

Prison Rape Elimination Act (PREA) Audit Report Community Confinement Facilities

Interim Final

Date of Interim Audit Report: N/A

Date of Final Audit Report: December 9, 2021

Auditor Information

Name: Amy J. Fairbanks

Email: [REDACTED]

City, State, Zip: [REDACTED]

Telephone: [REDACTED]

Date of Facility Visit: November 1-2, 2021

Agency Information

Name of Agency: Western Mass. Recovery and Wellness Center

Governing Authority or Parent Agency (If Applicable): Hampden County Sheriff's Department

Physical Address: 155 Mill St.

City, State, Zip Springfield, MA 01108

Mailing Address:

City, State, Zip:

The Agency Is:

Military

Private for Profit

Private not for Profit

Municipal

County

State

Federal

Agency Website with PREA Information: <http://hcsdma.org>

Agency Chief Executive Officer

Name: Nicholas Cocchi, Sheriff

Email: [REDACTED]

Agency-Wide PREA Coordinator

Name: Matthew Roman

Email: [REDACTED]

Telephone: [REDACTED]

PREA Coordinator Reports to:

Brian Hoar-Assistant superintendent

Number of Compliance Managers who report to the PREA Coordinator: 4

Facility Information

Name of Facility: Western Mass Recovery and Wellness Center

Physical Address: 155 Mill St

City, State, Zip: Springfield, MA 01108

Mailing Address (if different from above):

City, State, Zip:

The Facility Is:

Military

Private for Profit

Private not for Profit

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County

State

Federal

Facility Website with PREA Information : <http://hcsdma.org>

Has the facility been accredited within the past 3 years? Yes No

If the facility has been accredited within the past 3 years, select the accrediting organization(s) – select all that apply (N/A if the facility has not been accredited within the past 3 years):

ACA

NCCHC

CALEA

Other (please name or describe:

N/A

If the facility has completed any internal or external audits other than those that resulted in accreditation, please describe:
Dept. Public Health, Mass. DOC, BOP, DPS

Facility Director

Name: Anthony Scibelli

Email: [REDACTED]

Facility PREA Compliance Manager

Name: Matthew Roman

Email: [REDACTED]

Facility Health Service Administrator N/A

Name: Richard Brathwaite

Email: [REDACTED]

Facility Characteristics

Designated Facility Capacity:

149

Current Population of Facility:

63

Average daily population for the past 12 months:

47

Has the facility been over capacity at any point in the past 12 months?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Which population(s) does the facility hold?	<input type="checkbox"/> Females <input type="checkbox"/> Males <input checked="" type="checkbox"/> Both Females and Males
Age range of population:	18-76
Average length of stay or time under supervision	168 days
Facility security levels/resident custody levels	Minimum and PRC (prerelease center)
Number of residents admitted to facility during the past 12 months	275
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 72 hours or more:	275
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 30 days or more:	275
Does the audited facility hold residents for one or more other agencies (e.g. a State correctional agency, U.S. Marshals Service, Bureau of Prisons, U.S. Immigration and Customs Enforcement)?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Select all other agencies for which the audited facility holds residents: Select all that apply (N/A if the audited facility does not hold residents for any other agency or agencies):	<input checked="" type="checkbox"/> Federal Bureau of Prisons <input type="checkbox"/> U.S. Marshals Service <input type="checkbox"/> U.S. Immigration and Customs Enforcement <input type="checkbox"/> Bureau of Indian Affairs <input type="checkbox"/> U.S. Military branch <input checked="" type="checkbox"/> State or Territorial correctional agency <input checked="" type="checkbox"/> County correctional or detention agency <input type="checkbox"/> Judicial district correctional or detention facility <input type="checkbox"/> City or municipal correctional or detention facility (e.g. police lockup or city jail) <input type="checkbox"/> Private corrections or detention provider6 <input type="checkbox"/> Other - please name or describe: Click or tap here to enter text. <input type="checkbox"/> N/A
Number of staff currently employed by the facility who may have contact with residents:	84
Number of staff hired by the facility during the past 12 months who may have contact with residents:	2
Number of contracts in the past 12 months for services with contractors who may have contact with residents:	3
Number of individual contractors who have contact with residents, currently authorized to enter the facility:	15
Number of volunteers who have contact with residents, currently authorized to enter the facility:	15

Physical Plant

<p>Number of buildings:</p> <p>Auditors should count all buildings that are part of the facility, whether residents are formally allowed to enter them or not. In situations where temporary structures have been erected (e.g., tents) the auditor should use their discretion to determine whether to include the structure in the overall count of buildings. As a general rule, if a temporary structure is regularly or routinely used to hold or house residents, or if the temporary structure is used to house or support operational functions for more than a short period of time (e.g., an emergency situation), it should be included in the overall count of buildings.</p>	1
<p>Number of resident housing units:</p> <p>Enter 0 if the facility does not have discrete housing units. DOJ PREA Working Group FAQ on the definition of a housing unit: How is a "housing unit" defined for the purposes of the PREA Standards? The question has been raised in particular as it relates to facilities that have adjacent or interconnected units. The most common concept of a housing unit is architectural. The generally agreed-upon definition is a space that is enclosed by physical barriers accessed through one or more doors of various types, including commercial-grade swing doors, steel sliding doors, interlocking sally port doors, etc. In addition to the primary entrance and exit, additional doors are often included to meet life safety codes. The unit contains sleeping space, sanitary facilities (including toilets, lavatories, and showers), and a dayroom or leisure space in differing configurations. Many facilities are designed with modules or pods clustered around a control room. This multiple-pod design provides the facility with certain staff efficiencies and economies of scale. At the same time, the design affords the flexibility to separately house residents of differing security levels, or who are grouped by some other operational or service scheme. Generally, the control room is enclosed by security glass, and in some cases, this allows residents to see into neighboring pods. However, observation from one unit to another is usually limited by angled site lines. In some cases, the facility has prevented this entirely by installing one-way glass. Both the architectural design and functional use of these multiple pods indicate that they are managed as distinct housing units.</p>	6
<p>Number of single resident cells, rooms, or other enclosures:</p>	0
<p>Number of multiple occupancy cells, rooms, or other enclosures:</p>	30
<p>Number of open bay/dorm housing units:</p>	0
<p>Does the facility have a video monitoring system, electronic surveillance system, or other monitoring technology (e.g. cameras, etc.)?</p>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<p>Has the facility installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology in the past 12 months?</p>	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

Medical and Mental Health Services and Forensic Medical Exams

<p>Are medical services provided on-site?</p>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<p>Are mental health services provided on-site?</p>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<p>Where are sexual assault forensic medical exams provided? Select all that apply.</p>	<input type="checkbox"/> On-site <input checked="" type="checkbox"/> Local hospital/clinic <input type="checkbox"/> Rape Crisis Center <input type="checkbox"/> Other (please name or describe: Click or tap here to enter text.)

Investigations

Criminal Investigations

Number of investigators employed by the agency and/or facility who are responsible for conducting CRIMINAL investigations into allegations of sexual abuse or sexual harassment:	11
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When the facility received allegations of sexual abuse or sexual harassment (whether staff-on-resident or resident-on-resident), CRIMINAL INVESTIGATIONS are conducted by: Select all that apply.	<input checked="" type="checkbox"/> Facility investigators <input checked="" type="checkbox"/> Agency investigators <input checked="" type="checkbox"/> An external investigative entity
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Select all external entities responsible for CRIMINAL INVESTIGATIONS: Select all that apply (N/A if no external entities are responsible for criminal investigations)	<input type="checkbox"/> Local police department <input type="checkbox"/> Local sheriff's department <input checked="" type="checkbox"/> State police <input type="checkbox"/> A U.S. Department of Justice component <input type="checkbox"/> Other (please name or describe: Click or tap here to enter text.) <input type="checkbox"/> N/A
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Administrative Investigations

Number of investigators employed by the agency and/or facility who are responsible for conducting ADMINISTRATIVE investigations into allegations of sexual abuse or sexual harassment?	6
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When the facility receives allegations of sexual abuse or sexual harassment (whether staff-on-resident or resident-on-resident), ADMINISTRATIVE INVESTIGATIONS are conducted by: Select all that apply	<input checked="" type="checkbox"/> Facility investigators <input type="checkbox"/> Agency investigators <input checked="" type="checkbox"/> An external investigative entity
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Select all external entities responsible for ADMINISTRATIVE INVESTIGATIONS: Select all that apply (N/A if no external entities are responsible for administrative investigations)	<input type="checkbox"/> Local police department <input type="checkbox"/> Local sheriff's department <input checked="" type="checkbox"/> State police <input type="checkbox"/> A U.S. Department of Justice component <input type="checkbox"/> Other (please name or describe: Click or tap here to enter text.) <input type="checkbox"/> N/A
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Audit Findings

Audit Narrative

On November 1-2, 2021, an audit was conducted at Western Mass. Recovery and Wellness Center to determine compliance with the Prison Rape Elimination Act standards finalized August 2012. The auditor was present at the facility on November 1, 2021, from 8:00am to 5:30pm and November 2, 2021, from 7:00am to 11:30am. The facility was previously audited in September 2018 and found to be in compliance with all standards. There were no barriers to completing the audit. The auditor was selected to complete the audit by responding to an inquiry from the agency, submitting a proposed contract and being awarded the bid.

Audit Methodology:

The PREA Resource Audit Instrument used for Adult Prisons and Jails is furnished by the National PREA Resource Center. This tool includes the following: A) Pre-Audit Questionnaire (PAQ), B) the Auditor Compliance Tool; C) Instructions for the PREA Audit Tour; D) the Interview Protocols; E) the Auditor's Summary Report; F) the Process Map; and G) the Checklist of Documentation. In addition, the Auditor Handbook 2021 was used to guide the audit process. The established 12-month review period is September 1, 2020, to August 31, 2021. Any events relative to the standards occurring beyond that period were discussed during the on-site audit.

Pre-audit:

The facility reported that posters announcing the audit with the auditor's name and address were placed throughout the facility on September 16, 2021, announcing the audit and identifying the auditor address in English and Spanish. Photographs were also sent to the auditor for further verification. They were observed by the auditor during the tour. The posters indicated that any correspondence sent to the auditor would be confidential and not disclosed unless required by law. The exceptions in the law were noted. No confidential correspondence letter was received in response to the posters announcing the audit. The PAQ and documentation was provided to the auditor via mail on a hard drive. Documentation was provided for each standard and provisions. The PAQ and corresponding documentation was reviewed prior to the on-site audit.

The Facility website was reviewed. Annual reports for 2014, 2015, 2016, 2017, 2018, and five previous PREA reports were available for review. Additionally, it provides the following: History and information regarding the law, the PREA program for this Sheriff's Department, and how to report abuse, including a Spanish version.

The auditor reviewed the mandatory reporting laws, laws regarding where and how juveniles are housed and laws regarding vulnerable adults for the Commonwealth of Massachusetts prior to the audit.

The auditor researched the Internet and found neither evidence of Department of Justice involvement, nor any concerning information about this operation. Contact was made with Just Detention International, a health and human rights organization that seeks to end sexual abuse in all forms of detention. They confirmed they had not received any concerns regarding this facility. Additionally, the auditor sent an email to Prison Legal Services (PLS). PLS is a not-for-profit legal services corporation, founded in 1972, that provides civil legal assistance to people who are incarcerated in Massachusetts state prisons and in the county jails and houses of correction. They engage in administrative advocacy, litigation, and public education on behalf of prisoners and their families. They keep tabs on the policies and practices affecting the over 25,000 individuals imprisoned in Massachusetts. No specific information regarding this facility was provided.

A tentative schedule was sent to the facility five days prior to the audit. In addition, the facility was provided specific requests for documentation of a random nature which assisted the auditor in determining compliance.

On-site audit:

A brief formal meeting was held with the Assistant Superintendent, Assistant Deputy Superintendent, PREA Coordinator, PREA Compliance Manager, and Shift Supervisor the morning of the first day of the audit. The following items were reviewed: purpose of audit, goals and expectations. Tentative schedules were developed regarding the tour, interviews and review of additional documentation. It had been arranged for interviews to be conducted in a private setting. Rosters of staff and residents were provided; a list of specialized, random and targeted interviews was developed.

A complete tour of the facility was conducted on November 1, 2021. The following areas and operations were visited and observed: resident living areas, dayrooms, laundry facilities, dining area/food storage, staff offices, maintenance, treatment areas, outdoor recreation areas, medical operations and staff supervision stations. All areas of the facility were visited that have resident access. Supervision practices, video monitoring, blind spots, bathroom facilities, and placement and number of telephones were observed. Cross-gender announcements were made prior to the opposite gender auditor entering the living units/bathrooms. Posters announcing the audit were observed throughout the facility.

Formal interviews were conducted with the following:

Assistant Superintendent (agency head)

Assistant Deputy superintendent (facility head, grievance coordinator)

PREA Coordinator

PREA Compliance Manager (sexual abuse incident review team, retaliation monitoring, training coordinator)

Intake Staff (Classification, medical)

Risk assessment staff

Counselors (intake staff, risk assessment staff, resident education, sexual abuse incident review team, retaliation monitoring)

Unit Manager (make housing assignment decisions)

Medical staff (Nursing Supervisor)

Mental Health staff (Clinical Supervisor, volunteer coordinator)

Human Resource Manager

Sexual Abuse Investigator

Volunteer Coordinator

Programming staff (Substance Abuse Education Supervisor)

Captain (disciplinary coordinator)

Sergeant, shift commander

Twelve random staff (Corporal, Lieutenant, Sergeant, correctional officers) representing all three shifts, two who were recently hired

Kitchen supervisor

Regional SANE Coordinator

Count on the day of the onsite audit was 60 residents (five female, fifty-five male). A total of eighteen residents were selected to be interviewed (two female, sixteen male), one declined the interview. There are no youthful offenders housed at this facility. A list of residents was provided. Residents with targeted issues were identified and selected (nine) and residents were randomly selected (eight). No letters were received from residents in response to the audit postings. Targeted resident interviews included the following:

- one resident self-admitted as homosexual/bi-sexual
- three residents who self-reported as having prior victimization

- three residents with limited English (staff interpreter used)
- one resident hard of hearing
- one resident with a physical disability
- one hard of hearing resident
- two cognitively impaired residents

No residents were identified as being blind, nor having reported sexual abuse at this facility. Resident interviews were held in the private interview rooms. Random interviews included the resident who is the oldest and the resident housed at this facility the longest. On the day of the onsite audit, the facility reported they have three residents classified as known vulnerable residents, zero classified as known predatory residents.

Investigations regarding sexual abuse can be conducted by one of ten trained investigators for the agency and are supervised by the Criminal Investigation Unit (CIU) supervisor. The facility indicated they have not had any sexual abuse or sexual harassment allegations/investigations during the previous 12-month review period.

The auditor was allowed free access to all areas of the facility, access to interview residents and staff selected randomly and intentionally, and to see any documentation requested.

An Exit meeting was conducted with the Superintendent, Assistant Superintendent, Assistant Deputy Superintendent, PREA Coordinator, PREA Compliance Manager, and Shift Supervisor at the conclusion of the onsite audit. Observations of the audit were discussed.

Post-Audit Phase:

Additional information was requested and received. Upon review and analysis, it was incorporated into the report and the final report was completed. Corrective action was required for standard 115.41 to enhance the practice of interviewing inmates during the 30-day assessment to ensure whether there is additional information as required by the Frequently Asked Questions (FAQ) issued by the Department of Justice (DOJ).

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) located adjacent to each other on the same compound in Ludlow, Massachusetts. The HCSD also operates the Western Massachusetts Women's Correctional Center (WCC) in Chicopee, MA, and a minimum-security community confinement facility, in Springfield, MA, the Western Massachusetts Recovery and Wellness Center (WMRWC).

WMRWC is located in the city of Springfield, Massachusetts, within minutes of the HCSD Main Institution. WMRWC is a broad-spectrum substance abuse and addiction center for individuals who have been convicted of crimes that are directly or peripherally related to their substance abuse. The facility services five Western Massachusetts counties (Hampden, Berkshire, Hampshire, Franklin and Worcester), and also houses Massachusetts Department of Correction inmates. This facility is a three-story building. There are six housing units consisting of female Units 1 and 2 on the First Floor, and male Units 3, 4, 5, and 6 on the Second and Third Floors. The basement floor of the facility contains the Maintenance Department, Laundry, Food Service and Resident Dining, Classroom, Library and Recreation Room.

The treatment program at WMRWC includes an Orientation Phase, Phase 1 and Phase 2. The Orientation phase is a seven-day period during which the new resident is introduced to the facility

through a series of 18 classes. Phase 1 is a seven-week intensive inpatient treatment program. Residents in this phase of the program participate in groups, classes, individual counseling and attend 12-Step meetings in the facility as well as in the community. The seven weeks are structured into weekly themes around which the main focus of treatment rotates. Those seven themes are Physiology and Pharmacology; Denial; Drugs Other Than Alcohol; Anger and the Addictive Personality; Family and Addiction; Recovery; and Relapse. Substance abuse education is presented in both English and Spanish/Bi-lingual. In addition to group services, individual clinical and case-management needs are addressed. Each resident is assigned a Substance Abuse Counselor, a Case Manager and when so indicated meet with the Clinical Manager, Forensic Social Worker and psychiatrist. While the main mission at WMRWC is substance abuse treatment, a considerable percentage of the population is also dealing with co-occurring mental health disorders.

Staffing consists of the following: Assistant Superintendent, Assistant Deputy Superintendent, Classification Supervisor, Unit Manager, Unit Supervisor, Counselors, Lieutenants, Sergeants, Corporals, Corrections Officers, Teacher, Clinical Manager, Substance Abuse Educator, Vocational Instructor, Nurses, in addition to other support staff.

Summary of Audit Findings

Standards Exceeded

Number of Standards Exceeded: 5

List of Standards Exceeded: 115.11, 115.17, 115.31, 115.32, 115.33

Standards Met

Number of Standards Met: 37

Standards Not Met

Number of Standards Not Met: 0

List of Standards Not Met:

PREVENTION PLANNING

Standard 115.211: Zero tolerance of sexual abuse and sexual harassment; PREA coordinator

115.211 (a)

- Does the agency have a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment? Yes No
- Does the written policy outline the agency's approach to preventing, detecting, and responding to sexual abuse and sexual harassment? Yes No

115.211 (b)

- Has the agency employed or designated an agency-wide PREA Coordinator? Yes No
- Is the PREA Coordinator position in the upper-level of the agency hierarchy? Yes No
- Does the PREA Coordinator have sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards in all of its facilities?

Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

The auditor reviewed, gathered, analyzed and retained the following evidence related to this standard:

- 3.5.3 PREA Plan
- PREA Coordinator and PREA Manager appointment letter March 5, 2020
- HCSD Mission Statement
- Interviews with the PREA Coordinator and PREA Manager
- Organization chart, May 18, 2021 agency
- Organization chart - facility
- Frequently Asked Questions (FAQs)

3.5.3 PREA Plan states,

The Hampden County Sheriff's Department (HCSD) promotes a zero tolerance of sexual abuse and sexual harassment.

1. *This policy & protocol outlines the Department's approach to preventing, detecting, and responding to such conduct and is published on the facility website.*
2. *The Sheriff has appointed a facility-wide PREA Coordinator with the authority to develop, implement, and oversee the facility compliance with the PREA standards in all of its facilities.*
3. *Each facility has a designated PREA Compliance Manager with the authority to coordinate the facility's compliance with the PREA standards in conjunction with the HCSD PREA Coordinator.*
 - a. *The Sheriff has designated Matthew Roman as the PREA Coordinator.*
 - b. *The Sheriff has designated the following staff as PREA Managers:
Western Mass. Recovery and Wellness Center (WMRWC) Diane Bator*

(a)

3.5.3 PREA Plan, dated 4/2013 with the most recent review of March 2021 is a detailed 58-page policy which includes the following: definitions, Prevention and Planning, Responsive Planning, Training and Education, Screening for Risk of Victimization and Abusiveness, Reporting, Official Response Following an Resident Report, Investigations, Discipline, Medical and Mental Care, and Data Collection and Review. Definitions are available to ensure consistent application of the standards.

(b)

The PREA Coordinator has direct access to the Superintendent as evidenced by the organization chart, and interview with the PREA Coordinator. This position is Assistant Superintendent of Standards. Per the interview, the PREA Coordinator duties also include standards/ accreditation. These duties give him ample time and authority to coordinate the agency's efforts. The PREA Coordinator states he conducts regular meetings with the PREA Managers. He is the chairperson for the annual staffing analysis meeting.

In accordance with the FAQ for this provision, the PREA Coordinator does has access to the Sheriff, Superintendent, and Assistant Superintendents. This was demonstrated to the auditor at an audit conducted in October 2020 for this agency as well as during this audit. Responsibility for accreditation

activities confirms that the PREA Coordinator has access to and influence necessary to lead, coordinate, guide and monitor successful ongoing implementation of policies and procedures that comply with the PREA standards across all departments/divisions within the facility.

A PREA Manager is assigned to ensure compliance with the WMRWC. Observations and interviews demonstrated that the PREA Coordinator and PREA Managers work seamlessly together to ensure compliance with the requirements are met. She additionally oversees standards and training at this facility. Both articulated that they have regular meetings and constant communication regarding updates needed to improve the goal of preventing sexual abuse and sexual harassment. The PREA Manager verbalized that she has sufficient time and authority to accomplish the goal of compliance with PREA standards.

Finding of compliance based on the following:

Policy is compliant with the requirements of the PREA standards including specifically giving authority to named individuals. It ensures there is a zero tolerance for sexual abuse and sexual harassment. Definitions are provided for specific application. Additionally, the mission statement specifically ensures compliance with the PREA standards. Interviews with the PREA Coordinator and PREA Manager support they have the time and authority as did observations during the on-site audit. Observations and evidence support a finding of "exceeds" the standard by additionally ensuring that an onsite person functions as the PREA Manager.

Standard 115.212: Contracting with other entities for the confinement of residents

115.212 (a)

- If this agency is public and it contracts for the confinement of its residents with private agencies or other entities including other government agencies, has the agency included the entity's obligation to comply with the PREA standards in any new contract or contract renewal signed on or after August 20, 2012? (N/A if the agency does not contract with private agencies or other entities for the confinement of residents.) Yes No NA

115.212 (b)

- Does any new contract or contract renewal signed on or after August 20, 2012 provide for agency contract monitoring to ensure that the contractor is complying with the PREA standards? (N/A if the agency does not contract with private agencies or other entities for the confinement of residents.) Yes No NA

115.212 (c)

- If the agency has entered into a contract with an entity that fails to comply with the PREA standards, did the agency do so only in emergency circumstances after making all reasonable attempts to find a PREA compliant private agency or other entity to confine residents? (N/A if the agency has not entered into a contract with an entity that fails to comply with the PREA standards.) Yes No NA
- In such a case, does the agency document its unsuccessful attempts to find an entity in compliance with the standards? (N/A if the agency has not entered into a contract with an entity that fails to comply with the PREA standards.) Yes No NA

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

The auditor gathered, analyzed and retained the following evidence related to this standard:

- Review of contracts in which HCSD holds residents for other agencies
- Interview with the Sheriff
- Interview with the contract monitor
- Observations during the tour
- 3.5.3 PREA Plan

PREA Plan states,

Contracting with Other Entities for the Confinement of Residents

1. *When the HCSD contracts for the confinement of its residents with private agencies or other entities, including other government agencies, any new contract or contract renewal shall include the entity's obligation to adopt and comply with the PREA standards.*
2. *Any new contract or contract renewal shall provide for agency contract monitoring to ensure that the contractor is complying with the PREA standards.*

Finding of compliance based on the following:

Policy addresses the requirements of the standard. The HCSD does not contract for housing of residents/residents outside of the agency. Review of the PAQ, and interview with the PREA Coordinator and PREA Manager confirmed this to the auditor. In the event the circumstances change, as noted above, the policy addresses the requirements of the standard. Therefore, this standard is deemed compliant.

Standard 115.213: Supervision and monitoring

115.213 (a)

- Does the facility have a documented staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse? Yes No
- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: The physical layout of each facility? Yes No
- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: The composition of the resident population? Yes No
- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: The prevalence of substantiated and unsubstantiated incidents of sexual abuse? Yes No

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Any other relevant factors? Yes No

115.213 (b)

- In circumstances where the staffing plan is not complied with, does the facility document and justify all deviations from the plan? (N/A if no deviations from staffing plan.)
 Yes No NA

115.213 (c)

- In the past 12 months, has the facility assessed, determined, and documented whether adjustments are needed to the staffing plan established pursuant to paragraph (a) of this section? Yes No
- In the past 12 months, has the facility assessed, determined, and documented whether adjustments are needed to prevailing staffing patterns? Yes No
- In the past 12 months, has the facility assessed, determined, and documented whether adjustments are needed to the facility's deployment of video monitoring systems and other monitoring technologies? Yes No
- In the past 12 months, has the facility assessed, determined, and documented whether adjustments are needed to the resources the facility has available to commit to ensure adequate staffing levels? Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

The auditor gathered, analyzed and retained the following evidence related to this standard:

- 3.5.3 PREA Plan
- 3.1.1 Supervision (WMRWC)
- PAQ
- Interviews with the twelve randomly selected correctional staff
- Interview with the PREA Coordinator
- Interview with the Assistant Superintendent
- Randomly required documentation of staffing sheets from the 6th of each month for the past 3 months which reflected appropriate staffing levels as well as monitoring of those levels/adjustment of positions.
- Observations of staffing levels during the tour
- Shift Minimum Calculations – All Facilities

The facility reports on the PAQ that the average daily population for which the plan was predicated is 47, the average daily population for the facility. The PAQ further indicates that the facility does not

deviate from the staffing plan. One housing wing was closed during the onsite audit due to the reduced population the facility is experiencing. Post orders for general population states, The Pod Officer follows the principles of “Direct Supervision” and “Unit Management”.

3.5.3 PREA Plan states, *Supervision and Monitoring*

1. *The HCSD ensures that each facility develops, documents, and makes best efforts to comply on a regular basis with a staffing plan that provides for adequate levels of staffing, and, where applicable, video monitoring, to protect residents against sexual abuse. In calculating adequate staffing levels and determining the need for video monitoring, the facilities shall take into consideration:*

All components of the facility’s physical plant (including “blind-spots” or areas where staff or residents may be isolated);

The composition of the resident population;

The number and placement of supervisory staff;

The prevalence of substantiated and unsubstantiated incidents of sexual abuse; and

Any other relevant factors.

2. *In circumstances where the staffing plan is not complied with, the facility shall document and justify all deviations from the plan.*

3. *Whenever necessary, but no less frequently than once each year, for each facility the Department operates, in consultation with the PREA coordinator, the facility shall assess, determine, and document whether adjustments are needed to:*

a. *The staffing plan established pursuant to paragraph (a) of this section;*

b. *The facility’s deployment of video monitoring systems and other monitoring technologies; and*

c. *The resources the facility has available to commit to ensure adherence to the staffing plan.*

3.1.1 Supervision (WMRWC) ensures that female staff are available each shift.

(a)

The Assistant Superintendent indicated when interviewed that the agency does monitor staffing levels annually to ensure the facility has appropriate staffing in addition to checking rosters daily. Additionally, the interview confirmed that the camera system in place has been upgraded since the last PREA audit. He confirmed that he is content with the ability to capture blind spots in the facility with the addition of concave mirrors in remote areas. He confirmed that the following are considered when reviewing /implementing the staffing plan: all components of the facility’s physical plant (including “blind-spots” or areas where staff or residents may be isolated); the composition of the resident population; the prevalence of substantiated and unsubstantiated incidents of sexual abuse (this facility has had very few substantiated and unsubstantiated incidents of sexual abuse); and any other relevant factors. The interview with the PREA Coordinator confirmed to the auditor that he chairs all staffing plan meetings.

(b) (c)

In accordance with the PAQ and interviews with the Assistant Superintendent the facility does not deviate from the staffing plan. A staffing minimum has been established which will result in holding staff over in order to ensure that each position is filled. The auditor found no reason to dispute this during the audit process. The auditor reviewed 3.1.1 Supervision (WMRWC) April 2021. It addresses staffing levels for this operation to include placement of staff, 24 hours a day and placement required for key locations. The Shift Minimum Calculations supports the practice of this policy.

Finding of compliance based on the following:

Policy supports all aspects required by the standard. As summarized above, interviews, video evidence, documentation provided and randomly requested as well as observations all provided the auditor with sufficient evidence to support a finding of compliance.

Standard 115.215: Limits to cross-gender viewing and searches

115.215 (a)

- Does the facility always refrain from conducting any cross-gender strip or cross-gender visual body cavity searches, except in exigent circumstances or by medical practitioners?
 Yes No

115.215 (b)

- Does the facility always refrain from conducting cross-gender pat-down searches of female residents, except in exigent circumstances? (N/A if the facility does not have female residents.)
 Yes No NA
- Does the facility always refrain from restricting female residents' access to regularly available programming or other outside opportunities in order to comply with this provision? (N/A if the facility does not have female residents.) Yes No NA

115.215 (c)

- Does the facility document all cross-gender strip searches and cross-gender visual body cavity searches? Yes No
- Does the facility document all cross-gender pat-down searches of female residents? (N/A if the facility does not have female residents). Yes No NA

115.215 (d)

- Does the facility have policies that enable residents to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks? Yes No
- Does the facility have procedures that enables residents to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks? Yes No
- Does the facility require staff of the opposite gender to announce their presence when entering an area where residents are likely to be showering, performing bodily functions, or changing clothing? Yes No

115.215 (e)

- Does the facility always refrain from searching or physically examining transgender or intersex residents for the sole purpose of determining the resident's genital status? Yes No
- If a resident's genital status is unknown, does the facility determine genital status during conversations with the resident, by reviewing medical records, or, if necessary, by learning that

information as part of a broader medical examination conducted in private by a medical practitioner? Yes No

115.215 (f)

- Does the facility/agency train security staff in how to conduct cross-gender pat down searches in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs? Yes No
- Does the facility/agency train security staff in how to conduct searches of transgender and intersex residents in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs? Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

The auditor gathered, reviewed, analyzed and retained the following evidence related to this standard:

- 3.5.3 PREA Plan
- 3.1.1 Supervision (WMRWC)
- Cross Gender Shift Announcement
- Review of curriculum for same gender clothed pat search and cross gender, transgender/Intersex pat search
- Statement of Search Acknowledgement Form
- Placards regarding cross gender announcements
- Example of a pat search alert in the computer system (Jail Management System)
- Examples of gender announcement documentation
- Documentation demonstrating all security staff training on searches
- FAQ December 2, 2016
- PAQ
- JMS Gender survey example
- Observations of showers, toilets changing areas during the tour.
- Announcement of female in the unit while the auditor toured male housing areas
- Pat Search Procedure guidelines

The PAQ indicates there have been no cross-gender strip searches conducted, nor any body cavity searches of residents conducted in the previous 12 months. The PAQ indicates there have been no pat down searches of female residents conducted by male staff. During the audit process, the auditor found no reason to dispute this. Additionally, auditor observed numerous male and female security staff present to accommodate appropriate gender searches.

The PAQ indicates that 100% of all security staff who received training on conducting cross-gender pat-down searches and searches of transgender and intersex residents in a professional and respectful manner, consistent with security needs.

3.5.3 PREA Plan states,
Limits to Resident Cross-Gender Viewing and Searches.

1. *The HCSD does not conduct cross-gender strip searches or cross-gender visual body cavity searches (meaning a search of the anal or genital opening) except in exigent circumstances or when performed by medical practitioners (See MI/WCC P&P 3.1.8/3.1.11 Searches)*
2. *The HCSD does not permit cross-gender pat-down searches of female residents, absent exigent circumstances.*
3. *All cross-gender strip searches and cross-gender visual body cavity searches of female residents must be authorized by the appropriate Supervisor and shall be documented.*
4. *Residents will be able to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks.*
5. *A facility-wide announcement is made by the Central Control Room (CCR) informing residents that staff of the opposite gender of the resident population will be entering the resident housing unit to provide care, custody and services throughout the shift. This announcement is made at the beginning of each shift.*
6. *In order to be consistent with PREA Standard 115.15 Limits to Cross-Gender Viewing and Searches, that requires staff of the opposite gender to announce their presence when entering a resident housing unit, staff maintain the following protocol.*
 - a. *PREA Standard 115.15 requires staff of the opposite gender to announce their presence when entering a resident housing unit. This is sometimes referred to as the “cover-up rule” and is intended to put residents on notice when opposite-gender staff may be viewing them. The announcement is required anytime an opposite-gender staff enters a housing unit and may be fully realized by requiring the announcement only when an opposite-gender staff enters a housing unit where there is not already another cross-gender staff present. For example, at the Main Facility, this means that an announcement is not required if the Pod Floor Officer is female and vice versa for the WCC.*
 - b. *This announcement is documented in POWS in the shift log under code “GA” for Gender Announcement. To accomplish this, simply click the icon located in the lower left corner titled “PREA Announcement.” This will display a message to scan the employee badge number (or type the 6-digit ID#). Simultaneously, scan the employee badge while activating the pod intercom system. A pre-recorded message of “Female on the Unit” or conversely at the WCC “Male on the Unit” will then play and the shift log code of “GA” and synopsis of “Female on the Unit” or conversely at the WCC “Male on the Unit” will automatically be updated in POWS. Females/Males with a visitor pass who enter the housing unit will be announced in the same manner with the exception being the Pod Floor Officer will not scan their employee badge number but will click on the “Female” or “Male” button.*
 - c. *Consistent with PREA standard 115.16 the agency shall take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency’s efforts to prevent, detect, and respond to sexual abuse and sexual harassment. Accordingly, the Pod Floor Officer will display the female laminated placard to supplement the verbal cross-gender announcement in male units with residents who are deaf or hard of hearing (and visa versa at the WCC). Any unit housing deaf or hard of hearing residents shall display the placard whenever a cross gender staff member is present on the unit.*
7. *The HCSD staff does not search or physically examine a transgender or intersex resident for the sole purpose of determining the resident’s genital status. If the resident’s genital status is unknown, it may be determined during conversations with the resident, by reviewing medical records, or, if necessary, by learning that information as part of a broader medical examination conducted in private by a medical practitioner.*
8. *HCSD shall train security staff in how to conduct cross-gender pat-down searches, and searches of transgender and intersex residents, in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs and policy.*

The auditor reviewed 3.1.1 Supervision (WMRWC) SEARCHES OF INDIVIDUALS and concluded that it addresses the following:

- searches are solely for the purpose of enhancing security
- requirements for when a strip search can be conducted
- strip searches are always performed in relative privacy with as much dignity as possible by security and conducted by staff of the same sex as the resident
- procedure for searches of a transgender resident which provides the resident input regarding the gender of the staff conducting the strip search, including the use of a consent form. This process is in accordance with the interpretation provided by the PRC December 2016.
- procedures and techniques for pat search and clothing searches.

(a)

Policy supports the requirement of this provision. The PAQ supports that no cross-gender strip or visual body searches have been conducted. During the tour and random resident interviews, the auditor found no reason to dispute this.

(b)

Policy supports that female residents will not be searched by male staff. During the tour, the staff demonstrated to the auditor how programming occurs at this facility for both males and females simultaneously, without having to mix the populations, through defined movement schedules security and cameras to reinforce this is not occurring. No resident reported any restriction of programming during the resident interviews.

(c)

It was reported to the auditor that a cross-gender visual body cavity search would be documented in an incident report. Policy supports this process. As stated, no cross-gender searches have been conducted.

(d)

Policy requires that residents will be able to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks. All resident interviews confirmed that the announcement regarding a female coming entering a male unit and a male staff entering a female unit. Some residents further noted that the card is present over the officer's station. Examples of these announcements was provided to the auditor with the preaudit documentation. All resident interviews confirmed that they shower, change clothes, and use the toilet without having a female watch (males) or a male watch (females). All staff interviews confirmed that residents can shower, use the toilet, change their clothes without a opposite gender staff observing. The room doors provided relative privacy. During on-site review, auditor observed all resident shower/bathroom areas, and evaluated the video monitoring regarding the shower/toilet areas. Showers had curtains with meshing on the top and bottom, toilets had stall doors. The auditor has concluded that residents are afforded required privacy without opposite gender viewing, while still providing security personnel with the required supervision necessary, i.e. views of head/upper torso and lower legs/feet.

(e)

Policy prohibits staff from searching a transgender or intersex resident for the sole purpose of determining that resident's genital status. If further supports that If the resident's genital status is unknown, it may be determined during conversations with the resident, by reviewing medical records, or, if necessary, by learning that information as part of a broader medical examination conducted in private by a medical practitioner. As indicated, 3.1.1 Supervision (WMRWC) SEARCHES OF INDIVIDUALS provides the procedure for searching a transgender resident.

(f)

3.5.3 PREA Plan requires security staff to be trained to conduct cross-gender pat-down searches and searches of transgender and intersex residents in a professional manner, and in the least intrusive manner possible, consistent with security needs and policy. This training was provided to all security staff when initiated and is now provided in the Academy training (per the PREA Coordinator and Training Manager). All staff interviews confirmed that they have been appropriately trained on how to conduct cross gender searches as well as searches of transgender/intersex residents. Many interviews then continued with explaining to the auditor that due to the change in the state law, a transgender is now allowed to request where they want to be housed and which gender, they want to search them. Documentation was provided to the auditor demonstrating that this information is assessed at intake and recorded in the JMS. These then are not considered a cross-gender search. A synopsis of the training was provided to the auditor. Both the training curriculum and Search Procedures Guidelines address specific techniques for male and female areas.

Finding of compliance based on the following: Policies support the requirements of the standard and further clarify how the requirements will be accomplished. All staff interviews provided the auditor with confidence that they are appropriately training on how to conduct cross-gender pat searches and how to conduct searches of transgender/intersex residents ensuring professional and respectful manner, and in the least intrusive manner possible, consistent with security needs. All staff are aware that transgender/intersex residents are not to be searched just to determine genital status. As stated, throughout the audit it was reported that no cross-gender search has occurred, which the auditor found credible.

Standard 115.216: Residents with disabilities and residents who are limited English proficient

115.216 (a)

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who are deaf or hard of hearing? Yes No
- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who are blind or have low vision? Yes No
- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have intellectual disabilities? Yes No
- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have psychiatric disabilities? Yes No
- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect,

and respond to sexual abuse and sexual harassment, including: Residents who have speech disabilities? Yes No

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Other? (if "other," please explain in overall determination notes.) Yes No
- Do such steps include, when necessary, ensuring effective communication with residents who are deaf or hard of hearing? Yes No
- Do such steps include, when necessary, providing access to interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary? Yes No
- Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Have intellectual disabilities? Yes No
- Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Have limited reading skills? Yes No
- Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Are blind or have low vision? Yes No

115.216 (b)

- Does the agency take reasonable steps to ensure meaningful access to all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment to residents who are limited English proficient? Yes No
- Do these steps include providing interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary? Yes No

115.216 (c)

- Does the agency always refrain from relying on resident interpreters, resident readers, or other types of resident assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the resident's safety, the performance of first-response duties under §115.264, or the investigation of the resident's allegations? Yes No

Auditor Overall Compliance Determination

Exceeds Standard (*Substantially exceeds requirement of standards*)

- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

The auditor gathered, analyzed and retained the following evidence related to this standard:

- 3.5.3 PREA Plan
- PAQ
- 4.5.9 Special Needs and Services
- 5.1.1 Program (WMRWC)
- Power Point presentation on Americans with Disability Act (ADA) and PREA
- Resident Handbook, English and Spanish
- Language Bridge Contract 2022
- List of dual language staff (102 total Spanish, Sign Language, Haitian Creole, Italian, Bosnian, Russian, Portuguese, Cambodian, Polish, French, Patwah, Swedish, Gaelic)
- Observations during the tour
- Observation of Language Line equipment

3.5.3 PREA Plan states,

Consistent with PREA standard 115.16 the agency shall take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment. Accordingly, the Pod Floor Officer will display the female laminated placard to supplement the verbal cross-gender announcement in male units with residents who are deaf or hard of hearing (and visa versa at the WCC). Any unit housing deaf or hard of hearing residents shall display the placard whenever a cross gender staff member is present on the unit.

Residents with Disabilities and Residents who are Limited English Proficient.

1. *The HCSD takes appropriate steps to ensure that residents with disabilities (including, for example, residents who are deaf or hard of hearing, those who are blind or have low vision, or those who have intellectual, psychiatric, or speech disabilities), have an equal opportunity to participate in or benefit from all aspects of the Department's efforts to prevent, detect, and respond to sexual abuse and sexual harassment. These steps shall include (when necessary to ensure effective communication with residents who are deaf or hard of hearing) providing access to interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary. In addition, the HCSD ensures that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities, including residents who have intellectual disabilities, limited reading skills, or who are blind or have low vision. The HCSD is not required to take actions that it can demonstrate would result in a fundamental alteration in the nature of a service, program, or activity, or in undue financial and administrative burdens, as those terms are used in regulations promulgated under title II of the Americans With Disabilities Act, 28 CFR 35.164.*
2. *The HCSD takes reasonable steps to ensure meaningful access to all aspects of the facility's efforts to prevent, detect, and respond to sexual abuse and sexual harassment to residents who are limited English proficient, including steps to provide interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary.*

3. *The HCSD does not rely on resident interpreters, resident readers, or other types of resident assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the resident's safety, the performance of first-response duties under Protocol 6D, Staff First Responder Duties of this P&P, or the investigation of the resident's allegations.*

4.5.9 Special Needs and Services ensures that residents are evaluated and those *having special needs (mentally ill, drug addicts, handicapped, emotionally disturbed, chronically ill) shall be managed, and where necessary, housed separately.*

5.1.1 Program (WMRWC) confirms that resident access to all services and programs shall not be prohibited on the basis of sex, sexual orientation, age, creed, color, national origin, physical handicap, or political belief. . . . *When a resident exhibits a special need which cannot be attended to and serviced within the institutional program, the Unit Counselor and Counselor shall be responsible for securing the necessary and appropriate community-based resources. A current listing of functioning community agencies is contained in the facility's Community Resource Directory/SCOPE database. Additionally, any resident determined to have a language or literacy problem shall be referred by the Unit Counselor to the ESL program (see Academic Education procedures).*

(a)

All staff receive training on ADA and PREA. The auditor reviewed training documentation that confirmed that this training was designated as mandatory training, therefore requiring all staff to ensure they received it. The PowerPoint presentation, ADA and PREA, addresses physical, cognitive/intellectual, psychiatric and sensory disabilities. As medical staff conduct the initial PREA risk assessment, in addition to numerous other assessments, these needs are immediately identified when the resident enters the facility. Staff interviews confirmed that appropriate accommodations are addressed. This included the use of a placard to identify when a female is in the unit, closed caption video educating residents on PREA, assistive devices for residents who are legally blind, availability of a video relay telephone, and placement in a unit designed to accommodate cognitive/intellectual, and psychiatric needs. Residents were interviewed with physical disabilities, two with cognitive/mental illness disabilities. The interviews revealed no concerns with residents with the needs not being able to have an equal opportunity to participate in or benefit from all aspects of the Department's efforts to prevent, detect, and respond to sexual abuse and sexual harassment.

(b)

The auditor interviewed three residents who are limited English proficient (LEP). A staff interpreter was used for these interviews. The posters throughout the facility were available in English and Spanish. Resident Handbooks are available in English and Spanish. The video shown to residents has closed captioning in English and subtitles in Spanish and Hmong. Language Bridge contract is current. The auditor received documentation that it has been used twelve times in the past twelve months. As evidenced by the staff dual language list, the agency maintains a current list of qualified staff who can provide interpretation for a variety of languages.

(c)

The PAQ indicates that no resident has been used to interpret for another resident in the previous twelve months. This was also supported by interviews with corrections officers. Corrections officer interviews revealed that they were aware that if there were exigent circumstances, they could use another resident but would be required to document the reason for this. The auditor found no reason to dispute this.

Finding of compliance based on the following: Policies support compliance with the standard. The agency ensures that staff are aware of the requirements of the ADA and how it interrelates with the

PREA requirements through mandatory training. The maintenance of the language contract and list of bi-lingual staff demonstrates that the agency takes extra measures to ensure that residents are able to effectively communicate with staff and vice versa. The staff interviews demonstrated that they are aware of the requirements for using a resident interpreter, only when there are exigent circumstances.

Standard 115.217: Hiring and promotion decisions

115.217 (a)

- Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997)? Yes No
- Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse? Yes No
- Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has been civilly or administratively adjudicated to have engaged in the activity described in the question immediately above? Yes No
- Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997)? Yes No
- Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse? Yes No
- Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has been civilly or administratively adjudicated to have engaged in the activity described in the question immediately above? Yes No

115.217 (b)

- Does the agency consider any incidents of sexual harassment in determining whether to hire or promote anyone who may have contact with residents? Yes No
- Does the agency consider any incidents of sexual harassment in determining whether to enlist the services of any contractor, who may have contact with residents? Yes No

115.217 (c)

- Before hiring new employees who may have contact with residents, does the agency: Perform a criminal background records check? Yes No
- Before hiring new employees who may have contact with residents, does the agency, consistent with Federal State, and local law: Make its best efforts to contact all prior institutional employers

for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse? Yes No

115.217 (d)

- Does the agency perform a criminal background records check before enlisting the services of any contractor who may have contact with residents? Yes No

115.217 (e)

- Does the agency either conduct criminal background records checks at least every five years of current employees and contractors who may have contact with residents or have in place a system for otherwise capturing such information for current employees? Yes No

115.217 (f)

- Does the agency ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in written applications or interviews for hiring or promotions? Yes No
- Does the agency ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in any interviews or written self-evaluations conducted as part of reviews of current employees? Yes No
- Does the agency impose upon employees a continuing affirmative duty to disclose any such misconduct? Yes No

115.217 (g)

- Does the agency consider material omissions regarding such misconduct, or the provision of materially false information, grounds for termination? Yes No

115.217 (h)

- Does the agency provide information on substantiated allegations of sexual abuse or sexual harassment involving a former employee upon receiving a request from an institutional employer for whom such employee has applied to work? (N/A if providing information on substantiated allegations of sexual abuse or sexual harassment involving a former employee is prohibited by law.) Yes No NA

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

The auditor gathered, analyzed and retained the following evidence related to this standard:

- 3.5.3 PREA Plan
- 1.3.1 Human Resources, reviewed March 2020, 81-page policy
- Candidate Questionnaire - 8 pages, asks the questions required of 115.17 (a)
- Promotional candidates interview form
- PREA Self Evaluation completed during the annual evaluation
- Review of randomly requested documents (newly hired staff,
- PAQ
- Interview with the Human Resources Manager

The PAQ indicates that the facility has hired two staff and three contractual staff during the previous 12 months for which a background check was conducted.

3.5.3 PREA Plan states,
Hiring and Promotion Decisions.

1. *In reference to the HCSD Human Resources Policy (See P&P 1.3.1 Human Resources Policy Manual), the Department does not hire or promote anyone who may have contact with residents, and shall not enlist the services of any contractor who may have contact with residents, who—*
 - a. *Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997);*
 - b. *Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or*
 - c. *Has been civilly or administratively adjudicated to have engaged in the activity described in paragraph (1)(b) of this section.*
2. *The HCSD considers any incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any contractor, who may have contact with residents.*
3. *Before hiring new employees who may have contact with residents, the HCSD will:*
 - a. *Perform a criminal background records check;*
 - b. *Consistent with Federal, State, and local law, make its best efforts to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse.*
4. *The HCSD also performs a criminal background records check before enlisting the services of any contractor who may have contact with residents.*
5. *The HCSD conducts a criminal background records check at least every five (5) years of current Employees, Contractors, Volunteers and Interns who may have contact with residents.*
6. *The HCSD shall ask all applicants and employees who may have contact with residents directly about previous sexual abuse misconduct described in paragraph (1) of this section in written applications and/or interviews for hiring or promotions and in any interviews or written self-evaluations conducted as part of reviews of current employees. The HCSD also imposes upon employees a continuing affirmative duty to disclose any such misconduct.*
7. *Material omissions regarding such misconduct, or the provision of materially false information, shall be grounds for termination.*
8. *Unless prohibited by law, the HCSD provides information on substantiated allegations of sexual abuse or sexual harassment involving a former employee upon receiving a request from an institutional employer for whom such employee has applied to work.*

1.3.1 Human Services states, *In accordance with M.G.L Chapter 268, Section 21A the HCSD will investigate and prosecute any employee, contractor, or volunteer found to have engaged in any sexual relations with any resident. In criminal prosecution of such misconduct, the law deems an resident incapable of consent. Acts of sexual contact or sexual misconduct with an resident, as well as retaliation against an resident is prohibited. In addition, invasion of privacy, acts of intimacy, or*

anything other than purely professional relationships with residents is prohibited and violators are subject to appropriate discipline.

PROTOCOL 3: Personnel File Requirements

A. Upon hiring, a personnel file is generated on all new employees and will include, but not limited to, the following information regarding the employee:

- 1. Initial application*
- 2. Reference letters (optional)*
- 3. Verification of training and experience*
- 4. Wage and salary information*
- 5. Job performance evaluations*
- 6. Birth certificate*
- 7. Incident reports, if any*
- 8. Commendations and disciplinary actions, if any.*
- 9. Results of employment investigations*

(a)

To ensure that the agency is not hiring or promoting anyone who has (1) Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997); (2) Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or (3) Has been civilly or administratively adjudicated to have engaged in the activity described in paragraph (a)(2) of this section, these questions are asked in the pre hire/promotional questionnaire. An interview with two staff confirmed that they were asked these questions during the hiring process. During the audit, the auditor requested to review promotional personnel files and personnel files for newly hired staff. The questionnaire was present in the newly hired applications and the promotional interview questions.

(b)

The Candidate Information Questionnaire asks the potential candidate if they have engaged in or been accused of engaging in sexual harassment in any prior employment. In addition to the policy, the interview with the Human Resources Manager, and the Assistant Superintendent for Human Resources confirmed that if a candidate had indications of incidents of sexual harassment, it would warrant further review and consideration by their office, which may include the Sheriff. Additionally, they would seek more information from the agency where this occurred.

(c)

Review of personnel files revealed that they included a background check. The methods utilized by the HCSD result in clearance checks conducted with the MA Bureau of Probation (BOP), the III-NCIS, Warrant Management-WMS-MA, and a Driver's History. The interview with the Human Resources Manager supported that all prior employers including those who have had institutional experience have reference checks completed. Candidates sign a release to ensure that the office can conduct informative background checks.

(d)

The auditor requested and viewed the personnel documents for the last two newly hired contractual staff. Documentation reflecting background checks were present. The interview with the Human Resources Manager confirmed that these are conducted on all contractual staff, interns, volunteers, and summer candidates.

(e)

The interview with the Human Resources manager confirmed that the agency has a system for ensuring that background checks are conducted every three years, exceeding the requirements of the standard. The auditor viewed the working documents reflecting completion of these checks for 2014, 2017 and 2020.

(f) (g)

Review of the application supports that it asked the questions required of subpart 1, a,b c. The application also requires that the person sign indicating that they have a continuing affirmative duty to immediately report in writing to the Sheriff any such misconduct during the time employed by, contracted with or volunteering for the HCSD. It states failure to do so will result in disciplinary action up to and including discharge. Additionally, all employees sign for an employee handbook. Within this hand book is the following statement: “ Employees are required to report any involvement they may have with law enforcement officials including being taken into custody; being questioned by police; being arrested, being issued a criminal summons or indicted; as well as court appearances or the like regarding any criminal matter involving the employee, at the earliest possible opportunity to their immediate supervisor, Unit Superintendent, Assistant Superintendent of Human Resources, Chief of Security, Deputy Chief of Security, and/or the Assistant Superintendent of Operations.

(h)

In addition to policy supporting this requirement, the interview with the Human Resource Manager confirmed that with the appropriate signed release, she would provide information on former employees including those with a pending investigation, to inquiries received regarding these former employees. It was further confirmed that this department is made aware of all investigations of staff when they begin and would be able to advise of an ongoing PREA investigation as well.

Finding of compliance based on the following:

Policies address all requirements of this standard. The interview with the Human Resource Manager, and review of the randomly requested documentation all provided the auditor sufficient evidence to find this agency in compliance. Additionally, as noted, the Agency exceeds the standard by ensuring a background check is conducted every three years.

Standard 115.218: Upgrades to facilities and technologies

115.218 (a)

- If the agency designed or acquired any new facility or planned any substantial expansion or modification of existing facilities, did the agency consider the effect of the design, acquisition, expansion, or modification upon the agency’s ability to protect residents from sexual abuse? (N/A if agency/facility has not acquired a new facility or made a substantial expansion to existing facilities since August 20, 2012, or since the last PREA audit, whichever is later.)
 Yes No NA

115.218 (b)

- If the agency installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology, did the agency consider how such technology may enhance the agency’s ability to protect residents from sexual abuse? (N/A if agency/facility has not installed or updated a video monitoring system, electronic surveillance system, or other monitoring

technology since August 20, 2012, or since the last PREA audit, whichever is later.)

Yes No NA

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

The auditor gathered, analyzed and retained the following evidence related to this standard:

- 3.5.3 PREA Plan
- Schematics for the facility with the pre-audit documentation
- Video monitoring schematics
- Interviews with the Assistant Superintendent
- Observations made during the on-site inspection.
- PAQ

The PAQ indicates there have been no modifications to the facility but there have been upgrades to the video monitoring technology since the last PREA audit.

3.5.3 PREA Plan states,

Upgrades to Facilities and Technologies.

1. *When designing or acquiring any new facility and in planning any substantial expansion or modification of existing facilities, the HCSD considers the effect of the design, acquisition, expansion, or modification upon the Department's ability to protect residents from sexual abuse.*
2. *When installing or updating a video monitoring system, electronic surveillance system, or other monitoring technology, the HCSD considers how such technology may enhance the Department's ability to protect residents from sexual abuse.*

Finding of compliance based on the following:

Policy above supports the requirements of the standard. The interviews with the Assistant Superintendent confirmed that PREA was considered when making changes to technology.

RESPONSIVE PLANNING

Standard 115.221: Evidence protocol and forensic medical examinations

115.221 (a)

- If the agency is responsible for investigating allegations of sexual abuse, does the agency follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.)
 Yes No NA

115.221 (b)

- Is this protocol developmentally appropriate for youth where applicable? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.) Yes No NA
- Is this protocol, as appropriate, adapted from or otherwise based on the most recent edition of the U.S. Department of Justice's Office on Violence Against Women publication, "A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents," or similarly comprehensive and authoritative protocols developed after 2011? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.) Yes No NA

115.221 (c)

- Does the agency offer all residents who experience sexual abuse access to forensic medical examinations, whether on-site or at an outside facility, without financial cost, where evidentiarily or medically appropriate? Yes No
- Are such examinations performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) where possible? Yes No
- If SAFEs or SANEs cannot be made available, is the examination performed by other qualified medical practitioners (they must have been specifically trained to conduct sexual assault forensic exams)? Yes No
- Has the agency documented its efforts to provide SAFEs or SANEs? Yes No

115.221 (d)

- Does the agency attempt to make available to the victim a victim advocate from a rape crisis center? Yes No
- If a rape crisis center is not available to provide victim advocate services, does the agency make available to provide these services a qualified staff member from a community-based organization, or a qualified agency staff member? (N/A if agency *always* makes a victim advocate from a rape crisis center available to victims.) Yes No NA
- Has the agency documented its efforts to secure services from rape crisis centers? Yes No

115.221 (e)

- As requested by the victim, does the victim advocate, qualified agency staff member, or qualified community-based organization staff member accompany and support the victim through the forensic medical examination process and investigatory interviews? Yes No
- As requested by the victim, does this person provide emotional support, crisis intervention, information, and referrals? Yes No

115.221 (f)

- If the agency itself is not responsible for investigating allegations of sexual abuse, has the agency requested that the investigating agency follow the requirements of paragraphs (a) through (e) of this section? (N/A if the agency/facility is responsible for conducting criminal AND administrative sexual abuse investigations.) Yes No NA

115.221 (g)

- Auditor is not required to audit this provision.

115.221 (h)

- If the agency uses a qualified agency staff member or a qualified community-based staff member for the purposes of this section, has the individual been screened for appropriateness to serve in this role and received education concerning sexual assault and forensic examination issues in general? (N/A if agency *always* makes a victim advocate from a rape crisis center available to victims.) Yes No NA

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

The auditor gathered, analyzed and retained the following evidence related to this standard:

- 3.5.3 PREA Plan
- MOU with the YWCA
- PREA Evidence kit
- Interview with the Western MA (WMA) Regional Coordinator, Department of Public Health
- 3.1.7 Special Teams
- PAQ
- HCSD Job Description Victim Impact Coordinator
- Investigator Training Manual
- Interview with the Sexual Abuse investigator

The PAQ indicates there has been no SANE exam conducted in the last 12 months, no SANE exams since the last audit. The auditor found this credible during the audit process.

3.5.3 PREA Plan states, *Evidence Protocol and Forensic Medical Examinations.*

1. *To the extent the HCSD is responsible for investigating allegations of sexual abuse, the Department follows a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions.*
2. *The HCSD offers all victims of sexual abuse access to forensic medical examinations, whether on-site or at an outside facility (Baystate Medical), without financial cost, where evidentiary or medically appropriate. These examinations will be performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) where possible. If SAFEs or SANEs cannot be made available, the examination can be performed by other qualified medical practitioners. The Department documents its efforts to provide SAFEs or SANEs.*

3. *The HCSD makes available to the victim a Victim Advocate from the YWCA Rape Crisis Center. If the YWCA Rape Crisis Center is not available to provide victim advocate services, the Department has a qualified staff member. The Department's staff will document the efforts to secure services from the YWCA Rape Crisis Center.*
4. *As requested by the victim, the victim advocate or qualified HCSD staff member shall accompany and support the victim through the forensic medical examination process and investigatory interviews and shall provide emotional support, crisis intervention, information, and referrals.*
5. *The requirements of paragraphs (1) through (4) of this section shall also apply to:*
 - a. *Any State entity outside of the Department that is responsible for investigating allegations of sexual abuse in prisons or jails; and b. Any Department of Justice component that is responsible for investigating allegations of sexual abuse in prisons or jails.*

3.1.7 Special Teams states,
Potentially Traumatizing Events

Response to any work-related event including, but not limited to: suicide attempt, suicide, serious injury to staff or staff responding to serious injury of an resident, PREA response, Line of death physical plant emergency.

Additionally, there is a section outlining responses to sexual assault in accordance with National Commission on Correctional Health Care (NCCHC) standards.

(a)

In addition to policy, the interview with the trained investigator confirmed that the agency does follow an established uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions. This is accomplished through the maintenance of PREA kits to ensure evidence is properly collected. This Kit contains a change of clothing, evidence bags and tags, chain of custody forms, and a sheet to lay upon the floor during evidence collection/changing of clothing. The outline provided in the investigator Field Manual (Confidential) has a section dedicated to sexual abuse response. The auditor reviewed the confidential information in the Field Manual and found that it provides detailed information on ensuring a uniform evidence protocol which maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions. The Massachusetts State Police handle evidence and process it at the State Police Crime Lab. The complete evidence collection procedures to be utilized are detailed within the Special Teams policy, 3.1.7.

The auditor found on the website the following: *The Massachusetts State Police (MSP) has a zero-tolerance policy toward sexual abuse and sexual harassment of any kind towards any detainee while in State Police custody. All detainees have equal rights to safety, dignity, and justice and have the right to be free from sexual abuse and sexual harassment.* Lock up facilities under their supervision have been certified compliant with PREA which further reinforces compliance with the standard.

(b)

Evidence Protocol and Forensic Medical Examinations are based on the Sexual Assault Investigator Certification Curriculum, Municipal Police Training Committee. Per the interview with the Western Massachusetts Regional SANE Coordinator, this program is based on the U.S. Department of Justice's Office on Violence Against Women publication, "A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents", most current version.

(c)

As noted in policy, residents are afforded a SANE exam at no cost. The interview with the Western Massachusetts Regional Coordinator revealed the following: SANE examiners are certified through the Massachusetts Public Health. MOUs are in place with the hospital. Within this MOU is the verification

that there is no cost for the examination. She confirmed that the MOU indicates specifically that residents will receive these examinations, therefore they cannot be denied by the hospitals that offer these examinations.

(d) (e)

As noted in policy and in the MOU with the YWCA, the agency does provide a victim advocate from a rape crisis center. Ongoing services are provided to the resident in two manners, by calling the hotline and asking to be referred to an appointed counselor (this call is not monitored but occurs in the living unit) or through use of an office phone with the assistance of a staff counselor (this call is monitored but occurs in a private setting). Additionally, this MOU indicates it will provide free, confidential counseling to survivors who are confined by the HSCD. It states that these services are not contingent on cooperating with the investigation. Meetings occur in a private room at the facility. Auditor has reviewed the SANE Program Goals document/curriculum, utilized by the Western Massachusetts Regional Coordinator, MA Sexual Assault Nurse Examiners Program, as presented to HCSD personnel during a training workshop. The Auditor interviewed the Department of Public Health (DPH) Regional SANE Coordinator, who has jurisdiction concerning three Western Massachusetts counties, including Hampden County. The Regional Coordinator confirmed that SANEs are on-call at BMC, and that there are several full-time SANEs employed there.

The interview with the Regional SANE Coordinator indicated that the YWCA victim advocate services would be activated by the Emergency Room staff at Baystate Medical Center, upon admittance of a resident victim, or the YWCA could be contacted directly by the HCSD staff.

(f)

As noted in policy and the interview with the investigators, the agency may use the Massachusetts State Police to investigate. The MSP does follow the requirements of the standard as confirmed by the statement on their website and the compliance of the MSP lock up facilities with the PREA standards.

(g)

Auditor not required to audit this provision.

(h)

This provision is not applicable to this agency as they make a victim advocate from a rape crisis center available to victims per 115.21(d).

Finding of compliance based on the following: Polices support compliance with this standard. The MOU and interview with Regional SANE Coordinator additionally provided ample evidence for the auditor to support a finding of compliance.

Standard 115.222: Policies to ensure referrals of allegations for investigations

115.222 (a)

- Does the agency ensure an administrative or criminal investigation is completed for all allegations of sexual abuse? Yes No
- Does the agency ensure an administrative or criminal investigation is completed for all allegations of sexual harassment? Yes No

115.222 (b)

- Does the agency have a policy and practice in place to ensure that allegations of sexual abuse or sexual harassment are referred for investigation to an agency with the legal authority to conduct criminal investigations, unless the allegation does not involve potentially criminal behavior? Yes No
- Has the agency published such policy on its website or, if it does not have one, made the policy available through other means? Yes No
- Does the agency document all such referrals? Yes No

115.222 (c)

- If a separate entity is responsible for conducting criminal investigations, does the policy describe the responsibilities of both the agency and the investigating entity? (N/A if the agency/facility is responsible for conducting criminal investigations. See 115.221(a).) Yes No NA

115.222 (d)

- Auditor is not required to audit this provision.

115.222 (e)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

The auditor gathered, analyzed and retained the following evidence related to this standard:

- 3.5.3 PREA Plan
- 3.1.7 Special Teams
- PREA Process Map
- Interview with the Assistant Superintendent
- Interview with the Investigator
- PAQ

The PAQ indicates there were zero sexual abuse or sexual harassment criminal investigations completed in the previous 12 months. As stated, the auditor reviewed five administrative investigations.

3.5.3 PREA Plan states,

Policies to Ensure Referrals of Allegations for Investigations.

1. *The HCSD ensures that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment.*
2. *The HCSD ensures that allegations of sexual abuse or sexual harassment are referred for investigation to an agency with the legal authority to conduct criminal investigations, unless the*

allegation does not involve potentially criminal behavior. The facility documents all such referrals.

4. *Any State entity responsible for conducting administrative or criminal investigations of sexual abuse or sexual harassment in prisons or jails shall have in place a policy governing the conduct of such investigations.*
5. *Any Department of Justice component responsible for conducting administrative or criminal investigations of sexual abuse or sexual harassment in prisons or jails shall have in place a policy governing the conduct of such investigations.*

3.1.7 Special Teams states, *The Criminal Investigation Unit (CIU) investigates departmental complaints and/or incidents of a serious nature, within the facilities of the Sheriff's Department domain.*

Criminal Investigative Unit (CIU)

A. Investigations are initiated when the alleged serious violation(s) of existing facility rules and regulations and/or the alleged violations of existing local, State and Federal laws is apparent, and possible criminal prosecution is indicated.

B. All investigations are conducted in an organized and cooperative manner, including appropriate written documentation and evidence collection.

C. By the authority of the Sheriff of Hampden County, the Criminal Investigation Unit (CIU) is authorized to ensure the protection of the legal rights of residents, staff and/or visitors. The CIU is created to ensure that a thorough and unhampered collection of all pertinent, factual information and the preservation of all necessary evidence is collected in an acceptable and timely manner.

D. CIU Investigation Authorization

1. *An official, formal inquiry, referred to as an investigation, into an actual or alleged event occurring contrary to Facility, Local, and State or Federal regulations commences upon notification of said event.*
2. *The Criminal Investigation Unit will investigate alleged resident infractions of a serious nature directed toward another resident, staff and/or visitor(s).*
3. *The intent of an investigation is to gather all facts relevant to the matter and to establish what actually occurred.*
4. *The CIU staff determines culpability, utilizing the resources of outside law enforcement agencies which may include, but not be limited to, the Massachusetts State Police and/or District Attorney's Office Staff, State Fire Marshall's Office, Drug Task Force, and/or other Law Enforcement Agencies when necessary to proceed with legal action, as required by the Policy and Protocol and/or Law.*
5. *The CIU staff ensure the continuing thorough and unhampered collection of all information, both factual and physical. Necessary reports are forwarded to the Housing Unit Staff to facilitate the disciplinary/classification process.*
6. *Evidence is preserved in a safe and secure manner, per the dictates of the CIU and Policy & Protocol 3.1.8 Searches & Control of Contraband.*

E. Supervision/CIU

1. *The CIU-Unit Commander, working within the Special Operations Unit has responsibilities which include, but are not limited to:*
 - a. *The CIU-Unit Commander provides information to the Assistant Superintendent of Operations, Assistant Superintendent of Special Operations, the Sheriff, and Facility/Unit Superintendent relative to the progress of the investigation.*
 - b. *Notification regarding an investigation and the continuing progress of an investigation is given to the supervisory staff in the appropriate area or a Unit Superintendent whose tower staff/resident(s) are affected by the CIU-Unit Commander. Responding CIU staff reports to the Housing Unit Supervisor for the coordination of an investigation.*
 - c. *The CIU-Unit Commander ensures compliance with specific requirements in regards to any time limits or constraints set forth by policy and/or law, accurate consolidation of all information and documentation obtained by the unit, and retaining said factual information.*
 - d. *The CIU-Unit Commander ensures that the final conclusion, as a result of an investigation, is forwarded to the appropriate individual(s) in writing.*

F. Criminal Investigation Notification

1. At the time of the alleged incident, the Special Operations Supervisor will notify the Criminal Investigation Supervisor of the following:

- a. Serious injury to an resident, employee and/or visitor*
- b. Death of anyone on facility property*
- c. Serious assaults to resident(s), staff and/or visitor(s)*
- d. Robbery or theft, if substantial*
- e. Sexual assaults*
- f. Arson*

(a)

In addition to policies, the interviews with the Assistant Superintendent (agency head) and investigator confirmed to the auditor that all allegations of sexual abuse and sexual harassment will be investigated administratively and if applicable criminally at this agency. A process map has been developed which illustrates how allegations received will be forwarded for investigation.

(b) (c)

As documented above, the agency has a policy to ensure that allegations of sexual abuse or sexual harassment are referred for investigation to an agency with the legal authority to conduct criminal investigations, unless the allegation does not involve potentially criminal behavior. The policy describes the resources used (Massachusetts State Police) when the circumstance warrants.

(d) (e)

As noted, the auditor is not required to audit these provisions.

Finding of compliance based on the following: Policies support compliance with the standard provisions. The interviews with the Superintendent, Investigators, and review of the process map, coordinated response plan and investigations gave the auditor ample evidence to support a finding of compliance.

TRAINING AND EDUCATION

Standard 115.231: Employee training

115.231 (a)

- Does the agency train all employees who may have contact with residents on: Its zero-tolerance policy for sexual abuse and sexual harassment? Yes No
- Does the agency train all employees who may have contact with residents on: How to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures? Yes No
- Does the agency train all employees who may have contact with residents on: Residents' right to be free from sexual abuse and sexual harassment Yes No
- Does the agency train all employees who may have contact with residents on: The right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment? Yes No

- Does the agency train all employees who may have contact with residents on: The dynamics of sexual abuse and sexual harassment in confinement? Yes No
- Does the agency train all employees who may have contact with residents on: The common reactions of sexual abuse and sexual harassment victims? Yes No
- Does the agency train all employees who may have contact with residents on: How to detect and respond to signs of threatened and actual sexual abuse? Yes No
- Does the agency train all employees who may have contact with residents on: How to avoid inappropriate relationships with residents? Yes No
- Does the agency train all employees who may have contact with residents on: How to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents? Yes No
- Does the agency train all employees who may have contact with residents on: How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities? Yes No

115.231 (b)

- Is such training tailored to the gender of the residents at the employee's facility? Yes No
- Have employees received additional training if reassigned from a facility that houses only male residents to a facility that houses only female residents, or vice versa? Yes No

115.231 (c)

- Have all current employees who may have contact with residents received such training? Yes No
- Does the agency provide each employee with refresher training every two years to ensure that all employees know the agency's current sexual abuse and sexual harassment policies and procedures? Yes No
- In years in which an employee does not receive refresher training, does the agency provide refresher information on current sexual abuse and sexual harassment policies? Yes No

115.231 (d)

- Does the agency document, through employee signature or electronic verification, that employees understand the training they have received? Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

Does Not Meet Standard (*Requires Corrective Action*)

The auditor gathered, analyzed and retained the following evidence related to this standard:

- 3.5.3 PREA Plan
- 1.4.1 Staff Training and Development Plan
- New Staff Orientation Training PREA curriculum
- Memo all staff
- Mandatory PODNet training
- PREA Training Curriculum
- Acknowledgement\ of completion
- Training record for PREA 2021
- PAQ
- FAQ
- Interviews with random staff
- Interview with the training coordinator

The PAQ indicates that the agency has PREA training annually which is mandatory.

3.5.3 PREA Plan states,

PROTOCOL 3: TRAINING AND EDUCATION

A. Employee Training -

1. *The HCSD trains all employees who may have contact with residents on (See P&P 1.4.1 Staff Training and Development Plan):*
 - a. *Its zero-tolerance policy for sexual abuse and sexual harassment;*
 - b. *How to fulfill their responsibilities under Department sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures;*
 - c. *Residents' right to be free from sexual abuse and sexual harassment;*
 - d. *The right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment;*
 - e. *The dynamics of sexual abuse and sexual harassment in confinement;*
 - f. *The common reactions of sexual abuse and sexual harassment victims;*
 - g. *How to detect and respond to signs of threatened and actual sexual abuse;*
 - h. *How to avoid inappropriate relationships with residents;*
 - i. *How to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents; and*
 - j. *How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities.*
2. *The training is tailored to the gender of the residents at the employee's facility. The employee receives additional training if they are reassigned from a facility that houses only male residents to a facility that houses only female residents, or vice versa.*
3. *All current employees who have not received such training are trained within one (1) year of the effective date of the PREA standards (August 20, 2012), and the Department provides each employee with refresher training every two (2) years to ensure that all employees know the Department's current sexual abuse and sexual harassment policies and procedures. In years in which employees do not receive refresher training, the Department provides refresher information on current sexual abuse and sexual harassment policies.*
4. *The Department documents via employee signature or electronic verification (Training Database), that employees understand the training they have received.*

1.4.1 Staff Training and Development Plan confirms that all new employees receive training in PREA. Interviews with the two newly hired staff confirmed to the auditor that this training is received prior to working in the facility, supporting compliance with the interpretation in the FAQ issued by the DOJ.

Between the mandatory training, there was documentation provided to reflect the following: (2-5-2021) Memo all staff Please review at Roll Calls for all groups (Staff Meetings for non-uniform staff)

This topic should be annotated on your shift reports and meeting minutes.

Mass. General Law 268 Chapter 21A prohibits "sexual contact" with any resident under the custody of the Sheriff's Department. That term is very broadly defined.

Should you engage in this type of behavior you would face a felony prosecution punishable by 5 years in prison, a fine of \$10,000 or both.

This law applies to all staff (per diem, part time staff, contractual staff and full time employees).

The Sheriff's Department has a statutory obligation to investigate each allegation.

The Sheriff's Department has statutory obligation to report felonious conduct to the District Attorney's office.

You have the duty to immediately report any activity you become aware of that may fall under this statute.

(a)

The auditor reviewed the PREA training power point presentation. Topics included the following: review of the law and its evolution, review of statistics, definitions of staff on resident abuse and resident on resident abuse, zero tolerance, staffing levels, cross gender viewing and supervision, residents with disabilities, hiring and promotion processes, employee, volunteer/contractor resident education, specialized training, review of the standards, zero tolerance policy, staff responsibilities, resident screening and information use, staff reporting/first responder duties, resident rights, freedom from retaliation (staff and resident), the code of silence (common reactions), dynamic of sexual abuse and harassment in confinement, high risk residents, resident behaviors indicating sexual abuse, avoiding inappropriate relationships/warning signs, mandatory reporting law, gender identity/sexual orientation, communication techniques, and confidentiality. This training encompasses all required topics per this provision. All staff interviewed validated they are receiving training in the required topics. All staff indicate they receive the training annually and some further added that it is always available on the computer at their workstation through PodNet, training available through the intranet. They confirmed for the auditor that the mandatory topics are addressed.

(b)

Several slides in the training power point are dedicated to the different experiences and reactions of sexual abuse based on gender. As the agency operates male and female facilities, all staff receive this information on both genders.

(c)

Documentation was provided showing all employees, current and newly hired, have received this training. All staff confirmed they receive this training every year. PREA refresher training, as stated to the auditor, is available through PodNet.

(d)

Documentation of annual mandatory training confirms the following: *In signing this training form on this date and time, I certify that I have reviewed and understand the aforementioned Policies, Training Course/Curriculum and materials present in the In-Service PODNet database.*

Finding of compliance based on the following: Policy is compliant with the requirements of this standard. The curriculum addresses all required topics; staff interviews confirmed they are being trained on these topics. Training addresses the differences of the experiences of male and female

victims and dynamics. Finally, staff have to acknowledge that they understood the training they received. This provides the auditor with ample evidence to support a finding of compliance. A finding of “exceeds” compliance is given due to the annual mandatory training, in addition to in between memos regarding PREA.

Standard 115.232: Volunteer and contractor training

115.232 (a)

- Has the agency ensured that all volunteers and contractors who have contact with residents have been trained on their responsibilities under the agency’s sexual abuse and sexual harassment prevention, detection, and response policies and procedures? Yes No

115.232 (b)

- Have all volunteers and contractors who have contact with residents been notified of the agency’s zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents (the level and type of training provided to volunteers and contractors shall be based on the services they provide and level of contact they have with residents)? Yes No

115.232 (c)

- Does the agency maintain documentation confirming that volunteers and contractors understand the training they have received? Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

The auditor gathered, analyzed and retained the following evidence related to this standard:

- 3.5.3 PREA Plan
- 5.2.1 Volunteer and Citizen Involvement (WMRWC)
- Interns, Volunteers and Providers Clearance Check List
- Intern Orientation Power Point PREA
- Contractor Facility Orientation Training Power Point What is PREA
- Contractor training record
- Volunteer Handbook 6/10/21
- Summer Staff PREA Training records
- List of current Volunteers, Contractors, Interns Clearance 2021
- Vendor Orientation and Education
- PREA Acknowledgement Form
- PAQ
- Example of an application and signed acknowledgment

- Interview with the Volunteer Coordinator

The PAQ states there are 23 volunteers and contractors who have had training on their responsibilities under the agency's policies and procedures regarding sexual abuse/harassment prevention, detection and response.

3.5.3 PREA Plan states,

- B. Volunteer, Intern, and Contractor Training – (See MI/WCC P&P 1.4.1 Staff Training and Development Plan, 1.7.1 Volunteers/Interns, and 1.7.2 Volunteer Resource Service Handbook)*
- 1. The HCSD ensures that all volunteers, interns, and contractors who have contact with residents have been trained on their responsibilities under the Department's sexual abuse and sexual harassment prevention, detection, and response policies and procedures.*
 - 2. The level and type of training provided to volunteers, interns and contractors is based on the services they provide and level of contact they have with residents, but all volunteers, interns, and contractors who have contact with residents shall be notified of the Department's zero-tolerance policy regarding sexual abuse and sexual harassment and informed on how to report such incidents.*
 - 3. The Department maintains documentation confirming that volunteers, interns, and contractors understand the training they have received.*

5.2.1 Volunteer and Citizen Involvement (WMRWC)

The applicant will be given an Intern/Volunteer Handbook, which contains:

Receipt of Handbook Acknowledgement

Intern/Volunteer Application Form

Sexual Harassment Sign Off

Cori Permission

PREA Acknowledgement

Additionally, it confirms that all new Volunteers and Interns receive the PREA PowerPoint presentation

Interns, Volunteers and Providers Clearance Check List addresses receipt of signature of the PREA Acknowledgment and Criminal background check.

(a)

The auditor reviewed the process to become a volunteer, intern or contractual employee through applications, documentation and checklists. All have a background check conducted. The auditor received an example of the Volunteer application. As noted earlier, contractual staff complete the same questionnaire as potential employees. Volunteers sign indicating, "I hereby affirm that I have read and understand that the information which I have provided, on the Volunteer Resource Services Application form is true and complete to the best of my knowledge. I agree that my omission or falsified information shall subject me to disqualification from further consideration for an internship or volunteer and shall be considered justification for immediate termination or my internship, if discovered at a later date." A PREA acknowledgement form is completed in which the volunteer/intern is informed of the zero tolerance policy, their obligation to report immediately any knowledge, suspicion or information of sexual abuse or sexual harassment, retaliation and/or staff neglect that may have contributed to an incident, in addition to other information.

A PowerPoint specific to contractual staff was provided to the auditor for review. Included is a section on sexual harassment, sexual misconduct, and PREA. It addresses zero tolerance and guidelines for preventing, detecting and responding to sexual abuse and violence in a correctional setting.

(b)

It was reported to the auditor that volunteers, interns and contractual staff receive one- and one-half hours of training dedicated to PREA. No contractual staff was on site during the audit; however documentation of training was provided to the auditor as evidence of compliance.

(c)

On the acknowledgement form it states, I hereby acknowledge that I have reviewed the aforementioned Policies and PowerPoint presentations as mandated yearly by the HCSD, DOC, ACA and NCCHC. I understand that it is my obligation to read, understand, and abide by all policies throughout my employment: Please print out this form, initial, sign and date where required and forward to the Training Department no later than November 30, 2021.

Finding of compliance based on the following: Policy supports the requirements of the standard. Additional documentation and volunteer orientation confirm that volunteers/contractors are properly educated regarding their role in preventing, detecting and responding to sexual abuse and sexual harassment. Volunteers/contractual staff confirm that they review and understand the information provided. Therefore, the auditor finds sufficient evidence to support a finding of compliance. The auditor finds the facility exceeds the standard by ensuring acknowledgement of training, background checks and yearly training for volunteers and contractual staff.

Standard 115.233: Resident education

115.233 (a)

- During intake, do residents receive information explaining: The agency’s zero-tolerance policy regarding sexual abuse and sexual harassment? Yes No
- During intake, do residents receive information explaining: How to report incidents or suspicions of sexual abuse or sexual harassment? Yes No
- During intake, do residents receive information explaining: Their rights to be free from sexual abuse and sexual harassment? Yes No
- During intake, do residents receive information explaining: Their rights to be free from retaliation for reporting such incidents? Yes No
- During intake, do residents receive information regarding agency policies and procedures for responding to such incidents? Yes No

115.233 (b)

- Does the agency provide refresher information whenever a resident is transferred to a different facility? Yes No

115.233 (c)

- Does the agency provide resident education in formats accessible to all residents, including those who: Are limited English proficient? Yes No
- Does the agency provide resident education in formats accessible to all residents, including those who: Are deaf? Yes No

- Does the agency provide resident education in formats accessible to all residents, including those who: Are visually impaired? Yes No
- Does the agency provide resident education in formats accessible to all residents, including those who: Are otherwise disabled? Yes No
- Does the agency provide resident education in formats accessible to all residents, including those who: Have limited reading skills? Yes No

115.233 (d)

- Does the agency maintain documentation of resident participation in these education sessions? Yes No

115.233 (e)

- In addition to providing such education, does the agency ensure that key information is continuously and readily available or visible to residents through posters, resident handbooks, or other written formats? Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

The auditor gathered, reviewed, analyzed and retained the following evidence related to this standard:

- 3.5.3 PREA Plan
- Orientation Acknowledgement Forms
- Intake flyer regarding PREA (English and Spanish)
- PAQ
- Interview with intake staff
- Interview with staff who conduct the 30 days follow up assessment
- Interviews with randomly selected residents
- Observations during the tour of the facility

The PAQ indicates that during the last 12 months, 275 residents were given information regarding PREA upon arrival to the facility. Additionally, during the past 12 months, 275 residents were given comprehensive information on zero tolerance, their right to be free from sexual abuse/sexual harassment, and retaliation.

3.5.3 PREA Plan states,

C. *Resident Education – (See MI/WCC P&P 3.3.3 & WCC Resident Handbooks & 4.1.8/3.5.6 Resident Orientation)*

1. *During the intake process, residents receive information (English & Spanish) explaining the Department's zero-tolerance policy regarding sexual abuse and sexual harassment and how to report incidents or suspicions of sexual abuse or sexual harassment.*
2. *Within thirty (30) days of intake, the facility provides a comprehensive education program for the residents regarding their rights to be free from sexual abuse and sexual harassment, to be free from retaliation for reporting such incidents, and regarding HCSD policies and procedures for responding to such incidents.*
3. *Residents who were incarcerated when the PREA standards became effective (August 20, 2012), were educated within the year and received education upon transfer to a different facility to the extent that the policies and procedures of the resident's new facility differ from those of the previous facility.*
4. *The facility provides resident education in formats accessible to all residents, including those who are limited English proficient, deaf, visually impaired, or otherwise disabled, as well as to residents who have limited reading skills.*
5. *The facility maintains documentation of resident participation in these education sessions.*
6. *In addition to providing such education, the Department ensures that key information is continuously and readily available or visible to residents through posters, resident handbooks, or other written formats.*

(a)

During the intake process, residents are provided with written information on PREA which includes zero tolerance, reporting options (staff verbal and in writing, the PREA Manager or PREA Coordinator (contact information provided), or the Rape Crisis Center hotline (contact information provided)). Residents sign for receipt of this information.

(b)

Upon arrival, the orientation counselor conducts orientation and provides residents with information regarding PREA, a pamphlet and information handout. This was confirmed by the interviews with the residents and the orientation counselor.

(c)

See comments for 115.16.

(d)

Residents sign at this orientation acknowledging they have received the written information regarding policies and procedures for reporting sexual assault, sexual misconduct, sexual harassment and how to access crisis counseling. During the audit, the auditor requested and received this documentation for ten additional residents (first ten to arrive August 2021) to confirm this process.

(e) In addition to posters observed throughout the facility, the resident telephone has an introductory message regarding sexual abuse, sexual harassment and a prompt for outside reporting. All residents interviewed testified to this message. The auditor listened to the message to confirm this and was provided a written transcript. Most residents interviewed confirmed knowledge of PREA and the ability to report due to this phone message, provided evidence that it is very effective.

Finding of compliance based on the following: Policy addresses the requirements of this standard. The information given to the resident at intake provides information the resident information when he/she arrives at the facility. The handbook provides specific information on how and who to report concerns, the telephone message is effective, and resident interviews confirmed that they are aware of these rights and know how to report any concerns. Due to the added enhancement of the phone message, the auditor finds that the facility exceeds the requirements of the standard.

Standard 115.234: Specialized training: Investigations

115.234 (a)

- In addition to the general training provided to all employees pursuant to §115.231, does the agency ensure that, to the extent the agency itself conducts sexual abuse investigations, its investigators receive training in conducting such investigations in confinement settings? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).)
 Yes No NA

115.234 (b)

- Does this specialized training include: Techniques for interviewing sexual abuse victims? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).) Yes No NA
- Does this specialized training include: Proper use of Miranda and Garrity warnings? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).) Yes No NA
- Does this specialized training include: Sexual abuse evidence collection in confinement settings? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).) Yes No NA
- Does this specialized training include: The criteria and evidence required to substantiate a case for administrative action or prosecution referral? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).)
 Yes No NA

115.234 (c)

- Does the agency maintain documentation that agency investigators have completed the required specialized training in conducting sexual abuse investigations? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).)
 Yes No NA

115.234 (d)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

The auditor gathered, analyzed and retained the following evidence related to this standard:

- 3.5.3 PREA Plan
- Investigator training records
- Review of the training curriculum
- PAQ

The PAQ indicates there are currently eleven staff trained at the agency to conduct sexual abuse investigations.

3.5.3 PREA Plan states,

D. Specialized Training –

1. Investigations

- In addition to the general training provided to all employees pursuant to Protocol 3:A, the HCSD ensures that, to the extent the Department itself conducts sexual abuse investigations, its investigators have received training in conducting such investigations in confinement settings.*
- Specialized training shall include techniques for interviewing sexual abuse victims, proper use of Miranda and Garrity warnings, sexual abuse evidence collection in confinement settings, and the criteria and evidence required to substantiate a case for administrative action or prosecution referral.*
- The Department maintains documentation that facility investigators have completed the required specialized training in conducting sexual abuse investigations.*

(a), (c)

As indicated, the PAQ indicates that eleven staff are trained to conduct sexual abuse investigations. The auditor interviewed one of the trained investigators assigned to this facility. In addition to documentation demonstrating she received the general training provided to all employees, documentation of her specialized training was provided in addition to certificates of completion for the other ten employees.

Interviews with one trained investigator supports that the training included techniques for interviewing sexual abuse victims, proper use of Miranda and Garrity warnings, sexual abuse evidence collection in confinement settings, and the criteria and evidence required to substantiate a case for administrative action or prosecution referral. She attended the PREA Sexual Assault Investigation Training conducted by the Massachusetts Department of Correction.

(b)

The auditor reviewed the training curriculum. The training curriculum addresses the following topics over a course of three days: Introduction to Sexual Assault Investigation; Defining PREA; Evidence Protocol; Interviewing, including Miranda and Garrity; Investigative Outcomes Documentation; and Post Allegation responsibilities. The details of this training does address the requirements of this provision.

Finding of compliance is based on the following: Interview with the investigators, documentation of specialized training for investigators, documentation of regular PREA training for the investigators as well as policy supporting the requirements of the standard provide sufficient evidence to support a finding of compliance.

Standard 115.235: Specialized training: Medical and mental health care

115.235 (a)

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to detect and assess signs of sexual abuse and sexual harassment? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)

Yes No NA

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to preserve physical evidence of sexual abuse? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.) Yes No NA
- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to respond effectively and professionally to victims of sexual abuse and sexual harassment? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.) Yes No NA
- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How and to whom to report allegations or suspicions of sexual abuse and sexual harassment? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.) Yes No NA

115.235 (b)

- If medical staff employed by the agency conduct forensic examinations, do such medical staff receive appropriate training to conduct such examinations? (N/A if agency does not employ medical staff or the medical staff employed by the agency do not conduct forensic exams.) Yes No NA

115.235 (c)

- Does the agency maintain documentation that medical and mental health practitioners have received the training referenced in this standard either from the agency or elsewhere? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.) Yes No NA

115.235 (d)

- Do medical and mental health care practitioners employed by the agency also receive training mandated for employees by §115.231? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners employed by the agency.) Yes No NA
- Do medical and mental health care practitioners contracted by and volunteering for the agency also receive training mandated for contractors and volunteers by §115.232? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners contracted by or volunteering for the agency.) Yes No NA

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

Does Not Meet Standard (Requires Corrective Action)

The auditor gathered, reviewed, analyzed and retained the following evidence related to this standard:

- 3.5.3 PREA Plan
- PREA Medical Training curriculum
- Training curriculum for Specialized Training for Mental Health Staff
- PAQ
- Interviews with medical staff, mental health staff
- Training records for medical and mental health staff, specialized training and regular PREA training

The PAQ indicates that there are eight medical and mental health staff at this facility, 100% of medical and mental health staff have received specialized training.

3.5.3 PREA Plans states,

D. Specialized Training -

2. Medical and Mental Health Care -

a. The HCSD ensures that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in:

- 1. How to detect and assess signs of sexual abuse and sexual harassment;*
- 2. How to preserve physical evidence of sexual abuse;*
- 3. How to respond effectively and professionally to victims of sexual abuse and sexual harassment; and*
- 4. How and to whom to report allegations or suspicions of sexual abuse and sexual harassment.*

b. If medical staff employed by the Department conduct forensic examinations, such medical staff shall receive the appropriate training to conduct such examinations.

c. The Department shall maintain documentation that medical and mental health practitioners have received the training.

d. Medical and mental health care practitioners shall also receive the training mandated for employees under Protocol 3:A or for contractors, interns, and volunteers under Protocol 3:B, depending upon the practitioner's status at the facility.

(a)

The auditor reviewed the training curriculums for medical and mental health staff. Both meet the requirements of the standard ensuring that medical and mental health staff are trained in (1) How to detect and assess signs of sexual abuse and sexual harassment; (2) How to preserve physical evidence of sexual abuse; (3) How to respond effectively and professionally to victims of sexual abuse and sexual harassment; and (4) How and to whom to report allegations or suspicions of sexual abuse and sexual harassment.

(b)

The auditor verified that medical staff at this facility do not conduct forensic medical examinations. This is supported with the evidence relied upon for a finding of compliance for standard 115.21.

(c)

Documentation was provided showing detailed training records for a sample of the medical/mental health staff reflecting they have completed the in-service training and specialized training. Medical and mental health have received the specialized training.

(d)

Medical and mental health staff are employees of the facility and attend regular PREA training – documentation provided, and interviews confirmed this.

Finding of compliance is based on the following: Policy supports the requirements of the standard. Interviews with the medical and mental health staff confirmed this process. Training records supported compliance with both specialized and regular PREA training.

SCREENING FOR RISK OF SEXUAL VICTIMIZATION AND ABUSIVENESS

Standard 115.241: Screening for risk of victimization and abusiveness

115.241 (a)

- Are all residents assessed during an intake screening for their risk of being sexually abused by other residents or sexually abusive toward other residents? Yes No
- Are all residents assessed upon transfer to another facility for their risk of being sexually abused by other residents or sexually abusive toward other residents? Yes No

115.241 (b)

- Do intake screenings ordinarily take place within 72 hours of arrival at the facility?
 Yes No

115.241 (c)

- Are all PREA screening assessments conducted using an objective screening instrument?
 Yes No

115.241 (d)

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has a mental, physical, or developmental disability? Yes No
- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: The age of the resident? Yes No
- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: The physical build of the resident? Yes No
- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has previously been incarcerated?
 Yes No
- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident’s criminal history is exclusively nonviolent?
 Yes No

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has prior convictions for sex offenses against an adult or child? Yes No
- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident is or is perceived to be gay, lesbian, bisexual, transgender, intersex, or gender nonconforming (the facility affirmatively asks the resident about his/her sexual orientation and gender identity AND makes a subjective determination based on the screener's perception whether the resident is gender non-conforming or otherwise may be perceived to be LGBTI)? Yes No
- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has previously experienced sexual victimization? Yes No
- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: The resident's own perception of vulnerability? Yes No

115.241 (e)

- In assessing residents for risk of being sexually abusive, does the initial PREA risk screening consider, when known to the agency: prior acts of sexual abuse? Yes No
- In assessing residents for risk of being sexually abusive, does the initial PREA risk screening consider, when known to the agency: prior convictions for violent offenses? Yes No
- In assessing residents for risk of being sexually abusive, does the initial PREA risk screening consider, when known to the agency: history of prior institutional violence or sexual abuse? Yes No

115.241 (f)

- Within a set time period not more than 30 days from the resident's arrival at the facility, does the facility reassess the resident's risk of victimization or abusiveness based upon any additional, relevant information received by the facility since the intake screening? Yes No

115.241 (g)

- Does the facility reassess a resident's risk level when warranted due to a: Referral? Yes No
- Does the facility reassess a resident's risk level when warranted due to a: Request? Yes No
- Does the facility reassess a resident's risk level when warranted due to a: Incident of sexual abuse? Yes No
- Does the facility reassess a resident's risk level when warranted due to a: Receipt of additional information that bears on the resident's risk of sexual victimization or abusiveness? Yes No

115.241 (h)

- Is it the case that residents are not ever disciplined for refusing to answer, or for not disclosing complete information in response to, questions asked pursuant to paragraphs (d)(1), (d)(7), (d)(8), or (d)(9) of this section? Yes No

115.241 (i)

- Has the agency implemented appropriate controls on the dissemination within the facility of responses to questions asked pursuant to this standard in order to ensure that sensitive information is not exploited to the resident's detriment by staff or other residents? Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

The auditor gathered, reviewed, analyzed and retained the following evidence related to this standard:

- 3.5.3 PREA Plan
- Completed Risk assessments- initial, reassessment, victim, perpetrator
- Completed 30-day reviews
- Interviews with Intake staff (who conducts the initial risk assessment when the resident arrives).
- FAQ's regarding this standard
- PAQ

The PAQ indicates that during the last 12 months 275 residents were screened for the risk of sexual vulnerability or sexual abusiveness; there were 275 residents who were reassessed within 30 days.

3.5.3 PREA Plan states,

SCREENING FOR RISK OF SEXUAL VICTIMIZATION & ABUSIVENESS

A. Screening for Risk of Sexual Victimization and Abusiveness

1. All residents shall be assessed during an Intake screening and upon transfer to another facility for their risk of being sexually abused by other residents or sexually abusive toward other residents. The assessment is conducted using an objective screening instrument in the PREA Database (See MI/WCC P&P 4.1.1/3.5.1 Resident Admissions/Booking and 4.2.1/3.6.1 Classification.)
2. The Intake screening ordinarily takes place within seventy-two (72) hours of their arrival at the facility.
3. The Intake screening considers, at a minimum, the following criteria to assess residents for risk of sexual victimization:
 - a. Whether the resident has a mental, physical, or developmental disability;
 - b. The age of the resident;
 - c. The physical build of the resident;
 - d. Whether the resident has previously been incarcerated;
 - e. Whether the resident's criminal history is exclusively nonviolent;
 - f. Whether the resident has prior convictions for sex offenses against an adult or child;
 - g. Whether the resident is or is perceived to be gay, lesbian, bisexual, transgender, intersex, or gender nonconforming;
 - h. Whether the resident has previously experienced sexual victimization;

- i. *The resident's own perception of vulnerability; and*
- 4. *The initial screening considers prior acts of sexual abuse, prior convictions for violent offenses, and history of prior institutional violence or sexual abuse, as known to the Department, in assessing residents for risk of being sexually abusive.*
- 5. *Within a set time period, not to exceed thirty (30) days from the resident's arrival at the facility (exigent any security or safety concerns, i.e. temporary hospitalization, etc.), the facility reassesses the resident's risk of victimization or abusiveness based upon any additional, relevant information received by the facility since the intake screening.*
- 6. *An resident's risk level shall be reassessed when warranted due to a referral, request, incident of sexual abuse/harassment, or receipt of additional information that bears on the resident's risk of sexual victimization or abusiveness.*
- 7. *Residents may not be disciplined for refusing to answer, or for not disclosing complete information in response to, screening questions asked pursuant to:*
 - a. *Whether the resident has a mental, physical, or developmental disability;*
 - b. *Whether the resident is or is perceived to be gay, lesbian, bisexual, transgender, intersex, or gender nonconforming;*
 - b. *Whether the resident has previously experienced sexual victimization;*
 - d. *The resident's own perception of vulnerability.*
- 8. *The HCSD implements appropriate controls on the dissemination within the facility of responses to questions asked pursuant to this standard in order to ensure that sensitive information is not exploited to the resident's detriment by staff or other residents.*

This standard has the following requirements:

(a)

Policy ensures that all residents are assessed upon intake for their risk of being sexually abused by other residents or being abusive towards other residents. Examples of risk assessments were provided with the pre-audit documentation. Additional risk assessments were requested and received by the auditor during the on-site audit. Random resident interviews generally confirmed that this assessment was done when they arrived.

(b)

Policy ensures that the intake screening shall ordinarily take place within 72 hours of arrival at the facility. Resident interviews recalled being asked the questions in the risk assessment. Intake risk assessments were completed upon arrival, typically the same day.

(c) (d) (e)

The facility has created an objective risk assessment tool which addresses all requirements of the provision (1) Whether the resident has a mental, physical, or developmental disability; (2) The age of the resident; (3) The physical build of the resident; (4) Whether the resident has previously been incarcerated; (5) Whether the resident's criminal history is exclusively nonviolent; (6) Whether the resident has prior convictions for sex offenses against an adult or child; (7) Whether the resident is or is perceived to be gay, lesbian, bisexual, transgender, intersex, or gender nonconforming; (8) Whether the resident has previously experienced sexual victimization; (9) The resident's own perception of vulnerability; It furthermore assesses prior acts of sexual abuse, prior convictions for violent offenses, and history of prior institutional violence or sexual abuse, as known to the agency, in assessing residents for risk of being sexually abusive. It additionally addresses whether the resident has a history of strong arming or assaults while in custody was sexually active while in custody. The intake nurse demonstrated to the auditor what questions are asked and provides a drop-down selection for the determination. The assessment is located within the Jail Management System (JMS).

(f)

The counselor in the orientation ensures that the 30 days risk assessment review is completed. As the system is computerized, she reported that she is prompted when these are due to ensure completion within the thirty days as required by the standard. It was confirmed during the audit that staff who complete the 30 days follow up were not conducting an additional interview with the resident; this was occurring for those who screened as a victim but not for everyone. This was immediately corrected; a form was developed for use until the JMS could be updated. Five examples were provided to the auditor after the onsite audit that demonstrated that compliance. This supports compliance as reflected in the FAQ, issued by the DOJ regarding this provision.

(g)

Policy indicates that a resident's risk assessment will be updated when warranted due to a referral, request, incident of sexual abuse, or receipt of additional information that bears on the resident's risk of sexual victimization or abusiveness.

(h)

Policy supports that resident's may not be disciplined for refusing to answer, or for not disclosing complete information in response to questions asked pursuant to paragraphs (d)(1), (d)(7), (d)(8), or (d)(9) of this section. All residents interviewed confirmed that they did not believe they would be disciplined if they did not answer the questions during this assessment. The interview with the intake nurse confirmed that they would not be disciplined if they choose to not answer.

(i) The initial risk assessment is located in a computer system. Appropriate controls on this information includes limiting access to who is given access to the information. It was reported by the PREA Manager and PREA Coordinator that counselors, supervisors and the PREA team can access the follow up risk assessment information. "Alerts" are incorporated into the system so that other staff that have a need-to-know are thereby notified of some degree of PREA concern.

Finding of compliance is based on the following: Policy supports the requirements of the standard. The updated risk screening process addresses the requirements as set forth by the standard and the FAQ. Resident interviews support that the process is occurring.

Standard 115.242: Use of screening information

115.242 (a)

- Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Housing Assignments? Yes No
- Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Bed assignments? Yes No
- Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Work Assignments? Yes No
- Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Education Assignments? Yes No

- Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Program Assignments? Yes No

115.242 (b)

- Does the agency make individualized determinations about how to ensure the safety of each resident? Yes No

115.242 (c)

- When deciding whether to assign a transgender or intersex resident to a facility for male or female residents, does the agency consider on a case-by-case basis whether a placement would ensure the resident's health and safety, and whether a placement would present management or security problems (NOTE: if an agency by policy or practice assigns residents to a male or female facility on the basis of anatomy alone, that agency is not in compliance with this standard)? Yes No
- When making housing or other program assignments for transgender or intersex residents, does the agency consider on a case-by-case basis whether a placement would ensure the resident's health and safety, and whether a placement would present management or security problems? Yes No

115.242 (d)

- Are each transgender or intersex resident's own views with respect to his or her own safety given serious consideration when making facility and housing placement decisions and programming assignments? Yes No

115.242 (e)

- Are transgender and intersex residents given the opportunity to shower separately from other residents? Yes No

115.242 (f)

- Unless placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting lesbian, gay, bisexual, transgender, or intersex residents, does the agency always refrain from placing: lesbian, gay, and bisexual residents in dedicated facilities, units, or wings solely on the basis of such identification or status? (N/A if the agency has a dedicated facility, unit, or wing solely for the placement of LGBT or I residents pursuant to a consent decree, legal settlement, or legal judgement.) Yes No NA
- Unless placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting lesbian, gay, bisexual, transgender, or intersex residents, does the agency always refrain from placing: transgender residents in dedicated facilities, units, or wings solely on the basis of such identification or status? (N/A if the agency has a dedicated facility, unit, or wing solely for the placement of LGBT or I residents pursuant to a consent decree, legal settlement, or legal judgement.) Yes No NA

- Unless placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting lesbian, gay, bisexual, transgender, or intersex residents, does the agency always refrain from placing intersex residents in dedicated facilities, units, or wings solely on the basis of such identification or status? (N/A if the agency has a dedicated facility, unit, or wing solely for the placement of LGBT or I residents pursuant to a consent decree, legal settlement, or legal judgement.)
 Yes No NA

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

The auditor gathered, reviewed, analyzed and retained the following evidence related to this standard:

- 3.5.3 PREA Plan
- 4.2.1 Classification Plan
- PAQ
- Resident interviews
- PREA Coordinator and PREA Manager interviews
- Interviews with risk assessment staff
- Interview with housing and program assignment staff
- Observations

3.5.3 PREA Plan states,

- B. Use of Screening Information and Transgender/Intersex Residents -*
1. *The HCSD uses the information from the Risk Screening Tool (required by Protocol 4:A) to inform housing, bed, work, education, and program assignments with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive.*
 2. *The Department makes individualized determinations about how to ensure the safety of each resident.*
 3. *In deciding whether to assign a transgender or intersex resident to a facility for male or female residents, and in making other housing and programming assignments, the Department considers on a case-by-case basis whether a placement would ensure the resident’s health and safety, and whether the placement would present management or security problems.*
 4. *Placement and programming assignments for each transgender or intersex resident is reassessed at least twice each year to review any threats to safety experienced by the resident.*
 5. *A transgender or intersex resident’s own views with respect to their own safety will be given serious consideration.*
 6. *Transgender and intersex residents will be given the opportunity to shower separately from other residents (See MI/WCC P&P 4.4.2/4.3.1 Resident Personal Hygiene.)*
 7. *The Department does not place lesbian, gay, bisexual, transgender, or intersex residents in dedicated facilities, units, or wings solely on the basis of such identification or status, unless such placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting such residents.*

8. *In regards to the C.J.R. Act, the fact that a prisoner is lesbian, gay, bisexual, transgender, queer or intersex or has a gender identity or expression or sexual orientation uncommon in general population shall not be grounds for placement in Restrictive Housing.*

(a)

Risk assessments and Alerts in the system ensure that a known predator and known victim are not placed in the same room. Efforts are made to ensure they are not in the same housing wing. The facility uses direct supervision; observed during the tour, the officer's station affords a full view of the housing wing. Additionally, frequent rounds are required by policy; staff use a "ring system" to electronically document these rounds. There is a video surveillance system that affords an additional coverage; monitors are located at the officer's station in addition to be accessible to other staff. The list of known predators and victims is confidentially shared via email with appropriate staff to assist in monitoring these residents during work and programming assignments.

(b)

One staff is mainly tasked with making housing assignments. During her interview, she relayed to the auditor in detail how she assesses residents for proper placement based on risk and numerous other factors.

(c) (d) (e)

4.2.1 Classification Plan states,

Protocol 3: Housing Plan for Transgender Residents

A. If during the initial Intake process, an resident is identified as being remanded to a facility which is not consistent with their birth gender, if gender reassignment/affirmation surgery has not been completed, or an resident requests to be housed in a facility which is not consistent with their birth gender, the resident will be temporarily housed in a secure unit for up to 72 hours (excluding weekends and holidays) while the Transgender Review Committee assesses subsequent housing options that address the following concerns:

Safety;

Protecting residents at high risk for abuse;

Minimizing perceived or actual fear of becoming a victim of violence or abuse; and,

The resident's personal preference.

B. An resident request for a Gender-based housing change should be documented on an Resident Request Form and submitted to the ADS of Classification.

C. The Committee, in making its decisions regarding the management plan, shall also consider the following:

Preferences and requests made by the resident. Such requests from the resident shall be considered as part of the Committee's discussions, but shall not be the only determining factors;

The physical and psychological findings provided by medical and behavioral health staff; and,

The safety and security issues as they relate to resident and staff, as well as the operations of the facility.

D. Prior to the Committee's meeting, a Shift Supervisor shall meet with the resident to discuss the purpose of the Transgender Review Committee and to explain the following:

Strip search preferences;

The housing classification process; and,

Any safety concerns regarding the resident's custody.

E. The Transgender Review Committee will apply criteria consistent with existing policies relative to:

Behavior (past or current behavior while in custody);

Charges (nature of charges); and,

Special needs (characteristics that potentially make the resident vulnerable in general population housing and physical or psychological needs identified by medical/behavioral health staff).

F. The Transgender Review Committee shall discuss the specifics of the transgender resident's case to determine the most appropriate housing option(s).

G. The Transgender Review Committee shall be given access to only the clinical information necessary to make a determination regarding the safe housing of the resident.

H. The Committee will develop a management plan for the resident which outlines at least the following:

Housing assignment;

Searches;

Showering;

Grooming/Clothing;

Escorts;

Transports;

Access to programs and activities; and,

Commissary.

I. The Committee shall review its findings and conclusions with the Sheriff and the Sheriff will make the final determination regarding placement.

J. The resident will be notified of the Sheriff's decision regarding housing.

K. Information discussed by the Committee members shall be kept confidential except as necessary to implement the decisions of the Committee and carry out the management plan.

L. The Committee shall conduct reviews every thirty (30) days to ensure transgender residents remain appropriately housed.

M. The resident's case management plan shall immediately be reassessed due to referral, request, incident of sexual abuse or physical abuse, or receipt of additional information that bears on the resident's risk of sexual victimization or abuse.

(f)

Policy supports that a transgender/intersex residents can shower separately, if requested. Showers are designed as individual stalls with concrete walls and appropriate doors to allow view of lower legs and shoulders and head (depending on height) . At the time of the audit, there was no request to shower separately (no transgender/intersex residents) but it was confirmed to the auditor that, if requested, this would occur.

(g)

This agency does not have a housing unit dedicated to the placement those identifying as lesbian, gay, bisexual, transgender or intersex. This was supported by policy and observations during the tour. Targeted resident interviews demonstrated housing of these residents in different pods.

Finding of compliance is based on the following: Policy supports the requirements of the standard. Practice ensures the information is used to prevent sexual abuse and sexual harassment when housing, working and programming residents as supported by the memo and computer system which uses "alerts". Resident and staff interviews confirm that the facility does ensure that residents can shower separately, and the views of transgender/intersex residents are given serious consideration. No dedicated housing unit was observed during the on-site audit. The auditor finds sufficient evidence to support a finding of compliance.

REPORTING

Standard 115.251: Resident reporting

115.251 (a)

- Does the agency provide multiple internal ways for residents to privately report: Sexual abuse and sexual harassment? Yes No
- Does the agency provide multiple internal ways for residents to privately report: Retaliation by other residents or staff for reporting sexual abuse and sexual harassment? Yes No
- Does the agency provide multiple internal ways for residents to privately report: Staff neglect or violation of responsibilities that may have contributed to such incidents? Yes No

115.251 (b)

- Does the agency also provide at least one way for residents to report sexual abuse or sexual harassment to a public or private entity or office that is not part of the agency? Yes No
- Is that private entity or office able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials? Yes No
- Does that private entity or office allow the resident to remain anonymous upon request? Yes No

115.251 (c)

- Do staff members accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously, and from third parties? Yes No
- Do staff members promptly document any verbal reports of sexual abuse and sexual harassment? Yes No

115.251 (d)

- Does the agency provide a method for staff to privately report sexual abuse and sexual harassment of residents? Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

The auditor gathered, reviewed, analyzed and retained the following evidence related to this standard:

- 3.5.3 PREA Plan
- 1.3.1 Personnel Policy Manual
- 3.1.6 Reporting of Incidents
- EAP – Concern Informed Consent Form
- MOU YWCA
- PREA Incident Response Chart
- Interviews with random officers

- Interviews with random residents
- Observations
- Resident Intake Information

PREA Plan states,

PROTOCOL 5: REPORTING

- A. *Resident reporting – (See MI/WCC 3.1.6/3.1.10 Reporting of Incidents and 3.3.3/WCC Resident Handbooks)*
1. *The HCSD provides multiple internal ways for residents to privately report sexual abuse, sexual harassment, retaliation by other residents or staff for reporting sexual abuse and sexual harassment, and staff neglect or violation of responsibilities that may have contributed to such incidents.*
 2. *The Department provides toll free calls via the pod/unit phones for residents to report sexual abuse or sexual harassment to the YWCA Rape Crisis Center (who will work with the resident to report the sexual abuse/harassment to Department officials).*
 3. *Staff accept reports made verbally, in writing, anonymously, and from third parties and promptly document any verbal reports.*
 4. *The Department contracts with Concern/EAP of the River Valley Counseling Center to provide a method for staff to privately report sexual abuse and sexual harassment of residents (see Form Concern/EAP Informed Consent & Limits of Confidentiality).*

1.3.1 Personnel Policy Manual states,
Employee Responsibilities

1. *Each employee is personally responsible to conduct themselves professionally and in no way sexually abuse, have sexual contact with, invade the privacy of, or engage in acts of intimacy with any inmates under their supervision.*
2. *Staff is informed of MGL Chapter 268, Section 21A.*
3. *Employees are required to report all allegations of intimacy, sexual abuse, and invasion of privacy, sexual contact or sexual misconduct to their supervisory chain-of-command. This applies to all uniform/not-uniform staff, contractors and volunteers.*
4. *Failure to report any allegation may result in disciplinary action.*
5. *Staff is required to report in writing any incident of inmate nudity, dressing or undressing observed (other than normal daily routines, body functions and daily dressing). Report will be submitted to the supervisor for investigation and disposition.*
6. *Staff is not to engage inmates in personal types of conversation or allow questions from an inmate of a personal nature, without sound penalogical reason. Appropriate professional boundaries need to be maintained. Flirtatious type of behavior such as requests for a date, comments about cologne, perfume or appearance, requests of a sexual nature, are to be reported to the supervisor for investigation and disposition.*
7. *Supervisory staff, upon receipt of an incident report concerning sexual misconduct, depending on the circumstances, may take one or more of the following measures if warranted (supervisory judgment needs to be utilized in determining appropriateness of measures, if any, to be implemented. Allegations can range from obvious frivolous nonsense to legitimate misconduct.*
8. *Based upon the circumstances of the allegation, the following Department action(s) may result:*
 - a. *Posting of staff pending further investigation.*
 - b. *Removal of staff from immediate contact with the inmate making the allegation/or alleged victim.*
 - c. *Removal of inmate from the immediate area (considerations should be given to classification/security issues, and the move should not be disciplinary in nature unless the inmate behavior dictates otherwise).*
 - d. *Taking of other appropriate precautions, if warranted.*

- e. *Conferring with the area administrator/designee, if warranted for advice and consultation. (This needs to be accomplished if there is an allegation of a serious/credible nature where prosecution under MGL Chapter 268, Section 21A could apply).*
- 9. *The Area Administrator/designee, if warranted, shall contact the Assistant Superintendent of Human Resources/designee, who if appropriate, will activate the investigation team.*
- 10. *All correspondence, incident reports, statements are confidential. Additionally, all questioned or interviewed staff are informed that the investigation is confidential and are directed not to speak to any other staff of inmates concerning the subject matter.*
- 11. *All findings/conclusions will be reported to the Superintendent/designee and the Human Resources Department.*
- 12. *Based on the investigation findings, a referral to the District Attorney (DA) and the Massachusetts State Police may be made.*
- 13. *Should the DA decide to pursue criminal charges, they will assign the State Police to do so.*
- 14. *The investigation will be prompt, impartial and confidential.*

(a) (b)

As stated, interviews were conducted with seventeen residents. They indicated they know they could report to any staff, in writing or verbally but most were aware of the hotline on the phone due to the introductory message providing them a prompt. The auditor reviewed the resident orientation information which provides specific information on how to report to include the following: speak to any staff, send a written request to any staff, request to speak with the PREA Manager or PREA Coordinator, call the Rape Crisis Center Hotline (number provided), report to the State Police (number provided). Due to the brief message on the phone, most residents were aware of this option for reporting, or confirmed they don't use the phone and indicated they would report to staff.

(c)

3.1.6 Reporting of Incidents states,

PROTOCOL 2: Initiation of an Incident Report

- A. *Staff must complete Incident Reports as soon after the incident as possible, but before the end of the shift.*
- B. *For all resident related incident reports (and related intelligence reports), staff will utilize the electronic incident report system. For Staff and other non-resident issues staff will utilize the hardcopy, manual Incident Report form.*
- C. *All staff issues will be reported via the manual/hard copy incident report form. All portions will be completed and include all parties involved, what occurred, where it occurred, when it occurred, how it occurred, and if known, why it occurred. The completed form will then be forwarded to the immediate supervisor of the reporting staff member.*

All random staff interviews confirmed the following: Staff will report suspicion and/or knowledge of any sexual abuse, sexual harassment, retaliation for making a report of sexual abuse or sexual harassment and/or staff neglect that may lead to sexual abuse or sexual harassment. They will accept reports verbally, third party, and/or anonymously.

(d)

As stated in policy The department contracts with Concern/EAP of the River Valley Counseling Center to provide a method for staff to privately report sexual abuse and sexual harassment of residents (see Form Concern/EAP Informed Consent & Limits of Confidentiality). Interviews with randomly selected staff confirmed their knowledge regarding this, or their ability to break chain of command if they felt their suspicions warranted it.

Finding of compliance is based on the following: Policy is compliance with standard requirements. Staff and resident interviews confirmed to the auditor that there are numerous methods for a reporting, an

effective method for reporting outside the agency, and a private avenue for staff reporting. The auditor finds there is sufficient evidence to support a finding of compliance.

Standard 115.252: Exhaustion of administrative remedies

115.252 (a)

- Is the agency exempt from this standard? NOTE: The agency is exempt ONLY if it does not have administrative procedures to address resident grievances regarding sexual abuse. This does not mean the agency is exempt simply because a resident does not have to or is not ordinarily expected to submit a grievance to report sexual abuse. This means that as a matter of explicit policy, the agency does not have an administrative remedies process to address sexual abuse. Yes No

115.252 (b)

- Does the agency permit residents to submit a grievance regarding an allegation of sexual abuse without any type of time limits? (The agency may apply otherwise-applicable time limits to any portion of a grievance that does not allege an incident of sexual abuse.) (N/A if agency is exempt from this standard.) Yes No NA
- Does the agency always refrain from requiring a resident to use any informal grievance process, or to otherwise attempt to resolve with staff, an alleged incident of sexual abuse? (N/A if agency is exempt from this standard.) Yes No NA

115.252 (c)

- Does the agency ensure that: A resident who alleges sexual abuse may submit a grievance without submitting it to a staff member who is the subject of the complaint? (N/A if agency is exempt from this standard.) Yes No NA
- Does the agency ensure that: Such grievance is not referred to a staff member who is the subject of the complaint? (N/A if agency is exempt from this standard.) Yes No NA

115.252 (d)

- Does the agency issue a final agency decision on the merits of any portion of a grievance alleging sexual abuse within 90 days of the initial filing of the grievance? (Computation of the 90-day time period does not include time consumed by residents in preparing any administrative appeal.) (N/A if agency is exempt from this standard.) Yes No NA
- If the agency determines that the 90-day timeframe is insufficient to make an appropriate decision and claims an extension of time (the maximum allowable extension of time to respond is 70 days per 115.252(d)(3)) , does the agency notify the resident in writing of any such extension and provide a date by which a decision will be made? (N/A if agency is exempt from this standard.) Yes No NA
- At any level of the administrative process, including the final level, if the resident does not receive a response within the time allotted for reply, including any properly noticed extension, may a resident consider the absence of a response to be a denial at that level? (N/A if agency is exempt from this standard.) Yes No NA

115.252 (e)

- Are third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, permitted to assist residents in filing requests for administrative remedies relating to allegations of sexual abuse? (N/A if agency is exempt from this standard.)
 Yes No NA
- Are those third parties also permitted to file such requests on behalf of residents? (If a third-party files such a request on behalf of a resident, the facility may require as a condition of processing the request that the alleged victim agree to have the request filed on his or her behalf, and may also require the alleged victim to personally pursue any subsequent steps in the administrative remedy process.) (N/A if agency is exempt from this standard.)
 Yes No NA
- If the resident declines to have the request processed on his or her behalf, does the agency document the resident's decision? (N/A if agency is exempt from this standard.)
 Yes No NA

115.252 (f)

- Has the agency established procedures for the filing of an emergency grievance alleging that a resident is subject to a substantial risk of imminent sexual abuse? (N/A if agency is exempt from this standard.) Yes No NA
- After receiving an emergency grievance alleging a resident is subject to a substantial risk of imminent sexual abuse, does the agency immediately forward the grievance (or any portion thereof that alleges the substantial risk of imminent sexual abuse) to a level of review at which immediate corrective action may be taken? (N/A if agency is exempt from this standard.)
 Yes No NA
- After receiving an emergency grievance described above, does the agency provide an initial response within 48 hours? (N/A if agency is exempt from this standard.) Yes No NA
- After receiving an emergency grievance described above, does the agency issue a final agency decision within 5 calendar days? (N/A if agency is exempt from this standard.)
 Yes No NA
- Does the initial response and final agency decision document the agency's determination whether the resident is in substantial risk of imminent sexual abuse? (N/A if agency is exempt from this standard.) Yes No NA
- Does the initial response document the agency's action(s) taken in response to the emergency grievance? (N/A if agency is exempt from this standard.) Yes No NA
- Does the agency's final decision document the agency's action(s) taken in response to the emergency grievance? (N/A if agency is exempt from this standard.) Yes No NA

115.252 (g)

- If the agency disciplines a resident for filing a grievance related to alleged sexual abuse, does it do so ONLY where the agency demonstrates that the resident filed the grievance in bad faith? (N/A if agency is exempt from this standard.) Yes No NA

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

The auditor gathered, reviewed, analyzed and retained the following evidence related to this standard:

- 3.5.3 PREA Plan
- PAQ
- Interview with a grievance coordinator
- Observations

The PAQ indicates there have been no grievances regarding sexual abuse, no emergency grievances, no grievances written in bad faith and no third-party grievances in the previous 12 months. To confirm this the auditor reviewed the grievances quickly for the previous 12 months and interviewed the grievance coordinator who confirmed this.

PREA Plan states,

B. Exhaustion of Administrative Remedies -

1. *The Department does not impose a time limit on when an resident may submit a grievance regarding an allegation of sexual abuse (See MI/WCC P&P 3.5.2/3.3.3 Resident Grievance.)*
2. *The Department may apply otherwise-applicable time limits to any portion of a grievance that does not allege an incident of sexual abuse.*
3. *The Department does not require an resident to use any informal grievance process, or to otherwise attempt to resolve with staff, an alleged incident of sexual abuse.*
4. *Nothing in this section shall restrict the Department’s ability to defend against an resident lawsuit on the ground that the applicable statute of limitations has expired.*
5. *The Department will ensure that;*
 - a. *An resident who alleges sexual abuse may submit a grievance without submitting it to a staff member who is the subject of the complaint, and*
 - b. *Such grievance is not referred to a staff member who is the subject of the complaint.*
6. *The HCSD shall issue a final facility decision on the merits of any portion of a grievance alleging sexual abuse within ninety (90) days of the initial filing of the grievance.*
7. *Computation of the ninety (90) day time period shall not include time consumed by residents in preparing any administrative appeal.*
8. *The HCSD may claim an extension of time to respond, of up to seventy (70) days, if the normal time period for response is insufficient to make an appropriate decision. The Department shall notify the resident in writing of any such extension and provide a date by which a decision will be made.*
9. *At any level of the administrative process, including the final level, if the resident does not receive a response within the time allotted for reply, including any properly noticed extension, the resident may consider the absence of a response to be a denial at that level.*
10. *Third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, will be permitted to assist residents in filing requests for administrative remedies*

relating to allegations of sexual abuse and will also be permitted to file such requests on behalf of residents.

11. *If a third party files such a request on behalf of an resident, the facility may require as a condition of processing the request that the alleged victim agree to have the request filed on their behalf, and may also require the alleged victim to personally pursue any subsequent steps in the administrative remedy process.*
12. *If the resident declines to have the request processed on their behalf, the Department will document the resident's decision.*
13. *The Department has a procedure for the filing of an emergency grievance alleging that an resident is subject to a substantial risk of imminent sexual abuse.*
14. *After receiving an emergency grievance alleging an resident is subject to a substantial risk of imminent sexual abuse, the facility will immediately forward the grievance (or any portion thereof that alleges the substantial risk of imminent sexual abuse) to a level of review at which immediate corrective action may be taken, will provide an initial response within forty-eight (48) hours, and will issue a final Department decision within (5) five calendar days. The initial response and final Department decision shall document the facility's determination whether the resident is in substantial risk of imminent sexual abuse and the action taken in response to the emergency grievance.*
15. *The Department will discipline an resident for filing a grievance (report) related to alleged sexual abuse where the Department demonstrates that the resident filed the grievance in bad faith (false allegation). For the purpose of disciplinary action, a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred shall not constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation.*

(a) (b) (c) (d) (e) (f) (g) This facility is not exempt from this standard. Policy mirrors all requirements of the standard. An interview with the grievance coordinator confirmed that he has not processed any grievances regarding any sexual abuse or sexual harassment in the previous twelve months.

Finding of compliance is based on the following: Policy , PAQ and interview with the grievance coordinator supports the requirements of the standard.

Standard 115.253: Resident access to outside confidential support services

115.253 (a)

- Does the facility provide residents with access to outside victim advocates for emotional support services related to sexual abuse by giving residents mailing addresses and telephone numbers, including toll-free hotline numbers where available, of local, State, or national victim advocacy or rape crisis organizations? Yes No
- Does the facility enable reasonable communication between residents and these organizations and agencies, in as confidential a manner as possible? Yes No

115.253 (b)

- Does the facility inform residents, prior to giving them access, of the extent to which such communications will be monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws? Yes No

115.253 (c)

- Does the agency maintain or attempt to enter into memoranda of understanding or other agreements with community service providers that are able to provide residents with confidential emotional support services related to sexual abuse? Yes No
- Does the agency maintain copies of agreements or documentation showing attempts to enter into such agreements? Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

The auditor gathered, reviewed, analyzed and retained the following evidence related to this standard:

- 3.5.3 PREA Plan
- MOU YWCA
- PREA Publications (four total, English and Spanish)
- Resident interviews

PREA Plan states,

- C. *Resident Access to Outside Confidential Support Services - (See MI/WCC P&P 3.3.3/WCC Resident Handbooks)*
1. *The HCSD provides residents with access to outside victim advocates for emotional support services related to sexual abuse by giving residents mailing addresses and telephone numbers, including toll-free hotline numbers where available, of local, State, or national victim advocacy or rape crisis organizations, and, for persons detained solely for civil immigration purposes, immigrant services agencies. The facility enables reasonable communication between residents and these organizations and agencies, in as confidential a manner as possible.*
 2. *The facility informs residents, prior to giving them access, of the extent to which such communications will be monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws.*
 3. *The Department maintains a memorandum of understanding (MOU) with the YWCA Rape Crisis Center who provides the residents with confidential, emotional support services related to sexual abuse. The Department maintains copies of these agreements.*

The Resident Educational Material provided at intake states the following:

The Hampden County Sheriff's Department (HCSD) has a zero tolerance towards sexual assault, sexual misconduct, staff sexual misconduct and sexual harassment. This includes any sexual act as noted above.

If you are a victim of sexual assault, sexual misconduct, sexual harassment, or staff sexual misconduct, you can report it in one of the following ways:

- *Speak to a Hampden County Sheriff's Department Staff member*
- *Send an resident request to any Hampden County Sheriff's Dept. Staff*
- *Request to speak with the PREA Manager or PREA Coordinator at your facility*
Your PREA Coordinator is Matt Roman
Your PREA Manager is Diane Bator

- *Call the Rape Crisis Center Hotline: 1(800) 796-8711; TTY (413) 733-7100; or Llàmanos Spanish Language 24-hr Helpline: 1(800) 223-5001*
- *Contact the National Sexual Assault Hotline Tel: 1(800) 656-HOPE*
- *Report it directly to the State Police (413) 736-8390*
- *Foreign Nationals may contact their Consular Officer or Diplomat and relevant official at the Dept. of Homeland Security (You may complete an Resident Request Form and submit it to your counselor/caseworker for assistance contacting these agencies or contact the Legal Resource Center by completing a Legal Access Program Request Form.)*

Calling the Rape Crisis Hotline and not informing Sheriff's office staff will not allow for your immediate protection and investigation of a crime. You should notify Sheriff's office staff immediately if you have been a victim of sexual misconduct or sexual assault.

Calls made to Rape Crisis Center Hotline are unmonitored and unrecorded.

If you are in need of rape crisis counseling, please notify staff so that they can assist you. If you want to receive confidential counseling you can contact the following agency:

YWCA of Western Mass., 1 Clough Street, Springfield, MA 01118

(Additional sites in Holyoke, Westfield, Huntington)

Hotline: (800) 796-8711

Office: (413) 732-3121

TTY: (413) 733-7100

The YWCA will be responsible for all counseling and information and referral services to Survivors at Baystate Medical Center and will provide education for continued care. The Hampden County Sheriff's Department agrees to respect the confidentiality of such counseling to the extent permitted by the safety and security considerations of the parties involved.

YWCA will give resident the following two options:

- Using the housing phone- the resident will call the YWCA hotline and ask to be transferred to appointed counselor. The call will not be recorded or monitored.*
- Using a phone in the office with a HCSD appointed staff; resident will call the appointed YWCA counselor. This call will be monitored.*

YWCA will provide the option of free, confidential counseling to survivors who are under the responsibility of the HCSD. YWCA will provide up to 12 sessions for survivors as capacity, determined by the YWCA, permits. All services provided to survivors are not contingent upon the survivor cooperating with any level of investigation by HCSD into the assault. Survivors can decide at any time to not cooperate with HCSD with no consequences to YWCA counseling. HCSD agrees to allow YWCA to enter into facilities as a professional. Sessions will not be monitored or recorded.

If you need this information explained to you in a different language or format, please notify staff.

(a) (b) (c)

The resident educational material provides the residents with information on how to obtain access to outside victim advocates for emotional support services related to sexual abuse. There is a phone number, mailing address and instructions to work with the counselor/caseworker. The MOU with the YWCA confirmed that it will provide confidential dialogue with a counselor that will not be recorded by asking the hotline operator to speak to an appointed counselor. It is communicated to the residents via the resident handbook. Additionally, the MOU indicates it will provide in person confidential counseling up to twelve sessions for survivors; this service is not contingent on the survivor cooperating with any level of investigation. Additionally, survivors can discontinue counseling with no repercussions. Sessions are not monitored or recorded. Meetings will occur in the facility legal visiting room. The MOU continues to indicate that participants will be informed of mandated reporting guidelines to include

threats of suicide, threats of homicide, abuse/neglect of child, abuse/neglect of someone with a disability and abuse/neglect of someone over the age of 65.

Random resident interviews confirmed that residents are aware of the hotline, but many were not aware of the continued counseling services should they want to participate in this type of treatment. Some residents commented that they saw the phone number posted but had no interest in this service.

Finding of compliance is based on the following: Policy supports the requirements of the standard. The auditor finds that the resident responses regarding emotional support services are typical. Information is available on posters, intake information and the phone message each time a resident uses the phone. The MOU supports a strong relationship with the YWCA in which additional counseling is provided. Phones are available in each housing unit, appropriately spaced to afford reasonable communication in addition to being available throughout the day for use. Residents are informed that the phone calls will not be monitored or recorded.

Standard 115.254: Third-party reporting

115.254 (a)

- Has the agency established a method to receive third-party reports of sexual abuse and sexual harassment? Yes No

- Has the agency distributed publicly information on how to report sexual abuse and sexual harassment on behalf of a resident? Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)

- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

- Does Not Meet Standard** (*Requires Corrective Action*)

The auditor gathered, reviewed, analyzed and retained the following evidence related to this standard:

- 3.5.3 PREA Plan
- Agency website
- Visitor Orientation
- Interview with the PREA Coordinator

3.5.3 PREA Plan states, *D. Third-Party Reporting.*

1. *The HCSD has established a method to receive third-party reports of sexual abuse and sexual harassment and distributes publicly (via the website) information on how to report sexual abuse and sexual harassment on behalf of an resident.*

The agency reports they have not received any third-party allegations in the previous 12 months. The Hampden County Sheriff's Department website, www.hcsdma.org, includes all pertinent PREA information and the agency's emphasis on zero tolerance concerning sexual abuse and sexual harassment. The posted information includes instructions on reporting incidents or suspicions of abuse that may have happened at one of the HCSD facilities. The public is encouraged to call the agency

PREA Coordinator at (413) 858-0914, or by calling the Massachusetts State Police. The mailing address to the PC is also posted, as: 627 Randall Road, Ludlow, Ma. 01056. The public can also contact the Hampden County Rape Crisis Center at: YWCA of Western Mass. 1 Clough Street, Springfield, MA 01118. The YWCA Hotline is included: (800) 796-8711; Office (413) 732-3121; TTY: (413) 733-7100; and the 24 Hour Llamanos Spanish Language Helpline, at: (800) 223-5001 c/o YWCA of Western Mass. The agency website also has a link to Text-A-Tip, a tool that allows people to send anonymous tips to police over any cell phone that allows text messaging. Text-A-Tip is a joint operation of the HCSD, the Hampden County District Attorney's Office and the Springfield and Holyoke Police Departments. The public needs only to text to: 274637 and enter SOLVE, and then message.

The auditor reviewed the power point designed to educate visitors. It provides information to visitors about the facility opportunities for the residents. It also has the following information:

Safe and Secure for Everyone Zero Tolerance statement:

*The Hampden County Sheriff's Department has zero tolerance for sexual assault or abuse, and each case will be thoroughly investigated. The Hampden Sheriff's Department views all sexual contact between residents or between residents and staff as coercive and NEVER consensual. Residents can talk to any staff person they feel comfortable with such as an Officer, Supervisor, Counselor, Nurse, Chaplain, Teacher, or any other Sheriff's Department staff or even a family member. As a family member or friend you can assist by reporting to any staff member so we can help. You can also call: Rape Crisis Center Hotline:
(800) 796-8711 (English)
(800) 223-5001 (Español)*

Finding of compliance is based on the following: Policy ensures compliance with the standard. The website and the visitor orientation further enhance the ability for a third party-reporting process. Therefore, the auditor finds sufficient evidence to support a finding of compliance.

OFFICIAL RESPONSE FOLLOWING A RESIDENT REPORT

Standard 115.261: Staff and agency reporting duties

115.261 (a)

- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency? Yes No
- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding retaliation against residents or staff who reported an incident of sexual abuse or sexual harassment? Yes No
- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding any staff neglect or violation of responsibilities that may have contributed to an incident of sexual abuse or sexual harassment or retaliation? Yes No

115.261 (b)

- Apart from reporting to designated supervisors or officials, do staff always refrain from revealing any information related to a sexual abuse report to anyone other than to the extent necessary,

as specified in agency policy, to make treatment, investigation, and other security and management decisions? Yes No

115.261 (c)

- Unless otherwise precluded by Federal, State, or local law, are medical and mental health practitioners required to report sexual abuse pursuant to paragraph (a) of this section? Yes No
- Are medical and mental health practitioners required to inform residents of the practitioner's duty to report, and the limitations of confidentiality, at the initiation of services? Yes No

115.261 (d)

- If the alleged victim is under the age of 18 or considered a vulnerable adult under a State or local vulnerable persons statute, does the agency report the allegation to the designated State or local services agency under applicable mandatory reporting laws? Yes No

115.261 (e)

- Does the facility report all allegations of sexual abuse and sexual harassment, including third-party and anonymous reports, to the facility's designated investigators? Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

The auditor gathered, reviewed, analyzed and retained the following evidence related to this standard:

- 3.5.3 PREA Plan
- Documentation of mental health staff report
- Interview with medial staff
- Interview with mental health staff
- Interview with the Assistant Superintendent
- Interview with investigator
- Interview with the PREA Coordinator
- Interview with the PREA Managers

PREA Plan states,

PROTOCOL 6: OFFICIAL RESPONSE FOLLOWING AN RESIDENT REPORT

A. Staff and Department Reporting Duties -

1. The HCSD requires all staff to report immediately any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the Department; retaliation against residents or staff who reported such an incident; and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation.

2. *Apart from reporting to designated supervisors or officials, staff shall not reveal any information related to a sexual abuse report to anyone other than to the extent necessary, as specified in Department policy, to make treatment, investigation, and other security and management decisions.*
3. *Unless otherwise precluded by Federal, State, or Local law, medical and mental health practitioners shall be required to report sexual abuse pursuant to part (A)(1) of this section and to inform residents of the practitioner's duty to report, and the limitations of confidentiality, at the initiation of services.*
4. *If the alleged victim is under the age of eighteen (18) or considered a vulnerable adult under a State or Local vulnerable person's statute, the Department shall report the allegation to the designated State or Local services agency under applicable mandatory reporting laws.*
5. *The facility shall report all allegations of sexual abuse and sexual harassment, including third-party and anonymous reports, to the facility's designated Investigator (CIU), PREA Coordinator, and Facility PREA Manager.*

(a)

All random staff interviews confirmed to the auditor that staff are aware they need to report immediately any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency; retaliation against residents or staff who reported such an incident; and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation.

(b)

Interviews with the random staff confirmed to the auditor that staff are fully aware of the requirement to maintain confidentiality after responding to an incident and only reveal the information to those with a need to know, which included the investigation team. This requirement is addressed in training and in policy.

(c)

The PREA pamphlet (educational materials for residents) states the following: *Anything reported to Medical/Mental Health staff is confidential unless it is gang-related, plans of escape, a concern for your safety or a concern of other's safety, or any related security matters to include PREA related incidents. Staff have a duty to report anything that may jeopardize the safety and security of the facility.*

(d)

At this time, in accordance with state law the agency/facility does not house anyone under the age of 18yrs. In Massachusetts, The Elder Abuse website, <https://www.mass.gov/reporting-elder-abuse-neglect>, states Elder Protective Services can only investigate cases of abuse where the person is age 60 and over and lives in the community, so therefore it does not apply to incarcerated individuals.

(e)

The interview with the Assistant Superintendent, PREA Coordinator, PREA Manager, medical, mental health staff and investigators all confirmed that all knowledge, suspicion, retaliation, and/or staff neglect pertaining to sexual abuse and sexual harassment, including third-party and anonymous reports, are directed to the facility's designated investigators.

Finding of compliance is based on the following: Policy, interviews with the Assistant Superintendent, random staff, medical and mental health staff, the PREA pamphlet all provided ample evidence to support a finding with all provisions of the standard.

Standard 115.262: Agency protection duties

115.262 (a)

- When the agency learns that a resident is subject to a substantial risk of imminent sexual abuse, does it take immediate action to protect the resident? Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

The auditor gathered, reviewed, analyzed and retained the following evidence related to this standard:

- 3.5.3 PREA Plan
- PAQ
- Interviews with random staff
- Interview with the Assistant Superintendent
- Interview with the Assistant Deputy Superintendent

The PAQ indicates that there were no incidents when the agency determined a resident was subject to substantial risk of imminent sexual abuse. The auditor found no reason to dispute this during the audit process.

PREA Plan states,

B. HCSD Protection Duties - 1. When the HCSD learns that a resident is subject to a substantial risk of imminent sexual abuse, it will take immediate action to protect the resident.

The interview with the Assistant Deputy Superintendent and the Assistant Superintendent confirmed that actions would be taken to protect a resident that any staff believed would be at risk of imminent sexual abuse. All staff interviews confirmed that if they believed that a resident was at risk of imminent sexual abuse, they could and would take immediate action to remove the resident and place him in a protected area until further action, consideration can be given.

Finding of compliance is based on the following: Policy supports compliance with the standard. All staff interviews confirmed that action could and would be taken to protect the resident before abuse occurred and therefore provided the auditor with sufficient evidence to support a finding of compliance.

Standard 115.263: Reporting to other confinement facilities

115.263 (a)

- Upon receiving an allegation that a resident was sexually abused while confined at another facility, does the head of the facility that received the allegation notify the head of the facility or appropriate office of the agency where the alleged abuse occurred? Yes No

115.263 (b)

- Is such notification provided as soon as possible, but no later than 72 hours after receiving the allegation? Yes No

115.263 (c)

- Does the agency document that it has provided such notification? Yes No

115.263 (d)

- Does the facility head or agency office that receives such notification ensure that the allegation is investigated in accordance with these standards? Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

The auditor gathered, reviewed, analyzed and retained the following evidence related to this standard:

- 3.5.3 PREA Plan
- PREA Notification Letter format
- Interview with Assistant Superintendent
- PAQ

The PAQ indicates that zero allegations were received from a resident that he or she was sexually abused while confined at another facility, zero allegations were received from another facility of alleged abuse at HCSD.

PREA Plan states, *C. Reporting to Other Confinement Facilities -*

1. *Upon receiving an allegation that a resident was sexually abused while confined at another facility, the head of the facility that received the allegation shall notify the head of the facility or appropriate office of the agency where the alleged abuse occurred.*
2. *Such notification shall be provided as soon as possible, but no later than seventy-two (72) hours after receiving the allegation.*
3. *The Department shall document that it has provided such notification.*
4. *The facility/department head that receives such notification will ensure that the allegation is investigated in accordance with these standards.*

(a) (b) (c)

Policy and the interview with the Assistant Superintendent confirmed that if information was received, it would be immediately sent to the facility head of where the alleged incident occurred by the Assistant Superintendent within 72 hours, as required by policy.

(d)

The interview with the investigator confirmed that allegations received from another agency regarding sexual abuse that occurred at this facility are investigated and reported back to that facility where the resident is housed.

Finding of compliance is based on the following: Policy supports the requirements of the standard. The interview with the Assistant Superintendent acknowledged he would make the notification, and this

would occur within the 72 hours as required by the standard. Information received would be immediately referred for investigation.

Standard 115.264: Staff first responder duties

115.264 (a)

- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Separate the alleged victim and abuser?
 Yes No
- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Preserve and protect any crime scene until appropriate steps can be taken to collect any evidence? Yes No
- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Request that the alleged victim not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating, if the abuse occurred within a time period that still allows for the collection of physical evidence? Yes No
- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Ensure that the alleged abuser does not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating, if the abuse occurred within a time period that still allows for the collection of physical evidence? Yes No

115.264 (b)

- If the first staff responder is not a security staff member, is the responder required to request that the alleged victim not take any actions that could destroy physical evidence, and then notify security staff? Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

The auditor gathered, reviewed, analyzed and retained the following evidence related to this standard:

- 3.5.3 PREA Plan
- Pocket Planner
- PAQ
- Interviews with random staff
- Pocket Planners carried by staff

The PAQ indicates there was no incident that allowed for time to collect evidence. The auditor found this information credible.

PREA Plan states, *D. Staff First Responder Duties -*

1. *Upon learning of an allegation that an resident was sexually abused, the first security staff member to respond to the report shall be required to:*
 - a. *Separate the alleged victim and abuser;*
 - b. *Preserve and protect any crime scene until appropriate steps can be taken to collect any evidence;*
 - c. *If the abuse occurred within a time period that still allows for the collection of physical evidence, request that the alleged victim not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating; and*
 - d. *If the abuse occurred within a time period that still allows for the collection of physical evidence, ensure that the alleged abuser does not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating.*
 - e. *If the first staff responder is not a security staff member, the responder shall be required to request that the alleged victim not take any actions that could destroy physical evidence and then notify security staff.*

(a) (b)

Policy and all random staff interviews, including the informal interviews all indicated to the auditor that staff are aware of their duties should be they be the first to respond to an incident where there is potential evidence. All indicated they will separate the residents, non-first responders indicated they would contact the nearest security staff. Many indicated that this information is available for reference in the pocket planner issued to them annually. The auditor was provided a document reflecting the pocket planner information which provides staff with the first responder duties for both security and on security staff. Training provided reinforces this requirement.

Finding of compliance is based on the following: Policy, training currently supports the requirements of the standard, especially regarding responses to the victim and alleged perpetrator. The staff pocket planner helps ensure staff have this information readily available should they be the first responder. For all these reasons, the auditor finds sufficient evidence to support a finding of compliance.

Standard 115.265: Coordinated response

115.265 (a)

- Has the facility developed a written institutional plan to coordinate actions among staff first responders, medical and mental health practitioners, investigators, and facility leadership taken in response to an incident of sexual abuse? Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

Does Not Meet Standard (Requires Corrective Action)

The auditor gathered, reviewed, analyzed and retained the following evidence related to this standard:

- 3.5.3 PREA Plan
- Interview with the Assistant Superintendent

PREA Plan states, *E. Coordinated Response -*

The facility has written institutional plans to coordinate actions taken in response to an incident of sexual abuse, among staff first responders, medical and mental health practitioners, investigators, resident advocate, and facility leadership (See MI/WCC P&P 4.5.9/4.2.10 Special Needs Residents and 3.1.7/3.1.26 Special Teams.)

When a staff member is made aware of an incident of sexual abuse and they are not security staff, they will immediately notify security staff

Security staff will notify Special Operations Supervisor of any incidents of sexual abuse. Security staff will separate the alleged victim and alleged abuser. The Special Operations Supervisor acts as the Incident Site Commander.

The Special Operations Supervisor will ensure that the crime scene is secured to prevent any possible contamination.

The Special Operations Supervisor is responsible for notifying the Medical Department and the CIU Commander. If the CIU Commander is not available, a member of the Criminal Investigation Unit will be activated.

The CIU Commander/designee is responsible for notifying the emergency chain of command to include: Facility/Tower Security Supervisor, Facility/Tower Superintendent, Chief of Security, and Assistant Superintendent of Operations, Superintendent and the Sheriff.

The CIU Commander/designee will ensure a report is made to the Sheriff/facility administrator and Chief of Security to effect a separation of the victim from their assailant in their housing assignments and immediately begin a criminal investigation. Also see Policy and Protocol 3.1.7 Special Teams Protocol 3: Criminal Investigative Unit (CIU).

The CIU Commander/designee will also report all allegations of sexual abuse and sexual harassment, including third-party and anonymous reports, to the facility's designated Investigator (CIU), PREA Coordinator, and Facility PREA Manager.

The Facility PREA Manager is responsible for facilitating a PREA investigation with a certified Sexual Assault Investigator in a Confinement Setting. The PREA Manager will ensure that the CIU team, medical response team and Special Operations duties are completed in a timely manner.

Medical will conduct an examination to document the extent of physical injury and to determine whether referral to Baystate Hospital is indicated.

If exam indicates that the victim is to be referred to Baystate Hospital, the Medical Supervisor will contact the Special Operations Supervisor. The Special Operations Supervisor is responsible for coordinating with the Transportation Department for the transportation of the victim to the hospital. In lieu of Transportation Staff not being available, Special Operations staff will be utilized.

Per the Memorandum of Understanding with the YWCA, Baystate Hospital staff will contact the YWCA for any individual who is the responsibility of HCSD who presents for medical care and/or a sexual assault nurse's examination.

The Medical Department will make a referral to the Forensic Mental Health Department for a qualified mental health professional for crisis intervention counseling and long-term follow-up.

Prophylactic treatment and follow-up care for sexually transmitted or other communicable diseases (e.g., HIV, Hepatitis B) are offered to all victims, as appropriate via the Medical Department.

The interview with the Assistant Superintendent supported the response plan as indicated in policy.

Finding of compliance is based on the following: The response supports the requirements of the standard, providing sufficient evidence for a finding of compliance.

Standard 115.266: Preservation of ability to protect residents from contact with abusers

115.266 (a)

- Are both the agency and any other governmental entities responsible for collective bargaining on the agency's behalf prohibited from entering into or renewing any collective bargaining agreement or other agreement that limits the agency's ability to remove alleged staff sexual abusers from contact with any residents pending the outcome of an investigation or of a determination of whether and to what extent discipline is warranted? Yes No

115.266 (b)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

The auditor gathered, reviewed, analyzed and retained the following evidence related to this standard:

- 3.5.3 PREA Plan
- HCSCOA contract
- NCEU Officer and Supervisors
- Interview with the Assistant Superintendent

PREA Plan states, *F. Preservation of Ability to Protect Residents from Contact with Abusers -*

- Neither the Department nor any other governmental entity responsible for collective bargaining on the Department's behalf will enter into or renew any collective bargaining agreement or other agreement that limits the Department's ability to remove alleged staff sexual abusers from contact with any residents pending the outcome of an investigation or of a determination of whether and to what extent discipline is warranted.*
- Nothing in this policy shall restrict the entering into or renewal of agreements that govern:*
 - The conduct of the disciplinary process, as long as such agreements are not inconsistent with the provisions of Protocols 7:B (Evidentiary Standard for Administrative Investigations) and 8:A (Disciplinary Sanctions for Staff); or*
 - Whether a no-contact assignment that is imposed pending the outcome of an investigation shall be expunged from or retained in the staff member's personnel file following a determination that the allegation of sexual abuse is not substantiated.*

(a)

The auditor reviewed the bargaining agreements and found no evidence to indicate that the bargaining unit would limit the agency's ability to remove alleged staff from contact with the known abuser. The

interview with the Assistant Superintendent confirmed this. Language of the Hampden County Superior Correctional Officers Association contract and the National Correctional Employees Union contract both state, "The Sheriff or his designee shall have the right to remove, dismiss, discharge, suspend or discipline a unit member, provided that no such action shall be taken except for just cause." Both contracts were provided for review in addition to documents demonstrating they are current.

(b) Auditor not required to audit this provision.

Finding of compliance is based on the following: Policy, contract language and the interview with the Assistant Superintendent provided the auditor with sufficient evidence to support a finding of compliance.

Standard 115.267: Agency protection against retaliation

115.267 (a)

- Has the agency established a policy to protect all residents and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other residents or staff? Yes No
- Has the agency designated which staff members or departments are charged with monitoring retaliation? Yes No

115.267 (b)

- Does the agency employ multiple protection measures, such as housing changes or transfers for resident victims or abusers, removal of alleged staff or resident abusers from contact with victims, and emotional support services for residents or staff who fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations? Yes No

115.267 (c)

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor the conduct and treatment of residents or staff who reported the sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff? Yes No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor the conduct and treatment of residents who were reported to have suffered sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff? Yes No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Act promptly to remedy any such retaliation? Yes No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor any resident disciplinary reports? Yes No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor resident housing changes? Yes No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor resident program changes? Yes No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor negative performance reviews of staff? Yes No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor reassignments of staff? Yes No
- Does the agency continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need? Yes No

115.267 (d)

- In the case of residents, does such monitoring also include periodic status checks?
 Yes No

115.267 (e)

- If any other individual who cooperates with an investigation expresses a fear of retaliation, does the agency take appropriate measures to protect that individual against retaliation?
 Yes No

115.267 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

The auditor gathered, reviewed, analyzed and retained the following evidence related to this standard:

- 3.5.3 PREA Plan
- Retaliation Monitoring Form
- PREA Reporting & Monitoring Retaliation power point
- Interview with the Assistant Superintendent
- Interview with staff who would monitor for retaliation
- PAQ
- Retaliation monitoring form completed (Feb. 2020)

The PAQ indicates that there have been no incidents of retaliation in the previous twelve months.

PREA Plan states,

G. Department Protection against Retaliation.

- 1. The Department has established this policy to protect all residents and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other residents or staff, and designates which staff members/departments are charged with monitoring retaliation.*
- 2. The Department employs multiple protection measures, such as housing changes or transfers for resident victims or abusers, removal of alleged staff or resident abusers from contact with victims, and emotional support services for residents or staff who fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations.*
- 3. For at least ninety (90) days following a report of sexual abuse, the Department shall monitor the conduct and treatment of residents or staff who reported the sexual abuse and of residents who were reported to have suffered sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff, and will act promptly to remedy any such retaliation. The Department will monitor any resident disciplinary reports, housing, or program changes, or negative performance reviews or reassignments of staff. The Department will continue this monitoring beyond 90 days if the initial monitoring indicates a continuing need.*
- 4. In the case of residents, this monitoring will also include periodic status checks.*
- 5. If any other individual who cooperates with an investigation expresses a fear of retaliation, the Department will take appropriate measures to protect that individual against retaliation.*
- 6. The Department's obligation to monitor for retaliation will terminate if the facility determines that the allegation is unfounded.*

(a)

The PREA Plan supports that the agency will protect all residents and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other residents or staff, and shall designate which staff members or departments are charged with monitoring retaliation. The interview with the Assistant Superintendent confirms that retaliation for reporting sexual abuse or sexual harassment will not be tolerated.

(b)

The agency form does prompt the reviewer to address the following: disciplinary report review, housing review, program review, and TRAX (medical information) review. Emotional support services would be provided by the YWCA and confirmed in the narrative regarding 115.53. For staff these services would be provided by the Concern/EAP of the River Valley Counseling Center.

(c)

The retaliation review occurs for 90 days past the incident report as supported by policy, interview with the staff who monitors for retaliation and the retaliation review provided to the auditor for review. The monitoring form requires the person conducting the monitoring to assess if continued monitoring is needed at the end of the 90-day review.

(d)

The person responsible for retaliation monitoring indicated she does personally check in with the resident periodically and this is noted on the form.

(e) (f)

Policy and interviews confirm that in the event another individual who cooperated with the investigation expressed fear of retaliation, the agency would take appropriate measures to protect the individual from

any retaliation. They also confirmed that monitoring concludes if the investigation is deemed unfounded.

Finding of compliance is based on the following: Policy, interview with staff who monitor for retaliation, review of the form and completed monitoring provided the auditor with ample evidence to support a finding of compliance.

INVESTIGATIONS

Standard 115.271: Criminal and administrative agency investigations

115.271 (a)

- When the agency conducts its own investigations into allegations of sexual abuse and sexual harassment, does it do so promptly, thoroughly, and objectively? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations. See 115.221(a).) Yes No NA
- Does the agency conduct such investigations for all allegations, including third party and anonymous reports? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations. See 115.221(a).) Yes No NA

115.271 (b)

- Where sexual abuse is alleged, does the agency use investigators who have received specialized training in sexual abuse investigations as required by 115.234? Yes No

115.271 (c)

- Do investigators gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data? Yes No
- Do investigators interview alleged victims, suspected perpetrators, and witnesses? Yes No
- Do investigators review prior reports and complaints of sexual abuse involving the suspected perpetrator? Yes No

115.271 (d)

- When the quality of evidence appears to support criminal prosecution, does the agency conduct compelled interviews only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution? Yes No

115.271 (e)

- Do agency investigators assess the credibility of an alleged victim, suspect, or witness on an individual basis and not on the basis of that individual's status as resident or staff? Yes No

- Does the agency investigate allegations of sexual abuse without requiring a resident who alleges sexual abuse to submit to a polygraph examination or other truth-telling device as a condition for proceeding? Yes No

115.271 (f)

- Do administrative investigations include an effort to determine whether staff actions or failures to act contributed to the abuse? Yes No
- Are administrative investigations documented in written reports that include a description of the physical evidence and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings? Yes No

115.271 (g)

- Are criminal investigations documented in a written report that contains a thorough description of the physical, testimonial, and documentary evidence and attaches copies of all documentary evidence where feasible? Yes No

115.271 (h)

- Are all substantiated allegations of conduct that appears to be criminal referred for prosecution? Yes No

115.271 (i)

- Does the agency retain all written reports referenced in 115.271(f) and (g) for as long as the alleged abuser is incarcerated or employed by the agency, plus five years? Yes No

115.271 (j)

- Does the agency ensure that the departure of an alleged abuser or victim from the employment or control of the agency does not provide a basis for terminating an investigation? Yes No

115.271 (k)

- Auditor is not required to audit this provision.

115.271 (l)

- When an outside entity investigates sexual abuse, does the facility cooperate with outside investigators and endeavor to remain informed about the progress of the investigation? (N/A if an outside agency does not conduct administrative or criminal sexual abuse investigations. See 115.221(a).) Yes No NA

Auditor Overall Compliance Determination

Exceeds Standard (*Substantially exceeds requirement of standards*)

- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

The auditor gathered, reviewed, analyzed and retained the following evidence related to this standard:

- 3.5.3 PREA Plan
- Letter from CIU Commander to Law Enforcement Agencies in the County
- PAQ
- Interview with Investigator
- Interview with Assistant Superintendent
- Interview with PREA Coordinator
- Interview with PREA Manager

3.5.3 PREA Plan states,

PROTOCOL 7: INVESTIGATIONS

A. Criminal and Administrative Department Investigations.

1. *When the HCSD conducts its own investigations into allegations of sexual abuse and sexual harassment, it will do so promptly, thoroughly, and objectively for all allegations, including third-party and anonymous reports.*
2. *Where sexual abuse is alleged, the Department will use investigators who have received special training in sexual abuse investigations pursuant to Protocol 3:D:1 Specialized Training: Investigations.*
3. *Investigators will gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data; will interview alleged victims, suspected perpetrators, and witnesses; and will review prior complaints and reports of sexual abuse involving the suspected perpetrator.*
4. *When the quality of evidence appears to support criminal prosecution, the Department will conduct compelled interviews only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution.*
5. *The credibility of an alleged victim, suspect, or witness will be assessed on an individual basis and will not be determined by the person's status as resident or staff. The HCSD will not require an resident who alleges sexual abuse to submit to a polygraph examination or other truth-telling device as a condition for proceeding with the investigation of such an allegation.*
6. **Administrative Investigations:**
 - a. *Will include an effort to determine whether staff actions or failures to act contributed to the abuse; and*
 - b. *Will be documented in written reports that include a description of the physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings.*
7. *Criminal investigations will be documented in a written report that contains a thorough description of physical, testimonial, and documentary evidence with attached copies of all documentary evidence, where feasible.*
8. *Substantiated allegations of conduct that appear to be criminal shall be referred for prosecution.*
9. *The Department will retain all written reports referenced in paragraphs (6) Administrative Investigations and (7) Criminal Investigations of this section for as long as the alleged abuser is incarcerated or employed by the Department, plus five years.*
10. *The departure of the alleged abuser or victim from the employment or control of the HCSD will not provide a basis for terminating an investigation.*
11. *Any State entity or Department of Justice component that conducts such investigations will do so pursuant to the above requirements.*
12. *When outside agencies investigate sexual abuse, the facility shall cooperate with outside investigators and shall endeavor to remain informed about the progress of the investigation.*

(a)

Interviews with the Assistant Superintendent, PREA Coordinator, PREA Manager and investigator all confirmed that investigations are initiated promptly, thoroughly and objectively.

(b)

All investigators have received the specialized training conducted by the Massachusetts Department of Corrections or another qualified training entity. See 115.34.

(c)

Interviews with the investigator confirmed that the investigator does gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data; interviews alleged victims, suspected perpetrators, and witnesses; and reviews prior complaints and reports of sexual abuse involving the suspected perpetrator.

(d)

The interview with the investigator confirmed that when the quality of evidence appears to support criminal prosecution, she only conducts compelled interviews after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution. If this scenario were to occur, it was indicated the CIU Commander would be conducting the investigation.

(e)

During the interview, the investigator confirmed that credibility is based on the statement and supporting evidence individually. She confirmed that no polygraph or truth telling devices are ever utilized.

(f)

The investigator confirmed that administrative investigations would be documented and would automatically include a review of the operations to ensure that staff actions are in accordance with policy.

(g)

During the interview, the investigator confirmed that criminal investigations would be documented in a written report which includes a description of physical, testimonial, and documentary evidence and attaches copies of all documentary evidence where feasible. No criminal investigations occurred during the audit review period to be examined.

(h)

Substantiated allegations of conduct that appears to be criminal are referred for prosecution, per the interviews will the Assistant Superintendent, investigator, PREA Coordinator and PREA Manager.

(i)

The investigator confirmed that all written reports are retained for as long as the alleged abuser is incarcerated or employed by the agency, plus five years.

(j)

Interviews will the investigator, PREA Coordinator and PREA Manager all confirmed that the departure of the alleged abuser or victim from the employment or control of the facility or agency shall not provide a basis for terminating an investigation.

(k)

Auditor not required to audit this provision

(l)

Per policy and confirmation by the investigator, when outside agencies investigate sexual abuse, the facility shall cooperate with outside investigators and shall endeavor to remain informed about the progress of the investigation. Additionally, the letter from the CIU Commander to law enforcement agencies in the Commonwealth of Massachusetts supports this.

Finding of compliance is based on the following: Policy, interview with investigator Assistant Superintendent, PREA Coordinator and PREA Manager, and letter to the outside enforcement agencies provided the auditor with sufficient evidence to support a finding of compliance.

Standard 115.272: Evidentiary standard for administrative investigations

115.272 (a)

- Is it true that the agency does not impose a standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated? Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

The auditor gathered, reviewed, analyzed and retained the following evidence related to this standard:

- 3.5.3 PREA Plan
- Interview with the investigators
- Review of completed investigations

PREA Plan states,

B. Evidentiary Standard for Administrative Investigations -

1. The Department imposes no standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated.

The interview with the investigator confirmed that a preponderance of evidence is used to determine the findings of an investigation.

Finding of compliance is based on the following: Policy supports the requirements of the standard. The interview with the investigator confirmed compliance giving the auditor sufficient evidence to support a finding of compliance.

Standard 115.273: Reporting to residents

115.273 (a)

- Following an investigation into a resident's allegation that he or she suffered sexual abuse in an agency facility, does the agency inform the resident as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded? Yes No

115.273 (b)

- If the agency did not conduct the investigation into a resident's allegation of sexual abuse in the agency's facility, does the agency request the relevant information from the investigative agency in order to inform the resident? (N/A if the agency/facility is responsible for conducting administrative and criminal investigations.) Yes No NA

115.273 (c)

- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The staff member is no longer posted within the resident's unit? Yes No
- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The staff member is no longer employed at the facility? Yes No
- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The agency learns that the staff member has been indicted on a charge related to sexual abuse in the facility? Yes No
- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility? Yes No

115.273 (d)

- Following a resident's allegation that he or she has been sexually abused by another resident, does the agency subsequently inform the alleged victim whenever: The agency learns that the alleged abuser has been indicted on a charge related to sexual abuse within the facility? Yes No
- Following a resident's allegation that he or she has been sexually abused by another resident, does the agency subsequently inform the alleged victim whenever: The agency learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility? Yes No

115.273 (e)

- Does the agency document all such notifications or attempted notifications? Yes No

115.273 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

The auditor gathered, reviewed, analyzed and retained the following evidence related to this standard:

- 3.5.3 PREA Plan
- PREA Notification Letter to Resident Form
- PAQ
- Interview with the Assistant Superintendent
- Notification form

The PAQ indicates the following:

Zero investigations of alleged sexual abuse completed;
Zero investigations of alleged sexual abuse completed where resident was notified of the results (verbally or in writing);
Zero sexual abuse investigations completed by an outside agency;
Zero notifications of the results of an investigation completed by an outside agency
Zero substantiated cases of staff sexual abuse;
Zero notifications made pursuant to those investigations
Zero notifications provided to residents;

PREA Plan states,

C. *Reporting to Residents -*

1. *Following an investigation into an resident's allegation that they suffered sexual abuse in a HCSD facility, the Department will inform the resident as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded.*
2. *If the Department did not conduct the investigation, it shall request the relevant information from the investigative agency in order to inform the resident.*
3. *Following an resident's allegation that a staff member has committed sexual abuse against the resident, the Department will subsequently inform the resident (unless the Department has determined that the allegation is unfounded) whenever:*
 - a. *The staff member is no longer posted within the resident's unit;*
 - b. *The staff member is no longer employed by the Department;*
 - c. *The Department learns that the staff member has been indicted on a charge related to sexual abuse within the facility; or*
 - d. *The Department learns that the staff member has been convicted on a charge related to sexual abuse within the facility.*

(a)

In addition to policy, the Notification letters inform the resident that the determination of the investigation was substantiated, unsubstantiated, or unfounded.

(b)

The Agency is responsible for conducting the investigations. If referred to the State Police, as noted, there is a letter to them from the CIU Commander, notifying them of the PREA compliance of this agency.

(c)

Policy and the notification form support the requirements of this provision. During the audit review period, there has been no incident that has occurred that would warrant this type of notification. The auditor found this credible as the facility allowed the auditor to view investigation reports prior to the 12 months review period which afforded no incident of sexual abuse or sexual harassment allegations.

(d)

Policy and the notification form support the requirements of this provision. During the audit review period, there has been no incident that has occurred that would warrant this type of notification.

(e)

Based on policy, interviews and review of the notification form, the notification would be documented.

Finding of compliance is based on the following: Policy, interviews with the investigator, review of the notification forms all support a finding of compliance.

DISCIPLINE

Standard 115.276: Disciplinary sanctions for staff

115.276 (a)

- Are staff subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies? Yes No

115.276 (b)

- Is termination the presumptive disciplinary sanction for staff who have engaged in sexual abuse? Yes No

115.276 (c)

- Are disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) commensurate with the nature and circumstances of the acts committed, the staff member's disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories? Yes No

115.276 (d)

- Are all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, reported to: Law enforcement agencies unless the activity was clearly not criminal? Yes No
- Are all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, reported to: Relevant licensing bodies? Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

The auditor gathered, reviewed, analyzed and retained the following evidence related to this standard:

- 3.5.3 PREA Plan
- 1.3.1 Human Resources
- Interview with the Assistant Superintendent

The PAQ indicates that no staff have been disciplined for violation of agency sexual abuse or sexual harassment policies; therefore, also no staff have been referred to appropriate licensing bodies. The auditor found no reason to dispute this during the audit process.

PREA Plan states,

PROTOCOL 8: DISCIPLINE

A. Disciplinary Sanctions for Staff -

1. *Staff will be subject to disciplinary sanctions up to and including termination for violating Department sexual abuse or sexual harassment policies.*
2. *Termination will be the presumptive disciplinary sanction for staff who have engaged in sexual abuse.*
3. *Disciplinary sanctions for violations of Department policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) will be commensurate with the nature and circumstances of the acts committed, the staff member's disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories.*
4. *All terminations for violations of Department sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, will be reported to law enforcement agencies, unless the activity was clearly not criminal, and to any relevant licensing bodies.*

1.3.1 Human Resources states,

B. Employee Responsibilities

1. *Each employee is personally responsible to conduct themselves professionally and in no way sexually abuse, have sexual contact with, invade the privacy of, or engage in acts of intimacy with any residents under their supervision.*
2. *Staff is informed of MGL Chapter 268, Section 21A.*
3. *Employees are required to report all allegations of intimacy, sexual abuse, and invasion of privacy, sexual contact or sexual misconduct to their supervisory chain-of-command. This applies to all uniform/not-uniform staff, contractors and volunteers.*
4. *Failure to report any allegation may result in disciplinary action.*
5. *Staff is required to report in writing any incident of resident nudity, dressing or undressing observed (other than normal daily routines, body functions and daily dressing). Report will be submitted to the supervisor for investigation and disposition.*
6. *Staff is not to engage residents in personal types of conversation or allow questions from an resident of a personal nature, without sound penalogical reason. Appropriate professional boundaries need to be maintained. Flirtatious type of behavior such as requests for a date, comments about cologne, perfume or appearance, requests of a sexual nature, are to be reported to the supervisor for investigation and disposition.*

7. Supervisory staff, upon receipt of an incident report concerning sexual misconduct, depending on the circumstances, may take one or more of the following measures if warranted (supervisory judgment needs to be utilized in determining appropriateness of measures, if any, to be implemented). Allegations can range from obvious frivolous nonsense to legitimate misconduct.
8. Based upon the circumstances of the allegation, the following Department action(s) may result:
 - a. Posting of staff pending further investigation.
 - b. Removal of staff from immediate contact with the resident making the allegation/or alleged victim.
 - c. Removal of resident from the immediate area (considerations should be given to classification/security issues, and the move should not be disciplinary in nature unless the resident behavior dictates otherwise).
 - d. Taking of other appropriate precautions, if warranted.
 - e. Conferring with the area administrator/designee, if warranted for advice and consultation. (This needs to be accomplished if there is an allegation of a serious/credible nature where prosecution under MGL Chapter 268, Section 21A could apply).
9. The Area Administrator/designee, if warranted, shall contact the Assistant Superintendent of Human Resources/designee, who if appropriate, will activate the investigation team.
10. All correspondence, incident reports, statements are confidential. Additionally, all questioned or interviewed staff are informed that the investigation is confidential and are directed not to speak to any other staff of residents concerning the subject matter.
11. All findings/conclusions will be reported to the Superintendent/designee and the Human Resources Department.
12. Based on the investigation findings, a referral to the District Attorney (DA) and the Massachusetts State Police may be made.
13. Should the DA decide to pursue criminal charges, they will assign the State Police to do so.
14. The investigation will be prompt, impartial and confidential.

Finding of compliance is based on the following: Policy supports the requirements of the standard. The auditor interviewed the Assistant Superintendent who confirmed that termination is the likely result of sexual abuse, and that licensing bodies would be notified and referral for prosecution would occur. Therefore, as no incident has occurred, the auditor finds this to be sufficient evidence to support a finding of compliance.

Standard 115.277: Corrective action for contractors and volunteers

115.277 (a)

- Is any contractor or volunteer who engages in sexual abuse prohibited from contact with residents? Yes No
- Is any contractor or volunteer who engages in sexual abuse reported to: Law enforcement agencies unless the activity was clearly not criminal? Yes No
- Is any contractor or volunteer who engages in sexual abuse reported to: Relevant licensing bodies? Yes No

115.277 (b)

- In the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer, does the facility take appropriate remedial measures, and consider whether to prohibit further contact with residents? Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

The auditor gathered, reviewed, analyzed and retained the following evidence related to this standard:

- 3.5.3 PREA Plan
- PAQ
- Interview with the Assistant Superintendent

PREA Plan states,

B. Corrective Action for Contractors, Interns, and Volunteers -

- 1. Any contractor, intern, or volunteer who engages in sexual abuse will be prohibited from contact with residents and will be reported to law enforcement agencies (unless the activity was clearly not criminal) and to relevant licensing bodies.*
- 2. The facility will take appropriate remedial measures, and will consider whether to prohibit further contact with residents, in the case of any other violation of Department sexual abuse or sexual harassment policies by a contractor, volunteer, or intern.*

The PAQ indicates that no volunteer or contractor has been removed due to substantiated allegations of sexual abuse or sexual harassment. As such, no volunteer or contractor has been referred to relevant licensing bodies. The auditor found no reason to dispute this during the audit process.

The auditor interviewed the Assistant Superintendent (Warden/Designee) who advised the auditor that in case of any violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer, the facility would take remedial measures to prevent further contact with residents, pending an investigation. The agency would disallow entrance until such time as the investigation is completed.

Finding of compliance is based on the following: Policy supports the requirements of the standard in addition to the interview with the Superintendent. The auditor found sufficient evidence to support a finding of compliance with the standard.

Standard 115.278: Interventions and disciplinary sanctions for residents

115.278 (a)

- Following an administrative finding that a resident engaged in resident-on-resident sexual abuse, or following a criminal finding of guilt for resident-on-resident sexual abuse, are residents subject to disciplinary sanctions pursuant to a formal disciplinary process? Yes No

115.278 (b)

- Are sanctions commensurate with the nature and circumstances of the abuse committed, the resident's disciplinary history, and the sanctions imposed for comparable offenses by other residents with similar histories? Yes No

115.278 (c)

- When determining what types of sanction, if any, should be imposed, does the disciplinary process consider whether a resident's mental disabilities or mental illness contributed to his or her behavior? Yes No

115.278 (d)

- If the facility offers therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse, does the facility consider whether to require the offending resident to participate in such interventions as a condition of access to programming and other benefits? Yes No NA

115.278 (e)

- Does the agency discipline a resident for sexual contact with staff only upon a finding that the staff member did not consent to such contact? Yes No

115.278 (f)

- For the purpose of disciplinary action does a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred NOT constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation? Yes No

115.278 (g)

- If the agency prohibits all sexual activity between residents, does the agency always refrain from considering non-coercive sexual activity between residents to be sexual abuse? (N/A if the agency does not prohibit all sexual activity between residents.) Yes No NA

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

The auditor gathered, reviewed, analyzed and retained the following evidence related to this standard:

- 3.5.3 PREA Plan
- 3.1.4 Disciplinary Plan (WMRWC)
- Resident Handbook
- Interview with the Disciplinary Officer
- PAQ

The PAQ indicates that no resident has been disciplined for substantiated sexual abuse.

PREA Plan states,

C. *Disciplinary Sanctions for Residents* -

1. Residents will be subject to disciplinary sanctions/mandated programming pursuant to a formal disciplinary process following an administrative finding that the resident engaged in resident-on-resident sexual abuse or following a criminal finding of guilt for resident-on-resident sexual abuse.
2. Sanctions will be commensurate with the nature and circumstances of the abuse committed, the resident's disciplinary history, and the sanctions imposed/mandated programming for comparable offenses by other residents with similar histories.
3. The disciplinary process will consider whether an resident's mental disabilities or mental illness contributed to their behavior when determining what type of sanction, if any, should be imposed.
4. The Department may discipline an resident for sexual contact with staff only upon a finding that the staff member did not consent to such contact.
5. For the purpose of disciplinary action, a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred shall not constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation.
6. The HCSD prohibits all sexual activity between residents and will discipline residents for such activity.

3.1.4 Disciplinary Plan (WMRWC) defines sexual misconduct as, *A resident commits this violation when s/he engages in sexual contact with another person or animal. "Sexual contact" means the touching of the sexual or other intimate parts of another for the purpose of gratifying the sexual desire of either party. A resident commits sexual misconduct when his/her sexual behavior becomes a threat to him/herself, others, or to the orderly running of the facility which includes gross and lewd behavior including exposing oneself and making obscene gestures. SANCTIONS: Minimum – Loss of EGT and/or removal to higher security - Maximum – 10 days disciplinary detention.* This is also defined in the Resident Handbook.

The interview with the staff who acts as the Disciplinary Officer confirmed to the auditor that a resident would not be disciplined for sexual misconduct with staff, when the staff consented to it, that sanctions could be withheld pending consultation with mental health staff, and that as noted in the policy, sanctions are commensurate with the act, the resident's prior disciplinary history, and sanctions given to other resident's for similar behavior.

Finding of compliance is based on the following: Policy meets the requirements of the standard. Staff interviews support that residents would be disciplined in accordance with the disciplinary requirements if an investigation was deemed substantiated for sexual abuse or sexual harassment towards another resident.

MEDICAL AND MENTAL CARE

Standard 115.282: Access to emergency medical and mental health services

115.282 (a)

- Do resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services, the nature and scope of which are determined by medical and mental health practitioners according to their professional judgment?
 Yes No

115.282 (b)

- If no qualified medical or mental health practitioners are on duty at the time a report of recent sexual abuse is made, do security staff first responders take preliminary steps to protect the victim pursuant to § 115.262? Yes No
- Do security staff first responders immediately notify the appropriate medical and mental health practitioners? Yes No

115.282 (c)

- Are resident victims of sexual abuse offered timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate? Yes No

115.282 (d)

- Are treatment services provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident? Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

The auditor gathered, reviewed, analyzed and retained the following evidence related to this standard:

- 3.5.3 PREA Plan
- 4.5.9 Special Needs and Services
- SANE Coordinators
- Interview with medical staff
- Interview with mental health staff

3.5.3 PREA Plan states,

B. Access to Emergency Medical and Mental Health Services -

1. Resident victims of sexual abuse shall receive timely, unimpeded access to emergency medical treatment and crisis intervention services, the nature and scope of which are determined by medical and mental health practitioners according to their professional judgment.

2. If no qualified medical or mental health practitioners are on duty at the time a report of recent abuse is made, security staff first responders will take preliminary steps to protect the victim pursuant Protocol 6:B (HCSD Protection Duties) and will immediately notify the appropriate medical and mental health practitioners.

3. Resident victims of sexual abuse while incarcerated will be offered timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate.

4. Treatment services will be provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident.

4.5.9 Special Needs and Services states,

PROTOCOL 8: PROTOCOL IN THE EVENT OF SEXUAL ASSAULT

A. The medical and psychological trauma of a sexual assault are minimized as much as possible by prompt and appropriate health intervention.

B. Victims of sexual assault are referred to a community facility for treatment and the gathering of evidence. The following will be accomplished by the community facility. Also see Policy and Protocol 3.1.7 Special Teams Protocol 3: Criminal Investigative Unit (CIU).

1. A history is taken and qualified health care professionals conduct an examination to document the extent of physical injury and to determine whether referral to another medical facility is indicated. With the victim's consent, the examination includes the collection of evidence from the victim, using a kit approved by the local legal authority.

2. Prophylactic treatment and follow-up care for sexually transmitted or other communicable diseases (e.g., HIV, Hepatitis B) are offered to all victims, as appropriate.

C. Following the physical examination, a referral is made to a qualified mental health professional for crisis intervention counseling and long-term follow-up. Also see Policy and Protocol 3.1.7 Special Teams Protocol 3: Criminal Investigative Unit (CIU).

D. A report is made to the Sheriff/facility administrator and Deputy Chief of Security to effect a separation of the victim from his assailant in their housing assignments and immediately begin a criminal investigation. Also see Policy and Protocol 3.1.7 Special Teams Protocol 3: Criminal Investigative Unit (CIU).

E. A sexual assault is a sexual act that is coercive or assaultive in nature and that involves the use or the threat of force.

(a)

Policy and interviews with the medical and mental health staff confirm that resident victims of sexual abuse shall receive timely, unimpeded access to emergency medical treatment and crisis intervention services, the nature and scope of which are determined by medical and mental health practitioners according to their professional judgment. 4.5.2 Emergency Medical Care confirms, *In order to quickly address emergency medical situations, the facility maintains an Emergency Medical Notification and Response System, providing 24-hour emergency medical, dental, and psychiatric care, which is approved by the health authority and facility administrator.* As supported by 4.5.12 Mental Health Services, *Hampden County Sheriff's Department(HCSD) supports centralized Mental Health Services throughout the department (MI, WCC, WMRWC, PRC). Under the direction of the Clinical Director, each facility, pod or unit has an assigned a MH Clinician to work directly with individuals in need of mental health support or treatment.*

(b)

It was confirmed through interviews that medical staff can be available twenty-four (24)hours, seven days a week (24/7) by accessing staff at the Main Institution (jail). Mental health staff are present on-site during business hours. Crisis services 24/7 can be accessed by accessing the on-call schedule at the Main Institution.

(c)

Policy and interviews with the medical and mental health staff confirm that resident victims of sexual abuse while incarcerated shall be offered timely information about and timely access to sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate. This may occur at the hospital or be provided upon return to the facility.

(d) Policy and interviews with the medical and mental health staff confirm that treatment services shall be provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident.

Finding of compliance is based on the following: Policy addresses the requirements of the standard. The interviews with the medical and mental health director support that medical/mental health care is timely, prophylactic and follow up services would be provided and services would be consistent with community standards. The auditor finds there is sufficient evidence to support a finding of compliance.

Standard 115.283: Ongoing medical and mental health care for sexual abuse victims and abusers

115.283 (a)

- Does the facility offer medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility? Yes No

115.283 (b)

- Does the evaluation and treatment of such victims include, as appropriate, follow-up services, treatment plans, and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody? Yes No

115.283 (c)

- Does the facility provide such victims with medical and mental health services consistent with the community level of care? Yes No

115.283 (d)

- Are resident victims of sexually abusive vaginal penetration while incarcerated offered pregnancy tests? (N/A if “all-male” facility. *Note: in “all-male” facilities, there may be residents who identify as transgender men who may have female genitalia. Auditors should be sure to know whether such individuals may be in the population and whether this provision may apply in specific circumstances.*) Yes No NA

115.283 (e)

- If pregnancy results from the conduct described in paragraph § 115.283(d), do such victims receive timely and comprehensive information about and timely access to all lawful pregnancy-related medical services? (N/A if “all-male” facility. *Note: in “all-male” facilities, there may be residents who identify as transgender men who may have female genitalia. Auditors should be sure to know whether such individuals may be in the population and whether this provision may apply in specific circumstances.*) Yes No NA

115.283 (f)

- Are resident victims of sexual abuse while incarcerated offered tests for sexually transmitted infections as medically appropriate? Yes No

115.283 (g)

- Are treatment services provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident?
 Yes No

115.283 (h)

- Does the facility attempt to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners? Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

The auditor gathered, reviewed, analyzed and retained the following evidence related to this standard:

- 3.5.3 PREA Plan
- 4.5.9 Special Needs and Services
- 4.5.12 Mental Health Services

3.5.3 PREA Plan states,

C. *Ongoing Medical and Mental Health Care for Sexual Abuse Victims and Abusers -*

1. *The facility offers medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility.*
2. *The evaluation and treatment of such victims includes, as appropriate, follow-up services, treatment plans, and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody.*
3. *The facility provides such victims with medical and mental health services consistent with the community level of care.*
4. *Resident victims of sexually abusive vaginal penetration while incarcerated will be offered pregnancy tests.*
5. *If pregnancy results from the conduct described in paragraph (4) of this section, such victims will receive timely and comprehensive information about, and timely access to, all lawful pregnancy-related medical services.*
6. *Resident victims of sexual abuse while incarcerated will be offered tests for sexually transmitted infections as medically appropriate.*
7. *Treatment services will be provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident.*
8. *All facilities will attempt to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners.*

4.5.9 Special Needs and Services states,

PROTOCOL 8: PROTOCOL IN THE EVENT OF SEXUAL ASSAULT

A. *The medical and psychological trauma of a sexual assault are minimized as much as possible by prompt and appropriate health intervention.*

B. Victims of sexual assault are referred to a community facility for treatment and the gathering of evidence. The following will be accomplished by the community facility. Also see Policy and Protocol 3.1.7 Special Teams Protocol 3: Criminal Investigative Unit (CIU).

1. A history is taken and qualified health care professionals conduct an examination to document the extent of physical injury and to determine whether referral to another medical facility is indicated. With the victim's consent, the examination includes the collection of evidence from the victim, using a kit approved by the local legal authority.

2. Prophylactic treatment and follow-up care for sexually transmitted or other communicable diseases (e.g., HIV, Hepatitis B) are offered to all victims, as appropriate.

C. Following the physical examination, a referral is made to a qualified mental health professional for crisis intervention counseling and long-term follow-up. Also see Policy and Protocol 3.1.7 Special Teams Protocol 3: Criminal Investigative Unit (CIU).

D. A report is made to the Sheriff/facility administrator and Deputy Chief of Security to effect a separation of the victim from his assailant in their housing assignments and immediately begin a criminal investigation. Also see Policy and Protocol 3.1.7 Special Teams Protocol 3: Criminal Investigative Unit (CIU).

E. A sexual assault is a sexual act that is coercive or assaultive in nature and that involves the use or the threat of force.

(a)

Policies and interviews with the medical and mental health staff confirm the facility offers medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse while housed at their facilities.

(b)

Policies and interviews with the medical and mental health staff confirm the evaluation and treatment of such victims shall include, as appropriate, follow-up services, treatment plans, and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody.

(c)

Policies and interviews with the medical and mental health staff confirm that the facility provides victims with medical and mental health services consistent with the community level of care.

(d)

Not applicable to this facility as they do not house female offenders.

(e)

Not applicable to this facility as they do not house female offenders.

(f)

Policies and interviews with the medical and mental health staff confirm resident victims of sexual abuse while incarcerated shall be offered tests for sexually transmitted infections as medically appropriate.

(g)

Policy and interviews with the medical and mental health staff confirm that treatment services shall be provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident.

(h)

Not applicable to this facility as it is a jail.

Finding of compliance is based on the following: Policy addresses the requirements of the standard. The interviews with the medical and mental health director support that medical/mental health care is timely, and that prophylactic and follow up services would be provided and services would be consistent with community standards. The auditor finds there is sufficient evidence to support a finding of compliance.

DATA COLLECTION AND REVIEW

Standard 115.286: Sexual abuse incident reviews

115.286 (a)

- Does the facility conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation, including where the allegation has not been substantiated, unless the allegation has been determined to be unfounded? Yes No

115.286 (b)

- Does such review ordinarily occur within 30 days of the conclusion of the investigation? Yes No

115.286 (c)

- Does the review team include upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners? Yes No

115.286 (d)

- Does the review team: Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse? Yes No
- Does the review team: Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; gang affiliation; or other group dynamics at the facility? Yes No
- Does the review team: Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse? Yes No
- Does the review team: Assess the adequacy of staffing levels in that area during different shifts? Yes No
- Does the review team: Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff? Yes No
- Does the review team: Prepare a report of its findings, including but not necessarily limited to determinations made pursuant to §§ 115.286(d)(1) - (d)(5), and any recommendations for improvement and submit such report to the facility head and PREA compliance manager? Yes No

115.286 (e)

- Does the facility implement the recommendations for improvement, or document its reasons for not doing so? Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

The auditor gathered, reviewed, analyzed and retained the following evidence related to this standard:

- 3.5.3 PREA Plan
- Incident Review form
- Interview with the Assistant Superintendent
- Interview with the Incident Review Team Member
- Interview with the PREA Coordinator

3.5.3 PREA Plan states, *PROTOCOL 10: DATA COLLECTION AND REVIEW*

A. *Sexual Abuse Incident Reviews-*

1. *The facility conducts a sexual abuse incident review at the conclusion of every sexual abuse investigation, including where the allegation has not been substantiated, unless the allegation has been determined to be unfounded.*
2. *These reviews ordinarily occur within thirty (30) days of the conclusion of the investigation.*
3. *The review team includes upper-level management officials, line supervisors, investigators, and medical or mental health practitioners.*
4. *The review team will:*
 - a. *Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse;*
 - b. *Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; or gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility;*
 - c. *Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse;*
 - d. *Assess the adequacy of staffing levels in that area during different shifts;*
 - e. *Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff; and*
 - f. *Complete a report of its findings, including but not necessarily limited to determinations made pursuant to paragraphs (4)(a)-(4)(e) of this section, and any recommendations for improvement and submit the report to the facility Superintendent, PREA Coordinator, and facility PREA Manager.*
5. *The facility will implement the recommendations for improvement or will document its reasons for not doing so.*

(a)(b) (c) (d) (e)

The auditor interviewed members of the PREA team. They confirmed that the incident review team does review all instances of sexual abuse, within 30 days of the investigation. The auditor reviewed the PREA Incident Review form. The form requires the review of the following: (1)is there a need to change policy or practice,(2) was the incident motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; or gang affiliation; or was motivated or

otherwise caused by other group dynamics at the facility; (3) an examination of the area; (4) staffing levels, (5) monitoring technology, and (6) recommendations for improvement.

Finding of compliance is based on the following: Policy supports the requirements of the standard. The form used (policy attachment) compels the team to address the areas required, review of completed forms supported this is occurring. The interviews with staff on the team confirmed they are conducting the meetings as required. Therefore, there is sufficient evidence for the auditor to support a finding of compliance.

Standard 115.287: Data collection

115.287 (a)

- Does the agency collect accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions? Yes No

115.287 (b)

- Does the agency aggregate the incident-based sexual abuse data at least annually? Yes No

115.287 (c)

- Does the incident-based data include, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice? Yes No

115.287 (d)

- Does the agency maintain, review, and collect data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews? Yes No

115.287 (e)

- Does the agency also obtain incident-based and aggregated data from every private facility with which it contracts for the confinement of its residents? (N/A if agency does not contract for the confinement of its residents.) Yes No NA

115.287 (f)

- Does the agency, upon request, provide all such data from the previous calendar year to the Department of Justice no later than June 30? (N/A if DOJ has not requested agency data.) Yes No NA

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

Does Not Meet Standard (*Requires Corrective Action*)

The auditor gathered, reviewed, analyzed and retained the following evidence related to this standard:

- 3.5.3 PREA Plan
- SSV 2019
- Annual PREA reports
- Interview with the PREA Coordinator
- Interview with the Assistant Superintendent

3.5.3 PREA Plan states,

1. *The HCSD collects accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using the PREA, Trax Casemanagement, HealthTrax, and SOU databases.*
2. *The incident-based data is collected at least annually and will include, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence (SSV) conducted by the Department of Justice.*
3. *The Department will maintain, review, and collect data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews.*
4. *The Department also obtains incident-based and aggregated data from every private facility with which it contracts for the confinement of its residents.*
5. *Upon request, the Department will provide all such data from the previous calendar year to the Department of Justice no later than June 30.*

(a)

The agency collects uniform data using the following definitions noted in the 3.5.3 PREA Plan:

Substantiated Allegation: An allegation that was investigated and determined to have occurred.

Unfounded Allegation: An allegation that was investigated and determined not to have occurred.

Unsubstantiated Allegation: An allegation that was investigated and the investigation produced insufficient evidence to make a final determination as to whether or not the event occurred.

Nonconsensual Sexual Act: Sexual contact of any person without his or her consent, or of a person who is unable to consent or refuse; contact between the penis and the vulva or the penis and the anus including penetration, however slight; contact between the mouth and the penis, vulva, or anus; or penetration of the anal or genital opening of another person, however slight, by a hand, finger, object, or other instrument.

Abusive Sexual Contact: Sexual contact of any person without his or her consent, or of a person who is unable to consent or refuse; intentional touching, either directly or through the clothing, of the genitalia, anus, groin, breast, inner thigh, or buttocks of any person. Exclude incidents in which the contact was incidental to a physical altercation.

Sexual Harassment: Repeated and unwelcome sexual advances, requests for sexual favors, or verbal comments, gestures, or actions of a derogatory or offensive sexual nature by one resident directed toward another or repeated verbal statements, comments or gestures of a sexual nature to an resident by an employee, volunteer, contractor, official visitor, or other agency representative (exclude family, friends, or other visitors). Include— Demeaning references to gender; or sexually suggestive or derogatory comments about body or clothing; repeated profane or obscene language or gestures.

Sexual Misconduct: Any behavior or act of a sexual nature directed toward an resident by an employee, volunteer, contractor, official visitor or other agency representative (exclude family, friends or other visitors). Sexual relationships of a romantic nature between staff and residents are included in this definition. Consensual or nonconsensual sexual acts include— Intentional touching, either directly or through the clothing, of the genitalia, anus, groin, breast, inner thigh, or buttocks that is unrelated to official duties or with the intent to abuse, arouse, or gratify sexual desire; completed, attempted, threatened, or requested sexual acts; occurrences of indecent exposure, invasion of privacy, or staff voyeurism for reasons unrelated to official duties or for sexual gratification.

(b)

An annual report is available on the facility webpage for 2015, 2016, 2017, 2018 and 2019. A copy of the 2020 Annual report was provided to the auditor.

(c)

These definitions conform to those on the Survey of Sexual Victimization.

(d)

Per the interview with the PREA Coordinator, this information is maintained, reviewed and collected from all incident-based documents such as reports, investigations and sexual abuse incident reviews.

(e)

This facility/agency does not contract with private facilities for the confinement of residents.

(f)

The last SSV requested by the Department of Justice was in 2019, a copy was provided to the auditor.

Finding of compliance is based on the following: Policy, review of the Annual reports, and interview with the PREA Coordinator and Assistant Superintendent support that the facility maintains appropriate documentation, reviews and analyses the information, and makes efforts towards improvement on an annual basis; therefore, providing sufficient evidence to support a finding of compliance.

Standard 115.288: Data review for corrective action

115.288 (a)

- Does the agency review data collected and aggregated pursuant to § 115.287 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Identifying problem areas? Yes No
- Does the agency review data collected and aggregated pursuant to § 115.287 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Taking corrective action on an ongoing basis? Yes No
- Does the agency review data collected and aggregated pursuant to § 115.287 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Preparing an annual report of its findings and corrective actions for each facility, as well as the agency as a whole? Yes No

115.288 (b)

- Does the agency's annual report include a comparison of the current year's data and corrective actions with those from prior years and provide an assessment of the agency's progress in addressing sexual abuse? Yes No

115.288 (c)

- Is the agency's annual report approved by the agency head and made readily available to the public through its website or, if it does not have one, through other means? Yes No

115.288 (d)

- Does the agency indicate the nature of the material redacted where it redacts specific material from the reports when publication would present a clear and specific threat to the safety and security of a facility? Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

The auditor gathered, reviewed, analyzed and retained the following evidence related to this standard:

- 3.5.3 PREA Plan
- Annual PREA reports
- Agency website <http://hcsdma.org/public-resources/prea/>
- Interview with the Assistant Superintendent
- Interview with the PREA Coordinator
- Interview with the PREA Manager

3.5.3 PREA Plan states,

C. *Data Review for Corrective Action -*

1. *The HCSD reviews data collected and aggregated pursuant to Protocol 10:B (Data Collection) in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by:*

- a. *Identifying problem areas;*
- b. *Taking corrective action on an ongoing basis; and*
- c. *Preparing an annual report of its findings and corrective actions for each facility, as well as the Department as a whole.*

2. *The Department's report will be approved by the Sheriff or designee and made available to the public through its website.*

3. *These reports will include a comparison of the current year's data and corrective actions with those from prior years and will provide an assessment of the Department's progress in addressing sexual abuse.*

4. *The Department will redact specific material from the reports when publication would present a clear and specific threat to the safety and security of the HCSD's facilities, but must indicate the nature of the material redacted.*

(a)

The annual reports reflect the review of data collected and aggregated for the calendar year. A paragraph is provided to reflect on corrective action and continued compliance and improved effectiveness with complying with the PREA standards.

(b)

The report did not include a comparison of current year to previous years statistics. The facility corrected by revising the previous report and sending the newer version to the auditor.

(c)

The interview with the Assistant Superintendent confirmed that he and the Sheriff approve the report before it is published, as required by the policy. The auditor accessed the report which is available for review on the agency website.

(d)

No redactions were required on the Corrective Action Plan.

Finding of compliance is based on the following: Policy supports the requirements of the standard. The updated Annual report provides a comparison of each year to the previous year. The interview with the PREA Coordinator and the Assistant Superintendent support that the requirements of the standards are addressed annually, the report is approved by the agency head (Sheriff). The auditor finds sufficient evidence to support a finding of compliance.

Standard 115.89: Data storage, publication, and destruction

115.89 (a)

- Does the agency ensure that data collected pursuant to § 115.87 are securely retained?
 Yes No

115.89 (b)

- Does the agency make all aggregated sexual abuse data, from facilities under its direct control and private facilities with which it contracts, readily available to the public at least annually through its website or, if it does not have one, through other means? Yes No

115.89 (c)

- Does the agency remove all personal identifiers before making aggregated sexual abuse data publicly available? Yes No

115.89 (d)

- Does the agency maintain sexual abuse data collected pursuant to § 115.87 for at least 10 years after the date of the initial collection, unless Federal, State, or local law requires otherwise? Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

The auditor gathered, reviewed, analyzed and retained the following evidence related to this standard:

- 3.5.3 PREA Plan
- <http://hcsdma.org/public-resources/prea/>
- Interview with the PREA Coordinator

3.5.3 PREA Plan states,

D. Data Storage, Publication, and Destruction -

1. *The HCSD will ensure that data collected pursuant to Protocol 10:B (Data Collection) is securely retained.*
2. *The Department will make all aggregated sexual abuse data, readily available to the public at least annually through its website.*
3. *Before making aggregated sexual abuse data publicly available, the Department will remove all personal identifiers.*
4. *The Department will maintain sexual abuse data collected pursuant to Protocol 10:B (Data Collection) for at least 10 years after the date of the initial collection unless Federal, State, or Local law requires otherwise.*

(a)

Policy and the interview with the PREA Coordinator confirm that data collected is securely retained. The investigator (CIU Commander) ensures files are secured in his office, other information is retained securely in the TRAX or JMS system.

(b)

Annual reports are available on the website for 2014, 2015, 2016, 2017, and 2018. As stated, this agency does not contract with private agencies.

(c)

No information in the report required redaction.

(d)

The agency maintains sexual abuse data collected pursuant to § 115.87 for at least 10 years after the date of the initial collection unless Federal, State, or local law requires otherwise, in accordance with policy and confirmed during the interview with the PREA Coordinator.

Finding of compliance is based on the following: Policy, review of the annual reports found on the agency website, and the interview with the PREA Coordinator supports that there is sufficient evidence for a finding of compliance.

AUDITING AND CORRECTIVE ACTION

Standard 115.401: Frequency and scope of audits

115.401 (a)

- During the prior three-year audit period, did the agency ensure that each facility operated by the agency, or by a private organization on behalf of the agency, was audited at least once? (*Note: The response here is purely informational. A "no" response does not impact overall compliance with this standard.*) Yes No

115.401 (b)

- Is this the first year of the current audit cycle? (*Note: a "no" response does not impact overall compliance with this standard.*) Yes No

- If this is the second year of the current audit cycle, did the agency ensure that at least one-third of each facility type operated by the agency, or by a private organization on behalf of the agency, was audited during the first year of the current audit cycle? (N/A if this is **not** the *second* year of the current audit cycle.) Yes No NA
- If this is the third year of the current audit cycle, did the agency ensure that at least two-thirds of each facility type operated by the agency, or by a private organization on behalf of the agency, were audited during the first two years of the current audit cycle? (N/A if this is **not** the *third* year of the current audit cycle.) Yes No NA

115.401 (h)

- Did the auditor have access to, and the ability to observe, all areas of the audited facility? Yes No

115.401 (i)

- Was the auditor permitted to request and receive copies of any relevant documents (including electronically stored information)? Yes No

115.401 (m)

- Was the auditor permitted to conduct private interviews with residents? Yes No

115.401 (n)

- Were residents permitted to send confidential information or correspondence to the auditor in the same manner as if they were communicating with legal counsel? Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

(a) During the three-year period starting on August 20, 2013, and during each three-year period thereafter, the agency shall ensure that each facility operated by the agency, or by a private organization on behalf of the agency, is audited at least once. (b) During each one-year period starting on August 20, 2013, the agency shall ensure that at least one-third of each facility type operated by the agency, or by a private organization on behalf of the agency, is audited.

Hampden County Sheriff's Office Western Mass. Recovery and Wellness Center is one of five facilities operated by the Sheriff's Office. This is the second audit.

(c) The Department of Justice may send a recommendation to an agency for an expedited audit if the Department has reason to believe that a particular facility may be experiencing problems relating to

sexual abuse. The recommendation may also include referrals to resources that may assist the agency with PREA-related issues.

No referral or recommendation has been made by the Department of Justice regarding this facility.

(d) The Department of Justice shall develop and issue an audit instrument that will provide guidance on the conduct of and contents of the audit.

The PREA Resource Audit Instrument used for Adult Prisons and Jails is furnished by the National PREA Resource Center. This tool includes the following: A) Pre-Audit Questionnaire; B) the Auditor Compliance Tool; C) Instructions for the PREA Audit Tour; D) the Interview Protocols; E) the Auditor's Summary Report; F) the Process Map; and G) the Checklist of Documentation. In addition, the Auditor Handbook 2021 was used to guide the audit process.

(e) The agency shall bear the burden of demonstrating compliance with the standards. **Documentation used to support compliance was provided by the agency/facility.**

(f) The auditor shall review all relevant agency-wide policies, procedures, reports, internal and external audits, and accreditations for each facility type. **See comments in the report.**

(g) The audits shall review, at a minimum, a sampling of relevant documents and other records and information for the most recent one-year period. **See comments in the report.**

(h) The auditor shall have access to, and shall observe, all areas of the audited facilities. **See comments in the report.**

(i) The auditor shall be permitted to request and receive copies of any relevant documents (including electronically stored information). **The auditor was not denied access to or copies of any documents requested.**

(j) The auditor shall retain and preserve all documentation (including, e.g., video tapes and interview notes) relied upon in making audit determinations. Such documentation shall be provided to the Department of Justice upon request. **The auditor has retained documents used to determine compliance.**

(k) The auditor shall interview a representative sample of residents, residents, and detainees, and of staff, supervisors, and administrators. **See report – methodology.**

(l) The auditor shall review a sampling of any available videotapes and other electronically available data (e.g., Watchtour) that may be relevant to the provisions being audited.

The auditor was able to view and analyze video monitoring stations at the facility.

(m) The auditor shall be permitted to conduct private interviews with residents, residents, and detainees.

The auditor was allowed to conduct private interviews with residents, and staff.

(n) Residents, residents, and detainees shall be permitted to send confidential information or correspondence to the auditor in the same manner as if they were communicating with legal counsel.

Posters were visible during the audit. The auditor asked residents if they saw the posters and/or were aware of the audit. Most did not indicate yes but were not concerned about sexual abuse or sexual harassment. No confidential correspondence letter was received from staff or residents.

(o) Auditors shall attempt to communicate with community-based or victim advocates who may have insight into relevant conditions in the facility. **The auditor communicated with two victim advocacy organizations via email exchange. Comments are noted in the report.**

Standard 115.403: Audit contents and findings

115.403 (f)

- The agency has published on its agency website, if it has one, or has otherwise made publicly available. The review period is for prior audits completed during the past three years PRECEDING THIS AGENCY AUDIT. The pendency of any agency appeal pursuant to 28 C.F.R. § 115.405 does not excuse noncompliance with this provision. (N/A if there have been no Final Audit Reports issued in the past three years, or in the case of single facility agencies that there has never been a Final Audit Report issued.) Yes No NA

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

(a) Each audit shall include a certification by the auditor that no conflict of interest exists with respect to his or her ability to conduct an audit of the agency under review. – **noted in report**

(b) Audit reports shall state whether agency-wide policies and procedures comply with relevant PREA standards - **noted in report**

(c) For each PREA standard, the auditor shall determine whether the audited facility reaches one of the following findings: 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). The audit summary shall indicate, among other things, the number of provisions the facility has achieved at each grade level. – **noted in report**

(d) Audit reports shall describe the methodology, sampling sizes, and basis for the auditor's conclusions with regard to each standard provision for each audited facility and shall include recommendations for any required corrective action. – **noted in report**

(e) Auditors shall redact any personally identifiable resident or staff information from their reports but shall provide such information to the agency upon request and may provide such information to the Department of Justice. **No redactions required**

(f) The agency shall ensure that the auditor's final report is published on the agency's website if it has one or is otherwise made readily available to the public. **See policy and interview with Facility PREA Coordinator.**

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 resident or staff member, except where the names of administrative personnel are specifically requested in the report template.

Amy J. Fairbanks

Auditor Signature

Date: December 9, 2021