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

☐ **Interim** ☒ **Final**

Date of Report September 11, 2018

Auditor Information

Name: Louis Folino	**Email:** lsf168@verizon.net
Company Name: Louis Folino LLC	
Mailing Address: 168 Big Horn Rd	**City, State, Zip:** Pittsburgh, PA 15239
Telephone: 412-354-1557	**Date of Facility Visit:** August 6-8th, 2018

Agency Information

Name of Agency: Hampden County Sheriff's Department		**Governing Authority or Parent Agency** *(If Applicable)*: Click or tap here to enter text.	
Physical Address: 627 Randall Road, Ludlow, MA 01056Click or tap here to enter text.		**City, State, Zip:**	
Mailing Address: 627 Randall Road, Ludlow MA 01056		**City, State, Zip:** Click or tap here to enter text.	
Telephone: **413-547-8000** Click or tap here to enter text.		**Is Agency accredited by any organization?** ☒ Yes ☐ No	
The Agency Is:	☐ Military	☐ Private for Profit	☐ Private not for Profit
☐ Municipal	☒ County	☐ State	☐ Federal
Agency mission: 1.1.1. Mission Statement Policy			
Agency Website with PREA Information: http://hcsdma.org/			

Agency Chief Executive Officer

Name: Nicholas Cocchi	**Title:** Sheriff
Email: Nicholas.Cocchi@sdh.state.ma.us	**Telephone:** 413-547-8000 ext. 2101

Agency-Wide PREA Coordinator

Name: Mary Baker	**Title:** ADS Standards, Health and Safety

Email: Mary.Baker@sdh.state.ma.us	**Telephone:** 413-547-8000 ext. 2914
PREA Coordinator Reports to: Mike Colbert, Assistant Superintendent of Housing	**Number of Compliance Managers who report to the PREA Coordinator** 5

Facility Information

Name of Facility:	Western Massachusetts Recovery and Wellness Center (WMRWC)			
Physical Address:	155 Mill Street, Springfield, MA 01101 Click or tap here to enter text.			
Mailing Address (if different than above):	Click or tap here to enter text.			
Telephone Number:	413-886-0110			
The Facility Is:	☐ Military	☐ Private for Profit	☐ Private not for Profit	
☐ Municipal	☒ County	☐ State	☐ Federal	
Facility Type:	☒ Community treatment center	☐ Halfway house	☐ Restitution center	
	☐ Mental health facility	☐ Alcohol or drug rehabilitation center		
	☐ Other community correctional facility			
Facility Mission:	1.1.1. Mission Statement Policy			
Facility Website with PREA Information:	http://hcsdma.org/			
Have there been any internal or external audits of and/or accreditations by any other organization?	☒ Yes ☐ No			

Director

Name: Anthony Scibelli	**Title:** Assistant Superintendent
Email: Anthony.Scibelli@sdh.state.ma.us	**Telephone:** 413-886-0110 ext. 3132

Facility PREA Compliance Manager

Name: Tina Mole	**Title:** Standards and Training Coordinator Click or tap here to enter text.
Email: Tina.Mole@sdh.state.ma.us	**Telephone:** 413-886-0110 ext. 3237

Facility Health Service Administrator

Name: Richard Brathwaite	**Title:** Health Services Administrator
Email: Rich.Brathwaite@sdh.state.ma.us	**Telephone:** 413-858-0344

Facility Characteristics

Designated Facility Capacity: 149	**Current Population of Facility:** 92		
Number of residents admitted to facility during the past 12 months			447
Number of residents admitted to facility during the past 12 months who were transferred from a different community confinement facility:			76
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 30 days or more:			430
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 72 hours or more:			447
Number of residents on date of audit who were admitted to facility prior to August 20, 2012:			0
Age Range of Population: 18-76	☒ Adults Click or tap here to enter text.	☐ Juveniles Click or tap here to enter text.	☐ Youthful residents Click or tap here to enter text.
Average length of stay or time under supervision:			3 months
Facility Security Level: Minimum			Minimum
Resident Custody Levels: Minimum			Minimum
Number of staff currently employed by the facility who may have contact with residents:			87
Number of staff hired by the facility during the past 12 months who may have contact with residents:			7
Number of contracts in the past 12 months for services with contractors who may have contact with residents:			9

Physical Plant

Number of Buildings: 1	**Number of Single Cell Housing Units:** 0
Number of Multiple Occupancy Cell Housing Units:	0
Number of Open Bay/Dorm Housing Units:	5

Description of any video or electronic monitoring technology (including any relevant information about where cameras are placed, where the control room is, retention of video, etc.): Monitoring cameras located on all 3 floors, with respective security CCTV monitoring stations. Additional monitoring station located in Captain's Office. Cameras strategically placed on exterior of building providing camera coverage of recreation areas/entrances/exits. System has retrieval/record capability, and retention reported to be 45 days. Click or tap here to enter text.

Medical

Type of Medical Facility:	Medical Department/Community based referrals
Forensic sexual assault medical exams are conducted at:	Baystate Medical Center, Springfield, MA

Other

Number of volunteers and individual contractors, who may have contact with residents, currently authorized to enter the facility:	88
Number of investigators the agency currently employs to investigate allegations of sexual abuse:	8

Audit Findings

Audit Narrative

The auditor's description of the audit methodology should include a detailed description of the following processes during the pre-onsite audit, onsite audit, and post-audit phases: documents and files reviewed, discussions and types of interviews conducted, number of days spent on-site, observations made during the site-review, and a detailed description of any follow-up work conducted during the post-audit phase. The narrative should describe the techniques the auditor used to sample documentation and select interviewees, and the auditor's process for the site review.

A Prison Rape Elimination Act, PREA, audit of the Hampden County Sheriff's Department (HCSD), was conducted from August 6 thru August 8, 2018. The purpose of the audit of the Western Massachusetts Recovery and Wellness Center (WMRWC), located in Springfield, Massachusetts, was to determine facility compliance with the PREA standards which became effective August 20, 2012.

The HCSD administrative staff, facility personnel and the auditor, Louis S. Folino, conducted an entrance meeting in the facility Administrative Conference Room the first morning of the on-site review. In attendance were HCSD leadership officials: Superintendent James Kelleher, Assistant Superintendent of Special Departments Kevin Crowley, Assistant Deputy Superintendent of Standards, Health and Safety/PREA Coordinator (PC) Mary Baker, and Standards and Training Director Matthew Roman. WMRWC leadership officials attending the meeting included: Classification Manager/Director Elizabeth Hanna, Standards and Training Coordinator/PREA Compliance Manager (PCM) Tina Mole, Mental Health Manager Helen Gannon, Registered Nurse Supervisor Maureen Marotte, Programs Manager Joanne Burke, Unit Manager Karen Dean, Unit Manager Sherly Gaynor, Unit Manager/Day Reporting Director Kathleen McBride, Unit Supervisor Aracelis Fargas, Lieutenant Kevin Sloat, and Correctional Officer Casey Mastay. Auditor notes the audit introductory dinner meeting scheduled for the evening prior was cancelled due to auditors' flight cancellation/delays en route to Massachusetts.

Following staff and auditor introductions, auditor reviewed the comprehensive practice-based audit processes and the triangulation of compiling the information, Site Review observations and interview results in order to verify the agency's compliance with the PREA standards. Auditor discussed the very tentative schedule for the week, emphasizing the priorities to be targeted for our team during the first two days in order to successfully conclude the audit on the third day. The auditor reviewed the facility and auditors progress completed to-date during the pre-audit phase. Auditor provided an overview of the post-audit evidence review and report compilation phase, discussing the Interim or Final Report procedures, corrective action period and timelines.

Following the entrance meeting, auditor commenced a thorough Site Review of all facility areas, beginning on the Third Floor (male Units 5 and 6), Second Floor (Male Units 3 and 4), First Floor (female Units 1 and 2), and Ground Floor (Maintenance, Laundry, Food Service and Resident Dining, Classrooms, Library, Staff Offices and Recreation Room. The site review included the Intake area, Medical Department, Lobby, Visiting, Control Station/Captains Office, Administrative Offices, outdoor recreation/yard areas, and facility entrance/staff parking lot.

During Site Review auditor greeted all staff encountered and engaged numerous residents and personnel informally, i.e. 13 residents and 22 personnel. Auditor observed posted PREA signage, Hotline numbers posted on the resident telephones, video monitoring cameras and CCTV control areas, and evaluated for blind spots, staff supervision presence, and resident accountability. Auditor observed appropriate resident bathroom/shower areas maintained in all the housing units. Auditor witnessed individual gender announcements being made during the site review and throughout the audit week. Auditor observed staff and resident interaction and the positive and comfortable established culture of the facility. During on-site review, auditor observed the auditor's June 25, 2018 Notice of Audit, posted prominently in all housing units and other common areas, in English and Spanish. Auditor notes he did not receive any confidential correspondence from any resident, prior-to or subsequent-to the audit, as of September 11, 2018.

Auditor conducted a total of 32 interviews of randomly selected personnel and those specialized staff required to be interviewed based upon audit protocols. Interviews included full-time, seasonal/summer help, 2 contracted staff (one Transport and one Mentor), a volunteer, and one intern. In addition, auditor interviewed by telephone 2 community officials, i.e. the Director of Support Programs at the Western Massachusetts YWCA, and the MA Department of Public Health Western Region SANE Coordinator.

Interviews were conducted of security staff on all three shifts, and included a representation of various ranks/classifications, genders and race. Consistent and thorough interview responses indicate staff are highly trained and knowledgeable concerning the agency's zero tolerance policy, their first responder duties, mandatory reporting, proper notifications/communications and search methods. Uniformed staff were professionally attired and evidence facility and agency pride. The spirit of teamwork and a strong sense of camaraderie was evident among agency personnel, to include the contracted staff, summer-help, volunteer and the intern interviewed. Auditor noted that personnel were not only very familiar with their own duties and responsibilities concerning PREA, but many had acquired a considerable awareness of other employee's/department's areas of responsibility. Auditor found staff to be enthusiastic to speak with auditor concerning the agency's PREA efforts and practices, and their facility operations and programs.

Auditor interviewed 19 total residents selected by the auditor. Resident interviews consisted of 10 random; 3 Limited English Proficient (LEP); 2 mental health/cognitive disability; 1 LGBTI; 2 disabled and 1 Reporter of Prior Victimization. There were no residents available to interview in the facility that had reported a sexual abuse. No residents under the age of 18 are confined to correctional facilities or jails in Massachusetts but are referred to the Department of Youth Services (DYS). Auditor interviewed White, Black and Hispanic residents, and residents from every housing unit. The 18 residents interviewed consisted of Massachusetts Department of Corrections (MADOC) residents, and Hampden County or other area county residents. Residents transferred to WMRWC from the HCSD MI and from WCC were also interviewed. Responses received from the resident population indicate that the residents feel sexually safe at the facility, with multiple residents expressing appreciation for the programming at the facility and the caring nature of the personnel. The residents are clearly receiving the PREA education; are being properly assessed for victimization and abusiveness; and are informed of the multiple methods of reporting available to them. Resident interviews indicate that they have no hesitation to report such sexual abuse or sexual harassment to agency personnel, which evidences the maintenance of a quality correctional environment. Auditor found the clear majority of residents' cooperative and relaxed during interviews. It was inspiring for this auditor to spend time with so many residents that expressed sincere recognition for the agency services, for their ability to participate in

those services and for their sharing of the personal growth and awareness resulting from their time at the WMRWC. No resident declined to be interviewed.

The Out-Brief with Sheriff Cocchi, 24 of his agency leadership staff, WMRWC administrative, supervisory, uniformed and non-uniformed line staff and a contracted employee was conducted on the afternoon of August 8, 2018. During Out-Brief, auditor provided a status report on the week's activities, and thanked the Administration, the PREA Team, and all staff that courteously accommodated auditor's many requests during the week. Auditor described the evidence review of the PAQ with supportive documentation, Auditor Compliance Tool (ACT), site-review notes, and staff and resident interviews which will now be further scrutinized by auditor. Auditor will thoroughly and objectively review the individual standards in order to satisfy a Meets, Exceeds or Does Not Meet rating. At the time of exit, auditor has not encountered any major areas of concern to share with personnel, at this time. As we work thru the standards' review, auditor discussions and report compilation, auditor will be in close and frequent communication with the PCM. Within 45 days, auditor will provide the agency with either an Interim or Final Report, dependent upon standards' compliance. Only if areas of concern were identified that did not meet the requirements of the PREA standards and are not addressed within the 45-day period will the agency then enter a corrective action period.

The auditor wishes to thank Sheriff Cocchi and his PREA Team for their cooperation and assistance throughout the audit process. The organization and presentation of documentation during the pre-audit phase and the effective facilitation of the Site Review enabled auditor to conduct a very efficient and thorough audit. The auditor would like to recognize Mary Baker, Matt Roman and Tina Mole, particularly, for their experienced and dedicated efforts in preparing for the audit, functioning as PREA officials in various capacities for their agency, and in effectively working together as a team with auditor to accomplish all onsite objectives. The core PREA Team at the HCSD has effectively implemented the agency's policy (PREA PLAN 3.5.3), and strategies designed to prevent, detect and respond to sexual abuse and sexual harassment within their facilities. Buy-in by agency personnel to the Prison Rape Elimination Act was evident to auditor, and reflected in the various employee's interview responses, the observed performance and positive attitudes of staff and the effective results achieved by the agency since implementation of PREA, and activation of the new WMRWC site.

Following three full, long days conducting on-site review, auditor departed the WMRWC and commenced a detailed evidence review and report compilation. Agency PREA staff continued to be responsive to auditor's needs in providing additional confirming documentation, clarifying facility procedures and practices, and supplying supportive information relevant to standard's compliance.

Auditor is pleased to provide the following Final Report. With assistance and prompt facilitation by many agency personnel, auditor accomplished both on-site and post-audit tasks in an efficient manner. It has been a pleasure to work together with such a large group of dedicated corrections professionals. Agency efforts to implement PREA to enhance inmate safety were evident to auditor during policy review, staff and inmate interviews, on-site observations, review of the investigations conducted, review of the many detailed training curriculums, and observing the intake processing/orientations conducted in my presence. Largely, through the maintenance of a safe, secure, orderly, humane and productive working and living environment, the facility has established a harmonious culture, while still maintaining all required security controls in an appropriate community confinement setting. Such a positive culture, absent institutional tension, promotes resident compliance and cooperation, and employee compliance, cooperation and job satisfaction. Auditor extends his appreciation and Congratulations to all agency and facility personnel.

Facility Characteristics

The auditor's description of the audited facility should include details about the facility type, demographics and size of the inmate, resident or detainee population, numbers and type of staff positions, configuration and layout of the facility, numbers of housing units, description of housing units including any special housing units, a description of programs and services, including food service and recreation. The auditor should describe how these details are relevant to PREA implementation and compliance.

The Western Massachusetts Correctional Alcohol Center (WMCAC) was relocated to its current site and renamed the Western Massachusetts Recovery and Wellness Center (WMRWC) in December 2016. The name change is reflective of the programming and services provided to address the needs of its population. The facility is a minimum security, community based, residential treatment facility. WMRWC is located in the city of Springfield, Massachusetts, within minutes of the HCSD Main Institution, Pre-Release Center, Women's Correctional Center, Baystate Medical Center and the Western Massachusetts YWCA.

The Western Massachusetts Recovery & Wellness Center 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 MADOC residents. This facility is a three-story leased (10- year lease) building with the interior totally renovated to securely house 100+ residents in a suitable community confinement setting. 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. On the first day of the on- site audit the facility housed a total of 92 residents (19 female and 73 male). The basement floor of the facility contains the Maintenance Department, Laundry, Food Service and Resident Dining, Classroom, Library and Recreation Room.

On a separate wing on the 2nd Floor, beginning the week of May 14, 2018, WMRWC began housing male Section 35 residents in Unit 3. Section 35 residents are voluntary, civilian/non-criminal residents participating in the WMRWC drug and alcohol programming separately from the other facility residents. The facility constructed a hallway wall prior to receiving the Section 35 residents, to effectively segregate them from the criminally committed residents. Movement, dining, recreation procedures and schedules have been modified to prevent interaction with the other floor/facility residents. Section 35 residents utilize the rear unit stairwell exclusively, to prevent contact with the other residents. Nonetheless, the HCSD and WMRWC provide the same intake processing and PREA orientation for these civilian residents. Identical security monitoring equipment is utilized, with the Section 35 unit evidencing the posting of PREA posters and Hotline phone numbers on the resident telephones. The unit residents were not a subject of auditor's formal audit, but auditor completed a site review of the Section 35 unit and determined that sufficient physical barriers and operational procedures have been implemented to ensure the required separation of the Section 35 residents, and compliance with PREA (posters, showers/toilets, supervision).

The treatment program at WMRWC is organized into three phases – Orientation, 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. A cornerstone of treatment at WMRWC is the Escort Program. Through this program, those who have been residents for a minimum of twenty-one days may be classified to participate in 12-Step meetings in the community via volunteer escorts from the AA and NA community.

Upon completion of Phase 1 residents are assigned to various job assignments as they move on to Phase 2, a work therapy and restitution program. In some cases, the job assignments are within the facility in the Food Service department, laundry or building maintenance department. Others are assigned to jobs with not for profit agencies in the community or to one of the many work crews that go into the community to work with Habitat for Humanity, keeping the city streets clean or restoring the parks and schools in the county. In Phase 2, residents learn the importance of giving back to their community. They learn how to work as a team, to follow the directions of a supervisor and the value of being held accountable for assignments and tasks. The two most important features of any successful treatment program are the quality of the therapeutic relationship and an ongoing aftercare program. These two are an integral part of the WMRWC program. It is the belief of the Hampden County Sheriff's Department that reintegration begins on day one.

Summary of Audit Findings

*The summary should include the number of standards exceeded, number of standards met, and number of standards not met, **along with a list of each of the standards in each category**. If relevant, provide a summarized description of the corrective action plan, including deficiencies observed, recommendations made, actions taken by the agency, relevant timelines, and methods used by the auditor to reassess compliance.*

***Auditor Note:** No standard should be found to be "Not Applicable" or "NA". A compliance determination must be made for each standard.*

Number of Standards Exceeded: 19

115.211, 115.213, 115.215, 115.216, 115.217, 115.218, 115.221, 115.222, 115.231, 115.232, 115.233, 115.234, 115.242, 115.251, 115.253, 115.265, 115.271, 115.288, 115.401

Number of Standards Met: 22

115.212, 115.235, 115.241, 115.252, 115.254, 115.261, 115.262, 115.263, 115.264, 115.266, 115.267, 115.272, 115.273, 115.276, 115.277, 115.278, 115.282, 115.283, 115.286, 115.287, 115.289, 115.403

Number of Standards Not Met: 0

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Summary of Corrective Action (if any)

No Corrective Action required.

PREVENTION PLANNING

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

All Yes/No Questions Must Be Answered by The Auditor to Complete the Report

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*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's

conclusions. This discussion must also include corrective action recommendations where the facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

In order to make a determination of compliance, auditor has reviewed the **Hampden County Sheriff's Department Core Policy and Protocol**, **3.5.3. PREA Plan, Protocol 1: Prevention and Planning, page 9.**

The WMRWC PAQ reports the facility has a written policy (HCSD 3.5.3 PREA Plan) which mandates zero tolerance toward all forms of sexual abuse and sexual harassment. The policy includes definitions of prohibited behaviors, outlines a plan for implementation, includes sanctions for those found to have participated in prohibited behaviors, and includes strategies and responses to reduce and prevent sexual abuse and sexual harassment of agency inmates/residents. The agency policy (51 pages issued in April 2013 and last revised March 2018) mirrors that of the PREA standards, and includes all requirements and elements as established by the federal legislation.

Auditor reviewed the facility Table of Organization (TO) and the agency TO. The WMRWC TO places the PREA Compliance Manager/Standards and Training Coordinator, in the management hierarchy of the facility chain of command. She reports directly to the Assistant Deputy Superintendent who reports to the Assistant Superintendent. The Assistant Superintendent is the overall chief administrator of the facility.

The agency PREA Coordinator (PC) is an upper level administrative position, Assistant Deputy Superintendent (ADS) who reports directly to the HCSD Assistant Superintendent of Housing. The agency PC is the original PREA Coordinator trained and appointed in 2013 to lead the PREA implementation effort for the HCSD. Both the PCM and the PREA Coordinator have advised auditor that they have sufficient time and authority concerning their respective duties to develop, implement, and oversee agency/facility efforts to comply with the PREA standards at WMRWC and in all agency confinement facilities, i.e. Stony Brook Jail and House of Correction (Main Institution and Pre-Release Center), Ludlow, MA; Western Massachusetts Women's Correctional Center (WMWCC), Chicopee, MA; and the Western Massachusetts Recovery and Wellness Center (WMRWC), Springfield, MA. The agency PC has 4 PCM's assigned to the 4 agency confinement facilities that have PREA reporting responsibilities to her office.

Auditor interviewed the PC who advised that she utilizes the respective 5 facility PCMs to coordinate the agency's efforts to comply with the PREA standards. Issues or trends are reviewed by the PCMs with her office and through the Incident Review Team process of review. Recommended actions to address issues are provided to the administration of the HCSD for evaluation and approval. Staff work together to address issues encountered. Auditor notes that the HCSD has also designated the Treatment Director of the community After Incarceration Support Systems (AISS) functioning as that facility's PCM, despite that community facility not being a confinement facility.

The Hampden County Sheriff's Department has a cadre of long-term agency PREA officials that were trained in 2013-2014 and contributed to PREA implementation statewide through training and implementation conferences/meetings. PREA information is shared among the Sheriff's Office facilities and between the agency PC and facility PCMs. The current configuration is that the Women's Correctional Center Standards and Training Director (STD)/PCM, one of the original PREA team members trained and appointed in 2013, serves as a mentor and direct reporting official for the WMRWC PCM, who is facilitating the first PREA audit of the WMRWC at its new location. The STD/WCC PCM has actively participated in all HCSD facility PREA audits conducted to-date, i.e. 4

PREA Audits. The PC utilized the WMRWC PCM for training and orientation purposes during the 2017 PREA Audit of the Main Institution and Pre-Release Center. During the 3 days of the PREA site review, the agency PC, WCC PCM, WMRWC PCM and an Assistant PCM (STAR- Standards Training Auditor Representative) were present each day to effectively facilitate the objectives of the site review.

Based upon the auditors review of agency and facility policy/PREA documentation/TO's, staff interviews of the agency PC and facility PCM, and review of agency PREA implementation, oversight, coordination and compliance, auditor has determined that the facility substantially exceeds the requirements of this standard.

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

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

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 OR the response to 115.212(a)-1 is "NO".) ☐ 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*)

Instructions for Overall Compliance Determination Narrative

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

The agency policy, **3.5.3. PREA Plan**, **Protocol 1, Prevention and Planning**, Section B. Contracting with Other Entities for the Confinement of Inmates, page 10, provides language which mirrors that of the PREA Standard, requiring any such private entity or other agency to comply with the PREA standards. Any new contract shall provide for contract monitoring to ensure that the contractor is complying with the PREA standards.

The WMRWC PAQ reports having 0 contracts with a private agency or other entity for the confinement of facility residents.

Based upon this information, auditor has determined that the facility is in compliance with the standard.

Standard 115.213: Supervision and monitoring

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.213 (a)

- Does the agency develop for each facility a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse? ☒ Yes ☐ No

- Does the agency document for each facility a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the physical layout of each facility in calculating adequate staffing levels and determining the need for video monitoring? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the composition of the resident population in calculating adequate staffing levels and determining the need for video monitoring? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the prevalence of substantiated and unsubstantiated incidents of sexual abuse in calculating adequate staffing levels and determining the need for video monitoring? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration any other relevant factors in calculating adequate staffing levels and determining the need for video monitoring? ☒ 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*)

Instructions for Overall Compliance Determination Narrative

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

Auditor has reviewed the agency **PREA Plan**, **Protocol 1: Prevention & Planning**, Section C. Supervision and Monitoring, pages 10-11, which requires that each facility develop, document and make 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 inmates against sexual abuse. The policy further considers all factors as required by the PREA standard, requires documentation be submitted in event the staffing plan is not complied with, and requires an annual review of facility staffing.

The WMRWC PAQ reports 0 deviations from the staffing plan during the last 12 months. The PAQ documents that the staffing plan is predicated on a population of 135 residents, which is the average daily number of residents at WMRWC since August 20, 2012.

Auditor has reviewed the 9-page June 12, 2017 Staffing Analysis Review report/minutes prepared by the HSCD PC. HCSD administrative staff participating at the annual meeting included the PREA Coordinator, Assistant Superintendent of Special Operations, Assistant Superintendent of Human Resources, Assistant Superintendent of Housing Operations and the Chief of Security. Auditor notes that the HCSD employs a Security Staff Scheduler and conducts weekly meetings held at the Main Institution (MI) on Wednesdays, during which staff from each HCSD facility attends and participates in staffing discussions of shift needs for the coming week, e.g. “During that meeting each shift from Sunday morning through Saturday night is analyzed to determine the number of staff available to meet the minimum number of personnel required. In that meeting which is attended by the WMRWC Captain, resources are evaluated and shared between each department. The post assignments/designations within the 4 facilities and all three shifts are used to forecast and adjusted to meet operational needs including the minimum number of staff to begin each shift. Auditor reviewed multiple staff rosters evidencing the hiring and shift assignments of numerous “summer help” security officers utilized by all agency facilities to effectively manage the facility’s shifts during peak vacation seasons.

Auditor has reviewed the Control/Shift Supervisor Post Orders, the Post Orders for Female Unit Post Overview and the POST Orders for the “Floor” Post Assignments and other facility posts, for the three shifts, i.e. 7:25 A.M – 4:00 P.M./ 3:25 P.M. – 12:00 A.M./11:25 P.M. – 8:00 A.M. Auditor has reviewed the purchase orders for the construction of 4 officer’s stations prior to the December 2017 occupancy of the WMRWC facility. During site review auditor observed the officer’s stations to be strategically placed and facilitating effective supervision by personnel on each floor of the facility. Electronic surveillance cameras and mirrors were noted to be placed to provide coverage required in common areas, yards/exterior areas, and stairwells. The agency transferred some serviceable security equipment from the prior facility location in Holyoke, Massachusetts. Auditor also reviewed multiple 2016 purchase orders documenting the preparations for opening of the facility, to include the October 2016 purchase and installation of 27 additional security cameras to the hallways, common rooms and exterior of the facility. Additional planning and purchases included an electronic Guard Tour system (GTI Guard), a Sentry Scan personnel duress alarm system, and electronic door hardware. Initial 2016 Electronic Security Systems purchases totaled $174,693.62, followed by subsequent purchases and recommended renovations as staff and residents populated the new facility.

Auditor reviewed the November 28, 2017 WMRWC PREA Vulnerability Assessment report conducted by the PCM and facility ranking Commissioned Officer/Captain. This report was forwarded to the facility administration and provided/receipted-for by the agency PREA Coordinator. During this assessment the committee evaluated facility staffing levels, lighting, camera coverage, blind spots, staff security patrols, security of doors/rooms/closets, resident shower and toilet areas for required privacy, and PREA postings, among other items. Staff were seeking to identify any weaknesses or security deficiencies throughout the facility. Auditor notes that the PCM made documented notes concerning several blind spots requiring attention, several potential problematic staff and resident procedural practices, and

recommendations for camera installation/relocation, security mirror mounting, and the establishment of additional “off-limits” zones, i.e. red tile placed on floor to indicate no resident presence authorized.

During site review, auditor observed personnel maintaining the required separation of the facility men, women and Section 35 residents. Procedures and schedules have been implemented to prevent contact between the females in Units 1 and 2 (First Floor-1 wing of building), and the males on Units 4, 5 and 6 (Second and Third Floors). The Section 35 non-committed residents are only housed in Unit 3, which is one wing of the 2nd Floor, partitioned-off by a newly constructed wall. The separation of the Section 35 residents with the criminally convicted residents has been effectively managed by the installation of the 2nd Floor dividing wall and the use of the rear stairwell, with the Section 35 residents under staff escort. On each floor, auditor evaluated the positioning of the security cameras strategically positioned in the hallways, dayrooms and stairwells; staff sightlines; and security mirrors and door alarms. Staff supervision posted was observed to be adequate, with auditor observing both uniform and civilian staff working together to accomplish the day’s routine.

During interview the agency Director (Sheriff designee) advised auditor that each HCSD facility has developed and maintains a staffing plan, which is reviewed annually. Staff regularly meet to ensure adequate staffing levels are maintained to ensure all mandatory posts are covered. Staff consider the physical layout of the facility, the composition of the inmate or resident population, the prevalence of substantiated and unsubstantiated incidents of sexual abuse, and other relevant factors. The HCSD Superintendent advised auditor that the HCSD multiple facilities are able to share staff, so that this ability enables the main institution to obtain needed coverage from the WCC, or WMRWC staff to be assigned to the Pre-Release Center in accordance with shift scheduling needs. Such staff flexibility enables the agency to reduce overtime expenditures and provide required coverages to fill the shift complements in an effective manner.

The auditor interviewed the PREA Coordinator (PC) who advised that each facility considers all factors required by the PREA standard when assessing staffing levels and the need for video monitoring. As PC, she is aware and informed of any issues. All staffing plans are reviewed at least annually, and these reports are documented.

The facility PREA Compliance Manager (PCM) advised auditor that the HCSD and WMRWC staff evaluated the physical plant of the new Mill Street location prior to renovations being initiated, well before occupancy. The administration and PREA Staff considered staffing levels and posts, security sightlines, and the need for sufficient cameras and security mirrors to support staff presence, deterrence and detection. The staffing plan is reviewed annually by the PCM and facility Assistant Superintendent.

Based upon auditor’s thorough review of the agency/facility policy and documentation, on-site review of each floor of the resident living and program areas, and interview with personnel, auditor has determined that the facility has exceeded standard requirements as noted and discussed above.

Standard 115.215: Limits to cross-gender viewing and searches

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

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 less than 50 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 less than 50 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?
  ☒ Yes ☐ No

115.215 (d)

- Does the facility implement policies and procedures 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 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*)

Instructions for Overall Compliance Determination Narrative

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

Auditor has reviewed the agency **PREA Plan**, **Protocol 1: Prevention and Planning**, Section E. Limits to Inmate Cross-gender Viewing and Searches, pages 12-14; Policy 3.1.1 Chapter 3, Security and Control, Section 1 – Supervision, Procedure R: Searches of Individuals, pages 17-20

The facility PAQ reports during the last 12 months 0 pat down searches of female residents by male staff, and 0 cross-gender strip or cross gender visual body cavity searches conducted. There were no searches of transgender or intersex residents conducted in the last 12 months for the sole purpose of determining that resident's genital status. Such a practice is prohibited by HCSD Policy. The PAQ reports 100% of staff have 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

The facility does not permit cross gender pat down searches of female residents by male staff. The facility employs sufficient female security and program staff to provide all shifts with the necessary female personnel to conduct female pat down searches or strip searches in unusual incidents with the authorization of the Assistant Superintendent, as required by local policy (3.1.1) and procedures (HCSD Pat Searches). **Procedure F. Staff Availability**, No. 5 of Policy 3.1.1. requires the presence of both male and female staff to be on duty at all times.

During random interview with staff, auditor was advised that there are always female security staff present, or as necessary, female civilian staff that are qualified and trained to conduct pat searches. Female resident activities are never curtailed due to the absence of female staff. Or the Shift Commander could telephone WCC and request female staff be dispatched to conduct any necessary

searches. Both the male and female random staff interviewed advised that they had received hands-on pat down training at the academy, and through the HCSD pat down video used during annual training on PODNET (HCSD Computer Based Training-CBT). Auditor has reviewed this 7- minute video produced by the HCSD training division in 2014, featuring a Main Institution Captain and Corrections Officer demonstrating proper search methods to be utilized for same gender, cross gender and transgender/intersex residents. Auditor has reviewed staff training rosters verifying 50% staff completion of the POD Gender Announcement PODNET training in the last 6 months. All staff interviewed were aware of the prohibition against strip searching a transgender or intersex resident for the sole purpose of identifying that resident's genital status. The agency reportedly also utilizes an ADA PREA PowerPoint program for all new hires.

The random supervisors interviewed advised auditor that they always ensure that their staff receive the required pat down training annually. The majority of staff interviewed advised auditor that they had received pat down training in the last couple months or back to March 2018, during annual training. Multiple staff interviewed advised that strip searches of residents are not conducted at WMRWC. A civilian Caseworker/Correctional Officer interviewed advised auditor that she has been called-upon to conduct pat down searches of residents in the past due to unavailability of a female correctional officer.

Auditor interviewed 5 female residents to determine whether their outside activities or programs had been restricted due to availability of female staff to conduct pat-down searches. Auditor interviewed Hispanic (2), Black (1), White (2), a LGBTI resident and a LEP resident. All residents advised auditor that their activities have never been restricted due to absence of female staff to conduct pat-down searches. The residents all stated that male staff announce their presence and that the residents are never naked in full view of male staff. There were no transgender/intersex residents housed at the facility during site review.

During site review, auditor made visits to the female unit on 2 of the 3 days. On the 2 days visited auditor observed female security staff posted on the unit and in the recreation yard. Other female staff were also observed performing duties on the unit. Auditor engaged informally with residents in the rear yard, in the hallway and in the dayroom/laundry room area. Staff and resident interaction was observed to be excellent, reflecting a positive culture and the intended community nature of this residential program. The residents were receptive and courteous with this auditor. Auditor received unsolicited praise for the WMRWC personnel and the program itself from multiple residents encountered both informally and from those officially interviewed.

Auditor evaluated all bathroom/shower rooms in the building, noting that there are no "wet" rooms or cells at WMRWC. All rooms are 4 male/female rooms with the exception of 1 five-man cube on the 3rd Floor. All bathrooms/shower rooms are properly equipped with a half-way up frosted vision panel hallway door; PREA shower curtains which provide privacy for residents while affording patrolling security staff with vision of the higher and lower body in order to confirm single use of such showers; and toilet stalls equipped with hard-panel ½ partition swinging doors. The male urinals are mounted in compliance with the standard.

Auditor witnessed cross-gender personnel appropriately announcing their presence while knocking on the bathroom entry doors, and upon entering the opposite gender housing units, in accordance with agency policy. A written agency "Announcement/Anuncio" is posted in all housing units informing the residents of cross-gender staff presence on the unit at any given time. In addition, a blue-colored Man on the Unit or pink-colored Woman on the Unit placard is placed at the officer's station informing the

residents visually that a cross-gender staff person is in the area. The opposite gender presence on the unit is further documented into the officer's station security system data base, JMS. Additionally, the agency has a practice of making both English and Spanish Public Address (PA) announcements at the start of each security shift in all facilities announcing that opposite gender staff may be in the area. This announcement is a pre-recorded automated announcement produced in 2014 by the PREA Coordinator and is documented each shift in the POWS security database. Auditor has reviewed multiple samples of individual opposite gender (male and female) visits to the male and female units in the computer system to verify such entries. Auditor notes there are no gender post assignments at the facility. Both male and female staff are able to be assigned to any post.

Auditor has determined that the facility Exceeds Standards based upon the thorough and frequent training provided, auditor's observed adherence by personnel to established procedures while on-site, and staff's intent to ensure the resident's privacy while maintaining the required security and safety of the residents.

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

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

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*)

Instructions for Overall Compliance Determination Narrative

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

Auditor reviewed the **PREA Plan**, **Protocol 1: Prevention and Planning**, Section F, pages 14-15; HCSD Policy 4.5.9 Special Needs and Services, **Protocol 1: Special Needs Treatment Plans**, pages 5-6, **Protocol 3: Mental Health Services**, page 8; ADA and PREA training curriculum (power point). The PAQ reports 0 instances in the last 12 months where resident interpreters, readers, or other types of resident assistants have been used in relation to allegations of sexual abuse or sexual harassment. Auditor notes that agency policy prohibits such use of resident interpreters, readers or assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the resident's safety, the performance of first-responder duties or the investigation of a resident's allegation.

Auditor reviewed the 2017 and 2018 WMRWC Mandatory Training annual requirements, which include the **American's with Disabilities Act (ADA)**: a. ADA and PREA Power Point and b. Disability Etiquette. Auditor reviewed the HCSD Purchase Order for translation services through Language Bridge LLC, effective for the contract period of 8/2015 through 6/2019. In addition to contracted translation services available, staff rosters evidence 12 WMRWC employees identified to provide translation services with residents, in Spanish, French, Haitian Creole, and Sign Language. 88 additional staff are available for translation services by contacting the other 3 nearby HCSD facilities and agency community programs. Languages able to be translated are Spanish, French, Russian, Portuguese, Bosnian, Sign Language, Cambodian, Gaelic, Italian, Patwah, Polish and Swedish.

Auditor verified that the agency issues a Spanish version of the Resident Manual when appropriate and all residents are provided an English and a Spanish PREA Pamphlet as a matter of practice. During PREA education sessions when the PREA video is shown, the staff facilitator also distributes a Spanish version of the PREA Information sheet read to the residents as they are being admitted at Intake. Auditor observed blue-colored Man on Unit and pink-colored Female on Unit placards prominently posted at the officer's work stations, accordingly, during our site review visits, as a visual means to inform deaf or hard of hearing residents that opposite gender staff are in the area.

In order to make a determination of compliance auditor interviewed random staff, who advised auditor that the facility has not used resident interpreters and would only use them if there was an immediate need. Multiple random staff interviewed advised auditor that the facility has sufficient bilingual (Hispanic speaking) personnel that are routinely utilized for resident translation.

The Agency Head (designee) advised auditor that agency facilities take action to ensure that all inmates or residents are informed of all rules and regulations, including PREA. The agency issues bilingual Inmate Handbooks and PREA Pamphlets and utilize personnel who speak various languages to translate as necessary. If staff are not available or a specific language is required, the agency has contracted for translation services to address communications with those inmates. Staff post gender

Placards in the housing units to inform deaf or hearing deficient individuals that opposite gender staff are in the area.

Auditor interviewed 1 LEP female resident and 2 male LEP residents in order to make a determination of compliance and to assess the resident's awareness of PREA. All 3 residents interviewed advised auditor that the facility provides information about sexual abuse and sexual harassment that they can understand. All residents had used staff interpreters in the past, i.e. 3 different staff members, 2 Counselors and an Officer) to assist the resident concerning routine facility matters. All residents advised auditor that they were issued Spanish versions of the Resident Handbook and the PREA Pamphlet. All 3 residents advised auditor that they would notify staff in event of a PREA issue involving themselves or others. All residents stated that they felt sexually safe at WMRWC. During the interviews, auditor utilized 1 Correctional Officer, 1 Counselor and 1 Food Service Supervisor to translate for the 3 LEP residents and auditor.

Based upon auditor's aforementioned review and findings, auditor has determined that the facility Exceeds the requirements of the standard. The facility makes a concerted effort to ensure all incoming residents are properly informed of their rights and to identify any special needs. Auditor sat through two resident Intakes during site review, observing two phases of the Intake/Orientation process conducted by two different staff persons. The third phase is conducted at Medical by a Registered Nurse who conducts the actual PREA inquiries/risk assessment. Each phase involved a thorough review conducted in an informal and caring manner by facility personnel. This comprehensive process allows for the resident to express any special needs or concerns, and for assigned personnel to make objective and subjective assessments in identifying any resident special needs or concerns.

Standard 115.217: Hiring and promotion decisions

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

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, or 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)

- Unless prohibited by law, 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*)

Instructions for Overall Compliance Determination Narrative

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

In order to make a determination of compliance, auditor reviewed HCSD Policy **3.5.3. PREA Plan**, **Protocol 1: Prevention and Planning**, Section G. Hiring and Promotion Decisions, pages 15-16. The agency policy mirrors that of the PREA standard, including all requirements for processing new hires, promotions of existing staff, conducting regular background checks, establishing an affirmative duty to report/disclose prior sexual abuse activity, and providing requested information to other requesting agencies. Auditor also reviewed policy **1.3.1 Human Resources**, **Protocol 6: Change of Status, Employee Requirement to Report**, page 13, and **Protocol 7: Involvement with Law Enforcement Officials**, page 14.

The PAQ reports 7 persons hired in the last 12 months who may have contact with residents who have had criminal background record checks conducted. The new hires consisted on 2 mentors, 1 new staff person and 4 summer help.

Auditor interviewed the Assistant Superintendent of Human Resources and the HR Administrative Assistant who advised auditor that HR conducts criminal background record checks on all new hires, interns, volunteers, contractors and summer help. The agency utilizes the Criminal Justice Information System (CJIC), and other systems to screen all staff persons. "We check within Massachusetts and everywhere." Promotional applicants must also respond to the PREA inquiries and they undergo a

criminal background record check. The agency requires all personnel to annually review their obligation to disclose any criminal arrests or previous misconduct. Employees must sign-off for this annually. The HR office will release information to another agency concerning a former employee once the HCSD confirms the legitimacy of the requestor, and the former employee signs a release of information. All staff undergo a criminal background records check every five years, on a rotating basis as managed by the HR Office.

Auditor reviewed the HCSD Candidate Information Questionnaire form, which includes on pages 3-6, the five required PREA inquiries, PREA definitions, and documents the "… continuing affirmative duty to immediately report in writing to the Sheriff any such misconduct during the time I am employed by, contracted with, or volunteer for the Hampden County Sheriff's Office." All applicants are required to sign and date this completed application form. Auditor has reviewed the Prison Rape Elimination Act (PREA) from which must be completed and filed annually in conjunction with the employee's annual Employee Performance Review (EPR). This form is signed by the employee and employee's supervisor and placed in the employee's Official Personnel File.

Based upon auditor's review, auditor has determined that the facility exceeds standards concerning the requirements of this PREA standard.

Standard 115.218: Upgrades to facilities and technologies

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

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*)

Instructions for Overall Compliance Determination Narrative

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

Auditor reviewed the HCSD policy, **3.5.3. PREA Plan**, **Protocol 1: Prevention and Planning**, Section H. Upgrades to Facilities and Technologies, page 16.

The PAQ reports a newly installed video monitoring system, electronic surveillance system, and other monitoring technology and security systems installed during major renovations to the newly occupied leased facility in Springfield, MA, opened in December 2016. The initial security and PREA assessments were developed by HCSD and WMRWC personnel. The initial major Purchase Order for electronics/monitoring/security systems was contracted with Security Design, Inc, Electronics Systems Development and Services, 13 Depot St. S. Grafton, MA 01560, www.security designinc.com, (508) 839-0058. The contract totaled $174,693.62 and was augmented subsequently by additional purchases and installations based upon staff input and a PREA Vulnerability Assessment conducted by WMRWC staff. Auditor has reviewed the schematic floor plans which include installed cameras, electronic door contacts/alarms, Guard Tour box locations, elevator key controls and staff reader card access areas. During site review, auditor evaluated all interior areas and floors for staff presence/supervision, remote monitoring, placement of security mirrors, vision panels, electronic duress boxes and room/closet access. The physical plant of all three housing floors and the basement floor program areas (classrooms, recreation room and library), maintenance, and kitchen-dining areas were equipped with excellent and abundant electronic monitoring equipment, as initially designed/installed and subsequently augmented based upon the subsequent PREA Vulnerability Assessment conducted, and staff input.

During interview the Agency Head/designee advised that the agency facilities always consider the effect of the design, acquisition, expansion or modification upon the agency's ability to protect residents from sexual abuse. The agency is always seeking to enhance staff's ability to protect residents from sexual abuse. The WMRWC Assistant Superintendent advised during interview the example of the construction of a wall to effectivley segregate the criminally sentenced offenders from the Section 35 residents housed on the 2nd Floor in Unit 3. The construction and placement of the officer's stations on each floor was designed to maximize sightlines and supervision of the units, to enhance the resident's protection from sexual abuse.

Auditor has determined that the facility exceeds the requirements of the standard due to the thorough and systematic manner in which facility technology was designed-into the newly leased facility and later augmented to provide fundamental security, resident accountability and to ensure the sexual safety of the resident population. The facility provides the security protections of a much higher-level confinement facility but does so in a controlled but relaxed community corrections center culture of cooperation.

RESPONSIVE PLANNING

Standard 115.221: Evidence protocol and forensic medical examinations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

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? ☒ Yes ☐ No

- 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 entity 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? (Check N/A if agency attempts to make a victim advocate from a rape crisis center available to victims per 115.221(d) above.) ☒ 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*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's

conclusions. This discussion must also include corrective action recommendations where the facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Auditor has reviewed the agency **PREA Plan, 3.5.3**. **Protocol 2: Responsive Planning** - Section A. Evidence Protocol and Forensic Medical Examinations, pages 17-18; **3.1.7 Special Teams**, **Protocol 3: Criminal Investigative Unit**, pages 9-19.

The PAQ reports 0 forensic medical exams conducted in the last 12 months at Baystate Medical Center due to a sexual abuse incident or allegation at WMRWC. The PAQ reports the facility to be in compliance with all requirements of the standard. Auditor has reviewed the Memorandum of Understanding (MOU) with the HCSD and YWCA of Western Massachusetts for providing rape crisis counseling and information, victim advocacy, and use of the YWCA's Rape Crisis Hotline. The YWCA allows the HCSD to include the Hotline numbers in the agency brochures and in education materials made available to all residents. The YWCA agrees to provide up to 12 confidential counseling sessions to residents/survivors. The YWCA staff meet with residents in the WMRWC Attorney/Professional Visiting Room.

Auditor reviewed the Job Description for the **HCSD Victim Services Coordinator**/Sexual Assault Victim Advocate (SAVA)– **General Statement of Duties and Responsibilities**. This position is tasked with Coordinating Victim Services, including victim-offender conferencing, other possible services desired by victims and providing support and advocacy to incarcerated victims of sexual assault. The Victim Services Coordinator assists the incarcerated victim to obtain a reasonable continuum of services throughout incarceration and following release as needed. This agency staff person also serves important roles as a liaison to community victim advocates/agencies, and with county and state parole offices.

Auditor interviewed the DPH Western Massachusetts Regional SANE Coordinator, who oversees SANE services provided at six hospitals in 3 counties (Hampden, Hampshire and Berkshire). If a SANE staff would not be on-duty or available, a Baystate Emergency Room clinician would assume the responsibility to conduct a forensic medical examination. The DPH Coordinator advised auditor that she had recently spoken with the HCSD Nursing Director about presenting a SANE workshop for the Sheriff's Department staff to be conducted at the Main Institution.

Auditor interviewed the YWCA Director of Support Programs, who reviewed the MOU with auditor concerning the programs available and provided to WMRWC residents at times, as YWCA Counselors often conduct counseling sessions with individual residents at WMRWC. She stated that the Counselors will provided 5 to 7 sessions with the residents, but it could be more sessions than that. When the residents are discharged from the facility, they can continue to be followed-up by the Y Counselors, as requested. The Counselors provide Domestic Violence Services and Sexual Assault Counseling services. A program offered by the YWCA "Ending the Game" will be provided to the residents at "Mill Street" (WMRWC) in the future, as coordinated with staff there.

Random staff interviewed advised auditor that they were aware of the agency's protocol for obtaining usable physical evidence if a resident alleged sexual abuse. Staff described the first responder actions they would take if an incident had occurred or an inmate alleged they were a victim of sexual abuse. Examples of responses provided to auditor were to: ensure victim safety and remove perp, monitor the residents involved, assign staff one on one with the involved residents, contain, isolate and notify, notify Superintendent/report to supervisor/contact PREA Investigator/medical, prevent residents from using the bathroom, washing, brushing teeth or showering or damaging evidence, secure the scene, lock

down the unit, retrieve PREA Bags from Control Supervisor's Office, write report. All the random staff interviewed were able to identify the facility Sergeant responsible for investigating PREA incidents and allegations.

The PREA Coordinator advised auditor during interview that the agency Victim Services Coordinator/SAVA functions as agency Victim Advocate for any inmate or resident sexual abuse or allegations of sexual abuse. The YWCA Counselors, through the MOU provide counseling services by visiting each of the agency facilities and providing individual services as requested by the inmate/resident.

The PCM advised auditor that the YWCA provides counseling services to the residents at WMRWC by visiting them inside the facility. There is a MOU with the YWCA in Springfield to provide such services. They are an established Rape Crisis Center. The HCSD Victim Services Coordinator/SAVA serves as the facility Victim Advocate as necessary.

Auditor interviewed the agency Victim Services Coordinator/SAVA who advised auditor that she has provided supportive services to an inmate/resident while housed at the Main Institution, Pre-Release Center and WMRWC in the last 12 months, concerning allegations received. Auditor has confirmed that the YWCA Counselors had also provided one-on-one counseling services to the same inmate/resident during 2017-2018, by visiting the Pre-Release Center and the WMRWC facility. There were no residents available to interview that had reported a sexual abuse.

During site review, auditor requested facility personnel to breach one of the two PREA Bags or evidence kits maintained by the facility in the Control Supervisor's Office. Auditor reviewed the contents and PREA Kit property inventory sheet which included paper and plastic evidence bags, plastic gloves, 1 bedding sheet to place on floor as victim/suspect removed clothing, a surgical pad, change of clothing/underwear/socks, flip-flops, evidence tag/chain of custody form, crime scene tape, evidence tape to secure evidence bags, bio-hazard bags w/bio-hazard stickers and instructions for first responders and crime scene investigators/Officer in Charge.

Based upon auditor's review of agency policies, documentation and PAQ, and staff interviews conducted, auditor has determined that the facility exceeds the requirements of the standard. Despite the ER of Baystate Medical Center as a matter of protocol activating the YWCA for victim advocacy and supportive rape crisis intervention services, the HCSD staff's their own Victim Services Coordinator position, responsible for all victim services coordination. Auditor has verified activation of both the YWCA counseling services and the HCSD SAVA for one resident making an allegation of inmate-on-inmate sexual abuse beyond the last 12 months, but still remaining in the custody of the HCSD/WMRWC facility and requesting such victim services (in the last 12 months). Both the HCSD Standards and Training Director and the WMRWC PCM also personally participated in the agencies efforts to satisfy the reported needs of this reporting inmate.

Standard 115.222: Policies to ensure referrals of allegations for investigations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

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 such publication 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*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does

not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Auditor reviewed the agency **PREA Plan**, **Protocol 2: Responsive Planning**, Section B. Policies to Ensure Referrals of Allegations for Investigations, pages 17-18, and **Protocol 7: Investigations**, Section A. Criminal and Administrative Department Investigations, pages 32-35. The agency policy includes all provisions required of the PREA standard concerning the conducting of administrative and criminal investigations, the referral of investigations to law enforcement, and the posting of this information on the agency website www.hcsdma.org. Policy **3.1.7 Special Teams**, **Protocol 3, Criminal Investigative Unit (CIU)**, pages 8-14, includes details of the CIU procedures, e.g. CIU Authorizations, Criminal Investigation Notifications, Supervision, Investigation of Crime Scene, interview Statements, Contraband and Investigation Reports.

The facility PAQ reports 1 allegation of sexual abuse or sexual harassment that was received in the last 12 months. An administrative investigation was conducted, with the allegation being determined to be unfounded. There were 0 allegations referred for criminal investigation.

Auditor reviewed the HCSD PREA Incident Review procedures PowerPoint document as established to serve as a checklist for the PREA Investigators. This document includes review of the Initial Incident Report, Review of Alleged Victims and Perpetrators, Investigation Steps, Investigation Findings/PREA Determinations and Administrative Timelines, to include Initial Incident Response, 30-day Incident Review, 90-day Retaliation Assessments (or longer) and agency notification to inmate. Auditor reviewed the HCSD PREA Process Map, which is a resource tool for all agency staff. This Process Map describes the assessments/screenings of incoming inmates, identification as Victim/Predator status, inputting data into the agency automated databases (TRAX and JMS), and investigation flow charts. Auditor reviewed the Sexual Assault Cases Inmate on Inmate document, which bifurcates the category of alleged incident into Abuse or Harassment, thereby providing direction for investigating personnel on the specific sequential steps involved during the investigative process.

The Agency Head (designee) advised auditor during interview that all allegations of any sexual abuse or sexual harassment, from any source, is referred for investigation. The CIU would conduct the investigation if the incident or allegation was serious or involved staff sexual abuse.
Auditor interviewed the WMRWC PREA Investigator who advised auditor that agency policy does not require that all allegations of sexual abuse or sexual harassment be referred to an agency with legal authority to conduct criminal investigations, as the CIU possesses has the authority to conduct criminal investigations. While on-site, auditor reviewed with the WMRWC PREA investigator the 3 PREA investigations/files conducted in the last 12 months.

Based upon auditor's review of agency policies, PAQ, PREA investigations conducted during the last 3 months, staff interviews and the agency's adoption of multiple staff training and resource documents/tools, auditor has concluded that the facility Exceeds the requirements of the PREA standard.

TRAINING AND EDUCATION

Standard 115.231: Employee training

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

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*)

Instructions for Overall Compliance Determination Narrative

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

In order to make a determination of compliance, auditor reviewed the agency **PREA Plan, 3.5.3 Protocol 3: Training and Education**, Section A. Employee Training, pages 18-19; **HCSD Staff Training and Development Plan 1.4.1 Protocol 2: Orientation and Training Requirements**, pages 8-14, **Protocol 3: Training Records and Documentation**, pages 14-15, **Protocol 5: Annual In-Service Trainings**, pages 17-19.

Auditor reviewed the comprehensive 2017 HCSD Basic PREA Training power point curriculum (87 slides) presented to all new hires attending the 6-week Basic Training Academy. This local Sheriff's Office production is a comprehensive review of PREA and includes valuable correctional insights into the dynamics of sexual abuse, the inmate Code of Silence, Building a Culture of Zero Tolerance, recognizing Red Flags, Communicating Effectively, myths and misconceptions, Universal Respect, and other key information designed to support staff's better understanding of confinement sexual abuse and sexual harassment.

Auditor has reviewed the 47-slide WMRWC PREA Audit # 2 Preparation PowerPoint, which serves as a study guide for personnel. All 15 Random Staff protocol questions are individually reviewed with

personnel, with suggested responses included. The facility assigned all personnel to complete the 15-question power point. Auditor has reviewed multiple training rosters/spreadsheets verifying completion by personnel. As an employee completes any PODNET Computer Based Training (CBT), they must scan in their ID card to activate the Acknowledgement of Completion and Comprehension. Additional PODNET PREA Training Videos/PowerPoint include Cross Gender Announcement Video, Transgender and Intersex Inmate Pat Search Video, ADA PREA and PREA. The agency also utilizes multiple National Institute of Corrections (NIC) PowerPoint courses. A total of 12 PowerPoints and Training Videos are utilized by the WMRWC to thoroughly train staff about PREA.

Auditor reviewed the 5-day New Staff Orientation (40 Hours) provided to the Summer Help staff, which includes a PREA module facilitated by the facilities Captain. Auditor reviewed the 2-week Training Program for Summer Help Correctional Officers. Both the one-week and two -week curriculums have training modules on the Prison Rape Elimination Act.

The PAQ reports all facility staff were trained or retrained on the PREA requirements in 2017, with 50% having completed PREA training for the current calendar year. Auditor has reviewed the 2018 WMRWC training spreadsheets reporting completion by facility personnel of the PREA PowerPoints provided on PODNET: PREA 15 Questions, Cross Gender Announcements, and Transgender/Intersex Pat Search. Auditor has reviewed random individual training completion certificates completed/signed by new personnel and verified random automated signature-completions for PODNET CBTs.

Random staff interviewed by auditor were very knowledgeable concerning all the PREA requirements contained within the standard, evidencing their thorough training at WMRWC. Staff were able to describe the various PREA trainings offered during annual in-service training, and during 8-hour and 16-hour training sessions. When asked follow-up questions concerning possible common reactions to sexual abuse or sexual harassment, how to avoid inappropriate relationships, and the dynamics of sexual abuse, staff responded in a confident and informed manner. All staff queried were able to describe the cross-gender pat search video in detail concerning the two Main Institution personnel featured in the training video and the praying hands/backs of the hands techniques to be utilized for opposite gender/transgender searches.

During site review, auditor encountered and engaged numerous uniformed and non-uniformed personnel informally (23 staff according to auditor's notes and facility back-up notations). All staff so-engaged or observed exhibited a professional confidence and team spirit. Pride in the facility and the culture maintained was voiced by multiple employees. Staff volunteered to demonstrate to auditor many of the security features implemented, such as cameras/monitoring stations, mirrors, guard tours, duress alarms and door alarms, PREA postings and many of the movement/escort procedures in place to ensure the sexual safety of the resident population. All facility staff receive an annual HCSD Pocket Planner which has been revised in 2017 to include staff first responder duties to follow in the event of an incident or allegation of sexual abuse.

Based upon the facility's commitment to training in all matters, to include PREA, auditor has determined that the facility has Exceeded the requirements of the standard.

Standard 115.232: Volunteer and contractor training

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

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*)

Instructions for Overall Compliance Determination Narrative

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Auditor reviewed the agency **PREA Plan**, **Protocol 3: Training and Education**, Section B. Volunteer, Intern, and Contractor Training, pages 19-20. Auditor has confirmed that this policy includes all requirements of the PREA Standard.

The PAQ reports 83 total volunteers, contractors, interns and summer help currently authorized to enter the facility who may have contact with residents. Auditor reviewed the multiple orientation/training documents required as part of the Volunteer, Intern or Contracted Staff orientation process. The Volunteer Applications and Acknowledgement Forms packet requires the new applicants to receipt for the Volunteer Handbook; receipt for the WMRWC Sexual Harassment form (which describes the criminal penalties resulting from sexual relations with a resident); receipt for the PREA Acknowledgement form; and to receipt for the WMRWC CORI Permission Form (Criminal Offender Record Information) which serves as a criminal background verification. Auditor has reviewed facility

spreadsheets which document applicant approvals to service the facility, with other applicants rejected as “Denied” due to failure of the individuals to pass the required criminal background checks.

The orientation/training process for Volunteers, Interns and Contracted staff requires a 40-hour facility orientation, to include PREA. This orientation/training is conducted both at the HCSD Main Institution (MI) and at the WMRWC site. The Summer Help Correctional Officers undergo 40 hours training at the MI and then another 40 hours at WMRWC.

Auditor interviewed 1 Volunteer, 1 Intern and 3 Contracted staff. The Volunteer advise auditor that he has received the PREA orientation at WMRWC and at a Connecticut prison where he also volunteers. He recalled the zero-tolerance policy being discussed and matters of resident manipulation and predators. He advised he would report any incident or information he received to the front Lobby Officer on duty. He may have to do a report. He is required to complete the training every year, watch a video and sign the paperwork.

The three contracted staff consisted of a Mentor, a Consultant/Transportation employee and a Summer Help staff. All contracted staff advised auditor that they had completed the computer training, lecture/in-class, at Main Institution, and thru video. One staff recalled the “15 modules on PODNET.” Subjects covered included first responder duties, cross gender announcements, transgender pat-searches, Zero Tolerance, Inmate Rights, Notifications, be a witness-not an investigator, secure the scene, document the information, the PREA Investigator or CIU would investigate. One contracted staff volunteered that “Training is constant here, we do it all the time-zero tolerance”.

The Intern interviewed advised auditor that she received the power point presentation her first day from the PCM. She recalled signing a document that the PCM also signed. She recalled the training covered a basic PREA overview, cross gender announcements when entering PODs, searches of residents and first responder duties.

In order to make a determination of compliance, auditor reviewed various training spreadsheets for 2017 and 2018 as provided by the facility. Auditor also reviewed individual receipts for training from 2018 and 2018 as completed by the volunteers, interns, and contracted staff (which includes mentors and summer help), and Individual Training Hours by Person documents, which reports all of an individual’s training subjects completed.

Based upon the aforementioned, it is evident that the WMRWC provides a clear and redundant message to all new hires, volunteers, interns, mentors, contracted staff and summer help, i.e. that the agency and facility maintains a zero-tolerance policy concerning sexual abuse or sexual harassment of the residents. Such new staff are thoroughly screened, trained and required to provide their signatures to multiple documents attesting to their training and understanding of agency policies, rules and regulations, and PREA. Auditor has therefore determined that the WMRWC Exceeds standard requirements for this standard.

Standard 115.233: Resident education

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

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*)

Instructions for Overall Compliance Determination Narrative

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Auditor reviewed the agency policy **3.5.3. PREA Plan**, **Protocol 3: Training and Education**, Section C. Inmate Education, page 20. The agency policy includes all requirements of the PREA standard.

The PAQ reports 447 residents admitted to WMRWC in the last 12 months that were provided information about the facility's zero tolerance policy, how to report incidents or suspicions of sexual abuse or sexual harassment, their rights to be free from sexual abuse and sexual harassment and to be free from retaliation for reporting such incidents, and regarding agency policies and procedures for responding to such incidents. The PAQ reports 76 residents were transferred from a different community confinement facility in the last 12 months, with all 76 new residents receiving the same PREA information/orientation/Trifold identical to all new commitments.

During site review, auditor requested and attended the Intake processing of two residents into the facility. Auditor observed the normal routine of the Director of Classification conducting the initial review of the resident's personal and criminal history/Intake Face Sheet. This initial session was followed by the facility orientation, to include PREA, along with all the facility's general rules and regulations. The second phase is conducted by the Intake Administrative Assistant who provides a comprehensive review of the Orientation Program, to include available facility services, Rules and Regulations, Program Participation, Visiting Hours, Property Allowance, Non-Smoking Policy/Zero Tobacco Tolerance, Religious Services, etc. The Intake staffer then reads a PREA Information document and has the newly arrived residents sign that they have received the PREA information and understand PREA. This PREA handout is distributed to all residents at the time of the video presentation/education sessions conducted on Thursdays. A Spanish version is distributed as needed. At Intake, upon arrival, all residents, including the Section 35 residents, also receive the HCSD PREA Pamphlet, in English and Spanish.

Auditor observed consistent posting of the auditor's Notice of Audit, in English and Spanish. The audit notices were posted on June 25, 2018, with the facility providing auditor 10 digital photographs to evidence the required postings that date. The HCSD PREA posters were prominently posted throughout the facility in secure display cases, providing the YWCA Hotline numbers in English and in Spanish, and the address for the YWCA. Auditor confirmed the PREA Hotline numbers affixed to the telephone bases in the resident hallways.

Auditor interviewed two Intake staff persons-the same two staff that auditor had previously observed providing the initial intake processing to the two residents earlier in the day. Both staff members advised that all incoming residents receive the initial PREA information before they leave Intake. The Administrative Assistant reads verbatim the PREA Information handout which contains reporting instructions, hotline phone numbers, identification of agency and facility PREA officials, the YWCA (address and phone numbers) rape crisis counseling services available, and the definitions of sexual abuse, sexual harassment and voyeurism. The residents are required to receipt by signature for the orientation and forms. The residents then receive the PREA trifolds and attend PREA class on the next Thursday with the facility Captain.

Random male and female residents interviewed advised auditor that they had received the PREA information the first day they arrived, at Intake. One male resident stated: "The first thing they said-PREA! Every day." All inmates recalled being informed about PREA, their rights and reporting methods, at intake and with video during the Captain's orientation. Auditor notes that the male residents attend the Captain's orientation on Thursday's, while the female residents attend a Thursday orientation on the female unit (Units 1 and 2) conducted by unit staff. The females view a different female-themed PREA video. Residents advised auditor during interview that the hotline numbers are on the PREA posters and on the telephones. The residents interviewed had arrived to WMRWC as far back as October 2017 and as recently as the week prior to the audit. All of the female residents were transferred from the Women's Correctional Center. The males were admitted to WMRWC from the Main Institution, Berkshire County, Worcester County, and from the community.

Auditor interviewed 3 LEPs, 2 physically disabled residents and 2 residents with mental health/cognitive limitations. All residents advised auditor that they were able to understand the PREA information provided, through the PREA Pamphlets, videos and by staff at Intake and during orientation. The LEPs informed auditor that each of them has used staff translators while at the facility, but never for any PREA written materials or to report sexual abuse or sexual harassment. One legally blind resident advised auditor of his use of a "viewer" to assist him in reading facility written materials. Auditor then accompanied the resident to his room for a demonstration of his personal Aladdin Pro+ Viewer. The resident advised auditor that he sometimes relies on other residents or employees to read certain materials for him when he is having bad days when his viewer is not sufficient to enable him to read smaller print.

Auditor has determined that the facility substantially exceeds the requirements of standard due to the thoroughness and repeated emphasis of PREA and the agency's zero tolerance policy to ensure the sexual safety of the resident population. The facility has made PREA a major priority, communicating this frequently and clearly to the residents through many means and personnel.

Standard 115.234: Specialized training: Investigations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

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 have received 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*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does

not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Auditor has reviewed the **HCSD PREA Plan 3.5.3, Protocol 3: Training and Education**, Section D. Specialized Training – 1. Investigations, page 21; **Policy 1.4.1 Staff Training and Development**, **PREA: Training and Education**, Specialized Training: Investigations, page 41.

The facility PAQ reports that the facility PREA investigator has been trained in conducting sexual abuse investigations in confinement settings. The agency maintains documentation showing this training. The agency currently employs 8 total investigators among the 4 agency confinement facilities that have completed the required specialized training.

Auditor has reviewed two training-completion certificates evidencing that the WMRWC PREA investigator attended: 1. A PREA Conference in Boston, MA February 22-24th, 2017, completing the Sexual Assault Investigation Training presented by the Massachusetts Department of Corrections (MDOC); 2. A Municipal Police Training Committee 40- hour Sexual Assault Investigator Certification Course conducted at the University of Massachusetts (UM) Amherst Campus January 16-20, 2017.

In order to make a determination of compliance auditor interviewed the WMRWC PREA investigator. The investigator advised that she had attended two sexual assault investigative trainings, one a three-day training sponsored by the MDOC in 2017, and another at UM in 2017 which consisted of five days and was presented by the Municipal Police Training Committee. The Sergeant investigator advised auditor that the trainings provided an overview of PREA, discussed evidence collection, interviewing techniques for victims and suspects, documentation, legal aspects, wrapping-up, providing notifications of outcomes, proper use of Miranda and Garrity warnings, and the criteria and evidence required to substantiate a case for administrative or prosecution referral.

Based upon auditor's review, it is determined that the WMRWC Exceeds standards. Auditor notes that the facility and agency expended funds for the designated WMRWC PREA investigator to attend an additional investigator training, above and beyond the basic requirements as established by the standard, Hampden County Sheriff's Department and MDOC. Further, the agency employs 7 additional trained PREA investigators locally available at the Main Institution/CIU and WCC.

Standard 115.235: Specialized training: Medical and mental health care

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

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? ☒ Yes ☐ No

- 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? ☒ Yes ☐ No

- 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? ☒ Yes ☐ No

- 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? ☒ Yes ☐ No

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 medical staff at the facility 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? ☒ Yes ☐ No

115.235 (d)

- Do medical and mental health care practitioners employed by the agency also receive training mandated for employees by §115.231? ☒ Yes ☐ No

- 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 for circumstances in which a particular status (employee or contractor/volunteer) does not apply.] ☒ 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*)

Instructions for Overall Compliance Determination Narrative

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

Auditor has reviewed the **PREA Plan, 3.5.3 Protocol 3: Training and Education**, Section D. Specialized Training – 2. Medical and Mental Health Care, pages 21-22. **1.4.1 Staff Training and Development Plan, PREA: Training and Education**, Specialized Training – Medical and Mental Health Care, page 41.

The facility PAQ reports 100% of facility medical and mental health practitioners who work regularly at the facility have received the specialized training as required by the agency and the standard. At WMRWC, this includes the Medical Department Registered Nurse (RN), the RN Supervisor, and the Clinical Manager (Mental Health).

Auditor has reviewed the facility RN's Training Hours by Person report for the last 12 months, which shows the RN having completed the PREA Basic/PODNET, PREA Medical, PREA Auditors' 15 Questions for Staff, Transgender and Intersex Inmate Searches, Cross Gender Pod Entrance Announcements and PREA Investigations (one hour). The RN Supervisor's Training Hours by Person reports show the following trainings completed in the last 12 months: PREA Basic/PODNET, PREA Medical, PREA Auditors' 15 Questions for Staff, Transgender and Intersex Inmate Searches and Cross Gender Pod Entrance Announcements. The mental health staff person's Training Hours by Person report reviewed by auditor evidences that she has completed the PREA training required.

Auditor has reviewed the PREA Medical PowerPoint training program, which consist of 32 slides and includes sample screen shots for the HCSD inmate data base, Patient Record in HealthTrax, which includes the PREA risk assessment inquiries completed by the facility RN during the intake process. This Medical HealthTrax is only accessible to medical and mental health personnel.

Auditor interviewed the HCSD Assistant Superintendent of Health Services, who advised auditor that any forensic examinations would be done at Baystate. He has received specialized PREA training for medical and mental health over his career. He described the topics covered in the required annual training.

During interview with the Nurse Supervisor, she advised that any necessary forensic medical examinations would be conducted at Baystate Medical Center. There have not been any forensic examinations completed for a WMRWC resident in 20 years. The Supervisor advised that she and the RN are required to complete PREA training annually, between January and March of each year. She completes the specialized training required for medical. The RN interviewed advised that she is not a SANE Nurse, that such an examination would be conducted at Baystate. The RN stated she completes a special PREA component yearly, part of her 16 hours of annual medical in-service training. The specialized PREA training covered how to detect and respond to signs of sexual abuse and sexual harassment, how to preserve physical evidence of sexual abuse, how to respond to victims of sexual abuse and sexual harassment, and how to whom she would report allegations or suspicions of sexual abuse or sexual harassment. The RN advised auditor that she would report allegations or suspicions to her immediate supervisor, or to the facility Assistant Superintendent, or to the Classification Director, and down the line as necessary.

The mental health staff person interviewed advised auditor that a resident in need of a forensic examination would be sent out immediately for an examination by a SAFE/SANE. She receives specialized PREA training annually, which is mandatory. The Clinical Manager described the PREA training she has received. She advised auditor that she always asks the residents if they feel safe here (at WMRWC). She would assure a victim, not leave them alone, notify others and get help. Auditor requested and reviewed the facility mental health staff person's training records, which reflect her completing the basic and specialized PREA PODNET training during annual 16-hour training in October

2017, and the following PREA trainings completed in 2018: Cross-Gender Pod Entrance Announcements, Transgender and Intersex Inmate Services, PREA Auditor's 15 Questions for Staff, and PREA Basic.

Based upon auditors' review of agency policies, facility training records, review of the specialized medical/mental health PREA curriculum, and 4 staff interviews conducted, auditor has determined that the facility meets the requirements of the standard.

SCREENING FOR RISK OF SEXUAL VICTIMIZATION AND ABUSIVENESS

Standard 115.241: Screening for risk of victimization and abusiveness

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

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*)

Instructions for Overall Compliance Determination Narrative

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

Auditor reviewed the agency **PREA Plan 3.5.3**, **Protocol 4: Screening for Risk of Sexual Victimization & Abusiveness**, Section A. page 22-23; **4.2.1 Classification Plan**, **Protocol 3: Facility Classification**, pages 8-10; **WMRWC 4.1.1 Admission/Orientation/Release**, **Procedure C: Classification Plan**, pages 6-7 and **Procedure J: Admission,** 2**. Intake/Booking,** pages 14-16.

Auditor notes that the PREA Plan mirrors that of the PREA standard concerning all requirements for the conducting of the initial risk screening, the 30-day assessment reviews, restricted staff access to this confidential information, and other elements.

The PAQ reports 447 residents admitted to the facility whose length of stay in the facility was for 72 hours or more; 430 whose length of stay was for 30 days or more. The PAQ reports that personnel risk-screened all incoming residents within the required 72 hours, and that all residents whose length of stay was 30-days or more were properly reassessed within 30 days. Auditor has reviewed multiple samples of initial risk assessments conducted during the day of admission to the facility, conducted by multiple staff at Intake. Auditor has reviewed two emails sent from the Intake Administrative Assistant notifying appropriate facility personnel that a potential resident victim had been identified due to various risk factors noted during the objective portions of the intake processing. The final phase is completed the same day/first day of arrival upon processing in the medical department. The RN routinely completes the PREA Screening process by inquiring of the residents 6 PREA questions, and making the required subjective assessments required by the HCSD PREA Screening tool in the inmate/resident data base, TRAX. Auditor reviewed one mental health referral submitted in the last 12 months by a screening medical department employee for a resident who had reported a prior institutional sexual victimization.

Auditor has reviewed completed TRAX screen shots for the required 30- Day reviews conducted by the facility. Auditor notes that the facility generates a PREA Reviews Due Report which prompts assigned housing unit personnel to complete the 30-day reviews by the documented Due Date indicated on the Report. The PCM advised auditor that only staff that have a need-to-know have access into TRAX, such as Counselors, Unit Managers, Classification and medical.

During site review auditor observed the admittance process of two new residents on August 6, 2018. This process occurred immediately upon intake and was conducted by the Classification Manager and the Intake Administrative Assistant. Random sampling of residents confirmed that the intake processing as observed by auditor is a routine and highly regimented process conducted by the Classification Manager and the Admin Assistant.

In order to make a determination of compliance, auditor interviewed 2 Intake staff persons regularly involved in the intake screening process and the RN who routinely administers the final phase of the residents initial PREA Screening. The RN advised auditor that the residents upon admission are seen by several Intake staff where personal information and histories are confirmed. They then come across the hall to medical where the RN does the PREA Screening. The RN stated she weighs the residents and then sits them down and asks them the questions, yes or no, and documents any elaborations by the residents. The inquiries include whether the individual had ever been victimized within a correctional facility, reviewing any concerns for their safety, inquiring about their sexual preferences and making a subjective assessment. I enter the responses/input electronically, in the PREA Risk Assessment Survey in HealthTrax. Only medical or mental health staff have access into HealthTrax. The residents are assessed again any time they leave and then return from the MI or other outside transfer. “The residents are then reassessed within 30 days, I believe by the Classification Manager.” The residents are never disciplined for refusing to respond or for providing incomplete information.

Auditor reviewed facility documentation concerning the intake processing/risk screening conducted of a resident in the last 12 months that had previously reported a prior institutional victimization. This resident received a mental health referral and had a meeting with mental health at WMRWC. Auditor subsequently interviewed the resident who advised auditor that multiple personnel had interviewed him based upon his reported/documented history. He expressed appreciation for the staff concern and for auditor speaking with him.

All residents interviewed recalled the review of their personal and criminal histories and being thoroughly oriented, including PREA, immediately upon arrival. The residents recalled being seen by the nurse in medical and being asked the PREA questions. Multiple residents recalled staff by their first name, such as the Classification Manager, the Admin Assistant and the RN. One resident stated he did not recall being asked the PREA inquiries and was not asked them within 30 days of his arrival. Auditor requested and was provided documentation confirming that this resident was properly processed at intake in 2018, was PREA screened in medical by the RN the same day and was reassessed within 30 days. The majority of residents interviewed stated that either they did not recall being asked the PREA questions again by other staff or they were not asked the PREA questions a second time. Others stated they were asked the PREA questions by their unit counselors or the Captain. Based upon multiple residents not confirming that the 30- day reviews were completed individually with each resident, while evidence obtained indicated that some face-to-face 30- day reviews were being conducted, auditor discussed this finding while on-site with the agency PC and facility PCM and reviewed this finding at the audit close-out meeting the afternoon of August 8, 2018. Auditor discussed the best practice of conducting a second face-to-face reassessment with each resident, to provide them one more opportunity to report, and to utilize the opportunity for staff to conduct an additional objective and subjective assessment.

Based upon auditors review of policy and facility procedures, the PAQ responses/information, interviews with Intake personnel, auditors' observation of two intake receptions, auditor's observations of daily close interaction between staff and residents within each Unit, and resident interviews, auditor has determined that the facility meets the requirements of the standard.

Standard 115.242: Use of screening information

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

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? ☒ Yes ☐ No

- 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? ☒ Yes ☐ No

- 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? ☒ 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*)

Instructions for Overall Compliance Determination Narrative

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

Auditor reviewed the HCSD **PREA Plan 3.5.3**, **Protocol 4: Screening for Risk of Sexual Victimization & Abusiveness**, Section B. Use of Screening Information and Transgender/Intersex Inmates, pages 23-24; **4.2.1 Classification Plan**, **Protocols 1 and 2: Intake Classification and Facility Classification**, pages 6-10.

The PREA Coordinator during interview advised the auditor that the agency facilities use the risk screening results to identify those at risk of victimization or abusiveness. The computer software program then prohibits placement of inmates together in housing or programs that have contrary PREA codes. Assignments of housing, showers and programming are made on an individual basis for transgender or intersex inmates, based upon their expressed requests and staff review, based upon management or security issues. The agency facilities have adjusted to inmate's requests for separate shower times or locations, based upon the inmate's own views and requests, following staff review. The agency does not use dedicated pods or wings for housing. LGBTI may be housed to cells or beds closer to an officer's station, or in a unit that provides enhanced supervision.

The facility PCM advised auditor that an automated computer "alert" would notify staff if an officer attempted to house a victim with a perp, the system will not allow this to be done. The PCM advised that there has only been one transgender resident at the facility in the last 12 months, who was authorized to shower during different shower times in the male unit where the resident was housed. Staff ensured the resident had privacy for showering. Through staff review, the resident was authorized to recreate in the female unit. Auditor has reviewed documents verifying facility actions to accommodate many of the resident's requests. Auditor reviewed Offender Case Notes reporting numerous meetings conducted with the resident at WMRWC by various agency and facility staff, i.e. the agency Standards and Training Director, the agency Victim Services Coordinator/SAVA (Sexual Assault Victim Advocate), the YWCA Counselor, the WMRWC Assistant Superintendent, the facility PCM, Classification Manager, Clinical Manager, Counselor, and Lead Counselor.

Auditor reviewed the contract established by the WMRWC stipulating the facility conduct and programming with the transgender resident in August 2017. Auditor notes that the resident requested to change her stipulated shower times from count times to other times. This request was denied by the administration, making the decision to adhere to the original contract agreement for showers during count times.

Auditor interviewed a staff member responsible for conducting risk screening. The staff person advised auditor that perpetrators are not approved for transfer to the facility due to the community nature of the facility and the layout of the housing unit rooms. Potential perpetrators are not housed at the facility, but those identified by code are housed accordingly. A transgender or intersex residents own views would be considered in placement and programming assignments. The staff person advised auditor that a transgender resident was housed at WMRWC in 2017, and the residents' input was considered by the facility administration.

There were no transgender or intersex residents currently housed at WMRWC available to interview.

Based upon auditors' review, it is determined that the facility exceeds standard requirements. Auditor has conducted a thorough review of the facility's routine use of screening information, and the facility's concerted actions to address a resident's requests and security considerations in housing a transgender resident in 2017, which included housing, showering, phone calls, supportive meetings with staff, and staff facilitating the resident's parole/transfer/community placement. Staff and facility demonstrated a team approach to managing the adjustment of this resident, while taking the residents' own views and requests into consideration and making individualized determinations while also considering management and security issues.

REPORTING

Standard 115.251: Resident reporting

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

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*)

Instructions for Overall Compliance Determination Narrative

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

Auditor reviewed the agency policy **3.5.3. PREA Plan**, **Protocol 5: Reporting**, Section A. Inmate Reporting, pages 25-26: **3.1.6. Reporting of Incidents**, **Protocol 1: Reasons for Completing an Incident Report**, pages 2-4, and **Protocol 2: Initiation of an Incident Report**, pages 4-5; Policy **1.3.1 Human Resources**, **Protocol 23: Code of Ethics**, pages 37-40, and **Protocol 28: Sexual Misconduct**, pages 54-56.

Auditor reviewed the Initial Orientation which is read verbatim to every incoming resident being admitted to the WMRWC facility. This orientation form is signed by the resident indicating he/she has received the initial orientation. PREA is documented and discussed briefly on the main form, and a detailed PREA Information additional handout is read verbatim to all the incoming residents, which cites the HCSD zero tolerance policy toward sexual misconduct and sexual harassment, which "includes any sexual act,

touching, comments or gestures." Six reporting methods are provided to enable the residents to report sexual abuse or sexual harassment by phone to the YWCA Rape Crisis Center Hotline (1-800-796-8711; TTY 413-733-7100 or Liamanos Spanish language 24-hour helpline: 1-800-223-5011; the National Sexual Assault Hotline: 1-800-656-HOPE (4673); and directly to the Massachusetts State Police: 413-736-8390. Residents are directed to report verbally to a HCSD staff member, to send a resident request to any HCSD staff member, or request to speak with the PREA Manager or PREA Coordinator at the facility. The handout describes the rape crisis counseling available through the local YWCA and provides the address and multiple phone numbers for the YWCA. This PREA form is also signed/dated by the incoming resident and attending facility staff member.

Auditor reviewed the agency website, www.hcsdma.org Pubic Information-PREA- Reporting Sexual Abuse which provides the phone number (413-858-0914) for the agency PREA Coordinator for anyone that suspects sexual abuse has happened at one of the Hampden County Sheriff's Department facilities. Individuals can also write to the PREA Coordinator at 627 Randall Road, Ludlow, MA 01056. The English and Spanish 24-hour Helplines: English- (800)796-8711; (413)732-3121; TTY: (413) 733-7100, and Spanish-(800)223-5001 are provided, as is the YWCA address of YWCA of Western Mass. 1 Clough Street, Springfield, MA 01118. Also observed on the Sheriff's Department website is **Text-A-Tip**, described on the as a joint operation of the HCSD, Hampden County District Attorney's Office, and the Springfield and Holyoke Police Departments. This reporting resource allows people to send in anonymous tips via the text-message function on their cell phones. The police are unable to trace the message back to the sender. The **Text-A-Tip** directions advise citizens to TEXT TO: 274637-Type SOLVE (then the message). The SOLVE entry guarantees the message will be routed to the HCSD and forwarded to the local police department.

Auditor requested and attended the Intake orientation of two new residents on August 6, 2018, witnessing the Intake Administrative Assistant providing the detailed description, verbatim, of the Initial Orientation and PREA Review. A PREA Pamphlet, in English and one in Spanish, are then provided to every incoming resident before they leave intake for the Medical Department (across the hallway) PREA risk screening.

The HCSD PREA pamphlets/trifolds include the YWCA Rape Crisis Center 24-hour Hotline phone numbers. Auditor has successfully tested the English and Spanish YWCA Hotlines, which are staffed 24-7 by agency personnel. The trifolds, under How To Ask For Help, encourage residents to report by talking to their Counselor or Correctional Caseworker (CCW), talking to the Pod/Unit Officer or Supervisor, filling out an Inmate Request, or talking to a Mental Health Clinician or medical staff. Under How to report you have been sexually assaulted, the residents are encouraged to speak with any person they feel comfortable with such as the Pod Officer, Sergeant, Counselor, CCW, Caseworker, Nurse, Chaplain, Teacher, or any other Sheriff's Department staff or even a family member.

Auditor reviewed the agency MOU with the YWCA of Western Massachusetts, located in Springfield, Massachusetts. This YWCA operates the 24-hour Rape Crisis Center Hotlines. The YWCA agrees to allow the HCSD agency to include the Rape Crisis Hotline number in agency brochures and in education materials that are available to the inmates/residents. Auditor interviewed the YWCA Director of Support Programs who confirmed the MOU between the YWCA and the HCSD.

During auditor's site review, agency PREA posters were prominently posted in all housing units and common areas/dayrooms, posted normally in secure display cases. These posters included toll-free Hotline numbers. The Hotline numbers are also affixed to all resident telephones located on all three housing unit floors of the facility. Auditor also observed the facility Audit Notice, which was posted 6 weeks prior to the audit.

Auditor interviewed the PCM who advised auditor that residents can report using the YWCA Hotline or by informing families while on visits (third parties). Residents can remain anonymous during the reporting process through the YWCA or any other means of reporting.

In order to make a determination of compliance, auditor interviewed random staff concerning resident reporting. Staff advised auditor that residents can report using the Hotline phones available to them on each floor of the

facility, by speaking with the unit officer, caseworker, counselor, medical staff, by anonymous note to staff, through a third party, or grievance. Staff stated such reports would remain confidential and could be made verbally, in writing, anonymously and from third parties. All staff interviewed indicated they would document such a verbal report of sexual abuse or sexual harassment, immediately, ASAP and “Right away, while fresh in my mind.” All staff interviewed were familiar with the Employee Assistance Program (EAP) through River Valley Counseling Center which provides a method for private staff reporting. Auditor has reviewed the EAP Informed Consent & Limits of Confidentiality form developed for the HCSD which accepts confidential reports from agency personnel reporting the sexual abuse or sexual harassment of inmates/residents of the Hampden County Sheriff’s Department. During staff interviews, it was apparent that staff were well educated and trained concerning their reporting responsibilities. This the result of numerous PREA trainings effectively presented on an ongoing basis.

Random residents interviewed revealed a well-oriented population of individuals, advising that they would report sexual abuse or sexual harassment to the CO on the floor at desk, to the Counselor, Captain, Lieutenant, to family, by calling the PREA Hotline, calling the police and by filing a grievance. Residents were aware that they could make such reports anonymously, verbally, in writing and through a third party. Many of the residents interviewed mentioned that the PREA posters were everywhere and the numbers were on the phones. No resident interviewed stated that he/she had reported sexual abuse or sexual harassment while confined at the WMRWC. No resident expressed hesitation of reporting an incident or information to a staff member, reflecting the resident trust and reliance of facility personnel. One resident interviewed was the victim of sexual harassment by another resident in the last 12 months. This incident was reported to facility personnel by a third party (another resident). The perpetrator admitted his conduct and was transferred back to higher security. This resident advised auditor that he felt safe at WMRWC.

Auditor reviewed a 2017 Resident Grievance submitted alleging staff sexual harassment. During site review, auditor reviewed this grievance investigation with the PREA investigator and viewed the evidentiary CCTV recording of a nearby camera. This case was determined to be Unfounded while demonstrating a thorough investigation conducted resulting from a grievance submission. Auditor reviewed a 2015 Incident Report submitted by a staff nurse documenting a verbal allegation received from a resident. Agency personnel utilize a flow chart document for information and referral: “Staff notification of a sexual assault to Shift Commander” which addresses the handling of the victim, assailant(s), first responder duties, evidence collection/preservation, medical and mental health evaluation/services, transportation, investigation, outside supportive services and victim advocate, retaliation monitoring and incident review.

Auditor has determined that the WMRWC Exceeds standards based upon the aforementioned auditor discussion of the facility’s effective communication of the multiple reporting methods established, staff knowledge, and staff response to allegations received.

Standard 115.252: Exhaustion of administrative remedies

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

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 ☐ NA

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*)

Instructions for Overall Compliance Determination Narrative

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

Auditor reviewed the agency **PREA Plan**, **Protocol 5: Reporting**, Section B. Exhaustion of Administrative Remedies, pages 26-28. Auditor found that agency policy/grievance procedures includes all requirements of the PREA standard.

The PAQ reports 0 grievances filed in the last 12 months that alleged sexual abuse. There were 0 emergency grievances filed in the last 12 months. There were 0 misconducts filed for residents filing a grievance in bad faith. Auditor reviewed one grievance filed in the last 12 months that alleged sexual harassment which was investigated and determined to be Unfounded. Auditor review this investigation with the facility PREA investigator during the formal interview process. Auditor reviewed another sexual harassment investigation, resulting from a third-party report, which was substantiated in the last 12 months.

During site review auditor observed the resident mail box located in the lobby area accessible to all residents. The grievance process is explained to the residents in Section 6 of the Resident Manual, pages, 64-65. The residents are instructed to obtain a grievance form at the unit officer's station and submit grievance to the Unit Manager.

There were 0 sexual abuse allegations made in the last 12 months and 0 residents available to interview that had reported a sexual abuse in the last 12 months.

Auditor had determined that the facility meets the requirements of the PREA standard. The agency has policy and procedure in place for residents to seek relief through an established review process. Staff and residents are aware of this process, and as evidenced by one resident filing a sexual harassment grievance in the last 12 months, and another filing a third-party report to personnel.

Standard 115.253: Resident access to outside confidential support services

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

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*)

Instructions for Overall Compliance Determination Narrative

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

Auditor reviewed the agency **PREA Plan 3.5.3**. **Protocol 5: Reporting**, Section C. Inmate Access to Outside Confidential Support Services, page 28.

The facility PAQ reports that the facility maintains a Memoranda of Understanding (MOU) with a community service provider (YWCA) to provide residents with emotional support services related to sexual abuse. Auditor reviewed the MOU between the HCSD and the YWCA of Western Massachusetts, 1 Clough Street, Springfield, MA, 01118.

Auditor interviewed the YWCA Director of Support Programs who advised auditor that the YWCA will generally provide 5-7 individual counseling sessions with a resident of the WMRWC or other HCSD facility, within the facility where they are housed. There can be additional sessions authorized based upon the inmates/resident's request and the circumstances. The YWCA Sexual Assault Counselor can

follow-up with the resident on the street following discharge from the facility if the resident chooses. The services provided by the YWCA Counselors are Domestic Violence Services and Sexual Assault Counseling.

During site review of the facility auditor observed numerous HCSD PREA posters prominently posted throughout the facility. These PREA posters include the PREA toll-free numbers for the YWCA Rape Crisis Hotlines. Auditor has successfully tested the English and Spanish Rape Crisis Hotline phone numbers. The HCSD PREA Pamphlets also contain the PREA Hotline phone numbers and the address for the area YWCA to access sexual assault counseling services. The residents receive during the PREA education process the PREA Information document which encourages the residents to "please notify staff so that they can assist you." This handout also contains the Hotline and Office YWCA telephone numbers and the YWCA address to access confidential "rape crisis counseling" services.

The YWCA phone numbers (Hotline and Office), and address are posted on the agency website www.hcsdma.org.

Auditor interviewed random male and female residents concerning their awareness of the availability of community supportive services. The majority of residents interviewed were aware that there were such services available and that the YWCA was the agency providing such services. The types of services described to auditor were counseling, reentry, domestic abuse, housing, family advocates, one-on-one and group counseling, mental health and awareness, "A to Z, soup-to-nuts, legal, housing, counseling," Habitat for Humanity, Other residents were unsure of the type of programs but expressed that they believed such programs existed, and that if they had to use services they could find out through facility staff or AISS (HCSD After Incarceration Supportive Services). The residents advised that they had access to the telephones from 3pm till around 10:30-11pm on weekdays and from 8am-1am on weekends. Several residents stated that they believed staff would allow them to use the phones at any time concerning a serious situation.

One female resident advised auditor that she had several sessions with the YWCA Counselor at WCC before coming to WMRWC, and then the YWCA Counselor followed her to WMRWC at the residents' request where she has continued to meet with the resident. The resident advised auditor that she was inspired by the YWCA Counselor. The YWCA Director of Support Programs advised auditor that she has met this particular resident who has had 8 individual counseling sessions "because she is doing so well and on the right track."

Auditor notes the YWCA Counselor visiting WMRWC previously during 2017 to conduct individual counseling sessions with a transgender resident who had requested such services. Such visits were documented by HCSD and WMRWC personnel. This resident also had supportive interactions and meetings with multiple facility counselors, the PCM, SAVA and the HCSD Standards and Training Manager. The resident is no longer housed at WMRWC.

There were no residents available to interview that had reported a sexual abuse.

Based upon auditors review of agency policy, site review observations and staff (YWCA) and resident interviews, auditor has determined that the facility exceeds the requirements of the PREA standard. The facility makes a concerted effort to properly orient the residents, upon arrival and during their time at WMRWC, of the staff facility services available and the confidential YWCA services available. The WMRWC then facilitates such YWCA counseling visitations for the resident population. Resident interviews have confirmed the residents' educated awareness, their reliance upon facility personnel and their utilization of community supportive services.

Standard 115.254: Third-party reporting

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

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*)

Instructions for Overall Compliance Determination Narrative

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

Auditor has reviewed the agency **PREA Plan 3.5.3**. **Protocol 5: Reporting**, Section D. page 28, which provides for 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 inmate. Auditor visited the agency website at www.hcsdma.org and reviewed the **Text-A-Tip** reporting mechanism available to any citizen to report sexual abuse or sexual harassment of any agency inmate/resident to the HCSD and local law enforcement. **Text-A-Tip** is described on the agency website as a joint operation of the HCSD, Hampden County District Attorney's Office, and the Springfield and Holyoke police. This reporting resource allows people to send in anonymous tips via the text-message function on their cell phones. The police are unable to trace the message back to the sender. The Text-A-Tip directions advise citizens to TEXT TO: 274637-Type SOLVE (then the message). The SOLVE entry guarantees the message will be routed to the HCSD and forwarded to the local police department.

During site review, auditor reviewed all 3 PREA investigations conducted in the last 12 months. One PREA case was a third-party sexual harassment report made to personnel by a resident. This resident alleged that another resident had been being sexually harassed by a third resident. Staff took appropriate action, conducted an investigation which was substantiated, and the admitted perpetrator was transferred back to a higher security facility.

The agency website describes the policies in place to ensure referrals of allegations to agency investigators. the PREA Plan 3.5.3. is posted and available for citizen-review on the website. The website lists the contact information for the agency PREA Coordinator and the YWCA of Western Massachusetts.

Based upon auditors review of the agency PREA Plan and review of the methods available to enable third-party reporting, auditor has determined that the facility meets the requirements of the standard.

OFFICIAL RESPONSE FOLLOWING A RESIDENT REPORT

Standard 115.261: Staff and agency reporting duties

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

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*)

Instructions for Overall Compliance Determination Narrative

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

Auditor has reviewed the **3.5.3. PREA Plan**, **Protocol 6: Official Response Following An Inmate Report**, Section A. Staff and Department Reporting Duties, pages 28-29. This policy protocol includes all requirements established by the PREA standard.

Auditor has reviewed 3 Incident Reports submitted in 2017 and 2018 by personnel reporting facility residents not in compliance with regulations pertaining to bathroom/shower operations and opposite gender supervision, i.e. Knock and Announce responses/conduct by residents in the bathroom/showers. A grievance was also reviewed by auditor which was turned over to the facility PREA investigator, investigated and determined to be Unfounded. Another PREA investigation was initiated in 2018 based upon a residents' allegation of sexual harassment by another resident. This matter was investigated, and the alleged perpetrator disciplined due to his admitted behavior. The perpetrator was subsequently transferred to a higher security confinement facility due to his conduct.

The Agency Director (designee) advised auditor that any and all reports received of sexual abuse or sexual harassment, regardless of the source, are treated the same and investigated, whether by a facility PREA investigator or by CIU.

The PREA Coordinator advised auditor during interview that the agency does not house offenders under the age of 18, but any vulnerable adult would be treated according to agency policy and reported to DPH officials. The PCM advised auditor that any incoming vulnerable adult would be identified, and this information communicated to appropriate staff by intake/classification personnel. If there was an

incident or allegation involving a vulnerable adult we would separate the residents by units, monitor their movements, and investigate.

The mental health staff interviewed advised auditor that she discloses the limitations of confidentiality and her duty to report at every session conducted with a resident. She is required to report any knowledge, suspicion or information of an incident of sexual abuse or sexual harassment to the Classification Manager, Assistant Superintendent, or security, the highest-ranking staff member present. She stated she has never become aware of an incident of sexual abuse at the WMRWC. The 3 medical staff interviewed advised auditor that they would disclose their limitations of confidentiality and duty to report at the initiation of services to a resident. They would report an incident or suspicions of an incident to the Assistant Superintendent or security. None of the medical staff were aware of a rape or sexual abuse of an inmate at WMRWC. One of the medical staff persons was informed by a security staff of a resident that reported being sexually harassed by another resident.

Random staff interviewed provided auditor with responses indicating staff are aware of their duty to report their information or suspicions ASAP, immediately right away and before end of shift. They would report to their Supervisor, the PREA Investigator, report to Shift Commander at the Main Institution (response from a WMRWC Shift Supervisor), report to PCM and CIU (response from a Shift Sergeant), report to CIU (response from a Shift Lieutenant), report to security supervisor on duty (response from Counselor).

Based upon auditors' review as noted, it is determined that the facility meets the requirements of the standard.

Standard 115.262: Agency protection duties

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

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*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does

not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Auditor has reviewed the HCSD **3.5.3. PREA Plan**, **Protocol 6: Official Response Following an Inmate Report**, Section B. 1. HCSD Protection Duties, page 29: When the HCSD learns that an inmate is subject to a substantial risk of imminent sexual abuse, it will take immediate action to protect the inmate**.**

The facility PAQ reports that there were 0 times in the last 12 months when the facility determined that a resident was subject to a substantial risk of imminent sexual abuse.

The Agency Head designee advised auditor that steps would immediately be taken to ensure the safety of the reporting resident. Investigation would start immediately. Staff would separate the residents, house separately or move one of the residents to another facility.

The facility Director (Assistant Superintendent) advised that we would make sure to separate the residents and investigate. The perpetrator would be moved to a higher security facility within the HCSD. The reporting resident may be moved to a room closer to the officers' station.

Random staff interviewed provided responses to auditor indicating they would immediately secure/separate/remove them from area/make them safe, notify their supervisor, interview the residents, preserve evidence, and document the incident.

Auditor has reviewed the agency PREA Plan and determined that the policy requirements are in place instructing personnel to respond to immediately take action to protect an inmate/resident that is subject to a substantial risk of imminent sexual abuse. Staff interviews have confirmed that agency leadership and line staff are aware of the standards' requirements and the importance of taking immediate action to ensure the resident's safety. Auditor has determined that the facility meets the requirements of the standard.

Standard 115.263: Reporting to other confinement facilities

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

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*)

Instructions for Overall Compliance Determination Narrative

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

Auditor has reviewed agency policy **3.5.3 PREA Plan**, **Protocol 6: Official Response Following an Inmate Report**, Section C. Reporting to Other Confinement Facilities, pages 29-30:

1. Upon receiving an allegation that an inmate 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 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.

The PAQ reports 0 allegations received in the last 12 months of a facility resident abuse while confined at another facility. There were 0 reports received from other facilities alleging that a resident had reported being sexually abused while confined at the WMRWC.

The Agency Head designee advised auditor that the HCSD investigates any report of sexual abuse received from another agency or facility, the same as any incident or allegation received by a HCSD inmate or resident. The WMRWC Director (Assistant Superintendent) advised auditor during interview that facility starts the investigation process right away upon receiving an allegation from another facility or agency that an incident of sexual abuse or sexual harassment occurred in the WMRWC. The PREA investigator would be contacted and proceed to gather evidence. The Assistant Superintendent advised auditor that there were no such cases in the last 12 months, but that the facility would follow-up if they would receive such information.

Based upon policy requirements and staff awareness, auditor has concluded that the facility meets the requirements of the standard.

Standard 115.264: Staff first responder duties

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

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*)

Instructions for Overall Compliance Determination Narrative

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

Auditor reviewed the **3.5.3 PREA Plan**, **Protocol 6: Official Response Following an Inmate Report**, Section D. First Responder Duties, page 30.

The facility PAQ reports 0 allegations in the last 12 months that a resident was sexually abused. There were no grievances filed or complaints received alleging that a resident had been sexually abused at WMRWC. There were therefore no inmates available to interview who had reported a sexual abuse.

In order to make a determination of compliance auditor interviewed random staff who responded to auditor that they would ensure victim safety and remove the perp from the area, monitor them, protect the scene, notify supervisor/medical-supervisor would contact PREA investigator, obtain information from residents, prevent residents from washing showering, using the bathroom, brushing teeth, contain/isolate and notify, obtain PREA Bags from the Control Supervisor's Office, document actions taken, lock unit down, get additional staff on scene. Staff responses indicated an excellent awareness of response and scene priorities, in accordance with agency training and the standard requirements.

Auditor interviewed a nonuniformed employee to assess staff awareness of first responder duties. This Employee advised auditor that she would secure the scene, separate those involved, ensure they are supervised and that no evidence is destroyed. Alert security, no eating, drinking washing or urinating. A security staff member advised auditor that he would separate the residents, take statements, notify the PCM, get medical attention and to hospital if necessary, get the PREA kits on scene, secure the scene, ensure an officer is posted with each person, ensure no showers or washing until cleared by medical and the investigators.

Auditor has reviewed the (annual) 2018 HCSD Pocket Planner which is issued to all agency personnel. This annual scheduling tool was revised effective 2017 to include the PREA First Responder duties. The intention is to provide a readily available checklist for on-scene personnel should they be involved in an incident or receive allegations of a sexual abuse. Essential steps are described as follows:

If you are the 1st security staff person to respond, you must:

1. Separate the victim and abuser.
2. Immediately notify your supervisor.
3. Secure the crime scene & protect any evidence until the proper CIU steps can be taken.
4. If the abuse occurred recently enough for physical evidence to be collected, keep the victim and abuser from doing anything to destroy the evidence like washing, brushing teeth, changing

clothes, drinking, eating or urinating/defecating. Immediately contact Medical & Mental Health practitioners for emergency treatment and crisis intervention services.
5. Complete a detailed incident report before the end of shift.

If you are the 1st staff person to respond but are not security staff, you must:

1. Ask the victim & abuser not to do anything that could destroy physical evidence.
2. Notify security staff.

Based upon auditors' findings, it has been determined that the facility meets the standard requirements. While there have been 0 incidents which have required the response of facility personnel, policy and procedures are in place and staff have exhibited an excellent awareness of their responsibilities in responding to such an incident or report received.

Standard 115.265: Coordinated response

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

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*)

Instructions for Overall Compliance Determination Narrative

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

Auditor has reviewed the **PREA Plan 3.5.3. Protocol 6: Official Response Following an Inmate Report**, Section E. Coordinated Response, page 30. In response to standard and the PREA Plan policy requirements to develop a written institutional plan to coordinate staff actions in response to an incident of sexual abuse, the agency has developed multiple written policies/procedures for such coordinated action.

The agency policy **3.1.7 Special Teams**, **Protocol 3: Criminal Investigative Unit (CIU)**, pages 9-13; **Protocol 4: Critical Incident Response Team (CIRT)**, pages 14-19; and **Section J-B-05 Response to Sexual Assault**, pages 27-28, direct the appropriate agency/facility departments and personnel in their response to a sexual abuse incident.

The Criminal Investigative Unit (CIU) has written guidelines, **CIU Sexual Assault Investigations**, which include Definitions related to Sexual Abuse (Rape), and Sexual Abuse (indecent Assault & Battery). The CIU will only investigate incidents of sexual abuse or allegations of sexual abuse. The CIU will not investigate allegations of sexual harassment.

The HCSD Victim Services Coordinator/SAVA has agency coordination duties with the facility PREA investigators and CIU. The SAVA coordinates Victim Services, providing victim-offender conferencing, and other possible services desired by victims. She provides support and advocacy to incarcerated victims of sexual assault and assists the incarcerated victim to obtain a reasonable continuum of services throughout incarceration and following release as needed. Auditor has interviewed the SAVA, and confirmed her intervention and services provided in coordinating facility mental health and counseling services, and YWCA sexual assault counseling services to an inmate that had alleged sexual assault by another inmate at a higher security level HCSD facility prior to transfer to WMRWC in 2017. The inmate had received such services prior to transfer and subsequent to transfer to the WMRWC. This matter also involved agency PREA investigators, CIU, SANE and the Massachusetts State Police working in a coordinated effort to investigate the inmates' allegation.

The PREA Process Map is a comprehensive agency flow chart depicting facility departmental responsibilities, Risk Screening, Victim/Predator Status, Triggers which precipitate an Investigation, Investigative Findings/Determination of charges if substantiated, Incident Reviews, 90-day Tracking, Medical/Mental Health Referrals, etc.

Based upon auditors' interview of both random staff (uniformed and non-uniformed), specialized staff, i.e. leadership, investigator, medical/mental health, and PCM, auditor has concluded that individual staff and the various departments work well in a coordinated effort to accomplish all operational and programming objectives. This includes the training of personnel, the orientation/education of the resident population, the risk screening of the incoming residents, the effective separation of males/females and Section 35 residents, and the thoroughness of the several PREA investigations conducted. Auditor has determined that the facility exceeds the requirements of the standard, based upon the written plans to respond to an incident of sexual abuse, the appointment and valuable utilization of SAVA, and the staff members adherence to agency policy, procedure and facility mission as a matter of routine.

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

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

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*)

Instructions for Overall Compliance Determination Narrative

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Auditor has reviewed the **PREA Plan**, **Protocol 6: Official Response Following an Inmate Report**, Section F. Preservation of Ability to protect Inmates from Contact with Abusers, page 31.

All bargaining unit agreements with agency employees contain contract language which protects the agency's "right to remove, dismiss, discharge, suspend or discipline an employee, provided that no such action shall be taken except for just cause." (Article 7, No 1. of Disciplinary Action, The National Correctional Employees Union)

The agreement with the Hampden County Superior Correctional Officers Association, Article 6 contains similar language: 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.

Auditor interviewed the Agency Head designee who advised auditor that there is no bargaining unit language or provisions that limits the employers' ability to remove alleged staff sexual abusers from contact with the residents pending the outcome of an investigation or of a determination of whether and to what extent discipline is warranted. The facility would reassign a staff member to another post or shift, as necessary. Staff would be informed of the reasons for such a change.

Based upon the requirements of the PREA Plan, the PAQ response, auditor's review of the existing bargaining unit agreements, and the staff interview of the Agency Head designee, auditor has determined that the agency is in compliance with the standard.

Standard 115.267: Agency protection against retaliation

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

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*)

Instructions for Overall Compliance Determination Narrative

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Auditor has reviewed the **PREA Plan**, **Protocol 6: Official Response Following an Inmate Report**, Section G. Department Protection against Retaliation, pages 31-32. This protocol language includes all elements of the PREA standard.

The facility PAQ reports 0 instances of retaliation which occurred in the last 12 months. There were 0 cases of retaliation monitoring in the last 12 months at WMRWC.

Auditor interviewed the facility PCM who is the designated facility staff member charged with monitoring retaliation. The PCM advised that she has not done any retaliation monitoring in the last 12 months. If she was tasked with monitoring she would look for any program moves of the resident, any disciplinary reports, note the residents' attitude and behavior, and she would consult with the resident's counselor regularly. To prevent retaliation, we would ensure a housing change is made of the resident or residents to ensure separation, possibly transfer a resident back to higher security, ensure they receive emotional support, ensure the counselors follow-up with them. All 3 cases in the last 12 months the residents were discharged from the facility before retaliation monitoring could be implemented. I would fulfill the monitoring requirements and input the information into TRAX weekly, if we had any retaliation monitoring occurring. We could exceed the 90-day monitoring period as necessary.

The Agency Head designee advised auditor that housing unit changes or transfer could be implemented as a protection measure, and even segregated housing as a last resort. Staff can be reassigned as needed. Retaliation monitoring would be initiated and could exceed the 90-day monitoring period.

The facility Director (Assistant Superintendent) advised auditor during interview that the facility can take several measures to protect residents and staff from retaliation. One would be to keep the reports confidential, maintain anonymity of the accusers, victims and any witnesses, possibly change the residents' programs or housing unit, and have the PCM monitor the resident. If we suspect retaliation we would start an investigation and go forward, if staff involved it may be of criminal level, a transfer may be necessary.

There were no residents currently housed in the facility that had undergone retaliation monitoring available for interview. This is due to the low number of PREA investigations conducted during the last 12 months, i.e. 3, and the short duration of the program with average length of stay being 3 months. Auditor did review a Retaliation Monitoring form (HCSD PREA Retaliation Assessment) from 2015 which evidenced appropriate monitoring by the facility PCM at that time. In that Unsubstantiated case, the resident was transferred-back to a higher security facility.

Based upon auditors' review, it is determined that the facility meets the requirements of the standard.

INVESTIGATIONS

Standard 115.271: Criminal and administrative agency investigations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

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*)

Instructions for Overall Compliance Determination Narrative

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

Auditor reviewed the agency **3.5.3. PREA Plan**, **Protocol 7: Investigations, Section A. Criminal and Administrative Investigations**, pages 32-34; HCSD 3.1.7 Special Teams, Protocol 3, Criminal Investigative Unit, Sections A-H, pages 9-12.

The agency **PREA Plan 3.5.3** includes all elements required by the PREA standard. The agency **Special Teams Policy 3.1.7** within **CIU Protocol 3** provides detailed instructions and guidance for personnel concerning investigative authority, crime scene management, evidence collection/preservation, agency and external notifications (MSP CPAC Unit/Detective Unit), report reviews, recording of interviewee statements, taking photographs and compilation/distribution of investigative reports. The CIU conducts investigations of inmate/resident infractions of a serious nature directed toward another inmate, staff and/or visitor(s). The HCSD CIU does not investigate sexual harassment allegations.

The facility PAQ reports 0 substantiated allegations that were referred for prosecution since August 20, 2012. The PAQ reports 0 administrative investigations of alleged resident sexual abuse that were completed by the facility in the last 12 months. There were therefore 0 residents available to interview that had reported a sexual abuse. The facility did conduct 3 PREA administrative investigations, based upon 2 resident reports of sexual harassment (one alleging harassment by another resident and one alleging harassment by staff); and a case of two residents observed in an unauthorized area together (both residents were transferred back to higher security). Two of the cases were Unsubstantiated and one was Substantiated (sexual harassment by another resident, with the admitted guilty party transferred back to higher security and disciplined).

Auditor reviewed the Criminal Investigative Unit (CIU) document, CIU Sexual Assault Investigations, which provides definitions and jurisdiction of the CIU Unit. Auditor has reviewed a HCSD/CIU May 1, 2015 memorandum distributed to all Commonwealth of Massachusetts law enforcement agencies announcing implementation of PREA at the Hampden County Sheriff's Department and requesting the sister agencies to forward any information or suspicions of sexual abuse at one of the HCSD facilities to the HCSD PREA Coordinator or by notifying the MA State Police.

The Agency Head designee advise auditor that cases investigated by the MSP are coordinated with our PREA officials and the CIU. We would stay in communication through emails and telephone. The HCSD PREA Coordinator advised that her office would be kept informed of any outside agency (MSP) investigations. Agency staff would facilitate any requests by the MSP.

In order to make a determination of compliance auditor interviewed the facility PREA investigator. The Sergeant advised auditor that an investigation is initiated immediately following an allegation received. She described the first steps of an investigation as separating the victim and perp, providing medical attention and SANE transport if necessary, collecting of any evidence-clothing, interviewing victim, suspect and witnesses, reviewing cameras, processing physical/bodily evidence to MSP, monitor phone calls, review prior info and any other allegations. All allegations are investigated, from any source. CIU handles any criminal level substantiated incidents, and coordination with MSP and prosecutor. The credibility of an alleged victim, suspect or witness is based upon past behavior, demeanor, if can be corroborated by witnesses, phone and mail evidence. A resident would not be subject to a polygraph exam or other truth-telling device as a condition for proceeding with an investigation. An investigation would proceed regardless of whether a staff member or resident involved left employment or was released from custody. If an outside agency were conducting an investigation of sexual abuse the investigator would serve as a liaison with that agency or the HCSD CIU. We would attempt to determine whether staff actions or failure to act contributed to an incident of sexual abuse.

All investigations are thoroughly documented…" Everything-who, what, when, where and how." All elements, such as interview statements, telephone records, videos, surveillance, correspondence, physical evidence, staff reports and agency forms. The standard of evidence used to substantiate sexual abuse or sexual harassment is a preponderance of evidence.

Based upon auditors review of agency policies, the 3 PREA investigations conducted in the last 12 months, the separation of division of labor concerning the CIU and facility PREA investigators, the training of 8 PREA investigators, and the staff interviews, auditors' overall determination is that the facility substantially exceeds the requirements of the standard.

Standard 115.272: Evidentiary standard for administrative investigations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

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*)

Instructions for Overall Compliance Determination Narrative

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

The **PREA Plan 3.5.3 Protocol 7: Investigations**, Section B. Evidentiary Standard for Administrative Investigations requires that the standard of evidence be no higher "than a **preponderance of the evidence** in determining whether allegations of sexual abuse or sexual harassment are substantiated."

The facility PREA investigator during interview advised auditor that the standard of evidence used in agency administrative investigations of sexual abuse and sexual harassment is a preponderance of evidence.

Based upon the agency policy requirement and the facility PREA investigators prior specialized training and understanding of the evidentiary standard, auditor has determined that the facility meets the requirement of the PREA standard.

Standard 115.273: Reporting to residents

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

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 an agency 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*)

Instructions for Overall Compliance Determination Narrative

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

Auditor reviewed the agency **PREA Plan**, **Protocol 7: Investigations**, Section C. Reporting to Inmates, page 34. This policy language includes all elements of the PREA standard.

The PAQ reports 0 criminal and/or administrative investigations of sexual abuse completed in the last 12 months. there were 0 outside agency or CIU investigations conducted at WMRWC in the last 12 months. There were 3 residents provided written notification of the results of administrative PREA investigations conducted in the last 12 months.

Auditor reviewed a completed WMRWC Employee & Violations Incident Report Form submitted in the last 12 months reporting the facility Captain's review of camera footage concerning an alleged PREA sexual harassment allegation. The facility utilizes such a form to officially document staff actions in response to investigative procedures taken. Auditor while onsite also reviewed this CCTV video recording, as the recording was contributory to the finding of Unfounded by the facility PREA

investigator. Auditor reviewed the Inmate Notification of PREA Sexual Abuse/Misconduct Action form provided to the resident following the completion of the investigation. This Inmate Notification was authored by the WMRWC PCM.

During interview with the facility Director (Assistant Superintendent) auditor was advised that the residents are notified in writing of the outcome of the investigation conducted.

The facility PREA investigator informed auditor that all residents that have made an allegation are informed in writing of the outcome of the investigation, whether the finding was substantiated, unsubstantiated or unfounded.

There were 0 residents that had filed an allegation of sexual abuse available to interview.

Based upon auditors' review of agency policy, interview with facility personnel, and review of the pertinent facility documentation cited, auditor has determined that the facility meets the requirements of the standard.

DISCIPLINE

Standard 115.276: Disciplinary sanctions for staff

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

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*)

Instructions for Overall Compliance Determination Narrative

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

The **PREA Plan 3.5.3 Protocol 8: Discipline**, Section A. Disciplinary Sanctions for Staff, page 35 provides for disciplinary sanctions up to and including termination for violating department sexual abuse or sexual harassment policies. Specific instructions concerning the severity of discipline, and termination notifications to law enforcement and licensing bodies is also included in the policy, in accordance with the PREA standard. Policy **1.3.1 Human Resources**, **Protocol 28: Sexual Misconduct**, pages 54-58 details Employee Responsibilities, Staff Training and Inmate Training related to sexual misconduct (sexual abuse and sexual harassment). Expectations of staff, staff response to an incident and reporting responsibilities are included in the policy.

The facility PAQ reports 0 WMRWC staff who have violated agency sexual abuse or sexual harassment policies in the last 12 months.

Auditor has determined that the facility is in compliance with the standard due to the agency policy language mirroring that of the PREA standard, and 0 instances of staff misconduct/discipline.

Standard 115.277: Corrective action for contractors and volunteers

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

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*)

Instructions for Overall Compliance Determination Narrative

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

Auditor reviewed the **PREA Plan**, **Protocol 8: Discipline**, Section B. Corrective Action for Contractors, Interns, and Volunteers, pages 35-36. This policy requires prohibition from the facility for any contractor, intern or volunteer who engages in sexual abuse with a resident, and will be reported to law enforcement, unless the activity was clearly not criminal, and to relevant licensing bodies. Appropriate remedial measures are to be taken, to include possible further contact prohibitions.

The PAQ reports there were 0 contractors, interns or volunteers reported to law enforcement agencies or relevant licensing bodies for engaging in sexual abuse with residents.

The facility Director (Assistant Superintendent) advised auditor that the facility would take appropriate action in the event of a contractor or volunteer violating sexual abuse or sexual harassment policies. The individual contractor or volunteer would be "posted" from the facility entrance, meaning a formal ban of the individual's further access to the facility. Such a "posting" would be made at all HCSD facilities. The individual would receive this notification in writing. The matter may be turned over to the MSP.

Based upon the agency's policy consistent with the PREA standard, 0 instances of contractor/volunteer/intern incidents, and the facility Assistant Superintendent's appropriate response, the auditor has determined that the facility meets the requirements of the standard.

Standard 115.278: Interventions and disciplinary sanctions for residents

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

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

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)

- 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*)

Instructions for Overall Compliance Determination Narrative

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

The **PREA Plan**, **Protocol 8: Discipline**, Section C. Disciplinary Sanctions for Inmates, page 36, states:

1. Inmates will be subject to disciplinary sanctions/mandated programming pursuant to a formal disciplinary process following an administrative finding that the inmate engaged in inmate-on-inmate sexual abuse or following a criminal finding of guilt for inmate-on-inmate sexual abuse.

2. Sanctions will be commensurate with the nature and circumstances of the abuse committed, the inmate's disciplinary history, and the sanctions imposed/mandated programming for comparable offenses by other inmates with similar histories.

3. The disciplinary process will consider whether an inmate's mental disabilities or mental illness contributed to his or her behavior when determining what type of sanction, if any, should be imposed.

4. The department may discipline an inmate 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 inmates and will discipline inmates for such activity.

The PAQ reports 0 number of administrative or criminal findings of resident-on-resident sexual abuse that have occurred in the facility in the last 12 months. The agency prohibits all sexual activity between inmates/residents. Auditor reviewed a PREA investigation conducted in the last 12 months which involved two residents unauthorized to be present together in the same bathroom area. This presence constituted a violation of facility regulations. The residents were both interviewed and denied sexual touching. They were both screened by medical. While the PREA investigation was determined to be Unsubstantiated, the residents were transferred back to higher security due to clearly violating the one-person rule in this facility work area.

The facility Director (Assistant Superintendent) advised auditor that a resident that engaged in sexual abuse with another resident would be transferred to higher security in disciplinary detention. He/she would not earn Good Time. The sanctions imposed would be proportionate to the nature of the abuses committed, the residents' disciplinary history, and the sanctions imposed for similar offenses by other residents with similar histories. A resident's mental disability or mental illness would be considered when determining sanctions.

Auditor interviewed a mental health staff person who advised auditor that the HCSD offers therapy and counseling designed to address the underlying reasons or motivations for sexual abuse at the Main Institution for males and at the Women's Correctional Center for females. Residents with sexually abusive histories are not housed at WMRWC.

Auditor has determined that the facility meets the standard requirements due to the existing policy language, staff awareness of the resident's disciplinary considerations and absence of any instances of resident-on-resident sexual abuse in the last 12 months.

MEDICAL AND MENTAL CARE

Standard 115.282: Access to emergency medical and mental health services

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

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*)

Instructions for Overall Compliance Determination Narrative

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

The **PREA Plan**, **Protocol 9: Medical and Mental Health Care**, Section B. Access to Emergency Medical and Mental Health Services, page 37; **4.5.2. Emergency Medical Care**, **Protocol 4: Emergency Medical Service (EMS) Response**, pages 9-10, **Protocol 5: Patient Escort Off Site**, pages 10-11, and **932.11: Emergency Health Care**, pages 15-16. HCSD defines within this policy: *Emergency* medical, mental health and dental health care is care for an acute illness or an unexpected health need that cannot be deferred until the next scheduled sick call or clinic. (page 18).

Policy language has been developed and implemented in accordance with the PREA standard. The facility PAQ reports the facility to be compliant with the policy and standard requirements.

Auditor interview a mental health employee who advised auditor that a resident victim would receive timely and unimpeded access to emergency medical treatment and crisis intervention services. This

would be immediate by staff reporting to security and medical, resident goes to hospital and is treated by SANE. The hospital makes suggestions for follow-up by facility staff with resident. The nature and scope of the services provided is determined by the SANE at the hospital. Residents are offered timely information about access to emergency contraception and sexually transmitted infection prophylaxis.

Auditor interview 3 medical personnel who advised auditor that the facility would transport a resident to Baystate Hospital immediately. The nature and treatment of services would be determined by the SANE there. The resident would be offered timely information about access to emergency contraception and sexually transmitted infection prophylaxis at the hospital. One medical staff person stated that the facility would notify the YWCA and they would meet us at the hospital to provide crisis intervention services.

Auditor interviewed a uniformed security staff first responder who advised auditor that 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 separate the residents, take statements, notify the PCM, secure the scene and post an officer with each resident, prevent showering or washing till cleared by medical and investigators, get resident medical attention at MI or WCC or to hospital if necessary if no medical staff are on duty. The non-uniformed staff member interviewed advised that she would secure the scene, separate those involved, ensure the residents are supervised, ensure no evidence is destroyed, alert security, don't allow eating, drinking, washing or urinating.

There were no residents available to interview that had reported a sexual abuse in the last 12 months.

Auditor has determined that the facility meets the requirements of the standard based upon agency policy requirements consistent with the PREA standard, the PAQ responses, and staff knowledge of the emergency response procedures to be utilized. Auditor notes that the WMRWC utilizes the medical services/personnel of the WCC (female) and MI (male) during evening/night shift hours when necessary and appropriate. The MI and WCC facilities are located within minutes of the WMRWC. WMRWC facility personnel would send a resident directly to Baystate as necessary at any time of day, for an emergency medical condition, e.g. appendicitis, sexual assault, hemorrhage, etc. The medical and mental health personnel interviewed by auditor were familiar with the role of the SANE at Baystate (also located minutes from WMRWC).

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

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

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.) ☒ 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.) ☒ 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*)

Instructions for Overall Compliance Determination Narrative

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

Auditor reviewed HCSD agency policies: **3.5.3 PREA Plan**, **Protocol 9: Medical and Mental Health Care**, Section C. Ongoing Medical and Mental Health Care for Sexual Abuse Victims and Abusers, page 38; **4.5.8. Health Promotion and Disease Prevention**, **Protocol 1: Health Education and Promotion**, Sections A-D, pages 4-6; **4.5.9. Special Needs**, **Protocol 3: Mental Health Services**, Sections A-D, pages 7-9, **Protocol 12: Protocol In The Event of Sexual Assault**: Sections A-E, pages 16-17; **4.5.12 Mental Health Services**, **Protocol 1: Mental Health Screening and Evaluation**, page 10; **Protocol 3: Non-Emergency Referral Process**, pages 13-14; **Protocol 4: Outpatient Mental Health Services**, page 14-17; **Protocol 5: Evaluation & Stabilization Program/Respite**, page 17-21.

In order to make a determination of compliance with the standard auditor interviewed a total of 4 medical/mental health personnel. Staff interviewed advised that the level of services provided is consistent with the community level of care. Evaluation and treatment of resident victimization consists of identifying what happened through a mental health referral and then providing a continuum of care. If/when the resident is released we would provide a referral as part of the discharge plan. The YWCA crisis counselor would come in prior to the resident's release, and then see them in the community. The mental health staff person stated she would contact an agency in the community for a resident that required follow-up mental health services. The medical and mental health staff interviewed advised that female residents would be given timely information and access to all lawful pregnancy-related services prior to release. Auditor was again advised that the WMRWC does not house sexual perpetrators. The MI and WCC have programming for perpetrators. A mental health referral would be submitted and a clinician would see the resident within 14 days. The mental health staff person interviewed advised that she can see on the electronic mental health referral in HealthTrax the who, when and why a resident was referred. They are ranked as Low, Medium, High and Urgent as far as priority to be seen (Risk Status). An emergency referral would be seen within 1 hour. Counselors make mental health referrals via emails (no form used).

The agency/facility have extensive policies concerning medical and mental health services provided to the inmate and resident populations at the agency facilities. It is auditor's observation, based upon policy review, on-site observations and staff interviews, that the WMRWC has sufficient medical and mental health personnel on-board who are knowledgeable of agency policy and the PREA standards. Staff understand each-others role in the response to a sexual assault or upon reception of an allegation of sexual abuse.

As there were no sexual abuse allegations or investigations received/conducted in the last 12 months, there were no residents available to interview that had experienced a sexual abuse or alleged a sexual abuse. Auditor did interview a resident that had reported a prior victimization during risk screening upon commitment to the agency in the last 12 months. The resident advised auditor that the HCSD MI staff interviewed him concerning his report and initiated procedures by contacting the other agency where the alleged abuse had occurred. The resident advised the agency that he did not want any action taken, that he only reported it because he was asked. When processed into WMRWC he did not report it, but staff interviewed him again, based upon his record of reporting the abuse at the MI. The medical department submitted a mental health referral based upon the resident's documented prior

victimization. He again informed staff that he did not desire any action to be taken. The resident informed auditor that another WMRWC employee has since checked with him to see how he was doing based upon his earlier report, and he again advised that he did not require any additional services. Auditor advised the resident that the facility has many qualified staff able to assist him should he decide to seek such support, and that the area YWCA also has certified counselors that come in to the facility regularly to meet with residents. The resident stated to auditor that the staff at WMRWC are very good about addressing those issues and "everything they do."

Based upon auditor's aforementioned review and discussion, it is determined that the facility meets the requirements of the standard.

DATA COLLECTION AND REVIEW

Standard 115.286: Sexual abuse incident reviews

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

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*)

Instructions for Overall Compliance Determination Narrative

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

Auditor reviewed the **PREA Plan**, **Protocol 10: Data Collection and Review**, Section A. Sexual Abuse Incident Reviews, pages 38-39. Agency Policy includes all requirements and language of the PREA standard.

The facility PAQ reports 0 criminal and/or administrative investigations of alleged sexual abuse completed at the facility.

Auditor reviewed a **HCSD PREA Post Incident Checklist** which is a four-page form documenting the involved resident participants, medical care/SANE provided to victim, Crime scene secured/use of PREA kit/collection of evidence, Predator medical evaluation, staff reports, PREA reassessments, investigator assigned, State Police notification, imposition of enemy alerts in JMS, referral for prosecution, written notification to alleged victim(s), 30-day Incident Review Completed, 90-day retaliation monitoring completed, Victim Advocacy Services offered, written notification to licensing bodies, Mental health evaluations of abusers/perpetrators within 60 days, update PREA Monitoring List/Alerts with applicable information to guide future housing, bed, work, education, and program

assignments, submission of Final Report to Facility Head and Agency Assistant Superintendent of Operations. This completed form is to be signed and dated by the facility PCM and the agency PC.

Auditor reviewed a 2017 **HCSD PREA Incident Review** completed on an allegation of sexual harassment which was determined to be Unfounded. This form was submitted/signed by the facility PCM following review of the investigation, review of video/area and consideration of motivating factors. Auditor reviewed the investigative **HCSD PREA Findings** of the facility Captain. The auditor reviewed the video footage of this alleged incident also, while on-site. The resident was notified of the outcome of the investigation (Unfounded).

Auditor interviewed the facility Director (Assistant Superintendent-AS) who advised auditor that the facility would conduct incident reviews if the facility had an incident or allegation of sexual abuse. The facility committee conducting the review would be the Assistant Superintendent, the Captain, the PCM and the PREA Investigator. The information from the sexual abuse incident review would be used to enable the facility to do a better job and to prevent such conduct. The facility would consider every possible motivation, the area of the incident/allegation, staffing levels and the presence of monitoring technology. The AS stressed the importance of facility culture in preventing such incidents.

The PREA Coordinator advised auditor that each facility is required to conduct incident reviews and to report the findings and any recommendations to the PC.

Auditor interviewed a member of the Incident Review Team (PCM) who informed auditor that the facility has not had to conduct an Incident Review due to 0 incidents of sexual abuse or allegations of sexual abuse. But they would consider all possible motivating factors, would examine the area in the facility where an incident allegedly occurred, review staff and camera coverage, and assess staffing levels. The PCM sees any/all reports of any sexual allegations. She would review compile reports and conduct review with the AS, PREA Investigator and the Captain. She would follow-up with notification to the resident of findings and initiate retaliation monitoring. She would get direction from her superiors of any changes directed. The PCM advised auditor that additional cameras were added under the facility stairwells on the basement level, due to the observed potential for misbehavior in that area.

Based upon the policy language which is consistent with the PREA standard, the reported 0 incidents or allegations of sexual abuse, staff awareness of their responsibilities in accordance with the standard, and auditors review of facility forms (PREA Incident Review and Post Incident Review Checklist), auditor has determined that the facility is in compliance with the requirements of the standard.

Standard 115.287: Data collection

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

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*)

Instructions for Overall Compliance Determination Narrative

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

Auditor has reviewed the **3.5.3. PREA Plan**, **Protocol 10: Data Collection and Review**, Section B. Data Collection, pages 39-40. The PREA policy language mirrors that of the PREA standard.

WMRWC reports affirmatively that the facility and agency are in compliance with the requirements of the standard. Auditor has reviewed the Survey of Sexual Victimization (SSV) submitted by the HCSD for calendar year 2014. This 6-page survey report includes aggregated data for the 4 confinement

facilities of the Hampden County Sheriff's Department, i.e. MI, PRC, WCC and WMRWC. The report does not contain data from contracted facilities as the agency does not contract for the confinement of its inmates/residents. The agency PC has advised that the HCSD submits the SSV to the BJS on an annual basis.

Auditor reviewed the agency website, at: www.hcsdma.org. The auditor reviewed the PREA tab of Public Information, readily locating the agency's Annual PREA Reports for calendar years 2014, 2015, 2016 and 2017. The 2017 6-page document is a comprehensive report describing in narrative format and utilizing various charts the inmate-on-inmate and staff-on-inmate sexual abuse aggregated data of all the HCSD confinement facilities. The HCSD Annual Reports include all the data necessary in order to answer all questions of the SSV conducted by the Department of Justice.

Based upon auditors' review, as cited, the agency/facility meets the requirements of the PREA standard.

Standard 115.288: Data review for corrective action

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

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*)

Instructions for Overall Compliance Determination Narrative

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

Auditor has reviewed the **3.5.3. PREA Plan**, **Protocol 10: Data Collection and Review**, Section C. Data Review for Corrective Action, page 40.

Auditor interviewed the Agency Head designee who advised auditor that the HCSD collects and reviews all data in order to assess and improve the effectiveness of the agency's sexual abuse prevention, detection and response policies, practices and training. Through the investigation of incidents and allegation, staff review to identify problem areas and to take corrective action. The agency PREA Coordinator prepares an Annual Report documenting findings and corrective actions.

The PREA Coordinator advised auditor that the agency on an ongoing basis collects and reviews the data from all of the facilities. Corrective actions may be implemented as necessary, such as review of security equipment or enhancements, modifying a process, and revising policy and procedures or Post Orders based upon the findings and recommendations of any incident review. The Annual Report is compiled, and details findings and corrective actions implemented. There are no personal identifiers in the annual report.

Auditor reviewed the Annual Report for calendar year 2016 posted on the agency website, www.hcsdma.org. there are no personal identifiers within this report. This comprehensive document includes the aggregated data required by the standard, a **PREA Background**, discussion of the SSV submitted to the Bureau of Justice Statistics (BJS), **Definitions** of Inmate on Inmate and Staff on Inmate Sexual Victimization, a **Data Analysis** chart/comparison covering the years 2014, 2015 and 2016, **Corrective Action**, **Accomplishments** and **Conclusion**. The Accomplishments section discusses the initial appointment of the agency PREA Coordinator and 6 facility PREA Managers (PCMs), PREA training of staff, PREA education of inmates/residents, training and appointment of six new agency investigators, the facility PREA Risk Assessments conducted at each facility, the screening for risk of victimization and abusiveness, the agency's progress in addressing sexual abuse, and the successful audits of each of the agency's facilities during the first audit cycle (2015-2017). Prior years'

agency Annual Reports and the audit reports of each facility, to include the 2015 WMRWC Audit Report, are posted on the agency website for citizen information and review.

Based upon the agency's compliance with the multiple elements of the standard, the interview responses from the Agency Head designee and PC, and the comprehensive and informative Annual Reports, auditor has concluded that the facility exceeds the requirements of the standard.

Standard 115.289: Data storage, publication, and destruction

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.289 (a)

- Does the agency ensure that data collected pursuant to § 115.287 are securely retained? ☒ Yes ☐ No

115.289 (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

115.289 (c)

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

115.289 (d)

- Does the agency maintain sexual abuse data collected pursuant to § 115.287 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*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's

conclusions. This discussion must also include corrective action recommendations where the facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Auditor has reviewed the **3.5.3. PREA Plan**, **Protocol 10: Data Collection and Review**, Section D. Data Storage, Publication, and Destruction, page 41. The facility PAQ reports that the agency is compliant with all PREA standard and HCSD policy requirements:

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.

3. 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.

The PC advised auditor during interview that the PREA data is securely stored and only accessed by passcode to those personnel having a need-to-know. The aggregated sexual abuse data is available to the public annually through the agency website (www.hcsdma.org). There are no personal identifiers within any of the Annual Reports or the SSVs submitted to the BJS. In accordance with policy, the agency will maintain sexual abuse data collected for 10 years.

Auditor has verified the posting of the aggregated sexual abuse data, in the form of the agency PREA Annual Reports posted on the agency website, for calendar years 2014, 2015 and 2016. Based upon auditors' review, it has been determined that the agency meets the requirements of the PREA standard.

AUDITING AND CORRECTIVE ACTION

Standard 115.401: Frequency and scope of audits

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

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 inmates, residents, and detainees? ☒ 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*)

Instructions for Overall Compliance Determination Narrative

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

The agency **3.5.3. PREA Plan**, **Protocol 11: Auditing and Corrective Action**, pages 41-42 addresses all requirements of the standard. Auditor has found the agency to be in compliance with each requirement, based upon the agency prior facility PREA audits conducted and posted to the agency website, auditor's access to all areas of the facility, auditor's ability to conduct private interviews of random residents and staff selected by the auditor, and the facility's prompt response in providing documents requested by the auditor.

The agency and facility personnel facilitated an effective on-site audit process, accommodating all of auditor's requests, and priority objectives. The facility was very prepared and receptive to auditor and the audit process. Auditor has confirmed that the Audit Notice was properly posted 6 weeks prior to audit. Auditor received 10 digital photographs confirming these postings throughout the facility. During site review, auditor observed the Audit Notices posted. Auditor did not receive any confidential correspondence from any resident as of September 5, 2018. Auditor has determined that the facility Exceed Expectations and the standard requirements.

Standard 115.403: Audit contents and findings

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.403 (f)

- The agency has published on its agency website, if it has one, or has otherwise made publicly available, all Final Audit Reports within 90 days of issuance by auditor. The review period is for prior audits completed during the past three years PRECEDING THIS AGENCY AUDIT. In the case of single facility agencies, the auditor shall ensure that the facility's last audit report was published. 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*)

Instructions for Overall Compliance Determination Narrative

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Auditor has confirmed that all prior agency PREA audits (2015-2017) of individual facilities have been properly posted on the agency website, www.hcsdma.org.

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.

Auditor Instructions:

Type your full name in the text box below for Auditor Signature. This will function as your official electronic signature. Auditors must deliver their final report to the PREA Resource Center as a searchable PDF format to ensure accessibility to people with disabilities. Save this report document into a PDF format prior to submission.[1] Auditors are not permitted to submit audit reports that have been scanned.[2] See the PREA Auditor Handbook for a full discussion of audit report formatting requirements.

Louis Folino September 11, 2018

Auditor Signature **Date**

[1] See additional instructions here: https://support.office.com/en-us/article/Save-or-convert-to-PDF-d85416c5-7d77-4fd6-a216-6f4bf7c7c110 .

[2] See *PREA Auditor Handbook*, Version 1.0, August 2017; Pages 68-69.