

**PREA AUDIT REPORT Interim Final
COMMUNITY CONFINEMENT FACILITIES**

Date of report: August 11, 2016

Auditor Information			
Auditor name: William Willingham			
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Telephone number: 850-718-7173			
Date of facility visit: 08/08/2016			
Facility Information			
Facility name: Shea Farm			
Facility physical address: 60 Iron Works Rd., Concord, NH 03302			
Facility mailing address: <i>(if different from above)</i>			
Facility telephone number: 603-271-6368			
The facility is:	<input type="checkbox"/> Federal	<input checked="" type="checkbox"/> State	<input type="checkbox"/> County
	<input type="checkbox"/> Military	<input type="checkbox"/> Municipal	<input type="checkbox"/> Private for profit
	<input type="checkbox"/> Private not for profit		
Facility type:	<input checked="" type="checkbox"/> Community treatment center	<input type="checkbox"/> Community-based confinement facility	
	<input type="checkbox"/> Halfway house	<input type="checkbox"/> Mental health facility	
	<input type="checkbox"/> Alcohol or drug rehabilitation center	<input type="checkbox"/> Other	
Name of facility's Chief Executive Officer: Kimberly MacKay			
Number of staff assigned to the facility in the last 12 months: 9			
Designed facility capacity: 47			
Current population of facility: 46			
Facility security levels/inmate custody levels: C-1, C-2			
Age range of the population: 21-50			
Name of PREA Compliance Manager: Kimberly MacKay		Title: Director of Community Corrections	
Email address: kimberly.mackay@doc.nh.gov		Telephone number: 602-271-0078	
Agency Information			
Name of agency: New Hampshire Department of Corrections			
Governing authority or parent agency: <i>(if applicable)</i> State of New Hampshire			
Physical address: 218 North State St., Concord, NH 03302			
Mailing address: <i>(if different from above)</i> PO Box 14, Concord, NH 03302			
Telephone number: 603-271-1801			
Agency Chief Executive Officer			
Name: William L. Wrenn		Title: Commissioner of Corrections	
Email address: william.wrenn@doc.nh.gov		Telephone number: 603-271-5601	
Agency-Wide PREA Coordinator			
Name: Colon K. Forbes Jr.		Title: Director of Professional Standards	
Email address: colon.forbes@doc.nh.gov		Telephone number: 603-271-5604	

AUDIT FINDINGS

NARRATIVE

The on-site visit to conduct a Prison Rape Elimination Act (PREA) compliance audit of the Shea Farm (SF), New Hampshire Department of Corrections, was conducted August 8, 2016. The 39 standards used for this audit became effective August 20, 2012. As part of the audit, a review of all PREA policy and a tour of the facility was completed. Prior to the on-site visit, the auditor held a conference call with the state PREA Coordinator to discuss the Pre-Audit Questionnaire and supporting documentation. At the time of this audit the facility employed 9 staff. The resident population was forty-six females during the course of the audit. Six residents were interviewed (there were no limited English, disabled, Bi-sexual, Transgender, or Intersex residents housed at the facility). One Lesbian resident was interviewed. Many residents were away from the facility on work-release during the audit. No incidents of sexual abuse or sexual harassment were reported from any resident. There was one report of a PREA violation within the last twelve months which resulted in a single investigation (ongoing). A total of six staff were interviewed. Two security staff (from different shifts) and four specialty staff were interviewed. The specialty staff interviewed included the Director, Assistant Director (selected as the local PREA Compliance Manager), a Case Manager and the Program Coordinator. No contractors or volunteers were available to be interviewed. Interview documentation was obtained for the Commissioner of Corrections (agency head designee interviewed) and the state PREA Coordinator and state PREA Victim Advocate were personally interviewed. A SAFE (Sexual Assault Forensic Examiner) nurse from a local hospital (where exams would take place if necessary) and a community Victim Advocate were also interviewed by phone. When the auditor first arrived at the facility, a meeting was held with the Director, Assistant Director, state PREA Compliance Coordinator and the state PREA Victim Advocate to explain the audit process. No letters were mailed to the auditor concerning the upcoming audit. During the course of the audit, any potential problems or recommendations were immediately brought to the attention of the Director.

DESCRIPTION OF FACILITY CHARACTERISTICS

The mission of Shea Farm (SF) is to provide a safe, secure, and humane correctional system through effective supervision and appropriate treatment of offenders, and a continuum of services that promote successful re-entry into society for the safety of citizens and in support of crime victims. The goal of SF is to provide residents a transition from prison to full integration back into the community. Program objectives intend to provide participants with the knowledge and skills necessary to develop and lead a productive lifestyle prior to returning home. SF consists of a 47 bed facility (several housing areas with administration offices in the same building) for adult females, referred from the New Hampshire Department of Corrections. Parole violators may also be assigned to the institution for up to seven days. Living areas consist of multiple occupancy dormitory-like rooms with double bunks and shared showers and bathrooms. The facility also has meeting rooms and leisure activity areas. SF is located in a rural residential neighborhood outside of the city of Concord, NH. The facility had previously been a very large old farmhouse. Services and programs include religious activities, counseling, parenting skills development, adult basic education, substance abuse treatment, and life-skills training (job interviews training, financial management instruction etc.). Additional services include individual assessment programs, employment assistance and housing placement referrals. Residents receive these services at the facility or in the community. Residents participate in this overall program for usually 6 to 9 months. The facility utilizes sixteen cameras to monitor activities, has adequate staff supervision and no "blind spots" (areas lacking adequate camera coverage or staff supervision) were discovered during the tour. Meals are provided at the facility, and are prepared by residents.

SUMMARY OF AUDIT FINDINGS

When the on-site audit was completed, a meeting was held with the administrative staff, to discuss the overall audit process. The auditor had been provided extensive and lengthy files of documentation prior to the audit, in an effort to support a conclusion of compliance with the PREA. During the course of the on-site visit, staff were found to be courteous, cooperative, and professional. The interviewed inmates stated they felt safe at the facility. Staff and resident morale appeared to be excellent. All areas of the facility toured were found to be reasonably clean and adequately maintained, considering the age of the facility. At the conclusion of the audit the auditor thanked the SF staff for their hard work and commitment to the PREA. A summary of the audit findings are listed below:

Number of standards exceeded: 1

Number of standards met: 36

Number of standards not met: 0

Number of standards not applicable: 2

Standard 115.211 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.

Prison Policy Directive (PPD) 5.19, 2.16 and corresponding local policy address this standard. The facility PREA Plan covers zero tolerance and the other sub-standards as required by this standard. In addition to the facility PREA Compliance Manager, there is a state PREA Coordinator, who also oversees compliance to zero-tolerance and the standard requirements. Interviews with staff and residents confirmed the zero-tolerance standard is in place and covered in training. The local PREA Compliance Manager stated she has sufficient time to complete her duties.

Standard 115.212 Contracting with other entities for the confinement of residents

- 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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The agency meets the mandates of this standard. A review of the documentation (provided by the state Contract Manager) and an interview with the state PREA Coordinator confirmed the NHDCC requires other entities contracted with (one county jail) for the confinement of inmates to adopt and comply with the PREA standards. The state contractual agreements have been modified to incorporate the language requiring the contractor to adopt and comply with PREA standards.

Standard 115.213 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.

PPD 5.19 addresses this standard. Policy requires each facility within the agency to review their respective staffing plans on an annual basis. The staffing plan is reviewed annually, taking into consideration the 47 bed capacity. Compliance to the PREA and other safety and security issues are always of primary focus when considering and reviewing staffing plans according to the facility Director. SF has been provided all necessary resources to support the programs and procedures to ensure compliance with the PREA. There has been no deviation from the staffing plan. The audit included an examination of all resident access to phones, housing assignments, and a review of all staffing rosters. "Rounds" (visits to areas in the facility) are conducted by administrative staff on a daily basis, and supervisors are able to enter the units with no warning to line staff. Also, interviews with residents and line staff confirmed that visits are conducted on an irregular basis, by administrative staff, to all areas of the facility. Correctional officers make "rounds" in a manner to provide excellent supervision. The video monitoring program (cameras) is sufficient to provide additional surveillance to ensure resident safety. Documentation supporting compliance to this standard was reviewed by the auditor. Staff and resident interviews also support compliance.

Standard 115.215 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.

PPD 5.19 addresses this standard. The facility does not allow cross-gender pat or strip searches. However, all staff reported that they received cross-gender pat search training (including how to search transgender and intersex residents). Staff reported that residents are always allowed to shower, dress and use the toilet privately, without being viewed by staff of the opposite gender. Male staff stated they announce their presence verbally when entering all areas holding residents. Announcements were observed by the auditor during the tour of the facility. Staff were aware that policy prohibits the searching of a transgender or intersex resident to determine their genital status. The interviewed residents confirmed they were afforded significant privacy from all staff when using the toilet, changing clothes, or when showering, and that announcements were made when opposite gender staff entered the housing units or any area holding residents. PREA notifications (English and Spanish) are posted in each housing area and in all resident program areas. The facility is compliant with this standard.

Standard 115.216 Residents with disabilities and residents 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.

PPDs 6.19, 6.31, 7.14 and corresponding local policy address the requirements of this standard. SF takes appropriate steps to ensure residents with disabilities and residents with limited English proficiency have an opportunity to participate in and benefit from the facilities efforts to prevent, detect, and respond to sexual abuse and sexual harassment. PREA handouts, postings, and resident handbooks are in English and Spanish (the facility is prepared to address the needs of other limited English speaking residents also through an interpreter service). Staff interviewed were aware that under no circumstance are resident interpreters or assistants to be used in dealing with any PREA related matter. SF is compliant with this standard.

Standard 115.217 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.

PPD 1.21 and 2.01 require compliance to this standard. The Human Resources Manager was interviewed and stated that all components of this standard have been met. Employees cannot be hired if they have a history of involvement with sexual abuse. All employees and the contractor have had criminal background checks completed. Staff also conduct background checks before approving staff promotions. A tracking system is in place to ensure that updated background checks are conducted every five years. Policy clearly states the submission of false information by any applicant is grounds for termination. SF makes a significant effort to contact all prior institution employers for information on substantiated allegations of sexual abuse prior to hiring staff permanently. SF is compliant with this standard.

Standard 115.218 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.

PPD 8.01 addresses this standard. The video monitoring system consists of sixteen cameras, monitored by staff, placed in hallways and activity areas. There have been upgrades to this system since August 20, 2012.

Standard 115.221 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.

PPMs 5.10, 5.19, and a document entitled “Attorney General’s Protocol” require compliance with all aspects of this standard. NHDOC investigators conduct administrative/criminal and the State Police conduct criminal investigations for the facility (involving staff). Specific actions and clinical decisions are required to determine if an inmate is to be transported to the local hospital to receive a SANE exam. No SANE exams were conducted within the last year. The facility has contracted with a local hospital to provide these services (the inmate will not be charged for any services related to PREA compliance). A Memorandum of Understanding was initiated with the local rape crisis center to provide confidential services if needed. The auditor discussed these services with the state PREA Victim Advocate, who was very knowledgeable concerning available services. The Victim Advocate from the local rape crisis center was interviewed. The state PREA Victim Advocate also indicated SF was PREA compliant concerning this standard. A review of documentation also confirmed compliance to this standard.

Standard 115.222 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.

Compliance with PPM 5.19 and 5.10 (covers this standard) was reviewed during the on-site inspection. Administrative or criminal investigations are completed on all allegations of sexual abuse and sexual harassment. The investigators were interviewed and found to be extremely knowledgeable concerning their responsibilities under the PREA. The NHDOC investigators initiate all investigations. The State Police are responsible for all criminal cases (staff involved) and work closely with the facility investigators on administrative/criminal investigations. There were no investigations to inspect. A review of documentation and staff interviews confirmed compliance to this standard.

Standard 115.231 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.

PPMs 5.19, 4.02 and 4.01 address all training required by this standard. The NHDOC provides extensive PREA standards training at the state academy, of which all correctional staff must attend and successfully complete (curriculum reviewed). All other staff are provided a similar training experience, relative to their PREA responsibilities, at SF. Changes to policy or updates are communicated to staff as needed. Annual refresher training is also provided to all employees. Staff acknowledge in writing their understanding of the PREA. The acknowledgement form lists all the required areas of the standard, relevant to their position. A review of the SF lesson plan demonstrates all the required areas are covered. All staff interviewed indicated that they received the required PREA training.

Standard 115.232 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.

PPDs 5.19 and 2.24 address this standard. During the past year all contractors and volunteers received training related to their responsibilities concerning the PREA (zero-tolerance, detection, prevention, response, and reporting requirements). All training is documented and was reviewed by the auditor. All contractors will be required to be trained in PREA policy as a requirement in upcoming bid proposals. The Director was interviewed concerning this standard (confirmed compliance).

Standard 115.233 Resident 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.

PPD 5.19 covers the requirements of this standard. Prior to being transferred to SF, most residents received PREA training at their previous facility (a state prison). All residents receive information at the time of intake verbally, in a PREA pamphlet, and there is information provided in the resident handbook (provided to residents at the time of intake in English or Spanish). Residents are advised of how to contact the state PREA Victim Advocate and outside sources for assistance if needed. Provisions are in place to meet the needs of all limited English proficient, illiterate, and disabled residents concerning this standard. There are posters throughout the facility addressing PREA issues. Residents sign an acknowledgement of having received PREA information at the time of intake. Staff and resident interviews confirmed compliance to this standard.

Standard 115.234 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.

PPD 5.19 and 5.10 address this standard. NHDOC and State Police investigators have received extensive local and State Police approved specialized training relevant to the PREA, and will conduct investigations at SF if necessary. The NHDOC investigators have also received training provided by the Moss group. An examination of the training records and staff interviews confirm completion of the required instruction, and compliance to this standard.

Standard 115.235 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.

PPD 5.19 addresses this standard. The facility has no full time medical or mental health staff. Medical and mental health staff visit the facility once a week, to address resident concerns. The medical staff and mental health contractor have received training (documented) commensurate with their responsibilities. All emergencies or incidents involving a need for PREA medical/mental health care will result in a resident being transported to the local hospital. The SAFE nurse assigned to provide these services was interviewed and explained the process (including the role of the rape crisis center) to the auditor. SF is considered compliant to this standard.

Standard 115.241 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.

PPDs 5.19 and 7.14 address the requirements of this standard. All residents are immediately assessed at intake by staff for their risk of being sexually abused by other residents or being sexually abusive towards others. A Case Manager (a mental health contractor also screens new arrivals within 7 days) screens all new arrivals within 72 hours following arrival. At the time of intake, staff also conduct additional screening by reviewing records or other information from another facility or other source which may be relevant to compliance with this standard. Residents cannot be disciplined for refusing to answer questions at intake (PREA related). Residents identified at high risk for sexual victimization or at risk of sexually abusing other residents would be referred to the mental health contractor for further assessment. Careful housing assignment (placement in a housing area with additional supervision) or other appropriate action would then be considered to address the resident’s needs. Any information received after intake relevant to the PREA is immediately considered, and may result in a change in housing or other necessary action. Status reassessments will occur within 30 days. Staff and resident interviews confirmed compliance to this standard.

Standard 115.242 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.

PPDs 7.14 and 5.19 address the mandates of this standard. Policy requires the use of a screening form to determine housing, bed, work, education, and program assignments with the goal of keeping residents at high risk of being sexually victimized separate from those who are at a high risk of being sexually abusive. The auditor inspected several screening forms, which were found to be compliant with this standard. Housing and program assignments are made on a case by case basis. There is in place a procedure for providing continued re-assessment and follow-up monitoring if needed. All documentation is considered confidential, and only disclosed to staff with a right or need to know. Staff and resident interviews, and a review of documentation, confirmed compliance to this standard.

Standard 115.251 Resident 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.

PPD 5.19 addresses this standard. A review of documentation indicated that there are multiple ways for residents to report sexual abuse or harassment. The facility does not house residents for civil immigration purposes. The Correctional Officers, Case Manager and residents interviewed stated residents may privately report any abuse, harassment, or neglect (which would contribute to a violation of the PREA) verbally, in writing, anonymously, or from a third party. Staff will immediately take all required further action and document the information. Posters and the inmate handbook explain the reporting procedures. SF is compliant with this standard.

Standard 115.252 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.

Not Applicable-All allegations of sexual abuse automatically result in the opening of a formal administrative or criminal investigation.

Standard 115.253 Resident 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.

PPD 5.19 addresses this standard. There is a Memorandum of Understanding (MOU) signed with the community rape crisis center that serves the Concord, NH area. A phone number and address to this program is provided to residents (residents are advised contact would be as confidential as possible). The rape crisis center Victim Advocate was interviewed. The auditor did discuss what services were available to residents with the Victim Advocate, who was very familiar with the program. The state PREA Victim Advocate would also assist inmates in contacting the local agency. Residents could mail a letter to contact her and initiate services. SF is compliant with this standard.

Standard 115.254 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)

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PPDs 5.19 and 5.26 address the requirements of this standard. Third-parties are notified of reporting procedures on the NHDOC website, posters in the SF visiting area, and are referenced in the inmate handbook. Staff and inmate interviews confirmed compliance to this standard.

Standard 115.261 Staff and agency reporting duties

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

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

PPDs 5.19, 2.16 and corresponding local policy includes the mandates of this standard. Staff were well aware of their duty to immediately report all allegations of sexual abuse, sexual harassment, neglect (which would cause a PREA violation) and retaliation relevant to PREA standards. All information is maintained confidentially. A review of policy and staff interviews supports the finding that the facility is in compliance with this standard.

Standard 115.262 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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PPD 5.19 and corresponding local policy addresses the mandates of this standard. Staff interviewed were well aware of their duties and responsibilities, as it relates to them having knowledge of an inmate being in imminent risk of being sexually abused or sexually harassed. All staff indicated they would act immediately to protect the inmate. They also stated they would separate the potential victim/potential predator, secure the scene to protect possible evidence, not allow inmates to destroy possible evidence and contact the shift commander and medical staff. In the past 12 months, there were no instances in which the facility staff determined that an inmate was subject to substantial risk of imminent sexual abuse. A review of policy/documentation and staff/inmate interviews supports the finding that the facility is in compliance with this

standard.

Standard 115.263 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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PPD 5.19 and corresponding local procedures address the mandates of this standard. Policy requires that any allegation by an inmate that he was sexually abused, while confined at another facility, must be reported to the head of the facility where the alleged abuse occurred, within 72 hours of receipt of the allegation. A local investigation must also be initiated. In the past 12 months, the facility received no allegations that an inmate was abused while confined at another facility. Staff interviews confirm compliance to this standard.

Standard 115.264 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.

PPD 5.19 and corresponding local procedures outline the mandates of this standard. All staff interviewed were very knowledgeable concerning their first responder duties and responsibilities, upon learning that a resident may be the victim of sexual abuse. The Correctional Officers interviewed quoted specific actions (such as protection of the victim, preservation of all evidence, contact medical staff and notification to the supervisor) to be taken, in compliance with the PREA. There have been no incidents within the previous year requiring first responder actions. Staff knowledge as a first responder is considered excellent. The facility is compliant with this standard.

Standard 115.265 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.

PPD 5.19 and corresponding local policy addresses the mandates of this standard. Documentation was reviewed by the auditor. The policy and checklist describe the coordinated actions to be taken by first responders, medical/mental health staff, investigators and facility administrative staff, in response to an incident of sexual abuse/harassment. There were no instances within the last year requiring a response relevant to this standard. The facility is compliant with this standard.

Standard 115.266 Preservation of ability to protect residents 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.

PPD 5.19 addresses this standard. The collective bargaining agreement (reviewed by auditor) between the applicable union and SF allows for the protection of victims from abusers, and complies with this standard. The state PREA Coordinator was interviewed concerning this standard, and also confirmed compliance.

Standard 115.267 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.

PPD 5.19 and corresponding local policy outline the mandates of this standard. The policy prohibits any type of retaliation against any staff or inmate who has reported sexual abuse, sexual harassment or cooperated in any related investigation. The state PREA Victim Advocate is charged with monitoring retaliation. When interviewed, she stated she would follow up every 30 days to ensure policy is being enforced and conduct periodic status checks on the frequency of unjust incident reports, housing reassignments and negative performance reviews/staff job reassignments. If there was a concern that there was the potential for possible retaliation, the Advocate indicated she would monitor the situation indefinitely. There have been no incidents of retaliation in the past 12 months. The facility is compliant with this standard.

Standard 115.271 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.

PPDs 5.19, 5.77 and 5.10 address this standard. The facility investigators (NHDOC) would conduct administrative or criminal investigations within the facility. If an allegation appears to be criminal in nature (involving staff), the investigator will call upon the State Police to conduct the investigation. The facility investigator will provide assistance and support to the State Police for criminal investigations. All investigators have received special investigation training relevant to the PREA. Investigation files are retained indefinitely. There were no cases referred for prosecution during this rating period. The facility is compliant with this standard.

Standard 115.272 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.

PPD 5.19 addresses the requirements of this standard. The evidence standard is a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated.

Standard 115.273 Reporting to residents

- 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.

PPD 5.19 addresses the mandates of this standard. There was one investigation opened within the last year that will require inmate notification per this standard. Policy requires notification be made to the resident pursuant to this standard. Staff interviews and a review of documentation support the finding that the facility is in compliance with this standard. The alleged victim was not available to be interviewed by the auditor.

Standard 115.276 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.

PPDs 5.19, 2.16 and corresponding local policy address the mandates of this standard. Staff are subject to disciplinary sanctions for violating NHDOC sexual abuse or sexual harassment policies. Such discipline would be subject to the requirements of this standard. There have been no confirmed cases of inmates engaging in sex with staff. No reports were made to any licensing board or law enforcement officials pursuant to this standard. Staff interviews confirm compliance to this standard.

Standard 115.277 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.

PPD 5.19 addresses the mandates of this standard. Policy complies with all required actions and reporting (advising licensing boards or law enforcement officials) concerning contractors and volunteers relevant to this standard. In the past 12 months, there have not been any contractors or volunteers accused of sexual abuse or sexual harassment of an inmate. Staff interviews and a review of policy confirm compliance to this standard.

Standard 115.278 Disciplinary sanctions for residents

- 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.

PPDs 5.19, 5.25 and corresponding local policy address the mandates of this standard. There have been no confirmed cases of staff and inmates engaging in sex during the past 12 months, and no cases of other staff abuse. There were no criminal findings of guilt for inmate-on-inmate sexual abuse. Therapy services would be available for victims and abusers at the facility. Policy does not allow consensual sex of any nature. Inmates having sexual contact with staff will be disciplined, if it is not consensual. SF does not discipline inmates who make allegations in good faith, even if the investigation does not establish evidence sufficient to substantiate the allegation. Interviews with staff and an investigator support a finding that the facility is in compliance with this standard.

Standard 115.282 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.

PPDs 5.19, 6.05 and 6.19 address the mandates of this standard. SF has had no resident in need of access to emergency medical or mental health treatment relevant to the PREA within the previous year. If a need occurred, the facility would ensure compliance with all actions required by this standard (free treatment, documentation of services, information about sexually transmitted diseases, confidentially). The resident would be immediately sent to a local hospital or rape crisis center where all required services will be provided. Interviews with staff, the SAFE nurse, Victim Advocates and a review of policy confirm compliance to this standard.

Standard 115.283 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.

PPDs 5.19, 6.05, and 6.03 outline the mandates of this standard. SF offers ongoing medical (in the local community-facility has no full time mental health or medical staff) and mental health evaluations and as appropriate, treatment to all inmates who have been victimized by sexual abuse. Services are consistent with a community level of care, without financial cost to the inmate. Known inmate abusers are evaluated and treatment is offered. A review of documentation and interviews with mental health staff support the finding that this facility exceeds compliance with this standard. SF provides many special programs to assist victims of sexual abuse considering the substantial needs of the female population. Interviewed inmates stated they were aware of the ongoing services available under this standard, participated in many of the programs and were very pleased with the provided interventions.

Standard 115.286 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.

PPD 5.19 and corresponding local policy outlines the mandates of this standard. The facility would conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation, unless the allegation was proven to be unfounded. An investigator was interviewed and found to be very knowledgeable concerning his duties and responsibilities in providing information to the incident review team. Based on interviews with a member of the incident review team (Director), the review is conducted within 30 days of the conclusion of the investigation and consideration is given as to whether the incident was motivated by race, ethnicity, gender identity, other status or gang affiliation. The team also makes a determination as to whether additional monitoring technology should be added to enhance staff supervision. The review team consists of mid and upper-level management. The sexual abuse incident review reporting form is completed as required. The facility is compliant with this standard.

Standard 115.287 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.

PPD 5.19 addresses this standard. The NHDOC collects accurate uniform data from for every allegation of sexual abuse at all facilities by using a standardized instrument. The data collection procedure allows the agency to submit the annual DOJ Survey of Sexual Violence in a timely fashion, prepare an annual PREA report, monitor trends, and take corrective action when indicated. The agency aggregates and reviews all data annually (including data provided from the only contractor). Staff interviewed, and a review if documentation, confirmed compliance to this standard.

Standard 115.288 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.

PPD 5.19 addresses the requirements of this standard. The facility PREA Manager forwards required information to the state PREA Coordinator, who reviews the data collected to assess and improve the effectiveness of sexual abuse prevention, detection, and response policies, and to identify problem areas and take corrective action. An Annual Report is reviewed and signed by the Commissioner of Corrections. The Annual Report is placed on the NHDOC web site. The Annual Report was reviewed by the auditor.

Standard 115.289 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.

PPD 5.19 outlines the mandates of this standard. The state PREA Coordinator reviews data (incident-based and aggregated) compiled by the facility PREA Manager and issues a report to the Commissioner on an annual basis. The data is retained in a secure file (over 10 years), and what is disclosable is published on the NHDOC web site. The report covers all data required by this standard.

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.



William Willingham

August 11, 2016