PREA AUDIT REPORT ☐ Interim ☒ Final

ADULT PRISONS & JAILS

Date of report: June 26, 2015

Auditor Information			
Auditor name: Louis S. Folino			
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Telephone number: 412-680-8342			
Date of facility visit: June 1-5, 2015			
Facility Information			
Facility name: Hampden County Sheriff's Department and Correctional Center			
Facility physical address: 627 Randall Road, Ludlow, MA, 01059			
Facility mailing address: *(if different from above)* Click here to enter text.			
Facility telephone number: 413-547-8000			
The facility is:	☐ Federal	☐ State	☒ County
	☐ Military	☐ Municipal	☐ Private for profit
	☐ Private not for profit		
Facility type:	☐ Prison	☒ Jail	
Name of facility's Chief Executive Officer: Michael J. Ashe, Jr.			
Number of staff assigned to the facility in the last 12 months: 911			
Designed facility capacity: Main Facility-1301; Pre-Release Center-218; Western Mass Correctional Alcohol Center- 126			
Current population of facility: Main-873; PRC-136; WMCAC-63 (Population as of June 5, 2015)			
Facility security levels/inmate custody levels: Minimum, Medium, Maximum, Pre-Release			
Age range of the population: 18-71			
Name of PREA Compliance Manager: Colleen Molta, Andrew Adams, Matthew Roman, Dan Moran		**Title:** Standards Coord.,Standards/Trng.,Supv./C.O.	
Email address: Colleen.Molta@SDH.State.Ma.US; Andrew.Adams@SDH.State.Ma.US; Matthew.Roman@SDH.State.Ma.US; Dan.Moran@SDH.State.Ma.US		**Telephone number:** 413-858-0954/413-858-0817	
Agency Information			
Name of agency: Hampden County Sherrif's Department			
Governing authority or parent agency: *(if applicable)* Click here to enter text.			
Physical address: 627 Randall Road, Ludlow, MA 01059			
Mailing address: *(if different from above)* Click here to enter text.			
Telephone number: 413-547-8000			
Agency Chief Executive Officer			
Name: Michael J. Ashe, Jr.		**Title:** Sheriff	
Email address: Michael.Ashe@SDH.State.Ma.US		**Telephone number:** 413-547-8000	
Agency-Wide PREA Coordinator			
Name: Mary Baker		**Title:** Standards Manager	
Email address: Mary.Baker@SDH.State.Ma.US		**Telephone number:** 413-858-0914	

AUDIT FINDINGS

NARRATIVE

Auditor will describe PREA Audit process conducted, and then comment within specific areas of focus, within the individual "Auditor discussion" Standards sections, below.

The Pre-Audit Phase involved Auditor's review of a large volume of documents provided by the HCSD PREA Coordinator. Through their IT Department, Auditor was able to retrieve all required documentation, i.e. Pre-Audit Questionaire (PAQ), Facility Policies, training curriculums, etc, plus supportive documentation, from "the cloud." Auditor subsequently received all such documentation downloaded to a large capacity external drive on the last day of the on-site visit. Phone calls/conferences and emails were regularly conducted with the PREA Coordinator/PREA Managers for approximately three months prior to the on-site visit. Several inquiries and requests for clarifications were presented to Auditor, and the PREA Resource Center was consulted by Auditor on two occasions to resolve questions, and to affirm local practices as acceptable. Auditor prepared for On-site Phase by conducting review of Pre-Audit Questionnaire (PAQ), in relation to requirements of PREA Standards. During this Phase, Auditor provided PREA Coordinator with required Audit Notice, which was posted throughout facility areas from April 20 through June 5, 2015. Audit Notice was posted in English and Spanish.

During Pre-Audit Phase facility personnel were extremely accommodating and always available to respond to Auditor. The Pre-Audit interaction with approximately ten HCSD personnel, to include Sheriff Michael J. Ashe, Jr, provided to Auditor an impression of a very professional organization, well-organized and focused to attain full PREA compliance.

The On-Site Audit Phase was conducted by unnaffiliated Auditor Louis S. Folino during a 5-day period, June 1-5, 2015. Auditor enjoyed dinner, Sunday evening, May 31st, with seven HCSD personnel, to include the HCSD PREA Coordinator, four PREA Managers, and two Assistant Superintendents. This informal introductory gathering provided an opportunity to finally meet the facility personnel primarily charged with PREA implementation, and several key HCSD Executive personnel.

The In-Briefing was conducted Monday morning and attended by 12 key HCSD personnel. Auditor provided overview of process and game-plan for the week. During the week, Auditor completed tours of all areas of the Main Institution and Pre-Release Center. Auditor observed excellent sanitation and cleanliness throughout. All areas, with exception of an active gymnasium area, were calm and quiet, to include the segregated housing units.
Appearance of uniformed and non-uniformed personnel was Outstanding, with personnel exhibiting pride and attentiveness to duties. Posted security personnel, and Unit Management/Counseling staff were very professional, courteous and helpful in assisting Auditor to understand the facility's state-of-the art IT system, which serves to assist compliance with PREA separations, inmate/resident risk notices, gender announcements, etc.

Auditor made a concerted effort to greet all post personnel, and any/all other facility personnel, and to spend some time allowing staff to discuss their units, programs, operations, PREA implementation/training, their careers, aspirations, etc. Auditor concluded that the HCSD possesses a very large cadre of Outstanding Performers. I sensed no resistance to PREA or my role there serving as Auditor. It appeared the vast majority of personnel were aware of my presence there, and welcomed this review. Similarly, the observed inmate/resident demeanor was calm and comfortable. Auditor observed inmates/residents in housing units/dayrooms, recreational areas, performing work, at school/programs, dining on units, being released-out to community, being processed-in at Intake, and going to/from housing units under escort/authorized movements.

During such tours, I evaluated inmate/resident showers and cell areas for privacy, while maintaining security; Bulletin Boards for posting of Audit Notice and PREA Posters; phone areas for access and PREA/Hotline information; CCTV coverage, and possible blind spots; documentation of officer/supervisory tours, or "rings"; and general inmate/resident morale and compliance. I shook random door handles to ensure unoccupied/unattended closets, rooms, offices, etc. were properly secured---I found all to be secure.

Auditor conducted 32 MI/PRC/WMCAC staff interviews during the week, which covered all shifts, and included security (line staff, supervisory, management and Administrative), maintenance, health care, mental health, Intake, Classification, Executive level, investigative, training, human resources, volunteer, contractors and purchasing. The PREA Coordinator and four PREA Managers were interviewed. Results obtained reflect the agency commitment and actions taken to comply with all PREA Standards. Facility planning was evident in the presentation of training to personnel and education to the inmate/resident population. Interview results supported facility policy documentation which details the 2 year project of PREA planning and implementation. Staff were cooperative during interview and displayed a dedication to their responsibilities, their coworkers (Teamwork) and the HCSD. Results obtained through personal interviews were consistent with the 75 various staff persons Auditor greeted and engaged in discussion while touring during the week, e.g. positive attitudes and commitment to mission of facility.

Auditor conducted 14 MI/PRC/WMCAC inmate/resident interviews, which included random, pre-trial, sentenced, segregated housing inmates/residents, Federal inmates and a Massachusetts DOC inmate; and those with Alerts/multiple Alerts, such as transgender, bi-sexual, predator, victim, Security Risk Group (gang), non-English speaking, high-profile cases, a disabled inmate and a Mental Health inmate.

Auditor interviewed Hispanic, White and Black inmates, and younger and older inmates/residents. It is noted that there are no youthful offenders housed at HCSD, per a MOU with the Department of Youth Services. Individuals under the age of 18 are no longer sentenced as adults, resulting from a Commonwealth of Massachusetts statute revision. Standard 115.14 is therefore NON-APPLICABLE. Similarly, Standard 115.12, is also NON-APPLICABLE, as HCSD does not contract with other entities for the confinement of inmates.

All inmates/residents interviewed expressed to Auditor that they felt safe in HCSD detention. They acknowledged being PREA-screened and as having received PREA education. They were familiar with reporting methods and were comfortable with reporting to personnel, e.g. unit officers, counselors, or via Requests/Grievances. A respect for facility staff and their performance of duties was related to Auditor, which included Sheriff Ashe. It is clear that all inmates are properly PREA informed of their rights and reporting methods at HCSD. Inmate interviews confirmed opposite gender announcements ("FEMALE ON THE UNIT") being regularly made by PA announcements, and a placard placed above the officers desk. At no time did any inmate/resident express that they were ever totally naked in front of female personnel in the units. It must be noted that one inmate forwarded correspondence to Auditor alleging a sexual incident with a staff person as having occurred in April, 2015. This allegation had been reported to authorities previously, however, and inmate was subsequently disciplined and is awaiting criminal prosecution for the filing of False Reports.

The objective of the Auditor's site visit is to confirm that Policy 3.5.3 PREA Plan has been implemented and the various provisions of the policy are actually in-practice; that the training and education documents are thorough and accurate, reflecting that both personnel and inmates/residents have been properly oriented; to assess inmate housing units and other facility areas for supervison and remote monitoring/record capability; to identify blind spots and/or other potential problem areas; to ensure posting of Audit Notice; to verify that PREA Posters and Rape Crisis/Support Center phones are accessible and Toll-Free; to gauge inmate and staff interaction and morale; to conduct numerous random and specialized interviews to obtain input on training/education, reporting methods, First-Responder duties, gender announcements, investigative methods, etc., etc. When combined with Auditors review of all pertinent Policy/procedure documentation, to include the PAQ; the thorough facility tour; and the staff and inmate interviews, the Auditor's objective is to then compile data and determine compliance with the respective PREA Standards.

During the Final Phase of Post-Audit Report Writing, the Auditor determines Standard Compliance, i.e. Does Not Meet, Meets or Exceeds. The PREA Coordinator and PREA Managers were again particularly helpful in responding to inquiries and promptly supplying information to the Auditor. This Final Phase involves extensive review of agency documentation, Auditor's notes, interview results, training logs, etc, in order to support and justify Standard compliance.

It is evident that the early planning, largely initiated with the development of a comprehensive PREA Plan Policy, 3.5.3., in April, 2013, and the activation of a PREA Team, led by PREA Coordinator Mary Baker, in July, 2013, resulted in the successful implementation of the 43 major PREA Standards and associated sub-standards. During the Audit, it was learned that the 14 Massachusetts county PREA Representatives and several MA DOC PREA Representatives met on a monthly basis to share curriculum/forms, trainings conducted, process, progress and implementation strategies. A Massachusetts Sheriff's Association Representative scheduled and chaired these meetings, providing focus on areas of need. Within the HCSD, Executive staff support was provided by Sheriff Michael J. Ashe Jr. and his Assistant Superintendents, the six appointed PREA Managers, and other key Team Members. The Team worked together closely to systematically address all Standard requirements. As a result of this local review, and a PREA Risk Assessment conducted to analyze risk factors related to sexual victimization within the facility, additional monies were requested and approved to expand and enhance electronic monitoring capability, in response to PREA. Another example of agency response was the valuable IT assistance and expertise rendered in the development of a new screening database. This database implemented new PREA Screening forms developed by the PREA Team, and incorporated automatic Alerts and prompts to assist employees in offender management. This database is used by all agency facilities for offender screening, classification, and monitoring.

Auditor has reviewed PREA Team committee Agendas which reflected a very organized approach in undertaking this priority project. Such an effective unified approach is clearly the Standard Operating Procedure and expectation at the Hampden County Sheriff's Department. Auditor made only several suggestions to facility personnel to further enhance their facility security and to ensure full compliance with PREA. Auditor found the very experienced and dedicated agency personnel always receptive to such input, and observed them to proceed only after due deliberation and evaluation. This concerted effort has served to reinforce and emphasize institutional safety and proper conduct of all parties in the varied confinement settings audited. Zero tolerance toward all forms of sexual abuse and sexual harassment is clearly the norm within the Hampden County Sheriff's Department Main Institution, Pre-Release Center and Western Massachusetts Alcohol Center. Recognition is extended to Sheriff Ashe, the HCSD Chain of Command, the PREA Coordinator and PREA Managers, and the many key stakeholders within the Table of Organization that have contributed to this collaborative effort.

An Out-Brief was conducted on the afternoon of June 5, 2015, with 25 HCSD personnel in attendance. Auditor provided preliminary overview of audit results and commended facility staff for their efforts in striving to achieve full compliance, and for their everyday teamwork and professionalism in managing such a fine facility. It has been a pleasure to visit your facility, to meet your dedicated and professional personnel, and to serve your agency in this capacity. Based upon this Auditors thorough review and consideration, Auditor has found the Main Institution, Pre-Release Center and Western Massachusetts Alcohol Center in compliance with all applicable PREA Standards: Meets-28; Exceeds-13; NA-2.

Thank You for your assistance and staff's hospitality in facilitating this Audit.

DESCRIPTION OF FACILITY CHARACTERISTICS

The Hampden County Sheriff's Department (HCSD) and Correctional Center is a multi-mission institution dedicated in 1992, with the Main Institution (MI), Pre-Release Center (PRC) and Western Massachusetts Correctional Alcohol Center (WMCAC) located on-site. These facilities/programs are the focus of this PREA Audit. Off-site, the HCSD operates a Womens Correctional Center, and multiple Community/Re-Entry operations serving as day centers for released inmates/residents. These include the Day Reporting Center, the After-Incarceration Support Systems (AISS) and the Olde Armory Grill.

Custody levels include minimum, medium, maximum security, and a population of Pre-Release Center residents. General Population consists of pre-trial, sentenced and a small number of federal inmates and others held for another authority, e.g. other Massachusetts county jails or Massachusetts DOC. The population of the areas audited (MI, PRC and WMCAC) was 49.8.% Hispanic; 30.3% White; 19.8% Black; and .2% Asian.

The Main Institution is comprised of seven buildings, three of which are housing towers for pre-trial detainees and sentenced inmates (up to 2 and ½ years). The General Population housing units operate under a Unit Management/Direct Supervision mode of operation, with very few group line movements. Nonetheless, the MI and PRC buildings are equipped throughout with a very sophisticated and efficient CCTV and IT system; and personnel are equipped with multiple methods of communicating emergency alerts. Posted personnel utilize radio communications to coordinate, monitor and and supervise all inmate individual and group movements in the Main Institution.

The Pre-Release Center also presently houses the Western Massachusetts Correctional Alcohol Center. Long-term future plans are to construct a separate new WMCAC in the nearby community of Springfield. Staff planning meetings and activities are presently underway concerning this relocation. Daily, approximately 120 PRC residents are processed-out to the community, consisting of 19 Community Service Teams which perform janitorial, highway, parks and recreation, and forestry duties in the community.
The PRC building is a large modular design 2-floor structure located approximately ½ mile from the MI. The PRC is a self-contained housing unit, with Resident visiting facilities, Food Service Department, recreational/dayroom areas, laundry, program space, Control Room and staff offices.

The Hampden County Sheriff's Department has been continously ACA Accredited from 1985 through 2013. This professional process was interrupted several years ago due to budgetary reasons, but the HCSD is presently considering resumption of the ACA Accreditation relationship. In addition, the MA DOC conducts annual inspections of the HCSD. The Medical/Mental Health Department is audited every three years by the National Commission on Correctional Health Care, with the latest successful audit being conducted in February, 2014.

The Sheriff of the HCSD, Michael J. Ashe, Jr., has been the elected official and leader of this major jail operation for 40 years. As result of the Sheriff's stable leadership, the HCSD has consistently expanded their programs and resources, all implemented by a dedicated workforce of professionals. The HCSD website states that "The Sheriff's Philosophy is that re-entry into the community begins on day one of incarceration, and the intent of the agency is to begin a continuum of return to the community as law-abiding, productive citizens." The facility personnel implement this philosophy, work together to provide a safe and secure enviornment, and to positively impact the inmate/resident population. The resulting favorable facility culture, staff and inmate, is evident.

SUMMARY OF AUDIT FINDINGS

Click here to enter text.

Number of standards exceeded: 13

Number of standards met: 28

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.

Agency developed comprehensive Policy, 3.5.3 PREA Plan in early 2013, in preparation of coming into full compliance with PREA requirements and Standards. This Policy established a zero tolerance toward all forms of sexual abuse and sexual harassment, provides required definitions of prohibited behaviors, includes sanctions for those found to have engaged in prohibited behaviors, and includes strategies and responses to reduce and prevent sexual abuse and sexual harassment of inmates. Appointment of an Agency PREA Coordinator and six PREA Managers (MI, PRC, WMCAC, Womens Correctional Center, Community Safety Center and Training), greatly assisted in agency implementation of procedures and development of facility protocol to attain compliance. This inititial activation and multitude of required taskes presented a very real challenge to the PREA Coordinator and PREA Managers, especially considering their other regular assigned duties. Agency personnel worked as a Team to develop implementation methods and variations of training presentations, to ensure thorough and accurate documentation, and to communicate expectations and project progress to all personnel. Such a unified approach has served to obtain buy-in by agency employees, who largely regard PREA as a further enhancement to their already safe, secure and professional operation. Auditor's interview results of staff and inmates/residents confirm this end result, due to the widespread understanding of PREA and the agencies zero tolerance policy. Personnel acknowledge that PREA initiatives will assist them in the fulfillment of their mission, and inmates/residents observe that the facility is concerned about their well-being, and will not tolerate sexual abuse or sexual harassment within the facilities.

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.

NOT APPLICABLE---no present or past contracts for inmate housing outside of HCSD.

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.

Agency addresses staffing levels/reviews and supervisory unannounced security rounds in accordance with Facility Policy, 3.5.3 PREA Plan. Annual meeting minutes were reviewed by Auditor. Staffing levels were observed to be considerable and effective, both for post personnel and Commissioned Officers, and Unit Management/counseling staff. Facility administration does not operate daily routine or shifts below compliment—scheduling adjustments or overtime is utilized to provide necessary post personnel at all times. Both Administrative/managerial and line staff were well aware of intentions and prohibitions of unannounced round's procedures. Such rounds, known as "rings" in HCSD, are documented electronically, and reviewed during unannounced rounds conducted by Supervisors. Auditor reviewed printed employee's "rings" reports as well as observing how Supervisors review subordinate's "rings" and document their own respective rounds.

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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NOT APPLICABLE –Hampden County Sheriff's Department does not house youthful offenders.

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.

The facility has not conducted any cross-gender strip searches or body cavity searches of inmates/residents, per Policy 3.5.3. Staff have expressed to Auditor that they understand this prohibition. No females are confined to the MI, PRC or WMCAC.
Inmates/residents are afforded required privacy, and gender announcements are made, accordingly. Such announcements in the Main Institution are made via a personalized computer/PA gender announcement, or a computer/PA general gender announcement activated by the post officer. In addition, a placard announcing a female employee is on the unit is also posted at the officer's station. Both staff and inmate interviews confirmed this practice, as did this Auditor during a thorough tour of all facility housing units. The Pre-Release Center/WMCAC has a unique linear design of four pods, dormitory-style with common restrooms/showers located centrally off of the middle of the pod hallways. There is an established opposite gender announcement procedure communicated to personnel and residents, which is adhered-to by employees and residents. Resident and employee interviews confirmed staff compliance to intent of 115.15, and their housing conditions related to female personnel posted/entering the pods.
Inmate shower and restroom areas were evaluated, and determined to provide the proper privacy, without sacrificing security needs. A pat-

search training video produced by facility personnel is an excellent training tool and has been reviewed by all personnel responsible for the care and custody of the inmate/resident population. Inmate interviews conducted by this Auditor reflect a respect for facility personnel for their professionalism in the performance of their duties.

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.

Facilty actions to address inmates/residents with disabilities and who are Limited English Proficient are consistent with established Policy. The posting of placards announcing cross-gender females on units is intended for hearing-deficient inmates/residents, and a reminder to all others. Sufficient staff interpreters are available as necessary, with this auditor utilizing the services of a Residential Supervisor (Spanish) and a Lieutenant (Spanish) during one inmate and one resident's interview. In addition, a computerized translation service is also available and was used recently by an Intake Nursing Supervisor to process the PRC inmate the Auditor would subsequently interview for this PREA Audit. Inmate interpreters are prohibited from being utilized. Inmate/resident interviews of limited-english inmates/residents and a disabled inmate evidenced their understanding of PREA and prior education received concerning their rights, reporting methods, etc. Documentation reviewed by Auditor confirmed such education/orientation as having been provided to the inmates/residents that were interviewed.

Standard 115.17 Hiring and promotion decisions

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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Agency has conducted criminal background checks of all new hires, volunteers and contractors, accordingly, i.e. 142 in last 12 months. In addition, facility has conducted criminal background checks of ALL employees during period 2013-2015. This action has served to resolve any doubt concerning possible criminal conduct of existing personnel/contractors. The criminal records checks are an established process in the Human Resources Department which is very systematic and well managed. This process of conducting required criminal background checks of current employees and contractors was described/displayed to Auditor during interview. Promotional interviews now include questions about previous sexual misconduct as described in 115.17 (a).

Standard 115.18 Upgrades to facilities and technologies

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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Agency/Facility has continuously upgraded their monitoring technology and capability. Auditor observed no major areas of concern. Several potentially vulnerable areas were either already to be addressed in a facility Plan-of-Action provided to Auditor, or are being presently evaluated as a result of Auditors discussions with facility executive personnel, i.e. Education Classrooms. A substantial expansion will be initated in new fiscal year, (July, 2015), with the expenditure of $64,449.98 to expand/upgrade camera coverage in the Pre-Release Center /WMCAC, Food Service Dept, C Tower and other areas. It is clear to this writer that facility personnel are quite conscientious concerning their security awareness and consideration of employee's input in such matters.

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)

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Auditor's review of Policy, established procedures, investigative training Certificates, investigative protocol/checklists, review of all 18 investigations conducted during last 12 months, review of facility PREA Kits (evidence response kits), and staff interviews evidence a strong, unified and coordinated approach to the conducting of criminal and administrative investigations. Excellent professional relationships are maintained with the MA State Police, District Attorney's Office and Baystate Hospital (SAFE/SANE). All required victim services are to be afforded to sexual abuse victims per policy and agreements/MOUs. Auditor confirmed commitments to provide such services to HCSD inmates/residents by contacting the Executive Director of the YWCA of Springfield Massachusettes, and the Contract Administrator at Baystate Medical Center.

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.

The Criminal Investigative Unit (CIU) of HCSD is primarily responsible to investigate facility incidents to include PREA incidents/allegations. These include criminal and administrative. Facility may determine whether to conduct a joint investigation with the

MA State Police, or refer an investigation to them—this has not occurred in previous 12 months. Policy 3.5.3 PREA Plan and Policy 3.1.7 Special Teams provide guidance and procedures to follow. In last 12 months, (18) PREA investigations were conducted by CIU, with one case proceeding to criminal court concerning a general Assault charge. Auditor reviewed Investigation and video concerning this PRC incident. Majority of other cases were inmate reports of alleged incidents to have occurred at other facilities/agencies, or alleged to have occurred at HCSD in year's past. Auditor reviewed all investigations with CIU Investigator and PREA Manager.

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.

Facility has provided initial PREA training, per 3.5.3. PREA Plan policy, to 761 personnel in the last 12 months. Employee interviews confirm this traning, as did the documentation provided to Auditor. HCSD uses a cadre of (12) trained and highly motivated Instructors to present initial and subsequent refresher and specialized trainings, presented in varied formats and opportunities, e.g. Basic Academy Training, initial PREA trng for existing staff, annual 16 hr in-service trainings, Roll Call, and unit trainings. Documentation verifying such trainings is thorough and well-organized by facility personnel. Auditor has confirmed training documentation, as asserted by all facility personnel interviewed. Interview results reflect an excellent understanding of PREA, as delineated in 115.31 (a), and proper search procedures, First Responder duties, various staff roles, etc. It is evident that training in any/all subjects, to include PREA, is a priority at HCSD, and it is well presented and received by personnel.

Standard 115.32 Volunteer and contractor training

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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Auditor interviewed both a Volunteer and a Contractor. Both had excellent understanding of intent of PREA, their responsibilities and procedures to follow as instructed per their training. Review of facility documentation verified such training. In last 12 months, facility has provided this required training to 240 Volunteers/Contractors that service the Main Institution, and 54 that service the Pre-Release Center/WMCAC.

Standard 115.33 Inmate education

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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

Facility provided PREA information/screening at time of Intake to 3,909 inmates during the past 12 months. Such information/screening was provided accordingly to Limited English Proficient, Deaf, Visually Impaired, Disabled and Limited Reading Skills. PREA brochures (English and Spanish) are issued, as are Inmate Handbooks, which provide required PREA information and guidance. Posters and PREA Information is posted beginning in Intake area, and thereafter throughout housing and other areas. Facility uses qualified personnel as interpreters, and also a computerized translation program. It must be noted approx. 49.8% of MI and PRC/WMCAC's population is Hispanic, while HCSD employs numerous qualified bi-lingual personnel to provide needed translation services. Inmate interviews conducted, to include (7) Hispanic inmates, two of which utilized two different staff interpreters, indicated all inmates had been properly oriented and educated concerning PREA, their rights in such matters, reporting methods to personnel, availability of YWCA Hotline, right to be free from retaliation, etc. Standard operating procedure generally results in recently received inmates receiving comprehensive education on PREA in B-1 Housing Unit/Reception Unit. Special cases may be oriented in C-10 Unit or Medical, etc, due to special needs.

Standard 115.34 Specialized training: Investigations

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Agency has three trained Investigators. Auditor interviewed Head Investigator (CIU Unit Commander), and reviewed training Certificates. Agency enrolls investigators in available in-service and out-service investigative training opportunities. OIC Unit Commander has completed 12 week MA State Police Academy (criminal procedures and police science), among many other appropriate courses.

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.

Auditor interviewed multiple Nursing personnel, a MH Clinician, and Staff Psychiatrist. All expressed understanding of PREA and their roles in handling such cases of reported sexual abuse. A Total of 139 Medical/Mental Health personnel have received PREA training, and

specialized training for medical/mental health personnel. No forensic exams are conducted at facility, per Policy. Agreement exists with Baystate Medical Center to provide such forensic examinations as necessary, and staff are aware of their roles in event such a sexual abuse situation would arise. It is noted there were no such referrals or escorts to Baystate Hospital during the last 12 months.

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.

In past 12 months, 3,160 inmates were processed, either through Intake or transfer, whose length of stay in the facility was 72 hours or more. Auditor toured Intake area, and observed the initial PREA screening process of inmates by security and nursing personnel. Auditor interviewed an Intake Lieutenant, a Registered Nurse, and an Admissions/Discharge Assistant. Responses by personnel and inmates recently received confirm required initial screening for risk of victimization and abusiveness is being conducted. Recent receptions/screening of a transgender inmate and a bi-sexual inmate, both subsequently interviewed by Auditor, were in accordance with Policy. Dissemination of PREA Screening information is limited to a need-to-know basis in order to adequately inform housing, security and classification. Confirmation of 30 day reviews following reception, with prompts for responsible personnel provided in automated system, were confirmed by this Auditor via facility documentation.

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.

Auditor viewed automated system which informs specific personnel of inmates/residents status, alerts, risk, etc. Housing Unit Officers, PREA Manager, Intake Lieutenant and Classification Coordinator all "walked" Auditor thru automated process, beginning with Intake screening, and subsequent distribution of such information to need-to-know personnel/posts. Specific Alerts incorporated into this automated sysytem will deny double-celling possibility in housing units. Inmate interviews of bi-sexual and transgender inmates confirmed case-by-case review conducted by personnel, and measures taken to ensure inmate's safety.

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.

Policy 3.5.3., PREA Plan, governs inmates placement to Protective Custody concerning high risk of sexual victimization. The fact that there were no placements in such restricted status during the past 12 months is consistent with established Policy, and reflective of facility philosophy, and use of alternative housing and/or means of separation. Housing Unit C-10 is a population unit utilized to house special cases, to include those determined to be at risk of sexual victimization, or other concerns, e.g. medical/mental heath, inmate separations, high-profile offenses, etc. During interview with Auditor, one inmate expressed concern about his continued housing in General Population, expressing a request to be housed in C-10, due to his expressed sexual orientation. This information was shared with facility personnel, and inmate was subsequently interviewed by unit management staff. Inmate then expressed desire to stay in current GP status. Inmate was advised to contact staff should any issues arise or if he believed a move to C-10 would be in his best interests. Such staff response reflects individual determinations/case-by-case handling by facility personnel.

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.

HCSD informs inmates/residents of reporting methods via PREA education, PREA Brochures, facility postings/posters and Inmate Handbook. Inmate interviews conducted revealed inmates were aware of the various reporting methods, e.g. to Counselor, to Unit Officer, to Rape Crisis Center Hotline, or by Grievance or Inmate Request. Personnel are similarly aware of reporting responsibilities and methods, from training on 3.5.3. PREA Plan, in-service trainings, and Unit and Roll Call trainings.

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.

Facility Policy and practice meet all standards of 115.52. In the past 12 months, three grievances were filed alleging sexual abuse. One unfounded grievance resulted in disciplinary action against the inmate for having filed the grievance in bad faith. The remaining two

grievances were: one unsubstantiated, and one unfounded. There were no cases of an inmate grievance alleging substantial risk of imminent sexual abuse filed in the past 12 months. There is a procedure for dealing with inmate grievances regarding sexual abuse—inmates were aware during interviews that a reporting method was to utilize the grievance system. In accordance with facility policy, there is no time limit to filing such grievances, and such grievances would not be referred to the staff member who is the subject of the complaint.

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.

HCSD maintains a Memorandum of Understanding (MOU) with the YWCA of Western Massachusetts, which provides a 24-hour Sexual Assault Hotline and Counseling Services. The Toll-Free number and information is posted in all inmate/resident housing units at all telephone locations. Auditor has received/reviewed this MOU, and called both the YWCA Hotline and YWCA Executive offices to confirm their services provided to the HCSD, per the MOU. Such sexual abuse supportive services are also provided by the YWCA at the Baystate Medical Center, as arranged between Baystate and the YWCA, for institutional and community incidents. Auditor has confirmed this arrangement by contacting the Baystate Medical Center. .

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.

Agency posts reporting information in Inmate/Resident Visiting areas and on website. Interviews of personnel and inmates/residents conducted confirmed education/training conducted, and revealed general knowledge concerning third-party reporting. Several inmates/residents did not fully comprehend the concept of third-party reporting, prior to Auditor explaining how this process would work.

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.

Facility Policy, 3.5.3. PREA Plan and resulting staff training clearly instruct personnel on reporting requirements and timelines, i.e. immediately/prior to the end of shift. Staff Interviews were consistent with Policy guidelines, and reflected staff response and reporting via the Chain of Command for all unusual incidents. Staff were knowledgable concerning their individual duty to promptly report, and other's duties, e.g. Investigators (CIU), Medical, PREA Coordinator/ PREA Managers, Baystate Medical Center as site for forensics, etc.

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.

No instances have occurred in the past 12 months where the facility has learned of a substantial risk of imminent sexual abuse. Policy provides for "immediate action to protect the inmate" in such cases. Staff interviews, to include line staff up thru executive staff, were consistent, expressing the immediate action necessary to separate/protect the inmate. Facility personnel have responded appropriately to provide protection as requested by inmates by housing them in a more secure environment, without segregating them from population.

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.

Facility Policy, 3.5.3. provides guidance concerning reports of sexual abuse while inmates were confined at other facilities, and reports received of sexual abuse from other facilities. Auditor reviewed all investigative files, correspondence, etc with CIU OIC. HCSD investigative and tracking process is consistent and thorough in this regard. Such reports, to/from other facilities, constitute the majority of sexual abuse allegations in the past 12 months, i.e. 6 reports of abuse having occurred at another facility; 4 reports of sexual abuse received as having occurred at HCSD. Auditor has reviewed correspondence generated by HCSD notifying other agencies of reported sexual abuse, and correspondence forwarded to HCSD reporting sexual abuse alleged to have occurred within HCSD. Agency CIU OIC processes such reports accordingly, and investigates reports of alleged abuse to have occurred at HCSD.

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.

During staff interviews, personnel had excellent understanding of facility policy and expectations concerning their respective First Responder duties. One assaultive incident occurred during the past 12 months where security personnel responded, separated the inmates involved, preserved the crime scene and evidence, notifed CIU, etc. On-Duty personnel responded in a timely manner and performed their First Responder duties per established Policy. This incident, while physically assaultive, had sexual overtones due to prior sexual activities between the two inmates. It is being prosecuted criminally for Assault, and will be reported as a PREA incident. Auditor reviewed entire investigative package and available video during interview with CIU Unit Commander. During interviews, non-security staff members advised Auditor of their knowledge of First Responder duties, and their own responsibilities concerning attending to sexual assault victims.

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.

Agency Policy, 3.1.7 Special Teams, provides institutional plan to coordinate staff actions taken in response to an incident of sexual abuse. This coordinated response was implemented in response to assaultive incident noted in Standard 115.64, by security first responders, medical and mental health practitioners, investigators and facility leadership.

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.

Agency renewed collective bargaining agreements with the National Correctional Employees Union and the Hampden County Superior Correctional Officers Association (Supervisors union), for the period July 1, 2014 through June 30, 2017. Agreements contain language

enabling agency to remove employees from contact with any inmate pending an investigation.

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.

Agency Policy 3.5.3. PREA Plan protects inmates/residents and staff from retaliation for reporting sexual abuse or sexual harassment, or who cooperate with sexual abuse or sexual harassment investigations. There were no reported instances of reported retaliation during the past 12 months. The respective Main Institution, Pre-Release Center and Western Massachusetts Correctional Alcohol Center PREA Managers are the designated staff members responsible for monitoring for possible retaliation. This process is provided oversight by the PREA Coordinator.

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.

There have not been any instances during the past 12 months when segregated housing was used to protect an inmate who is alleged to have suffered sexual abuse. The leadership, management, supervisory and line staff understand that alternative housing would be preferred option for victim, following the required administrative review. Specialized staff interviewed have good knowledge of Incident Review Team mission, and responsibilities. Philosophy and practice of HCSD is to seek alternative housing versus segregated housing of inmates/residents, in such cases.

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.

Agency is compliant with facility Policy 3.5.3. PREA Plan, and PREA Standard 115.71. One assaultive incident was referred for criminal prosecution during the past 12 months. This incident was strictly physically assaultive in nature, but resulted from past sexual relationship/activities between the two inmates. The properly trained and certified CIU investigators conduct all administrative and criminal investigations. In special cases, the CIU Unit Commander has advised that a joint investigation could be conducted with the MA State Police. The MA State Police conduct such investigations pursuant with Standard 115.71.

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.

Agency Policy, 3.5.3. PREA Plan requires no burden of proof beyond a preponderance of evidence. Review of CIU Investigations and interview with CIU Unit Commander corroborates this practice at HCSD, regarding both administrative and criminal investigations.

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.

Agency Policy requires the department to inform the inmate/resident as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded. Employee interviews indicate staff are aware of this notification requirement. Auditor has reviewed written notifications to inmates from the CIU Unit Commander, informing them of the outcome of the subject investigation. There have been no substantiated or unsubstantiated complaints of sexual abuse committed by a staff member in an agency facility in the past 12 months.

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.

Agency Policy provides protocol to ensure consistent application of discipline for staff, ranging from serious discipline, to include termination for sexual abuse, to other discipline based upon nature and circumstances of the acts committed, the staff members disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories. There have been no staff disciplined during the past 12 months for violating sexual abuse or sexual harassment policies. Staff interview results and Auditor's observations during 5 days in the facility are consistent with the absence of sexual abuse incidents/allegations, and the established professional workplace culture.

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.

Facility Policy, 3.5.3. PREA Plan requires a report to law enforcement authorities (unless the activity was clearly not criminal) and to relevant licensing bodies. Such individuals would be prohibited from further contact with inmates. Appropriate remedial measures are taken to address any other violation of sexual abuse or sexual harassment policies by a contractor, volunteer or intern. Interviews with both a volunteer and several contractors revealed good knowledge of their responsibilities and prohibitions, evidencing the training as provided by the agency. Documents to verify such training/orientation were reconciled by Auditor and determined to be accurate.

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.

The HCSD prohibits all sexual activity between inmates and will discipline inmates for such activity. Facility Policy, 3.5.3. PREA Plan is compliant with requirements of this Standard. During the past 12 months, no inmates have been disciplined for inmate-on-inmate sexual abuse.

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.

Facility practice is consistent with established Policy, concerning Medical and mental health screenings; history of sexual abuse. The interacting databases, PREA Screening and Medical and Mental Health Screenings/14 day follow-up, ensure the inmates are referred to Medical and Mental Health. HCSD IT personnel have incorporated automatic reminders and referrals into this electronic process. During the past 12 months, the percentage of screened inmates who disclosed prior victimization and were offered a follow-up meeting (within 14 days), with a medical or mental health practitioner was .2%. Inmates that have previously perpetrated sexual abuse are offered a follow-up meeting (within 14 days) by a medical or mental health practitioner. Information related to sexual victimization or abusiveness is restricted in distribution, but shared with appropriate personnel/offices, to properly inform housing decisions, employment, programming, education, work, etc.

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.

There has been one case of reported sexual abuse (physical assault resulting from on-going concensual sexual relationship of two inmates) during the past 12 months. In this case, both involved inmates received mental health crisis intervention services. MA State Police are processing Assault charges on cellmate. CIU investigation determined sexual abuse allegations to be unfounded. Auditor interviews with both medical and mental health staff verify PREA training as having been presented, in addition to specific medical/mental health training concerning handling of sexual violence cases. Staff were aware of the provision for timely emergency medical treatment, facility and community crisis intervention services, and sexually transmitted infectious prophylaxis without cost to inmate victims.

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.

Facility Policy and practice provide for appropriate medical and mental health evaluations and treatment, to all inmates who have been victimized by sexual abuse in any area/program of the HCSD. Agency maintains MOUs with community agencies to ensure community access and provision of services. No female inmates/residents were included in this audit. Facility provides required screening/services to known inmate-on-inmate abusers within 60 days of learning of such abuse history.

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.

Facility Administrators utilize the Incident Review Team accordingly, to review and evaluate sexual violence incidents, and all serious incidents, in order to improve facility safety and security. There have been no Incident Review Team activations to review a sexual abuse incident or resulting from an Administrative Investigation during the past 12 months. Only "unfounded" allegations/investigations would not be reviewed by the Incident Review Team. Incident Review Team findings and recommendations are documented and forwarded to higher level administrative staff for review and consideration. Facility evaluates recommendations for possible changes to procedures, purchase of additional monitoring equipment, staffing adjustments/deployments, staff training, recognition, etc.

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.

Agency has submitted Survey of Sexual Violence 2014 annual report for the 2013 calendar year. There were no sexual abuse incidents during the past 12 months to report, within the MI, PRC or WMCAC. The HCSD does maintain accurate records of all allegations of sexual abuse and sexual harassment. Auditor has reviewed this report and investigative files of all allegations made during the past 12 months. Agency does not contract other agencies/facilities for the confinement of its inmates.

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.

HCSD has an established practice of reviewing all facility incidents with the objective to identify problem areas and to take corrective action. The annual report is made available to the public by posting on the agency website at www.hcsdmass.org. The agency redacts personal identifiers from such posted reports. Auditor has accessed site and confirmed this posting. Agency has also posted The Prison Rape Elimination Act; Instructions on Reporting Abuse; The YWCA Rape Crisis phone number/address; the HCSD PREA Coordinator contact information; a link to the PREA Resource center; the 2015 PREA Audit Notice and the PREA Plan policy, 3.5.3.

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.

Agency securely maintains incident-based data for 10 years, in accordance with Federal guidelines and agency Policy, 3.5.3. PREA Plan. Agency does not contract with private facilities for the confinement of its inmates.

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.

Louis S. Folino June 26, 2015

Auditor Signature Date