NATIONAL PREA RESOURCE CENTER

BJA Bureau of Justice Assistance U.S. Department of Justice

PREA AUDIT REPORT ☐ Interim ☒ Final

ADULT PRISONS & JAILS

Date of report: October 16, 2015

Auditor Information			
Auditor name: Amy Fairbanks			
Address: P. O. Box 16054 Lansing, MI 48901			
Email: fairbaa@comcast.net			
Telephone number: (517) 303-4081			
Date of facility visit: September 28-29, 2015			
Facility Information			
Facility name: Norfolk Sheriff's Office			
Facility physical address: 200 West Street, Dedham, MA 02026			
Facility mailing address: *(if different from above)* P. O. Box 149 Dedham, MA 02026			
Facility telephone number: (781) 329-3705			
The facility is:	☐ Federal	☐ State	☒ County
	☐ Military	☐ Municipal	☐ Private for profit
	☐ Private not for profit		
Facility type:	☐ Prison	☒ Jail	
Name of facility's Chief Executive Officer: Gerard Horgan, Superintendent			
Number of staff assigned to the facility in the last 12 months: 240			
Designed facility capacity: 302			
Current population of facility: 522			
Facility security levels/inmate custody levels: Pre trial, minimum, medium, maximum, pre release			
Age range of the population: 18-80			
Name of PREA Compliance Manager: Peggy Hughes		**Title:** Accreditation Manager	
Email address: phughes@ norfolksheriffma.org		**Telephone number:** (781) 329-3705	
Agency Information			
Name of agency: Norfolks County Sheriff's Office			
Governing authority or parent agency: *(if applicable)* Commonwealth of Massachusetts			
Physical address: see above			
Mailing address: *(if different from above)* Click here to enter text.			
Telephone number: (781) 329-3705			
Agency Chief Executive Officer			
Name: Michael G. Bellotti		**Title:** Sheriff	
Email address: mbellotti@norfolksheriffma.org		**Telephone number:** (781) 329-3705	
Agency-Wide PREA Coordinator			

Name: Mary P. Kelley	**Title:** Asst. Deputy Superintendent
Email address: mpkelley@norfolksheriffma.org	**Telephone number:** (781) 329-3705

AUDIT FINDINGS

NARRATIVE

On September 28-29, 2015, an audit was conducted at the Norfolk Sheriff's Office to determine compliance with the Prison Rape Elimination Act standards finalized August 2012.

A complete tour of the facility was conducted on September 28, 2015. The following areas and operations were visited and observed: inmate living areas (restrictive housing, pre-trial housing, sentenced housing -multiple occupancy cells, & dormitory housing), medical operations, booking operations, laundry, programs, control center – video monitoring, and food service operations.

Documents reviewed for this audit included the completed PREA questionnaire, policy, contracts, training curriculums, staff training records, personnel files, contract/volunteer training records, logbooks, meeting minutes, sexual abuse & harassment complaints, accreditation reports, and population reports for the previous twelve months. Camera monitoring operations were also examined.

Formal staff interviews were scheduled through random selection of staff and offenders from schedules and rosters provided by the staff prior to the audit. They were conducted with the following: The Sheriff, Superintendent, PREA coordinator (Deputy Superintendent) PREA compliance manager (accreditation manager) medical staff (Health Services Administrator, RN, and mental health provider), human resources assistant, 11 corrections officers/sergeants from all areas of the jail and shifts (including special management housing), one investigator, Classification Director, classification staff who complete risk screens, volunteer coordinator (deputy superintendent), training captain, two shift commanders (Lt and Captain) and one food service staff.

Offender interviews were conducted with the following: 10 random inmates (pre-trial and sentenced), and 2 transgender inmates. Five offenders were spontaneously questioned during the tour.

The auditor was allowed free access to all areas of the facility, access to interview inmates and staff selected randomly and intentionally, and to see any documentation requested. Posters were visible throughout the facility announcing the audit. No letters were received prior to the audit. The auditor's name, addres and dates of the audit were posted on the website several weeks before the audit.

Prison Legal Services was identified as an advocacy group which has shown interest in this facility. Contact was made with Prison Legal Services in April 2015 as they were identified as an advocacy group that has acted upon the interests of inmates housed in the Massachusetts Department of Correction. The auditor's contact information was provided along with an explanation of the role of the auditor certifying PREA compliance with the state agency and a tentative schedule of audits. A meeting was held with Leslie Walker, Executive Director, Prisoners' Legal Services to discuss the audit process standards, and concerns from their organization on August 10, 2015.

DESCRIPTION OF FACILITY CHARACTERISTICS

Norfolk Sheriff's Office is located in central Massachusetts. It is a jail facility that houses offenders consisting of pre-trial, pre-release, maximum, medium and minimum custody (sentenced up to 30 months), with 240 staff. The average population is 520 males only. There is a special management housing areas that can hold 58 inmates. There is a minimum custody housing area as well. No females are housed at this facility. No youthful offenders are housed here. Contract services provide a variety of programming at this facility. The facility has two buildings, nine multiple occupancy cell housing units, one dormitory style unit and one single cell housing unit.

All cells had toilets and sinks except the dormitory unit. The bathroom was located to the left of the officers podium allowing good visibility for security but not violating privacy. Showers in the other units had privacy doors that also provided sufficient visibility for security. The facility operates by zones affording additional options for separation of offenders when warranted. There are 15 beds located in the medical units to address special needs, including placement of a victim, instead of using restrictive housing.

SUMMARY OF AUDIT FINDINGS

Click here to enter text.

Number of standards exceeded: 3

Number of standards met: 39

Number of standards not met: 0

Number of standards not applicable: 1

Standard 115.11 Zero tolerance of sexual abuse and sexual harassment; PREA Coordinator

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The requirements of this standard are addressed in the following policies: 239.01 Sexual Harassment and All Other Forms of Harassment, 518.01 Prison Rape Elimination Act Policy and Procedure, and 430.13 Disciplinary Sanctions for PREA Violations. A PREA compliance manager has been designated who serves as the facilty accreditation manager along with the PREA coordinator, the Assistant Deputy Superintendent. Both staff were present during the audit and readily available to address questions raised and provided documentation as requested. Both staff were interviewed during the audit. Review of documentation, interviews with staff and offenders and posters visibile throughout the facility support compliance with this standard.

Standard 115.12 Contracting with other entities for the confinement of inmates

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy 518.14 Treatment and Serivces supports compliance with this standard. The Sheriff's department has current contracts with the following agencies: Gavin House 14 beds, and Community Resources Justice (CRJ) 3 beds, Brooke House and South Shore Recovery House, 2 beds.

Standard 115.13 Supervision and monitoring

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The following policies address the requirements of this standard: 303.11 PREA Staffing Factors and 518.16 Prevention. The facility

established the current staff plan after a technical assistance visit with Nation Institute of Corrections in September 2014. It is reviewed every January and July. Essential positions have been established. The staffing plan is established by shift and based on the housing and programming operations, custody levels of the offenders, as well as supervisory oversight. There are no judicial findings of inadequacy, no federal investigative inadequacies or other indadequacies from internal or external oversight bodies. Deviations are documented. It has been noted that it is due to low offender count, closed units, emergencies and training. Overtime is used to ensure staffing does not fall below minimum required essential positions. There are no reported instances of non compliance with the staffing plan. Assignments sheets from one day for the past 12 months were reviewed. They support compliance with the standard. The most recent review was signed by the PREA coordinator May 21, 2015. Review of logbooks, staff and offender interviews support that supervisory staff are making unanncounced rounds.

Standard 115.14 Youthful inmates

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

This standard is not applicable. Part I, Title XVII, Chapter 119 and Section 58 effective September 2013 rquires offenders under the age of 18 to be confined to the Department of Youth Services. This was also supported by the tour, interviews, and review of documentation (random selection of intake screens).

Standard 115.15 Limits to cross-gender viewing and searches

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The following policies address the requirements of this standard: 506.09 Facility Search Plan and 518.09 General Policy (PREA), 216.14 Correctional Officers Training. The policies include the monitoring of video cameras cannot be done by opposite gender. Cross gender searches (patdown, strip search and cavity searches) are not authorized unless exigent circumstances exist. In the event, an incident report is required. Training curriculum addresses how to conduct searches for transgender/intersex inmates. Post Orders also confirm that opposite gender staff (females) will announce their presence when entering the unit. Five offenders were spontaneously interviewed while inside the facility and indicated that females are announced consistently. Formal offender interviews, staff interviews, and announcements made during every visit inside the facility support compliance with this standard.

Standard 115.16 Inmates with disabilities and inmates who are limited English proficient

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy 108.13 PREA Prevention Planning: Offender with Disabities and Offenders Who Are Limited English Proficient addresses the requirements of this standard. There is a plan in place to assist inmates who are blind, hearing impaired, mentally ill or disabled. Interviews support compliance with not using other inmates to interpret for sensitive issues unless it is an emergency. Language Line Services are available to assist staff. The Offender Handbook is provided in English and Spanish. Policy indicates materials will be read to offenders who are blind or limited intellect.

Standard 115.17 Hiring and promotion decisions

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy 201.08 Employment Eligibility Requirements address this standard. Review of documentation from four random personnel files support compliane with background checks every five years and documentation that the facility imposes a continuing affirmative duty to report conduct relevant to the requirements of this standard. The interview with the Human Resources assistant supports compliance as well. The facility reports that 32 staff were hired in the past 12 months. A random check of two personnel records of newly hired staff support compliance with background checks, reference checks and a pre-employment questionnaire that requires a duty to report. The review of the background check revealed an extensive investigation on new employees including personal and professional reference checks, credit checks, and contact with other correctional facilities when the candidate had experience. Potential employees sign a release authorizing the investigator the authrotiy to obtain specific information on them.

Standard 115.18 Upgrades to facilities and technologies

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These

recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policy 740.10 PREA Prevention Planning: Upgrades to Facilities and Technologies addresses the requirements of this standard. There are numerous video monitoring cameras located throughout the facility. Those cameras that can reveal personal activies of offenders are not monitored by female staff. Forty additional cameras recently installed were placed after a review of operations with PREA concerns in mind. No physical modifications have been completed; however, one was in progress that was to provide improvements to the control operations.

Standard 115.21 Evidence protocol and forensic medical examinations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy 200.08 Administrative Investigative Procedures and Guidelines addresses the requirements of this standard. A uniform protocol is used, evidence will be collected. Forensic exams are not offered at the facility – they are provided at the local hospital. A victim advocate is available at the hospital, provided by an MOU with the Boston Area Rape Crisis Center to provide advocacy services. This MOU is effective until 9/30/2016. An MOU is in place with the Norfolk District Attorney to investigate criminal PREA allegations.

Standard 115.22 Policies to ensure referrals of allegations for investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy 200.08 Administrative Investigative Procedures and Guidelines and 522.08 Goals & Objectives address the requirements of this standard. The complete PREA Policy & Procedure is available on the facility website. Staff interviews and review of all five completed investigations from the previous 12 months support compliance as well.

Standard 115.31 Employee training

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy 518.18 Staff Training, 216.23 PREA Training and PREA Lesson Plan all support compliance with this standard. Staff receive the training every two years and a refresher every other year. Policy and the training curriculum address all the ten specific requirements of this standard. New employees must pass a quiz. Staff interviews demonstrated a thorough knowledge with specific information on who to report to, how to separate offenders and what must be reported. Staff interviews confirm that they understand their role in preventing sexual abuse and harassment by being diligent and observant of the offenders, especially those that have not been in jail previously. Staff also provided feedback that they are aware of confidentiality requirements, and duty to report suspicious, neglectful and retaliatory observations. Staff indicated they can report privately to the investigator via use of the hotline. Staff are also provided a pocket guide which addreses all the PREA standards. Signed receipt of the policy indicates they understood the contents.

Standard 115.32 Volunteer and contractor training

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy 216.22 PREA Training Volunteer, Part-Time and Contractual Training addresses the requirements of this standard. The facility reports they use up to 161 volunteers/contractors as this facility. Volunteers receive orientation and also sign acknowledging receipt of the policy and that they understand it. Interviews with the volunteer coordinator and training captain support compliance as well.

Standard 115.33 Inmate education

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The following policies address the requriements of this standard: 518.10 Offender Screening, 441.11 PREA Evaluation, 493.07 Correctional Center Offender Admissions, 441 Offender Education and Vocational Training. The Offender Handbook is provided upon arrival to the facility. It provides information onf PREA including zero tolerance and multiple reporting methods. A BARCC pamphlet is also provided which explains their services and gives the number for the hotline that can be accessed from the offender phones in the units. A video which includes information regarding PREA is also shown to each offender within the first week. The information is provided in Spanish and also read to the offender if deemed necessary. Documentation of receipt of the handbook is maintained. The facility reports that over 3000 offenders who have stayed more than 30 days have received the information, in the past 12 months. A random check of file offender files

showed documentation of receipt of the handbook. Offender interviews support compliance as they all acknowledged getting this information, see the posters in the housing areas, indicated they are aware they can report anonymously/third party and know about the hotline number.

Standard 115.34 Specialized training: Investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy 216.23 PREA Trainning addresses the requirements of this standard. This facility has two investigators that have attended the training conducted by the Massachusetts Department of Correction which meets all the requirements of this standard. A review of training documents and interview with the investigator support compliance with this standard.

Standard 115.35 Specialized training: Medical and mental health care

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy 216.23 PREA Training and 518.18 Staff Training address the requirements of this standard. The facility reports they have 30 staff who provide medical/mental heath training. Medical staff are on site 24/7 hours/days while mental health is on site seven days a week with someone on call 24/7 hours/days. Interviews with medical and mental health staff demonstrate compliance with receiving training specific to their roles and informing offenders of the limits on confidentiality. Both medical and mental health staff have a role in the PREA intake screen process. Recently all medical and mental health staff received training from the Boston Area Rape Crisis Center staff on responding to sexual abuse and harassment in addition to training provided by the facility.

Standard 115.41 Screening for risk of victimization and abusiveness

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion

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

The following policies address the requirements of this standard: 493.07 Correctional Center Offender Admissions and 518.10 Offender Screening. Offenders are screened within 72 hours of arrival, typically immediately upon arrival. The tool addresses the ten specific requirements of the standard, prior violence and civil immigration status. Reassessment takes place within 30 days and when additional information is received or when warranted, however the facility reports no occasions have occurred that required a reassessment due to warranted circumstances. Screens are filed in the offender file and kept in a secure confidential area with limited access to those who need to see it (legal staff, casemanagers, administrators, investigators, etc). The classification director reviews and signs all intake screens to ensure proper placement for hosuing and programming based on the results of the screen. Five files were randomly selected and all contained completed intake screens.

Standard 115.42 Use of screening information

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy 420.08 Classification Plan and 441.10 Counseling and Program Placement address the requirements of this standard. The Classification Director monitors all housing and program placements in the jail. Transgender/intersex offenders are provided separate shower times, given consideration for decisions for placement and evaluated twice a year. They sign a form acknowledging their decision on showers. There is no consent decree in place regarding transgender inmates.

Standard 115.43 Protective custody

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy 420.08 Classification Plan address the requirements of this standard. The facility reports that to date, there has not been a high risk of victimization offender at this facility. Staff would utilize placement in the medical unit to protect the offender. This was confirmed by the interview with the medical custody supervisor and an officer from restrictive housing.

Standard 115.51 Inmate reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The following policies address this standard: 200.09 PREA Investigations, 518.11 Reporting Allegations, 522.11 Procedures for Filing a Complaint. Also supporting compliance are the Offender Handbook and the Employee Rulebook Attachment A. Offenders can access two hotlines to file a report, one goes to the facility, the other to the Boston Area Rape Crisis Center (BARCC). These calls are not monitored; no offender pin number is needed. One investigation supports compliance with accepting verbal reports and reporting as required. The offender phone was tested during the tour; contact was made with staff from BARCC. No offenders who initiated a complaint were available to interview as all had since left the jail. One allegation of an inappropriate comment made to an offender by an officer was made to the auditor which was immediately forwarded to the facility for investigation.

Standard 115.52 Exhaustion of administrative remedies

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The following policies demonstrate compliance with this standard: 491.08 Informal Resolution of Offender Grievances, 491.16 Time Periods, and 491.17 PREA Grievances. The facility reports that no grievances regarding sexual abuse have been filed in the previous 12 months. Interviews with staff and offenders support that grievances are readily available.

Standard 115.53 Inmate access to outside confidential support services

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy 518.14 Treatment and Services supports compliance with this standard. There is an Memo Of Understanding (MOU) in place with the Boston Area Rape Crisis Center (BARCC). Offenders can access their services by dialing *44; these calls are not monitored nor require a PIN.

Standard 115.54 Third-party reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy 522.11 Procedures for Filing a Complaint addresses the requirements of this standard. The entire Policy and Procedure Manual is posted on the website. The facility reports that one third party complaint regarding PREA allegations has been received in the past 12 months; the investigation was reviewed and appropriately handled.

Standard 115.61 Staff and agency reporting duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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Policy 522.11 Procedures for Filing a Complaint as well as 518.11 Reporting Allegations support compliance and instruct staff to report knowledge, suspicion, retaliation and/or neglect. It also requires that staff maintain confidentiality after the report is filed. See comments from 115.31.

Standard 115.62 Agency protection duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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518.09 PREA General Policy addresses the requirements of this standard. Staff interviews support immediate action will be taken, by first alerting the zone supervisor and separating offenders. The facility reports that no instance of imminent sexual abuse has occurred since the implementation of the standards.

Standard 115.63 Reporting to other confinement facilities

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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Policy 200.09 PREA Investigations supports compliance with this standard. A receipt notification form is in place to document if reports have been received. The facility reports that no allegations have been made by offenders or received from other facilities regarding abuse allegations. One allegation was made to a transportation officer that was forwarded to the non-correctional agency for proper handling.

Standard 115.64 Staff first responder duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The following polices support compliance with this standard: 200.09 PREA Investigations, 518.12 Responding to Sexual Assault Complaints, and 518.13 Incident Management. Staff interviews demonstrate knowledge of the requirements. No allegations of abuse warranting separation of victim/perpetrator or collection of evidence has occurred in the previous twelve months.

Standard 115.65 Coordinated response

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy 518.12 Responding to Sexual Assault Complaints provides the framework for the coordinated actions needed to address allegations at this facility. Staff interviews support that staff are knowledgable and consistent regarding how to respond.

Standard 115.66 Preservation of ability to protect inmates from contact with abusers

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy 200.09 PREA Investigations support compliance with this standard. A review of the Agreement with National Association of Government Employees and an MOU with County Corrections Officers Association both effective through 6/3/2017, support compliance with this standard, affording the facility the ability to change staff assignments and not restrict discipline for staff.

Standard 115.67 Agency protection against retaliation

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy 200.09 PREA Investigations and 522.13 Investigations support compliance with this standard. Staff are designated to monitor staff and offenders who have made reports. A review of the completed monitoring supports that multiple measures are taken such as interviews, video monitoring, and dialogue with staff. Staff report that no reviews have been conducted up to the 90 day requirements as the reporter has not stayed at the facility for that length of time. A review of five completed investigations supports compliance.

Standard 115.68 Post-allegation protective custody

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Plicy 420.08 Classification Plan addresses the requirements of this standard. The facility reports that no occurrences of a need for post-allegation protection has occurred. Interviews with staff, offenders and review of investigations support that this standard is compliant and that the facility is prepared to handle an incident of post-allegation protection. As previously noted, the facility would use the medical unit, not restrictive housing.

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Standard 115.71 Criminal and administrative agency investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The following policies address the requirements of this standard: 200.09 PREA Investigations 522.13 Investigations, and 200.12 Investigative Documentation and Record. As noted, two investigators have received specialized training. The facility reports that one allegation was referred for prosecution but not during the past 12 months. Interviews with the investigator, Sheriff and Superintendent plus the review of five completed investigations from the previous 12 months support compliance.

Standard 115.72 Evidentiary standard for administrative investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy 200.08 Administrative Investigative Procedures and Guidelines and Policy 522.13 Investigations support compliance with this standard. Compliance was also determined by the interviews with the investigators and review of investigations.

Standard 115.73 Reporting to inmates

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion

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

Policy 200.13 Reporting to Offenders demonstrates compliance with this standard. All five completed investigations had documentation showing compliance.

Standard 115.76 Disciplinary sanctions for staff

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy 230.16 Disciplinary Sanctions for Staff and Policy 518.15 Sexual Assault by a Staff Member supports compliance with this standard, indicating that staff can be terminated, punishment will be comensuarte with the act and reported to law enforcements and/or licensing bodies as required. The facility reports that no staff have been disciplined in the past 12 months for sexual abuse or harassment.

Standard 115.77 Corrective action for contractors and volunteers

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy 485.14 PREA Violations demonstrates compliance with this standard. The facility reports that no contractor or volunteer has been corrected or removed for sexual abuse or sexual harassment in the previous 12 months.

Standard 115.78 Disciplinary sanctions for inmates

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion

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

Policy & Procedure Offender Discipline and Policy 430.13 Disciplinary Sanctions for PREA Violations supports compliance with this standard. Offenders are prohibited from participating in sexual behavior.

Standard 115.81 Medical and mental health screenings; history of sexual abuse

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy 601.13 Receiving and Screening Procedures supports compliance with this standard. The facility reports 100% compliance with offering follow up evaluations. All offenders receive a mental health evaluation; however as the mental health staff participate in the intake screen process, they see offenders who have prior abuse or prior victimization sooner.

Standard 115.82 Access to emergency medical and mental health services

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy 601.18 Emergency Services and 518.14 Treatment Services address the requirements of this standard. No occurrence has resulted in the need for emergency treatment for an abuse allegations. Interviews with medical and mental health staff support compliance with having a system in place to send offenders out for emergency services when warranted.

Standard 115.83 Ongoing medical and mental health care for sexual abuse victims and abusers

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance

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

Policy 601.14 Unimpeded Access to Health Care and 650.13 Mental Health Evaluation support compliance with this standard. The interview with medical and mental health staff also support compliance. It was reported that no instance requiring ongoing medical/mental health care have occurred in the past 12 months.

Standard 115.86 Sexual abuse incident reviews

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy 200.09 PREA Investigations supports compliance with this standard. Incident review reports were reviewed for the completed investigations. No changes were deemed needed in current operations. A review of the completed investigations supports this conclusion.

Standard 115.87 Data collection

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy 518.20 Data Collection addresses the requirements of this standard. Standardized definitions are used based on the PREA standards, an annual report is written in accordane with the Survey of Sexual Violence, provided to the Department of Justice as required and posted on the website.

Standard 115.88 Data review for corrective action

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy 518.20 Data Collection addresses the requirements of this standard. The report is on the website.

Standard 115.89 Data storage, publication, and destruction

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy 518.20 Data Collection addresses the requirements of this standard. The annual report for 2014 is posted on the website. There is no personal identification. Information is securely maintained with the investigator and the PREA coordinator.

AUDITOR CERTIFICATION

I certify that:

☒ The contents of this report are accurate to the best of my knowledge.

☒ No conflict of interest exists with respect to my ability to conduct an audit of the agency under review, and

☒ I have not included in the final report any personally identifiable information (PII) about any inmate or staff member, except where the names of administrative personnel are specifically requested in the report template.

_Amy Fairbanks/Amy Fairbanks_________________ _October 16, 2015_____________

Auditor Signature Date