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

ADULT PRISONS & JAILS

Date of report: April 5, 2017

Auditor Information			
Auditor name: Amy Fairbanks & Wendy Hart			
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Telephone number: (517) 303-4081			
Date of facility visit: March 9-10, 2017			
Facility Information			
Facility name: MCI – Cedar Junction			
Facility physical address: 2405 Main St. South Walpole, MA 02071			
Facility mailing address: *(if different from above)*			
Facility telephone number: (508) 660-8000			
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: Michael Rodrigues, Superintendent			
Number of staff assigned to the facility in the last 12 months: 460			
Designed facility capacity: 633			
Current population of facility: 755			
Facility security levels/inmate custody levels: maximum with a medium component (permanant workforce)			
Age range of the population: 18-78			
Name of PREA Compliance Manager: Joann Lynds		**Title:** Deputy Superintendent	
Email address: Joann.Lynds@MassMail.State.MA.US		**Telephone number:** (508) 660-8000 ext 300	
Agency Information			
Name of agency: Massachusetts Department of Correction			
Governing authority or parent agency: *(if applicable)* Commonwealth of Massachusetts			
Physical address: 50 Maple Street Suite 3, Milford, MA 01757-3698			
Mailing address: *(if different from above)* Click here to enter text.			
Telephone number: (508) 422-3481/3483			
Agency Chief Executive Officer			
Name: Thomas A. Turco III		**Title:** Commissioner	
Email address: Thomas.Turco@MassMail.State.MA.US		**Telephone number:** (508) 422-3330	
Agency-Wide PREA Coordinator			

Name: Jennifer Gaffney	**Title:** PREA Coordinator
Email address: Jennifer.Gaffney@MassMail.State.MA.US	**Telephone number:** (508) 541-5301 ext. 13

AUDIT FINDINGS

NARRATIVE

On March 9-10, 2017 an audit was conducted at MCI-Cedar Junction, Massachusetts Department of Correction, to determine compliance with the Prison Rape Elimination Act standards finalized August 2012. This is the facility's second audit. A total of 18 hours was spent on site at the prison to complete this audit. The first PREA was conducted on May 11-12, 2015.

A complete tour of the facility was conducted on March 9 & 10, 2017. The following areas and operations were visited and observed: inmate living areas which consists of inmates received for processing to the prison system, a permanent work force unit, orientation unit, ICE detainees, Behavioral Management Unit (BMU), Disciplinary Detention Unit (DDU), restrictive housing medical operations, chapel area, library, booking & admissions, education areas, food services, facility maintenance operations, industry operations (license plate shop), recreation areas, barbershop, and laundry.

Documentation for each standard was provided by the facility prior to the visit in addition to the last ACA accreditation report, the annual vulnerability assessment, the staffing plan analysis, union contracts, interstate compact contracts, population reports, PREA pre-audit questionnaire and training curriculums. On site documentation randomly selected included personnel records from five randomly selected staff and contractual staff, five randomly selected risk screen assessments, 72 hour and 30 days follow up, training records for randomly selected staff, documentation of unnounced rounds (including video), review of video monitoring and PREA meeting minutes. Completed investigations from the previous 12 months were reviewed for compliance – a total of four.

Formal interviews were scheduled through random selection of staff and inmates from schedules and rosters provided by the staff the evening prior to the audit. Facility staff interviews were conducted with the following:
Superintendent
PREA Compliance Manager/Deputy Superintendent
Medical Director
Two Correctional Program Officers
Director of Nursing, one RN, one LPN – contract
11pm-7am one correction officer
7am-3pm Captain and nine correction officers (including the booking officer, health services officer, DDU officer, BMU officer, restrictive housing officer)
3pm-11pm Lieutenant
Inner Perimeter Security (IPS) supervisor and investigators (3 total) and the Superintendent's Special Invetigator)
Librarian
Imam

Inmate interviews were conducted with the following:
Nineteen inmates, selected randomly from each housing area, one refused the interview

The auditors were allowed free access to all areas of the facility, access to interview inmates selected randomly and intentionally, and to see any documentation requested. Posters were visible throughout the facility announcing the audit.

Contact was made with Prison Legal Services (PLS) as they were identified as an advocacy group that has acted upon the interests of inmates housed in the Massachusetts Department of Correction. A meeting was held with Leslie Walker, Executive Director, and three other members of PLS to discuss their various concerns with PREA and the auditors role. The meeting was informative as the auditor was able to give feedback on audits and get good insight from PLS on how to better review documents and investigtions based on the feedback they receive from their clients.

A problem occurred with the auditor's post office box as the post office failed to deem it open. The problem was corrected one week before the audit. No indication was received during the audit that someone had written a letter.

DESCRIPTION OF FACILITY CHARACTERISTICS

The Massachusetts Correctional Institution, Cedar Junction (MCI-Cedar Junction) is located in Walpole, Massachusetts, approximately 30 miles from downtown Boston. It is a multi-level facility that serves as the main reception center for male inmates. There is also the department's Disciplinary Detention Unit (DDU) in which all movement is restricted. There is a Behavioral Modification Unit (BMU) in which 10 inmates are provided mental health programing under tight security. All cells have single occupancy with the exception of some of the orientation unit housing and general population housing. There is also one area which houses federal detainees.

SUMMARY OF AUDIT FINDINGS

Number of standards exceeded: 8

Number of standards met: 34

Number of standards not met: 0

Number of standards not applicable: 1

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 and the institutional procedural attachment support 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 as well as the facility PREA Manager. The PREA Manager is the Deputy Superintendent. Both indicate they have time and authority to accomplish what is needed to be in compliance with the standards (b,c).

An interview with the Deputy Commissioner was conducted on March 7, 2017, Commissioner designee,(due to Commissioner illness). The Commissioner supports the agency PREA Coordinator. PREA is considered when upgrading video monitoring, during mission changes at individual facilities and during the statewide staffing analysis as was indicated within each facility analysis. It was noted that the annual report is shared with the executive staff and feedback is requested regarding the results.

Overall observations, interviews with the agency Deputy Commissioner, PREA Coordinator, Superintendent and PREA Manager supports compliance with this standard.

A copy of the draft revision of 103 DOC 519 Sexually Abusive Behavior Prevention and Intervention Policy was provided demonstrating upcoming improvements based on the review and analysis of the previous two years. It was subsequently reported to the audit team that the policy was approed by the Commissioner with an effective date of 4/16/2017.

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)

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corrective actions taken by the facility.

This agency uses an inter-state compact agreement with other states. A review of the contract supported the requirements of this standard which includes the obligation to comply with PREA standards and provide for agency contract monitoring.

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)

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(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 levels of correction officers and supervisors are reviewed formally annually by the agency. This 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. 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 into 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, video of night shift unnaounced rounds, staff and inmate interviews support compliance with unannounced and frequent rounds by supervisors. Supervisory interviews support compliance along with documentation (d).

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)

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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 are only 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 announce 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. This training module has been updated since the previous PREA audit to include more specific information on staff conduct when conducting transgender searches (f). Policy supports that transgender/intersex inmates will not be searched for the sole purpose of determining genital status (e). Training records (five randomly selected) 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.

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 and a video relay system which provides a visual sign language interpreter. Inmates with intellectual or psychiatric disabilities are assisted upon arrival by the medical & mental health staff, who identify these needs during the intake process and from the medical record which identifies the needs upon arrival. Informational materials (poster, handbook, PREA video) are available in English, Spanish, and closed caption(b). The Deputy Superintendent serves as the ADA coordinator and PREA Coordinator and ensures that physical, intellectual, psychiatric needs are addressed.

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)

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(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 sexual 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 Director for Human Resources was conducted on March 8, 2017. 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, including 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). Staff 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 the Asst. Deputy Commissioner of Administration dated 10/7/2016. This interview, as well as review of documentation, confirmed that those checks have been completed for all staff in this department. Additionally, the Director confirmed that her staff completes the background checks for perspective contractual staff.

(i) Personnel staff would provide information upon request of a perspective employer, about staff previously employed by Massachusets Department of Correction, upon receipt of a waiver signed by the previous employee. The office would investigate applicants with prior correctional facility experience as well, with a signed release.

Documentation was provided demonstrating five randomly selected staff have received the Blue Book, have had background checks, and references were checked. Staff interviews support a finding of compliance as well.

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)

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(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. Staff 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 physical plant modifications to the facility since the last audit. Additional cameras have been installed. Priority of placement of cameras is decided by the result of the vulnerability assessment (agency level) and by PREA incident reviews (facility 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 (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 (MSP) requesting that the MSP will comply with the investigation requirements of the PREA (e & f). Some of the MSP have been trained by the Agency PREA coordinator. In addition, there is a Department of State Police General Order entitled, Detainee Sexual Abuse and Sexual Harassment Investigations that indicates MSP 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. Staff 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). Additionally, BARCC staff have toured the facilities to become familiar with the layout, and provided additional training to staff and inmates. BARCC staff also personally present at the weekly orientation program at this facility, therefore exceeding the standard.

A review of completed investigations from the previous 12 months confirmed use of 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 was provided of the investigations completed at this facility in the past 12 months, which was pulled from the data base. Four 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)

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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 reflects 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 staff 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 demonstrating 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 five randomly selected staff has been trained. Training occurs annually, therefore exceeding the standard. In addition, all staff are trained in the reqirements that mental and medical staff are required to receive.

It is noteworthy that the Massachusetts Department of Correction developed and presented a national conference on the Prison Rape Elimination Act and it components, which was attended by staff from 37 different states.

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)

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(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 staff are required to participate in the same training and process as Massachusetts DOC employees.

PREA language has been incorporated into the volunteer recertification quiz, ensuring that they understand the training (a & c). All persons visiting (even though under escort at all times) are provided information regarding the law and requirements of the standards relevant to their visit (including a duty to report). 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 and administrators who participate in the hiring. 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)

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(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. The Inmate Handbook 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; "Did You Know . . ." facts sheets are provided to and readiliy available to the inmate population (f). This agency started educating inmates regarding PREA several years ago (c). Additional information is available in the inmate library. To be more diligent, this facility ensured that all key phone numbers (hotline and Boston Area Rape Crisis Center) are stenciled on the wall by the phones and are highly visible. All inmate interviews support compliance as well.

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)

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(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 criterion to establish a substantiated finding is a preponderance of evidence (b), as confirmed by the policy, training curriculum, and interview with the investigators. Two to three staff are assigned to conduct PREA investigations at this facility; however, all investigators have received the specialized training. Investigators from the Office of Investigative Services are also certified in the training. Documentation of completed training support compliance as well as interviews with the investigators and review of investigations (c).

Exceeds standard due to the consistent and thorough agency investigator training program which was also provided to participants at the 2017 conference as well as to the auditor.

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)

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(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 and mental health staff are contracted through Massachusetts Partnership of Correctional Health (MPCH)(d). Review of documentation indicates that medical staff receive 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 ten areas and is objective in that there are yes and no responses that determine what status an inmate is considered (c). 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.

The Booking staff member completes a portion of the assessment and medical staff completes the remainder of screen. Inmates are verbally asked if they perceive themselves as gay, lesbian, bisexual, transgender, intersex, or gender nonconforming by mental health staff. Correctional Program Officers complete the 30 day review and any warranted reassessments (f & g). A post incident checklist has been developed to ensure this screen is completed. Staff and inmate interviews confirm that the interview is conducted in a private setting.

Staff who conduct the risk screen have received individualized training. The PREA Manager reviews the screens to ensure consistency in the assessment and maintains active communication with the staff who complete these screens.

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.

Compliance has been determined by staff interviews, inmate interviews, and review of randomly selected risk assessments. Exceeds standards based on immediate screening process. and the database designed to provided consistency and a checks and balance on the process, further preventing the opportunity for sexual abuse or harassment.

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 assessments will inform staff on a case by case basis on housing, work, education and program assignments upon arrival.

Staff are dedicated full time to making housing and programing decisions, in additional to a housing assignment committee. 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. Appropriate 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 standard 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.

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 interviews with staff in the restrictive housing units support compliance with the practice/policy. In addition, there are several housing unit options available for separating inmates at risk without placing them in restrictive housing to address immediate needs. Review of the completed investigations confirmed this process. It has been reported that no high-risk victim has had to be placed in restrictive housing 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 report on their behalf, regularly scheduled staff access hours 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. Inmates are able to write the attorney general or prosecuting attorney (b).

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).

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. 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 March 9, 2017 to discuss the services with the auditor. He provided statistics indicating an increase in use over the past year. These services are provided to all Massachusetts Department of Correction prisons. Their toll free phone number and address are provided to the inmate population through the updated inmate handbook. Inmates are informed that the phone number 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 Chapter 233 and Section 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 agency 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 to the inmate in a manner which will not violate confidentiality.

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 conversations on the phone. Inmates in restrictive housing are allowed to make a "lawyer call" and staff will dial the number for them on a transportable phone. 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 responses from BARCC can be shared in that manner.

Updated handbooks have been issued describing these details of this service to the inmate population. Random questioning of inmates indicated they had a handbook in their possession.

Exceeds standards based on the actions of staff from BARCC to present at the orientation sessions (male and female), tour facilities, provide additional training to PREA managers and their presentation at the national conference.

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 no third party complaints have been received.

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 the staff to immediately report allegations of harassment, abuse, neglect and retaliation, 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, immediately, via a notification through the inmate management system via confidential incident reports. Interview with the superintendent and investigators, as well as review of the investigations supported compliance with these requirements.

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, followed by a visit 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 one report was received from another state, and one allegations was received regarding an incident in 1984. 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.

First security staff required to, separate, preserve, collect from victim, collect from abuser
If not security, staff required to request alleged victim not destroy physical evidence then notify security staff

519.06 Sexually Abusive Behavior Prevention and Intervention Policy addresses the requirements of this standard. Staff are provided a First Responder card to carry on their person so that they can refer to it in the event that they are the first to be notified of or witness an incident. This card requires staff to separate, preserve the ability to collect evidence and instruct the alleged victim and alleged abuser to not take action that would destroy potential evidence. The facility maintains PREA response kits to assist with ensuring proper evidence collection at the facility until the inmate/victim is taken to the local hospital. A review of the investigations supports compliance. Interviews with security staff and non-security staff support compliance as they are very knowledgeable regarding the requirements of the standard and the process established for ensuring proper actions.

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. PREA response kits are 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 for at least 90 days; this was demonstrated by review of documentation of monitoring reports. Monitoring is discussed during the monthly PREA incident review meetings. Staff verbally indicated numerous avenues they use to monitor for retaliation. This process has been further developed in the new policy.

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. 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 completed investigations conducted in the past 12 months, and interviews with three investigators who primarily handle PREA allegations. Investigators indicated they were notified immediately and initiated the investigation immediately, including the gathering and preservation of direct and circumstantial evidence. The investigators are available at the facility morning through evening and are on call and can be at the facility within thirty minutes, if needed. 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). Policy and interviews support that the investigation will continue even if the abuser is no longer at the facility (j).

Review of investigations also supports compliance that investigators use all resources available, including interviewing all inmates who would be in the area, before making determinations. Review of investigations supports that credibility was individually assessed and 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 interviewing the investigative staff and the review of 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 the appropriate licensing body, where applicable(d). This agency has a department, Central Prosecution Unit (CPU), which works directly with prosecutors when allegations of staff criminal behavior has been made. There is an investigator on site who reports to the superintendent and addresses staff sexual harassment or abuse allegations.

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 PREA Coordinator/contract supervisor supported that volunteers and/or contractors accused of harassment or abuse will not be allowed in the facility unless 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.

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 discipline is commensurate with the action (b). Policy also requires 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). 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 staff 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). The multi-disciplinary incident review team meets 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 2015 Annual PREA report is available on the website. The 2016 should be completed by August 2017 (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 Victimization (formerly Survey on Sexual Violence) was submitted to the DOJ as required (c & f). A copy was provided to the auditor.

Exceeds standard due to the avialability to aggregate information whenever a need presents based on the database, and therefore analyze information more than annually.

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 2015 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 2015 with the information from 2013, and 2014 (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 Deputy 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, 2014 and 2015 are posted on the website; no personal identification is in the report (b & c). The report for 2016 is expected to be posted by August 2017, summarizing statistics and trends from 2016.

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 5, 2017

Auditor Signature Date