PREA AUDIT REPORT ☐ Interim ☒ Final

ADULT PRISONS & JAILS

Date of report: June 6, 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: May 9-11, 2016			
Facility Information			
Facility name: Massachusetts Corretional Institution - Concord			
Facility physical address: 965 Elm Street Concord, MA 01742			
Facility mailing address: *(if different from above)*			
Facility telephone number: (978) 405-6100			
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: Lois Russo, Superintendent			
Number of staff assigned to the facility in the last 12 months: 521			
Designed facility capacity: 614			
Current population of facility: 580			
Facility security levels/inmate custody levels: medium			
Age range of the population: 19-75			
Name of PREA Compliance Manager: Greg McCann		**Title:** Deputy Superintendent	
Email address: Greg.McCann@MassMail.State.MA.US		**Telephone number:** (978) 405-6100 Ext. 400	
Agency Information			
Name of agency: Massachusetts Department of Corrections			
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: (508) 422-3481 ext. 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: Michael P. Donaher	**Title:** PREA Coordinator
Email address: Michael.P.Donaher@MassMail.State.MA.US	**Telephone number:** (505) 541-5301 Ext. 12

AUDIT FINDINGS

NARRATIVE

On May 9-11, 2016, an audit was conducted at Massachusetts Correctional Institution – Concord to determine compliance with the Prison Rape Elimination Act standards finalized August 2012.

An entrance meeting was held with the Superintendent and administrative staff from the facility and staff from the department that oversees policy development and compliance, accreditation and PREA activities for all facilities.

A complete tour of the facility was conducted on May 9, 2016. Areas and operations were observed during this tour that included the following: booking, visiting room, medical operations (including medical housing), programs building (recreation, gym, programming rooms, education, library), and food service operations. Housing units included J building, with six pods, L building with two dorintory housing units and special management housing. Closed units (E building and C building) were also toured.

Documents reviewed for this audit prior to and during the audit included the completed PREA questionnaire, PREA database, 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, inmate handbooks, PREA incident review meeting minutes, all closed sexual abuse & harassment investigations for the previous 12 months, 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 was conducted with the Commissioner on March 24, 2016. 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 the department wide initiative to continue to purchase cameras for monitoring based on needs identified in the report. Recently, a new Commissioner has been named, Thomas A. Turco III.

Twenty-six 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:
Superintendent
PREA Manager (Deputy Superintendent)
medical staff (Health Services Administrator, Mental Health Director, one night shift RN - contractual staff)
10 corrections officers from all areas of facility and shifts (including two from special management housing)
Training Lieutenant
Sergeant – Grievance Coordinator
Sgt. - booking
2 investigators (who also monitor for retaliation and participate in the PREA incident review team)
2 Correctional Program Officers
1 teacher
1 maintenance staff

A total of 20 formal interviews with inmates were held. Inmate interviews were conducted in an office which afforded privacy. One inmate from each housing unit was interviewed which included two who wrote a letter, one with mobility issues, one who was legally blind, three with non-heterosexual orientations (one transgender inmate), and one limited English speaking offender (with staff interpreter). In addition, two who were selected refused, one was away at court, and one had urgent medical issues.

A total of 20 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 inmates 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. Inmates 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 and where. An invitation to meet again was extended. To date no response has been received to the second contact.

An exit meeting was held with the Superintendent and key administrative staff, including two from the headquarters – PREA Coordinator and the Deputy Commissioner of Prisons.

DESCRIPTION OF FACILITY CHARACTERISTICS

MCI Concord is situated on 37 acres of state land with an estimated 25 acres inside the secure perimeter. Construction dates to 1878. The facility has undergone numerous transformations over the ensuing years. In 1884 the facility was designated as the Massachusetts Reformatory at Concord and served as a comprehensive training school for boys under 30. Additional construction in 1893 added 230 cells to the existing facility. In 1955 the age limit was eliminated and the facility was renamed the Massachusetts Correctional Institution at Concord. A building program to replace the entire institution began in 1964. The majority of existing buildings were opened from 1966 through 1978. In July 1989 construction was completed on "Phase I of J Building". This project added 240 cells. Phase II of J Building was completed in 1992 and provided program and treatment facilities. In May 1996 a modular unit, a dormitory style building capable of housing 140 inmates, was opened. In 1999 funding was approved for two additional dormitory style housing units, providing 164 additional beds. In more recent years MCI-Concord was designated as the state's Reception and Diagnostic Center. In June 2009 the Reception and Diagnostic Center moved from MCI-Concord to MCI-Cedar Junction and MCI-Concord was designated as a medium security/custody general population facility. In the past year, the population in the state prisons has declined and the majority of that reduction is reflected at this facility. The population is down approximately 50 %. Count on May 1, 2015 was 1054, counton February 1, 2016 582. Count on the day of the audit was 636. They no longer house pretrial detainees.

Two housing units are not occupied. Currently, this facility houses male inmates, medium custody. Two buildings house the inmates. J North and South each have three pods, with three levels of which the officer has direct supervision of all cells. Toilets and sinks are in the cells. Showers are on each level and have privacy curtains which allow the officer to view the top and the bottom secion only, to ensure security. L building has two dormitory units. Officer can observe all areas on the floor or in a pod. Bathrooms and showers are located on the rear between two bunk areas. There is good observation for security staff as the facilities are located to the left or right of the door and have curtains, walls between, privacy can be afforded to occupants.

The facility is enclosed by a 35 ft. wall. The portion of the wall that faces the heavily traveled Route 2 is constructed of brick in keeping with the historical nature of the concord community. The three other sides of the wall are concrete. There are six armed towers strategically placed along the wall. The administration building sits outside the secure perimeter.

Health care services (medical and mental health) have been provided by Massachusetts Partnership for Correctional Health Care (MPCH) since July, 2013. MCI-Concord has nursing coverage on site 24 hours a day, seven days a week. Spectrum provides programming.

Mission:
Department
The Massachusetts Department of Correction's mission is to promote public safety by managing offenders while providing care and appropriate programming in preparation for successful re-entry into the community.

Institution
MCI-Concord's mission is to provide a safe, secure and respectful environment for staff and offenders, through orientation, evaluation and assessment. We provide the foundation for a productive incarceration and the opportunity for successful re-entry into society.

SUMMARY OF AUDIT FINDINGS

Number of standards exceeded: 6

Number of standards met: 35

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 granted the position in October 2015 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.

Phone interview with the Commissioner on Thursday March 24, 2016, as well as brief interviews with the Deputy Commissioner, Assistant Deputy Commissioner and the Director of the Policy Development and Compliance Unit (PDCU) while they were at a facility for a previous audit 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 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 indicates that he conducts monthly meetings with the facility coordinators, 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 prison rape 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. 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 which confirmed that all posts were staffed. For closed positions, it was verified during the tour that the unit is closed. No deviations from the staffing plan were noted as overtime is used to meet required mandatory staffing. The PREA Manager has input in staffing levels as confirmed by interviews and documentation. Due to the reduction in count, staffing reviews have been conducted monthly.

Post orders additionally require unannounced rounds by supervisors and prohibit staff from alerting other staff of these rounds. Review of randomly selected documentation of unannounced rounds, as well as staff and inmate interviews support compliance with the requirement and showed frequent rounds by supervisors. One date was randomly selected and the video was compared to the rounds documented in the logbook. This demonstrated compliance with the unannounced supervisor rounds of the supervisor on the night shift.
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. Already addressed was the enlargement of many office windows for better visibility.

Additional sound correctional practices observed at this facility 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 to discuss events of the facility in which PREA concerns are addressed.
- Staff access time – Key staff make themselves available to the inmate population going to and from meals. Inmate interviews, staff interviews and documentation led to the conclusion that this is an effective practice to enhance communication and resolve problems before they become serious.
- The PDCU conducts extensive annual reviews to assess compliance with policy and ensures the practice is meeting its desired result.

Finally, there is a strong union presence in this agency that would not tolerate a reduction in posts. Staffing is unique at this facility in that staff bid for jobs and days off. As noted by the staffing numbers compared to inmate population, this facility is well staffed.

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 searches or cavity searches can only be conducted in the event of exigent circumstances (a). Cavity searches by policy are conducted by medical staff. 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 or cavity search, a report would be written and sent to 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 inmates interviewed 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.

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 Line services are available to assist with limited English speaking 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 one legally blind inmate. Inmates with intellectual or psychiatric disabilities are assisted by the medical & mental health staff, who identify these needs during the intake process. Medical staff would also address any inmates who are deaf or blind at intake and determine appropriate accommodations. The facility PREA Manager also functions in the role of ADA Coordinator for the facility and is responsible to ensure any needs are met.

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, been 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 for 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.

(d) 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. The 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 four randomly selected staff and one contractual staff received the blue book, had background checks, and references 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 in the facility vulnerability assessment. Additional cameras have been requested. Priority of placement is decided by the result of the vulnerability assessment and substantiated PREA investigations. 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. Additional review of the monitoring system occurred during the interview with the investigator. There have been no modifications to the facility.

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 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). Massachusetts State Police have participated in training conducted 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.

A review of fourteen completed investigations confirmed they are using a uniform evidence protocol. The agency has concluded their negotiations with an advocacy group, Boston Area Rape Crisis Center (BARCC) to provide services to victims and a MOU has been signed. Staffs from BARCC receive a minimum of 40 hours of training to assist victims of sexual abuse (g).

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, retaliation, and knowledge of abuse and harassment to the shift commander, who must then report to the superintendent immediately (a & d). This policy is available on the Massachusetts Department of Correction website (b). 522 Internal Affairs is also posted on the website (c). The superintendent ensures that the proper investigating entity is contacted (Office of Investigation Services, outside law enforcement or the staff investigator), as confirmed by interview with the superintendent and review of documentation (investigations).

A list of the investigations completed at this facility was provided. Fourteen completed investigations from the previous 12 months were thoroughly reviewed and demonstrated compliance with the standards.

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 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). Randomly selected training documents reviewed support the report that 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. 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 staff 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.

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 – not applicable
(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. 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, Garrity and Weingarten (union requirements for investigations) warnings and evidence collection (b). The criteria to substantiate is a preponderance of evidence (b), as confirmed by the policy, training curriculum and interview with the investigator. There are eight staff who have received the training for investigators. Two staff are assigned to conduct PREA investigations regarding inmates, and one staff (the superintendent's special investigator) investigates concerns with staff at this facility. Documentation of completed training as well as the interview with the investigators support compliance (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 is contracted through Massachusetts Partnership of Correctional Health (MPCH). There are 47 medical and mental health staff at this facility. 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). Interviews 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 and 650.02 Mental Health Services address all the requirements of this standard. Documentation reviewed which demonstrates compliance includes 72-hour Housing Risk Assessments (typically conducted immediately upon arrival) (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). 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).

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. Three randomly selected intake screens were reviewed – all demonstrated compliance with the standard.

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 determinations will occur at that time. Due to recent clarifications from the PREA Resource Center, this policy is currently being revised. In addition the the policy change, all transgenders have received a detailed individual evaluation to review their needs, enhancing previous assessments conducted.

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). 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 interviews and documentation. Massachusetts Department of Correction does not have a dedicated facility for transgender/intersex inmates (g). There was one transgender inmate, no intersex inmates housed at this facility at the time of the audit.

Exceeds standards is based on the practice of the use of a housing/program assignment committee that meets weekly and reviews housing assignemtns and review by the investigators before assigning a job. The Unit Captain is very familiar with the population and addresses individual needs daily.

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 unit support compliance with the practice. In addition, there are other options for separating inmates at risk without placing them in restrictive housing to address immediate needs. Review of the completed investigations supported that segregation was not used to place victims. Finally, it was 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 anything to dispute this.

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. 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 (PLS) 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. As stated, this facility has a liaison from PLS that comes to the facility regularly.

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). All 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. Review of completed investigations, interview with the investigator and grievance coordinator confirmed that no grievances have been received that initiated a PREA investigation in the past 12 months.

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/contract has been signed with the Boston Area Rape Crisis Center (BARCC) (a & c). A toll free hotline is available to all inmates from 9:00am to 9:00pm. 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 stated in the recorded introductory statement. A representative of BARCC was at a previous audit in this state to discuss the services with the auditor on March 23, 2016. 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 (inside and outside). Most are appropriately spaced to afford the inmate the ability to maintain a 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. This contract took effect August 2015. The PREA agency coordinator and BARCC representative have worked 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.

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 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 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. Review of the investigations support that action needed due to the awareness of imminent abuse was conducted within fifteen minutes. Staff interviews support knowledge of the requirement and how action is to be taken.

Protection is afforded through immediate separation from the area and medical 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 facility, five reports were sent to other facilities 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) First security staff required to, separate, preserve, collect from victim, collect from abuser
(b) 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. Staffs 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 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, while at the facility until 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 staff are knowledgeable regarding how to respond at this facility. A PREA 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. Negotiations have been completed for the upcoming contract. No changes affecting this standard were made.

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). The Inner Perimeter Security (IPS) members conduct monitoring for retaliation. A review of the monitoring activities indicate that multiple protection measures are utilized regarding those who report (b). Monitoring has occurred up to 90 days; this was demonstrated by review of documentation of monitoring reports.

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 interviews with staff in the restrictive housing unit support compliance with the practice. It has been reported that no high risk victim has had to be placed in the restrictive housing unit 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 14 completed investigations conducted in the past 12 months, and interviews with the three 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. Investigators 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. Evidence is assessed individually, factually and in a standard format, as demonstrated in completed investigations. Potential criminal matters are referred to internal affairs and 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). Many components of the investigations will remain on the database indefinitely. Policy and interviews 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 versus unfounded supports that credibility was individually assessed, findings based on evidence available. 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 have been made. There is an investigator on site who 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 Superintendent 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.

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 and sexual harassment as well as consensual sexual activity (a & g). Policy has an established sanctioning process to ensure sanctions 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). 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.

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
(e) If pregnant, appropriate legal treatment - NA
(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, there have been no occurrences that would warrant ongoing medical and mental health care due to sexual abuse. Continued mental health services are available if requested.

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, assignment sergeant, an industrial instructor, investigator, and the medical and mental health director (when relevant). (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. PREA incident review meeting minutes were randomly requested and reviewed supporting compliance with the standard.

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. Statistics are reviewed and compared with the previous year. 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 June 6, 2016

Auditor Signature Date