as the facility PREA Manager. Both indicate they have time and authority to accomplish what is needed to be in compliance with the standards (b,c).

Phone interview with the Commissioner on Thursday March 24, 2016 as well as brief interviews with the Deputy Commissioner, Assistant Deputy Commissioner and the Administrator of the Policy Compliance Unit (while they were at the facility on March 23, 2016) support that the agency PREA Coordinator has the support and authority to ensure compliance. Overall observations, interviews with the agency PREA Coordinator, Superintendent and facility PREA Manager (who is the deputy superintendent) supports compliance with this standard including staff having sufficient authority and time to oversee all efforts associated with eliminating prison rape.

Interview with the agency PREA Coordinator revealed that he conducts monthly meetings with the facility PREA Managers, and has included a representative from the Boston Area Rape Crisis Center (BARCC) at these meetings to collaborate and learn best practices to accomplish the goal of sexual abuse and sexual harassment elimination.

Standard 115.12 Contracting with other entities for the confinement of inmates

☐ Exceeds Standard (substantially exceeds requirement of standard)

☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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

The agency has recently discontinued the use of contracting for prerelease due to budget restraints. This

standard is now not applicable to this agency.

Standard 115.13 Supervision and monitoring

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

(a) staffing plan, includes eleven considerations
(b) document deviations
(c) PREA coordinator and agency determine adjustments
(d) Policy for unannounced rounds, prohibit staff from alerting others

510.01 Security Staffing Plan, 512.03 Post Orders and 519.05 Sexually Abusive Behavior Prevention and Intervention Policy address the requirements of this standard. The staffing needs of corrections officers and supervisors are reviewed formally annually by the agency which includes an assessment as defined by the eleven specific requirements to be reviewed with the staffing analysis(a). The facility assesses staffing levels daily at the multi-disciplinary meeting conducted every morning. There is a minimum staffing requirement that must be met daily. Staffing placement is based on location and time of staff programming. Five random daily assignment sheets were reviewed (one from each month for the past 12 months on the same day for determined months) which confirmed that all posts were assigned staff. No deviations from the staffing plan were noted as overtime is used to meet required mandatory staffing, when necessary.(b) The PREA Manager and Coordinator have input in staffing levels as confirmed by interviews and documentation(c).

Post orders additionally require unannounced rounds by supervisors and prevent staff from alerting other staff of these rounds. Review of randomly selected documentation of unannounced rounds, staff and inmate interviews support compliance with unannounced and frequent rounds by supervisors. Supervisory interviews support compliance along with documentation(d).

Due to the age and original intent of the facility, there are a variety of blind spots; however, staff are aware of them and diligent about rounds. This was confirmed by staff interviews, inmate interviews and documentation. A detailed vulnerability assessment was also conducted by the facility PREA investigators and facility PREA Manager to determine areas of concerns, and where to place additional cameras as they are received. Details were pointed out to the auditor during the tour of the facility.

Additional sound correctional practices observed at this facility/agency include the following:

- Staff dedicated to determining and reviewing inmate cell assignments and work assignments. In addition to the tool developed for PREA concerns, numerous other factors are considered when making these decisions. From observations made during rounds of the housing unit rooms, it was evident that staff work proactively to find inmates compatible to place in cells.

- Staff daily meetings – every morning key staff meet daily to discuss events of the facility in which PREA concerns are addressed.
- Staff access time – schedule times are determined in which key staff make themselves available to the inmate population going to and from meals. Inmate interviews, staff interviews and documentation determined the conclusion that this is an effective practice to enhance communication and resolve problems before they become serious.
- Policy Development & Compliance Unit conducts extensive annual audits to access compliance with policy and ensure the practice is meeting its desired result.

Standard 115.14 Youthful inmates

☐ Exceeds Standard (substantially exceeds requirement of standard)

☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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

This standard is not applicable. Part I, Title XVII, Chapter 119 and Section 58 effective September 2013 requires offenders under the age of 18 to be confined to the Department of Youth Services. This was also supported by the tour, interviews, and review of documentation.

Standard 115.15 Limits to cross-gender viewing and searches

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

(a) Only exigent circumstances for cross gender strip or cavity
(b) Prohibit cross gender pat down searches of females (August 15, 2015 or August 20, 2017) – NA no females housed at this facility.
(c) Document cross gender strip searches, cavity searches and pat down searches of females
(d) Inmates can shower, perform bodily functions, change clothes . . . opposite gender announce their presence when entering the housing unit

(e) Transgender not searched for sole purpose of determining genital status.
(f) Train security staff in cross gender pat down and transgender/intersex inmates

519.05 Sexually Abusive Behavior Prevention and Intervention Policy and 506.04 & 05 Search Policy address the requirements of this standard, indicating that cross gender strip or cavity searches can only be conducted in the event of exigent circumstances (a). It was reported that cross gender strip searches have not occurred. No evidence disputing this was observed or reported in interviews. In the event of exigent circumstances requiring a cross gender strip search, a report would be written and sent to the superintendent.Cavity searches areonly conducted by medical staff and require authorization by the superintendent. (c) Staff and inmate interviews as well as demonstration while touring the facility confirm that female staff announces their presence in the units. All inmate interviews confirmed that they are able to perform bodily functions, change clothes and use the shower without female staff watching them(d). Training curriculums address how to professionally conduct clothed and unclothed searches as well as pat down searches of transgender inmates (f). It further indicates that transgender/intersex inmates will not be searched for the sole purpose of determining genital status (e). Training records and staff interviews demonstrate that staff has been trained in how to conduct pat down searches of transgender/intersex inmates. Inmate interviews also supported a finding of compliance.

A recommendation was made to the agency to review available updated training information regarding transgender offenders and revise the training to ensure this is more emphasized and specific. This was made only because there is more current information available than what is being used.

Standard 115.16 Inmates with disabilities and inmates who are limited English proficient

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

(a) Disabilities, intellectual, psychiatric or speech have equal opportunity, including written materials
(b) Agency takes reasonable steps, including interpreters
(c) Not rely on inmate interpreters (unless limited circumstances)

519.04 Sexually Abusive Behavior Prevention and Intervention Policy, 207.01 Special Accommodations of Inmates, 401.03 Booking & Admissions and 488.03 Institution Procedures for Telephone Interpreter Service address the requirements of this standard (a). Language interpreter services are available to assist with limited English inmates (b). Staff interviews support compliance indicating they have used this when needed for conducting business with inmates. Staff and inmate interviews confirm that inmates will not be relied upon to interpret unless no other options are available(c). Currently at this facility there are no deaf inmates and no blind inmates. Processes and equipment are in place to address these needs such as a TTY which is tested regularly. Inmates with intellectual or psychiatric disabilities are assisted by the medical & mental health staff, who identify these needs during the intake process. Informational materials (poster, handbook, PREA video) are available in English and Spanish(b).

Standard 115.17 Hiring and promotion decisions

☒ Exceeds Standard (substantially exceeds requirement of standard)

☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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

(a) Not hire employee or contractor who has engaged in abuse, convicted of sexual activity by force, civilly or administratively adjudicated
(b) Shall consider incidents of sexual harassment
(c) Before hiring perform back ground checks, check references
(d) Including contractors
(e) Background check every five years
(f) Ask applicants about previous misconduct described and impose continuing affirmative duty
(g) Omissions grounds for termination
(h) Agency provides information to other institutions upon request.

201.06 & 09 Selection and Hiring, Rules and Regulations Governing All Employees of the Massachusetts Department of Correction (Blue Book) address the requirements of this standard, including incidents of previous sexual harassment (b). Staffs who have engaged in abuse, convicted of sexual activity by force, or civilly /administratively adjudicated will not be hired (a). Potential staffs and (d) contractors complete forms specifically asking the questions required of this standard. They are informed of their affirmative duty to report and that omission is grounds for termination (f & g).

Human Resources are centralized. An interview with the Deputy Director for Human Resources was conducted on March 22, 2016. This interview confirmed compliance with agency hiring practices with the standards, including background checks and reference checks(c). There is a requirement of acknowledgement of a continuing duty to report behavior outside the job that conflicts with PREA standards and that termination may result for omission. This is noted in the employee rules and regulations (Blue Book). Staffs sign for receipt. (e)

A background check every four years has been implemented for staff, therefore exceeding the requirements of the standard. This is enforced by a memo from Asst. Deputy Commissioner of Administration dated 2/23/2015. This interview, as well as review of documentation, confirmed that those checks have been completed for all staff in this department.

(h)Additionally, the Deputy Director confirmed that her staff would provide any information about staff previously employed upon receipt of a waiver signed by the previous employee for the agency requesting the information.

Documentation was provided demonstrating five randomly selected staff have received the blue book, have had background checks, and references were checked.

Standard 115.18 Upgrades to facilities and technologies

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

(a) New facility or expansion or modification
(b) Installing video monitoring

703.01 & .10 Design Criteria and Planning Guidelines address the requirements of this standard. Documentation showing review of video monitoring with consideration for the PREA requirements was provided. Additional cameras have been requested. Staffs have conducted an extensive review of operations; this report was reviewed as well as discussed during the tour. Camera placement was pointed out during the tour of the facility as well as where live monitoring stations are located and where recordable monitors are located. There have been no modifications to the facility. Priority of placement of cameras is decided by the result of the vulnerability assessment (facility level) and by PREA incident reviews (agency level).

Standard 115.21 Evidence protocol and forensic medical examinations

☒ Exceeds Standard (substantially exceeds requirement of standard)

☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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

(a) Uniform evidence protocol, maximizes potential for obtaining usable physical evidence–Protocols appropriate for youths
(b) Offer forensic medical exams, document efforts if they cannot
(c) Attempt to make available victim advocate from rape crisis center, if not then qualified staff person.
(d) Accompany the victim if requested
(e) Request investigating agency follow the requirements
(f) Includes State entity or DOJ
(g) Qualified advocate has received appropriate education and has been appropriately screened.

519.01, .02, .03, .04, .05, .06 Sexually Abusive Behavior Prevention and Intervention Policy and Massachusetts

Partnership for Correctional Health Care (MPCH) 57.00 Sexual Assault/PREA Compliance, IPS Field Manual 9.25A Evidence Gathering address the requirements of this standard (uniform evidence protocol)(a). In addition, there is a Letter of Agreement with a nearby hospital which indicates that victim services from and SANE exams are provided at the hospital (b & c).

There is a Memo of Understanding with the Massachusetts State Police requesting that they will comply with the investigation requirements of the PREA (e & f). Some of the Massachusetts State Police have been trained by the Agency PREA coordinator. There is a Memo of Understanding with the Massachusetts State Police indicating they will comply with the investigation requirements of the PREA standards. Massachusetts State Police have been trained by the Agency PREA coordinator, therefore exceeding the requirements of this standard. In addition, there is a Department of State Police General Order entitled, Detainee Sexual Abuse and Sexual Harassment Investigations that indicates it will comply with the Prison Rape Elimination Act for youths and adults.

The agency has concluded their negotiations with an advocacy group, Boston Area Rape Crisis Center (BARCC) to provide services to victims; a MOU has been signed. Staff from BARCC have ben attending the monthly meetings with the statewide PREA Coordinator and Managers. It was reported that they have attended the investigator training and are in the process of touring all facilities. Staffs from BARCC receive a minimum of 40 hours of training to assist victims of sexual abuse (g). These staff will accompany the victim if requested, as noted in the MOU(d).

A review of completed investigations confirmed they are using a uniform evidence protocol. There are no youths housed at this facility.

Standard 115.22 Policies to ensure referrals of allegations for investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

(a) Agency ensure administrative or criminal investigation completed for all allegations
(b) Policy in place ensuring all allegations are referred, published on website or other means, all referrals documented
(c) Publication describing responsibilities of separate entity and agency
(d) State entity shall have a policy governing conduct of these investigations
(e) DOJ - NA

519.03, .04, and .07 Sexually Abusive Behavior Prevention and Intervention Policy address the requirements of this standard. Staffs are required to report suspicions and knowledge of abuse, harassment, and retaliation in addition to neglect to the shift commander, who must then report to the superintendent immediately (a & d). This policy is available on the Massachusetts Department of Correction's website (b). 522 Internal Affairs Policy is also posted on the website (c).

A list of the investigations completed at this facility was provided. Seventeen completed investigations from the previous 12 months were thoroughly reviewed and demonstrated compliance with the standards. The superintendent ensures that the proper investigating entity is contacted (Office of Investigation Services, outside law enforcement or the staff investigator), as confirmed by interviews and review of documentation.

Standard 115.31 Employee training

☒ Exceeds Standard (substantially exceeds requirement of standard)

☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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

(a) Train all employees with contact with inmates on ten elements
(b) Tailored to the gender of the inmates at the facility
(c) Current employees trained within one year
(d) Document that employees understand the training they received.

216.13 Training and Staff Development reflect that staff with inmate contact receive training specific to the requirements of the PREA standards. A review of the training curriculum supports compliance as well with the ten elements required in the standard. It also addresses the gender of inmates and how sexual abuse and sexual harassment can manifest itself differently among the different genders (b). Training documents reviewed indicate all staffs with inmate contact have been trained (a & c). New employees sign a Basic Training Acknowledgement that they understood the training they received (d). In service training must be passed by taking a quiz acknowledging understanding of the training (d). Staff interviews confirmed compliance with the standard and a sound understanding of the reasons for the requirements and their role in preventing, detecting and responding to PREA allegations. Documentation was provided demonstrating that randomly selected staff have been trained. Training occurs annually, therefore exceeding the standard.

Standard 115.32 Volunteer and contractor training

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

(a) Train all volunteers/contractors with contact with inmates
(b) Tailored to the services they provide, zero tolerance and how to report
(c) Document that volunteers/contractors understand the training they received.

519.02 Sexually Abusive Behavior Prevention and Intervention Policy, 216.13 Training and Staff Development, and the Volunteer Orientation Handbook address the requirements of this standard. Contract staffs participate in the same training and process as Massachusetts DOC staff.

PREA language has been incorporated into the volunteer recertification quiz, ensuring that they understand the training (a & c). All persons visiting (even though under at escort all times) are provided information regarding the law and requirements of the standards relevant to their visit. A form is signed acknowledging this information before entering the facility (including the auditor) (b). Documentation has been reviewed supporting that volunteers are trained and recertified.

Contract training records have been reviewed and confirm compliance as well as interviews with contractual staff. A review of documentation regarding volunteers supports compliance as well.

Standard 115.33 Inmate education

☒ Exceeds Standard (substantially exceeds requirement of standard)

☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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

(a) Intake, inmates receive information zero-tolerance, how to report
(b) Thirty days, comprehensive information including retaliation
(c) Current inmates educated within one year and upon transfer if different
(d) Provide in format accessible to all inmates – disabled and limited English
(e) Documentation of inmate participation in education sessions
(f) Ensure key information is readily and continuously available

Policy 401.03 Booking & Admissions as well as 519.02 Sexually Abusive Behavior Prevention and Intervention Policy address the requirements of this standard. At intake, the specific needs of the inmate are identified to ensure appropriate communication is provided (d). The Inmate Orientation Handbook, which is provided within 24 hours of arrival, thoroughly reviews the information needed to educate the inmate population on how to prevent as well as report abuse, harassment, and retaliation (a). It is available in Spanish as well. Inmates sign noting receipt of the information. It includes the Department Duty Station phone number and information that it is not monitored. Receipt of the handbook is documented (b & e). Posters educating inmates on PREA were visible throughout the facility (f). This agency started educating inmates regarding PREA several years ago. Additional information is available in the inmate library. To be more diligent, this facility ensured that all key phones numbers (hotline and Boston Area Rape Crisis Center) are stenciled on the walls by the phones as well as included in each inmates laminated movement pass, supporting the finding of exceeds standard. All inmate interviews support

compliance as well. All inmates have been receiving training for several years on the prevention of sexual abuse and zero tolerance (c).

Standard 115.34 Specialized training: Investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

(a) Investigators have received special training
(b) Includes techniques for interviewing abuse victims, Miranda and Garrity, sexual abuse evidence collection, criteria to substantiate
(c) Documentation they have completed the training
(d) State and DOJ provides training

519.04 Sexually Abusive Behavior Prevention and Intervention Policy addresses the requirements of this standard (a). Review of the curriculum demonstrates that the training addresses interview techniques in addition to Miranda, and Garrity warnings and evidence collection (b). Staff in this state are compelled to tell the truth or receive disciplinary action up to termination. The criteria to substantiate are a preponderance of evidence (b), as confirmed by the policy, training curriculum, and interview with the investigators. Two staff are assigned to conduct PREA investigations at this facility; however, all investigators have received the specialized training. There is a Superintendent's Special Investigator assigned to this facility as well to handle staff issues; he has also received the specialized training. Documentation of completed training, although reveal no allegations against staff, support compliance as well as the interview with the investigators(c).

Standard 115.35 Specialized training: Medical and mental health care

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

(a) Full and part time medical and mental health care staff in the facility have been trained four requirements
(b) If they conduct forensic exams, they are trained - NA
(c) Documentation of training maintained

(d) Also include training required for contractors and volunteer if that is their status

216.13 Training and Staff Development addresses the requirements of this standard (a). The training curriculum addresses the required topics as well (a). Forensic exams are not conducted at the facility (b). Medical, mental health staff are contracted through Massachusetts Partnership of Correctional Health (MPCH). There are 35 medical and mental health staff at this facility(d). Review of documentation indicates that medical staff receives additional training regarding PREA and their role as medical staff in detecting signs, preserving evidence, how to respond effectively and when and how to report allegations (c). Interview with the medical and mental health staff demonstrate they have been trained and are knowledgeable regarding their role with prevention, detection and responding to sexual abuse and harassment allegations.

Standard 115.41 Screening for risk of victimization and abusiveness

☒ Exceeds Standard (substantially exceeds requirement of standard)

☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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

(a) All inmates assess during intake screening and upon transfer to another facility for their risk of being abused or being an abuser
(b) Takes place within 72 hours
(c) Objective screening instrument
(d) Considers ten areas
(e) Considers prior acts of violence
(f) Reassess within 30 days inmates risk
(g) Reassessed when warranted
(h) Not disciplined for not answering
(i) Appropriate controls on dissemination

519.04 Sexually Abusive Behavior Prevention and Intervention Policy, 401.05 Booking & Admissions and 650.02 Mental Health Services address all the requirements of this standard. Documentation reviewed which demonstrates compliance includes 72-hour Housing Risk Assessments, conducted immediately upon arrival, within 24 hours according to policy exceeding the standard (b), 30 day Housing Risk Assessments, and reassessments, when warranted. The risk screening includes the nine areas and is objective in that there are yes and no responses that determine what status an inmate is considered (c). There are no civially committed inmates housed in Mass DOC. The screening instrument includes 15 specific questions and criteria to determine vulnerability, and five questions to determine predatory behavior (d). It includes the ability to make notation, override the decision and provide the rationale. No inmates are detained solely for civil immigration purposes at this facility or this agency.

The Booking Officer completes a portion of the screen and mental health staff completes a portion of the screen. Inmates are verbally asked if they perceive themselves as gay, lesbian, bisexual, transgender, intersex, or gender nonconforming by mental health staff. Corrections Program Officers and mental health staff complete the 30 day review and any warranted reassessments (f & g). A post incident checklist has been developed to ensure this screen is completed. Inmates are again asked verbally how they perceive their gender orientation.

The facility reports that the screen has been completed on all current inmates. Inmates are not disciplined for refusing to answer (as determined by policy and staff/inmate interviews) (h). Information is maintained in a computerized format that affords the control of dissemination to only those staff needing to review the information (i). It further offers the ability to receive notifications if an attempt is made to place a predator and victim in the same room. An intake screening by the booking officer was observed during the tour of the facility and demonstrated compliance. Five randomly selected intake screens were reviewed – all demonstrated compliance with the standard, as well as interviews with the inmates.

Exceeds standards based on immediate screening process.

Standard 115.42 Use of screening information

☒ Exceeds Standard (substantially exceeds requirement of standard)

☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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

(a) Information used to inform housing, bed, work, education to keep separated
(b) Individualized determinations
(c) Transgender case by case
(d) Placement, programming for transgender determined twice a year
(e) Transgender, intersex own views given serious consideration
(f) Transgender, intersex given opportunity to shower separately
(g) Not placed in dedicated facilities unless due to a consent decree

Several policies address the requirements of this standard: 519.04 Sexually Abusive Behavior Prevention and Intervention Policy, 420.07 Classification, 652.06 & .09 Identification, Treatment and Correctional Management of Inmates with GD, 650.01 & .03 Mental Health Services, and 750.11 Hygiene Standards.

Placement of transgender inmates in a male or female facility occurs at the reception facility (Cedar Junction or Massachusetts Correctional Institution – Framingham) in accordance with how the court defines their gender (c). Policy indicates that case by case by case deteminations will occur at that time. (Due to recent clarifications from the PREA Resource Center, this policy is currently being revised).

Staffs are dedicated full time to making housing and programing decisions. Housing assignment staff and program staffs have access to risk assessment information, as well as other relevant information to make individualized

determinations on appropriate housing, education and work assignments to enhance safety (a & b). This facility/agency is very proactive regarding decisions about placement of housing and job assignments, using more information than required to make these decisions. Correctional staff reviews transgender/intersex classification twice annually. (d). Transgender/intersex views are given serious consideration in regards to housing and jobs. (e) Compliance of this was determined by observation, inmate/staff interviews and documentation. Processes are in place to provide separate shower times (f). This was confirmed by staff and inmate interviews. Massachusetts Department of Correction does not have a dedicated facility for transgender/intersex inmates (g).

Exceeds standards is based on the practice of the use of a housing/program assignment committee, and feedback received from the population regarding the belief this is a safe institution, given that the physical plant adds additional challenges.

Standard 115.43 Protective custody

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

(a) High risk victimization not placed in involuntary segregation unless no other alternative the less than 24 hours
(b) Will have access to programs, privileges, education, work to the extent possible. If restricted shall document limitations
(c) Assigned to involuntary until alternative means not to exceed 30 days
(d) Document
(e) Review every 30 days

519.04 Sexually Abusive Behavior Prevention and Intervention Policy and CMR 423 Special Management Units address the requirements of this standard. Policy indicates that placement in an administrative restrictive setting will only occur for the first 24 hours. Review of records as well as interview with staff in the restrictive housing support compliance with the practice. In addition, there are several housing unit options that provide options for separating inmates at risk without placing them in restrictive housing to address immediate needs. Review of the completed investigations revealed that on most occasions, the victim was transferred to another facility. It has been reported that no high risk victim has had to be placed in segregation for their protection in the past 12 months.

Standard 115.51 Inmate reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

(a) Multiple internal ways to privately report abuse, harassment, retaliation or staff neglect
(b) One method to report to public or private entity
(c) Staff shall accept verbal, writing, anonymous and third parties immediately and document
(d) Agency provides a method for staff to report privately

519.03 Sexually Abusive Behavior Prevention and Intervention Policy addresses the requirements of this standard. The Inmate Orientation Handbook provides information to the inmate population regarding multiple avenues for reporting sexual abuse/harassment.This includes that inmates can contact staff, file a grievance, have family reporton their behalf, staff access and a hotline that goes to the Inner Perimeter Security (IPS) office, or a hotline that goes to the department's Duty Station (central office). It includes information to the inmates that for the "privileged numbers" (attorney, clergy, mental health professional), calls are not monitored, but that an inmate PIN number is needed. Prison Legal Services number is considered a privileged number affording inmates the opportunity to report allegations (b). As this is a mandatory reporting state, the PLS must inform the prison if they receive such allegations. Interview with the Superintendent indicated that allegations have been received from PLS in the past.

Policy, interviews with staff and review of the completed investigations support compliance with staff accepting verbal, written, anonymous and third party reports of sexual abuse or harassment and taking immediate action(c). Two investigations were initiated by the hotline.

Inmate interviews confirmed that the population has been educated on the multiple reporting mechanisms available to them, including verbal reports, anonymous reports and third party reports. (a & c)
Staff incident reports are marked confidential and go directly to the superintendent. Staff interviews confirmed they believed this system afforded them a private way to report incidents (d).

Standard 115.52 Exhaustion of administrative remedies

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

(a) Agency exempt If no administrative procedures to use grievance for inmate abuse - NA
(b) No time limit on grievance for sexual abuse (1-4)
(c) Ensures not submitted to staff who is subject and not referred to that staff
(d) 90 days 1-4

(e) Third party permitted to file (1-4)
(f) Procedure for filing emergency grievance
(g) Can discipline where filed in bad faith

CMR 491 Inmate Grievances and Standard Operating Procedure Sexual Abuse Grievances demonstrates compliance with the requirements of this standard (b,c,d,e,f,g). Grievance forms were observed in the housing units. Review of completed investigations and interview with the Grievance Coordinator confirmed that grievances have not been received that initiated a PREA investigation in the past 12 months. Inmate interviews support that grievance forms are readily available to the inmate population. Both inmate and staff interviews indicate that grievances are placed in a locked box in the food service area, providing confidentiality should an inmate want to use that avenue.

Standard 115.53 Inmate access to outside confidential support services

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

(a) Access to outside victim advocates for emotional support services by mail or telephone, toll free hotline, reasonable communication in a confidential manner
(b) Informed of the extent that it will be monitored
(c) Maintain an MOU with community service providers

An MOU has been signed with the Boston Area Rape Crisis Center (BARCC) (a & c). This MOU took effect August 2015. A toll free hotline is available to all inmates from 9:00am to 9:00pm, as well as an address. A phone tree system is used to route the calls to the next available counselor. Services can be provided for English, Spanish and deaf (TTY) inmates. This information is noted in the recorded introductory statement.

A representative of BARCC was interviewed on Wednesday March 23, 2016 to discuss the services with the auditor. These services are provided to all Massachusetts Department of Corrections prisons. Toll free phone numbers and address are provided to the inmate population through postings in a secure bulletin board. Inmates are informed that it is toll free and will not be monitored (b). They are also informed that this is not an avenue in which to file complaints as the counselors are not allowed to report on their behalf in accordance with Massachusetts Law 233 and 20J unless it involves someone under 18 years old, older than 60, disabled, or they express they are a danger to themselves. Staff who work for this service are required to attend and pass 40 hours of training, pass a background check and obtain certification through the state of Massachusetts. Although there is an address, the mail is addressed differently as the staff cannot ensure confidentiality. Appropriate responses will be sent back.

Telephones at the facility are available to inmates in a reasonable number and location. They are appropriately spaced to afford the inmate the ability to maintain a private conversation. Several inmates

were informally questioned about privacy and felt they were able to conduct private conversation. Inmates in restrictive housing are allowed to make two personal calls a week however they will have to reveal the number they wish to call and the time.

The PREA agency coordinator and BARCC representative indicate they are working collaboratively to develop language to be added to inmate handbooks. Discussion also took place with the auditor that additional opportunities will be explored for inmates in restrictive housing. Currently, the process for handling mail does afford inmates in restrictive housing to send letters to BARCC confidentially as they are placed in a locked box passed around by the officer. However, as noted, only generic information can be shared in that manner.

The phone line was tested at the facility to ensure operation. It was difficult to hear the counselor due to static. The facility contacted the phone company and provided documentation that this problem has been corrected.

Standard 115.54 Third-party reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Method to receive and distribute publicly information on how to report

519.03 & .04 Sexually Abusive Behavior Prevention and Intervention Policy address the requirements of this standard. Information is available on the Massachusetts DOC website for third party reports, addressed in the Family & Friends Handbook (also posted on the website) and noted on PREA posters in the lobby and visiting rooms. Review of the investigations for the past 12 months indicates that one third party complaintshas been received (from another inmate).

Standard 115.61 Staff and agency reporting duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

(a) Staff required to report immediately
(b) Staff not reveal any information than it needs to appropriate staff
(c) Practitioners required to report abuse, limits on confidentiality
(d) If victim is under 18 - *NA*
(e) All reports to facility's designated investigator

519.03 & .06 Sexually Abusive Behavior Prevention and Intervention Policy and MPCH 57.00 Sexual Assault Policy address the requirements of this standard, requiring immediate report and to maintain confidentiality. Medical staff is aware of the requirement for reporting and limitations on confidentiality. This is addressed with the inmates at their facility intake interview (c). All staff interviews confirmed that staff understands the requirement to report immediately and to maintain confidentiality after reporting. All interviews confirmed that their report will go to the shift commander, then superintendent and investigator (e), immediately, via email. Interview with the superintendent and investigators,as well as review of the investigations supported compliance with these requirements as well.

Standard 115.62 Agency protection duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Inmate subjected to imminent abuse – immediately action

519.04 Sexually Abusive Behavior Prevention and Intervention Policy, 426.02 Conflicts, and MPCH 57.00 Sexual Assault Policy address the requirement of this standard. Staff interviews support knowledge of the requirement and how action is to be taken. Protection is afforded through immediate separation from the area and then taken to the medical area for an assessment of the inmate's medical needs.

Standard 115.63 Reporting to other confinement facilities

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

corrective actions taken by the facility.

(a) Reporting to another facility
(b) Within 72 hours
(c) Documented
(d) Facility head receives notification that investigation

519.03 Sexually Abusive Behavior Prevention and Intervention Policy addresses this standard, indicating that other facilities/agencies will be notified in 72 hours. Documentation, a review of the data base and staff interviews support compliance. A review of the investigations revealed that two reports were received from other facilities, no reports were sent to another facility in the past twelve months.

Standard 115.64 Staff first responder duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

(a) Reporting to another facility
(b) Within 72 hours
(c) Documented
(d) Facility head receives notification that investigation

519.03 Sexually Abusive Behavior Prevention and Intervention Policy addresses this standard, indicating that other facilities/agencies will be notified in 72 hours. Documentation, a review of the data base and staff interviews support compliance. A review of the investigations revealed that two reports were received from other facilities, no reports were sent to another facility in the past twelve months.

Standard 115.65 Coordinated response

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These

recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Institutional plan

519.06 Sexually Abusive Behavior Prevention and Intervention Policy as well as the institutional procedural attachment demonstrate compliance with this standard. Staff interviews demonstrate that staffs are knowledgeable regarding how to respond at this facility. A PREA response kit is maintained to ensure that items are readily available to ensure evidence is properly collected. A checklist has been developed to assist in ensuring all requirements of the standards are addressed.

Standard 115.66 Preservation of ability to protect inmates from contact with abusers

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

(a) Collective bargaining new contract limiting agency's ability
(b) This standard doesn't restrict discipline and no-contact assignment

230.06 Disciplines and Terminations addresses this standard. The following current contracts were reviewed and do not prohibit the facility from removing alleged staff: Massachusetts Correction Officer Federated Union, New England Benevolent Association Alliance, National Association of Government Employees (NAGE) and AFSCME/SEIU Local 509. The review of the completed investigations did not warrant that staff be reassigned.

Standard 115.67 Agency protection against retaliation

☒ Exceeds Standard (substantially exceeds requirement of standard)

☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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

(a) Policy protects inmates and staff who report
(b) Agency employs multiple protection measures
(c) Monitor for retaliation for 90 days or beyond if needed

(d) Inmates also periodic status checks
(e) If fear of retaliation expressed, agency shall take appropriate measures
(f) Do not have to monitor if allegation is unfounded

519.07 Sexually Abusive Behavior Prevention and Intervention Policy addresses the requirements of this standard (a). IPS members conduct monitoring for retaliation. A review of the monitoring activities indicate that multiple protection measures are utilized regarding those who report the incident including, video, telephone, mail reviews, disciplinary reports and interviews (b). Monitoring has occurred up to 90 days; this was demonstrated by review of documentation of monitoring reports. Monitoring is discussed during the monthy PREA incident review meetings. Review of the practice and documentation demonstrated that exceeds standards was earned.

Standard 115.68 Post-allegation protective custody

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

519.04 Sexually Abusive Behavior Prevention and Intervention Policy and CMR 423 Special Management Units address the requirements of this standard. Policy indicates that placement in an administrative restrictive setting will only occur for the first 24 hours. Review of records as well as interview with staff in the restrictive housing support compliance with the practice. Review of the completed investigations revealed that on some occasions, the victim was transferred to another facility. It has been reported that no high risk victim has had to be placed in segregation for their protection in the past 12 months. The auditor neither saw nor heard any evidence to dispute this statement.

Standard 115.71 Criminal and administrative agency investigations

☒ Exceeds Standard (substantially exceeds requirement of standard)

☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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

(a) Investigation done promptly, thoroughly, objectively
(b) Abuse – investigators have received specialized training

(c) Investigators gather and preserve direct and circumstantial evidence
(d) If criminal, will conduct interviews after consulting with prosecutor
(e) Credibility assessed individually
(f) Administrative investigations include whether staff actions or failures contributed, documented in the reports description of physical evidence, resonating behind credibility, investigative facts and findings
(g) Criminal investigations thorough description of physical, testimonial and documentary evidence
(h) Substantiated criminal referred
(i) Agency retains all reports as long as abuser is incarcerated or employed plus five years
(j) Departure of alleged abuser or victim does not terminate investigation
(k) State, DOJ
(l) Facility cooperates with outside investigators

519.02, .03. & .06 Sexually Abusive Behavior Prevention and Intervention Policy addresses the requirements of this standard.

Compliance is based on a thorough review of the 17 completed investigations conducted in the past 12 months, and interviews with two investigators who primarily handle PREA allegations. Investigators were notified immediately and initiated the investigation immediately, including the gathering and preservation of direct and circumstantial evidence. They are available at the facility from 7:00am to 9:00pm and are on call and can be at the facility within thirty minutes, if needed. This evidence is assessed individually, factually and in a standard format, as demonstrated in completed investigations. Potential criminal matters are handled by Superintendent's Special Investigator or staff at the agency's central office Internal Affairs unit (h). IPS investigators and the Special Investigator work with outside agencies to assist with investigations, when warranted (l). Policy requires the retention of the reports for five years past the employment or incarceration of the abuser(i). Investigators indicate they can and have retrieved investigations from 20 years past when needed due to recent allegations of prior abuse. Policy, interviews and one investigation supported that the investigation will continue even if the abuser is no longer at the facility(j).

Review of investigations also support compliance that investigators use all resources available, including interviewing all inmates who would be in the area before making determinations. Based on which investigations were deemed not substantiated verses unfounded supports that credibility was individually assessed, findings based on evidence available. All available evidence was gathered. Physical evidence was maintained where appropriate – specifically video recordings. Administrative investigations indicated that where relevant, staff actions or failures to act were considered and assessed.

Standard 115.72 Evidentiary standard for administrative investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

No standard higher than preponderance of evidence.

DOC 518 Inner Perimeter Security Team demonstrates compliance with this standard. Compliance was also demonstrated by the interview with the investigative staff and the review of the completed investigations from the previous 12 months.

Standard 115.73 Reporting to inmates

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

(a) Inform inmate whether allegation has been substantiated, unsubstantiated, or unfounded
(b) If agency did not conduct, will request relevant information from investigative agency
(c) When staff member did abuse (1 - 4)
(d) When an inmate did abuse (1 – 2)
(e) Notifications documented
(f) Obligation terminated if released from custody

519.07 Sexually Abusive Behavior Prevention and Intervention Policy supports compliance with the requirements of this standard (a-f). This policy includes Attachment I, Inmate Notification. Review of completed investigations from the previous twelve months support compliance with notification to inmates of the results of investigation.

Standard 115.76 Disciplinary sanctions for staff

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

(a) Staff disciplinary sanctions up to termination
(b) Termination presumptive when sexual abuse
(c) Commensurate with act, history, sanctions for similar histories
(d) All reported to law enforcements unless not criminal and to licensing bodies

230.66 Discipline & Terminations addresses the requirements of this standard, indicating that staff will be terminated for sexual abuse and there is a sanctioning schedule for other less serious offenses (a, b & c). It indicates that all criminal allegations will be referred for prosecution and licensing body, where applicable (d). This agency has a department, central prosecution unit, which works directly with prosecutors when allegations of staff criminal behavior has been made. There is an investigator on sight that reports to the superintendent that addresses staff sexual harassment or abuse allegations.

The facility reports that no disciplinary action or termination has been taken against staff for substantiated PREA allegations in the past 12 months. A review of the completed investigations for the previous 12 months supports compliance. The auditor neither saw nor heard any evidence to dispute this statement.

Standard 115.77 Corrective action for contractors and volunteers

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

(a) Contractor, volunteer reported unless not criminal
(b) Facility takes remedial measures, consider prohibiting contact when not criminal

519.07 & .08 Sexually Abusive Behavior Prevention and Intervention Policy addresses the requirements of this standard, indicating that substantiated abuse will be reported to law enforcement and licensing authorities, if applicable (a). Policy and interviews with the volunteer coordinator/contract supervisor supported that volunteers and/or contractors accused of harassment or abuse will not be allowed in the facility until they are exonerated from the allegations (b). The facility reports that no volunteers or contract staff have been disciplined or terminated due to substantiated PREA allegations, in the past 12 months. The auditor neither saw nor heard any evidence to dispute this statement.

Standard 115.78 Disciplinary sanctions for inmates

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

corrective actions taken by the facility.

(a) inmates subject to sanctions
(b) sanctions commensurate
(c) consider mental disabilities
(d) consider whether to require offender to participate in therapy
(e) against staff if no staff consent
(f) not falsifying if made in good faith
(g) agency can prohibit all sexual activity between inmates but not deem it abuse if not coerced

The following policies address the requirements of this standard: 519.02, .04, .06, & .07, Sexually Abusive Behavior Prevention and Intervention Policy, 650.09 Mental Health Services, and 103 CMR 430.16, .24, & .25 Inmate Discipline. Inmates are sanctioned for sexual abuse, sexual harassment as well as consensual sexual activity (a & g). Policy has an established sanctioning process to ensure they are commensurate with the action (b). Policy also ensures that mental disabilities are considered before determining guilt (c). The elements of the charge will not find an inmate guilty if the activity was with a staff person who consented (e). If an inmate is to be sanctioned for making a false report, it is seriously considered by administration before action is taken (f). At this facility, this occurred when an inmate confessed to filing a false report. The agency does not require participation in therapy as a condition of programming or other benefits (d).

Standard 115.81 Medical and mental health screenings; history of sexual abuse

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

(a) Prison inmate experienced prior victimization follow up in 14 days
(b) Prison inmate experienced prior perpetration follow up in 14 days
(c) Jail inmate experienced prior victimization follow up in 14 days - NA
(d) This information limited to mental/medical and other staff deemed necessary
(e) Get informed consent before reporting that didn't occur in an institutional setting

650.03 Mental Health Services addresses the requirements of this standard. As a section of the initial intake screen is conducted by mental health staff, referral is automatic and immediate for prior victims and prior perpetrators to be assessed for possible continued treatment (a & b). Policy reflected the requirements for confidentiality and informed consent as required by the standard (d & e). Staff interviews (medical and mental health staff) support compliance.

Standard 115.82 Access to emergency medical and mental health services

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

(a) Victims unimpeded access to emergency services
(b) If not on duty, first responders
(c) timely information and timely access to prophylactic treatment
(d) treatment provided to victims without costs

519.06 Sexually Abusive Behavior Prevention and Intervention Policy addresses this standard. 630 Medical Services and 650 Mental Health Services are referenced in the policy regarding access to emergency services. Medical staffs are on duty at all times at this facility. Policy supports that there will be unimpeded access, timely information and services regarding prophylaxis care and no costs incurred to the inmate. Staff interviews support this as well. Completed investigations from the previous 12 months demonstrate that no allegation warranted the need for emergency medical treatment outside the facility. Staff interviews support that all potential victims are assessed by medical staff.

Standard 115.83 Ongoing medical and mental health care for sexual abuse victims and abusers

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

(a) Mental, medical to all victims evaluation and ongoing
(b) Follow up, treatment plans, referrals
(c) Consistent with community care
(d) Pregnancy tests – NA (all male population)
(e) If pregnant, appropriate legal treatment – NA (all male population)
(f) STD tests
(g) Treatment services without costs
(h) Mental health evaluation of all known inmate on inmate abusers within 60 days

519.04 &.06 Sexually Abusive Behavior Prevention and Intervention Policy and 650.16 Mental Health Services address this standard indicating that on-going medical and mental health treatment would be provided, and also reflected no charge for the services. In the past 12 months, no allegations have been made that would warrant ongoing medical and mental health care due to sexual abuse. Continued mental health services are available if requested. A post incident checklist ensures that mental health will be contacted to conduct a

mental health evaluation of an inmate on inmate abuser.

Standard 115.86 Sexual abuse incident reviews

☒ Exceeds Standard (substantially exceeds requirement of standard)

☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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

(a) Incident review unless unfounded
(b) Within 30 days
(c) Team includes upper level management with supervisors, investigator, medical/mental health
(d) The team considers 1-6 (policy, motivation, area, staffing levels, monitoring technology, prepare a report)
(e) Implement or document why not

519.04 &.06 Sexually Abusive Behavior Prevention and Intervention Policy addresses the requirements of this standard(a). Multi-disciplinary incident review teams meet monthly (more often if needed) to review all incidents (b). The team consists of the superintendent, PREA manager, Director of Security, Health Services Director, Captain of Housing, correctional program officers, the housing assignment sergeant, investigators, and the grievance coordinator. (c) Meeting minutes reflect the reviews of cases, inmate monitoring and open dialogue. All areas noted in the standard are considered and included in the assessment requiring that it be addressed, and documented in the reviews (d). These reviews are maintained in the data base for future review and analysis. A section is included on each report regarding recommendations, and when and if implemented (or why it wasn't implemented (e). Incident reports were reviewed that demonstrated compliance.

With the development of the database, statistics regarding the prevalence of abuse and harassment can be easily retrieved for all facilities and trends can be assessed at anytime.

Standard 115.87 Data collection

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

(a) Accurate, uniform data, standardized instrument, definitions
(b) Aggregate annually
(c) Survey of Sexual Violence
(d) Maintain from all available incident-based
(e) Obtain from private facility
(f) Provide to DOJ June 30

519.09 Sexually Abusive Behavior Prevention and Intervention Policy addresses the requirements of this standard. The 2014 Annual PREA report is available on the website. The 2015 should be completed by August 2016 (b). The report includes information from all prisons within the Massachusetts Department of Correction (d). It utilizes the Survey of Sexual Violence and definitions provided in the standards to ensure uniform data is collected (a). With the development of the database, statistics regarding the prevalence of abuse and harassment from all facilities can be easily retrieved for all facilities and trends can be assessed at any time. It compares statistics with the previous year and includes information from contractual entities housing inmates. Staff report that the Survey on Sexual violence was submitted to the DOJ as required (c & f).

Standard 115.88 Data review for corrective action

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

(a) Agency reviews data to assess, improve (1-3) identify problem areas, take corrective action, prepare annual report
(b) Compare current with prior years
(c) Available to the public
(d) Redact information presenting a clear and specific threat to the facility

519.09 Sexually Abusive Behavior Prevention and Intervention Policy supports compliance with this standard. The Commissioner has approved the 2014 report. It is available on the website, in addition to educational material about the law (c). It provides a narrative assessment of the information from 2014 with the information from 2013 (b). A section is devoted to corrective action as well as resolved issues (a). No information required redaction (d). As noted, the interview with the agency Commissioner confirmed that this report is used for review of staffing, policy and technology improvements.

Standard 115.89 Data storage, publication, and destruction

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

(a) Securely retained
(b) Readily available to the public at least annually
(c) Removes all personal identification
(d) Maintained for 10 years

519.09 Sexually Abusive Behavior Prevention and Intervention Policy addresses the requirements of this standard in addition to the Record Retention Schedule (a & d). The Annual reports for 2013 and 2014 are posted on the website; no personal identification is in the report (b & c). The report for 2015 is expected to be posted by August 2016, summarizing statistics and trends from 2015.

AUDITOR CERTIFICATION
I certify that:

☒ The contents of this report are accurate to the best of my knowledge.

☒ No conflict of interest exists with respect to my ability to conduct an audit of the agency under review, and

☒ I have not included in the final report any personally identifiable information (PII) about any inmate or staff member, except where the names of administrative personnel are specifically requested in the report template.

Amy Fairbanks Amy Fairbanks April 25, 2016

Auditor Signature Date