PREA AUDIT REPORT ☐ Interim ☒ Final

COMMUNITY CONFINEMENT FACILITIES

Date of report: 11/19/2016

Auditor Information			
Auditor name: Jack Fitzgerald			
Address: 87 Sharon Drive Wallingford CT			
Email: jffitzgerald@snet.net			
Telephone number: 203 694-4241			
Date of facility visit: June 16-17			
Facility Information			
Facility name: Coolidge House			
Facility physical address: 307 Huntington Avenue Boston, MA 02115			
Facility mailing address: *(if different from above)* Click here to enter text.			
Facility telephone number: Click here to enter text.			
The facility is:	☐ Federal	☐ State	☐ County
	☐ Military	☐ Municipal	☐ Private for profit
	☒ Private not for profit		
Facility type:	☐ Community treatment center ☒ Halfway house ☐ Alcohol or drug rehabilitation center	☐ Community-based confinement facility ☐ Mental health facility ☐ Other	
Name of facility's Chief Executive Officer: Matt LeFrancosis			
Number of staff assigned to the facility in the last 12 months: 24			
Designed facility capacity: 116			
Current population of facility: 108			
Facility security levels/inmate custody levels: Community Confinement/ Pre-Release			
Age range of the population: 27-65			
Name of PREA Compliance Manager: Matt LeFrancois		**Title:** Program Director	
Email address: @cjr.org		**Telephone number:** Click here to enter text.	
Agency Information			
Name of agency: Community Resources for Justice			
Governing authority or parent agency: *(if applicable)* Click here to enter text.			
Physical address: 355 Boylston Street Boston MA 02116			
Mailing address: *(if different from above)* Click here to enter text.			
Telephone number: 617-482-2520			
Agency Chief Executive Officer			
Name: John Larivee		**Title:** President and CEO	
Email address: jlarivee@crj.org		**Telephone number:** 617 482-2520	
Agency-Wide PREA Coordinator			
Name: Susan Jenness Phillips		**Title:** Director of Standards and Quality Assurance	
Email address: sjenness@crj.org		**Telephone number:** 617-423-2020 X2300	

AUDIT FINDINGS

NARRATIVE

The Coolidge House Residential Reentry Center of Boston MA is one of several facilities in the northeastern United States of the larger organization Community Resources for Justice (CRJ). The Community Resources for Justice, whose administrative offices are located in Boston MA, is an organization with a 130 year history of social activism. From its earliest years the organization was focused on helping individuals as they left prison. The agency's mission today continues to service the disadvantaged dividing their focus into three areas: Social Justice Services, Community Strategies, and Crime and Justice Institute. The Coolidge House program is part of the Social Justice Services which include adult and juvenile residential programs. The mission of the facility is to support society's most challenged citizens as they transition from institutions to the community. The agency's commitment through innovative services, advocacy for system improvements and ongoing research has helped countless individuals move toward living safe and productive lives while enhancing public safety and quality of life.

Coolidge House currently employs 24 staff members including administrators, program monitors, and case management workers. The facility can house up to 116 male residents. Program Director Matthew LeFrancois and a dedicated management team bring a consistent and supportive approach to residents. The population of Coolidge House is individuals referred by the Federal Bureau of Prisons (FBOP) or Federal Probation inmates at risk of violation. The program serviced in excess of 200 residents in 2015 with a 4-6 month average stay in residence. The facility does not employ any direct care medical or mental health services. Residents go to medical and mental health treatment services in the community. No SAFE or SANEs are employed by the facility, but are available through agreement with the Brigham and Women's Hospital 24 hours per day. As part of the Pre audit activities the auditor spoke with a Nursing Supervisor at the hospital's Emergency Department who confirmed the ability to provide SAFE or SANE exams. The Auditors discussions with Boston Area Rape Crisis Centers (BARCC) representative also support knowledge of CRJ facilities and BARCC's willingness to assist victims of sexual abuse. In Massachusetts the Department of Public Health coordinates sexual assault services, trainings, and protocols. The state is organized into various regions including the greater Boston area. As part of DPH efforts they have developed links between the examiners and the local rape crisis service agencies.

The audit was completed by Certified PREA Auditor Jack Fitzgerald of Fitzgerald Correctional Consulting with the assistance of Walter Krauss Certified PREA Auditor on day one of the site visit. During the pre-audit phase the auditor reviewed the Pre Audit tool, the Coolidge House policies and procedures related to the PREA Audit, and the supportive documentation. Coordination and clarification of policy and supporting documentation was done with the agency-wide PREA Coordinator, Susan Jenness Phillips, during the pre-audit preparations. The auditor also called regional sexual assault advocacy organizations including the aforementioned BARCC who is the domestic and sexual violence agency with whom the facility has a letter of support to provide PREA related services. The auditor spoke with a representative of the BARCC who reported that she was not aware of historical complaints about the facility. The BARCC confirms the services to individuals who have been a victim of sexual and domestic violence, the services include counseling and support services include accompaniment during forensic assault exams. The auditor also spoke with, as part of Pre Audit activities, Chad Fultz, the northeast Residential Reentry Manager for the Federal Bureau of Prisons. Mr. Fultz reports no PREA related concerns about the Coolidge House facility and that he feels CRJ organization is good at communicating issues. Mr. Fultz confirmed the FBOP commitment to ensure PREA compliant environments and that they provide, through community based contracts, a variety of Mental Health and Substance Abuse services for residents at Coolidge House.

The auditor arrived in the Boston MA area on Wednesday June 15, 2016. The onsite work hours were from 8am to 6pm on June 16th and 7:00am to 4:00pm on June 17th. An entrance meeting was held on the morning of June 16th. In attendance were the following: Dick Guy, Assistant Director of Social Justice Services, Susan Jenness Phillips, CRJ Director of Standards and Accreditation and agency-wide PREA Coordinator; Matt LeFrancois, Director of Coolidge House; Program Administrator Joe Jarvis; Assistant Director Janaya Pierre-Mike, Jessica Tooley Quality Assurance Manager for CRJ and Walter Krauss Certified PREA Auditor.

The auditor team was able to interview twenty-five (25) of the one hundred and eight (108) residents. The team interviewed residents from each housing floor and in twenty-four (24) of the thirty seven (37) bedrooms. Residents of the other rooms were not available to auditor due to employment obligations. There were two residents identified with a disability who were interviewed. There were residents who were bilingual interviewed and a resident interviewed with the assistance of an interpreter. There were no residents to interview who had reported a PREA related incident in their current admission.

Twelve (12) staff members who worked on the two days of the audit were interviewed. Interview were also completed focusing on specialized roles including case management and intake staff member who completes screenings. Interview requirements also included the facility Director and Elizabeth Curtin the Director of Social Justice Services for the Agency Head, and EJ Brady Talent Acquisition Manager (Human Resources). Susan Jenness Phillips, the PREA Coordinator, was also interviewed and worked with the auditor to clarify concerns that arose during all three audit phases. There were no individuals who had to act in the first responder role, but questions were answered by staff as part of the random staff interview. Interviews were also done with various management staff including the Director, and the three Assistant Directors who oversee different aspects of the operations.

The residents who were interviewed as part of the site visit reported overwhelmingly that the facility is a safe place sexually. The residents mentioned the staff of Coolidge House address any sexualized comments/behaviors swiftly. Residents gave consistent examples of measures staff take to keep people safe. Staff also reported believing the facility is safe for residents and that staff does a good job addressing any PREA related behaviors. The Auditor thanked the individuals involved for the preparation and organization of materials. The auditor shared that all the evidence from the files, the interviews and the policies would be considered together to determine overall compliance and that if a corrective action measure was needed that they would work collaboratively in its development. The Auditor shared some of the strong positives that the staff and residents mentioned about the agency's effort to protect residents from sexual violence.

DESCRIPTION OF FACILITY CHARACTERISTICS

The Coolidge House Facility, consists of one five story brick structure at 307 Huntington Ave in Boston. The facility is in an urban mixed residential/business area. The neighborhood consists of small businesses, a large YWCA facility, apartments and condo buildings. The area is also home to universities including Northeastern and Harvard Medical School and cultural sites of the Boston Fine Arts Museum and the Boston Symphony Hall. The facility does not have an exterior space for residents. The facility was previously a hotel and as a result each room has its own bathroom. The bedrooms vary in capacity from two to four beds in a room. The adjacent small bathrooms contained a toilet, sink and showers. The housing occurred on floors two to five. The second floor had administrative and case management offices in addition to 2 bedrooms. The three floors above have 12 bedrooms, 11 bedrooms and 12 bedrooms.

The first floor of the facility has a Program Monitor station as you enter. The round elevated station provides direct sight to the entry point to the program and the visiting and common TV area. The space has monitoring screens for cameras throughout the facility. The front door is secured and has a an intercom. PREA related materials were provided upon arrival to the facility as was the notice of the audit. The first floor also serves as check in points for all residents when formal counts are done. The basement area houses the facility mechanical and storage areas that were locked when on the tour. The basement is set up with a space for laundry and a casual area for residents to read or write.

The Director, throughout the tour showed his knowledge of the potential blind spot hazards and discussed practices employed to address safety of clients. Staff on duty make random tours of the facility all day to ensure client safety and facility security. The facility also has mandatory counts that occur during the day. Since food services are produced off site and delivered to the site residents have little contact with the contractors. Each of the facility's thirty-two (32) cameras capture common areas, staircases and exterior spaces. On the first floor mirrors also are positioned to assist the staff at the front desk in seeing areas not visible on cameras. Staff utilize the cameras to watch residents movement in common areas. Staff perform random tours of the facility including bedrooms and bathrooms hourly. Residents confirm that all staff of opposite gender knock and announce presence when entering any bedroom or bathroom. Custody staff are aware of blind spots in the facility and will add additional tours to areas if residents congregate in these areas. Each of the bedrooms has residents sleeping in bunk beds with areas for personal storage. The agency has a dress code for residents when in common areas. In bedrooms all residents must be fully clothed while sleeping to eliminate incidental viewing incidents. The second floor houses bedrooms, a classroom, Case Manager's Office, Intake/Release Coordinators office and the Medication Station. Housing continues on the third floor through the fifth floor with additional office spaces for administrative and case management. In addition to the formal interviews, both residents and staff who were encountered on the tour of the facility were asked general questions about programming, rules and PREA.

SUMMARY OF AUDIT FINDINGS

Coolidge House was found to be in compliance with the majority of standards at time of the onsite visit. Few standards required the development of corrective action plans which included additional documentation and additional trainings. The agency posted the notice of the PREA Audit, including the auditor contact information, and residents were asked if they were aware of the audit on the facility tour. The postings were in public areas near the phones on each floor in addition to the staff station. The Auditor did not receive any request to be seen or other information prior to the audit from residents, staff or visitors. The Auditor also did not have any individual who requested to be seen while I was on site. In addition to the formal interviews with the random residents and staff, the auditor spoke briefly on the tour to additional staff and residents to gauge further the culture of the facility and the staff and residents understanding of the Prison Rape Elimination Act. Nearly two dozen residents and staff were spoken informally during the tour. The auditor completed all other applicable interviews with specialized staff and the administrative team of CRJ and Coolidge House.
The Auditor received electronic and hard copies of documents prior to and while on site to support the compliance with each standard element. If additional documentation was needed from the facility to support practice or to confirm consistent application, it was requested and provided. As part of the closure meeting at the facility, on day two, the auditor reviewed strengths and areas that could use improvement and the steps that would be used to create the corrective action plan. After completing a review of the materials presented during and prior to the visit the auditor determined that corrective action was needed in three areas. Standard 115.216 was determined to need further education of staff on the access to interpretive services. Standard 115.241 needed to ensure that all residents are screened and rescreened for potential aggressiveness or victimization within the agency and standard time requirements.

Number of standards exceeded: 0

Number of standards met: 39

Number of standards not met: 0

Number of standards not applicable: 2 A. Standard 115.212 Contracting for the confinement of residents B. 115.235 Specialized Training; Medical and Mental Health Staff

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.

Coolidge House has a policy in compliance with the expectations of this standard. In Policy 900.00 – Staff and Resident Sexual Abuse and Sexual Harassment. The agency, Community Resources for Justice, has a policy that outlines its efforts to keep residents safe from sexual abuse or harassment. The policy invokes the agency's zero tolerance policy and describes its expectations to prevent, detect and respond to sexual abuse and sexual harassment. As a contractor of the Federal Bureau of Prisons the agency is contractually obliged to provide an environment that is free of sexual abuse or sexual harassment and the contractual documentation provided also mandates annual training requirements as part of the Bureau's "Sexual Abuse Prevention and Intervention Program". The Agency employs their Department Director of Standards and Quality Assurance as the agency wide PREA Coordinator and is documented in the agency flow chart and is described in the policy. The Agency PREA Coordinator, Susan Jenness Phillips, also took the National Institute of Corrections training program for PREA Coordinators. The agency has developed an upper level management team approach to working toward PREA compliance. The PREA Coordinator has influence over policy and works collaboratively with the Director of Social Justice Services. The PREA Coordinator has worked with the agency wide staff to improve the quality and consistency of the documentation around PREA. During the tour and through interviews it was apparent that the Coolidge House Program Director and Assistant Director understand the role of the PREA Coordinator and know to report issues of concern in an effective and timely manner. In addition to the factors mentioned, compliance was also determined by interviews with staff, management, residents and the PREA Coordinator as well as training records that showed an understanding of the agency's commitment to preventing, detecting and responding to Sexual Abuse and Sexual Harassment within the Facility.

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)

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.

N/A This standard is not applicable as the Coolidge House is part of the Community Resources for Justice. This agency is a contractor of the Federal Bureau of Prisons and does not subcontract in any way for the confinement of individuals.

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)

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Coolidge House has developed a staffing plan that is in compliance with the requirements of the standard and the expectations of their funding source the Federal Bureau of Prisons. The staffing pattern allows for each shift to have a minimum of 2 staff on of which one must be male. The facility adds additional non security staff, such as case managers, on times when greatest number of residents are in the facility and awake. The Director reports no instance in which the staffing plan was not met. Policy 900.00 requires if the staffing plan is deviated from the instance is documented and justified and reported to the Director. The staffing plan is reviewed annually by the director, the Deputy Director of Social Justice Services and discussed with the PREA Coordinator in advance of the annual planning meeting. The facility has the ability mandate staff to cover vacant shifts.

The Coolidge House staff's supervision practices support sexual safety through the randomization of tours and responding to blind spots when more than one resident is out of view of staff. Custody Staff were also able to identify blind spots and measures taken to ensure safety. To assist in the efforts of monitoring residents Administrative and Case Management offices are spread between floors The Coolidge House facility has 32 cameras covering the 5 story facility. The residents comments about the safety of the facility and staff approachability speaks to a positive culture. The observation of camera positions, staff performing duties, as well as interviews with staff and residents support an active supervision model. Compliance is determined based on policy, staff interview, resident interviews and the camera and staff observation made on tour and during time on site. In addition to the narrative document which describes the elements this standard the facility provided as supportive documents including the actual staffing patterns and the floor plans showing electronic survalance locations.

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.

CRJ and Coolidge House policy (900.00) and resident and staff interviews confirm the facility prohibits strip searches of any type including to determine one's genital status. There are no cross-gender pat searches permitted at Coolidge House, this is addressed in Policy 900 and in the Search Policy. Pat-search training for all staff including respectful communication with transgender and intersex residents was provided by the facility. The auditor was able to see the training records of the staff who

were trained and verify through interviews the content. Staff were trained using the Moss Group's "A Guidance on Cross-Gender and Transgender Pat Search". Staff were able to identify the information in the video and how to not only complete the search, but were also aware that the facility practice would allow for the transgender resident to have a say in what gender staff performs the check. The indicator on female resident access to programming is not applicable in this facility as it is all male. All residents report, consistent with policy, that they are able to shower and perform bodily functions without staff of opposite gender viewing them. The auditor was able to see and hear female staff announcing their presence before entering the resident rooms which include the resident's showers. There were no reported exigent circumstances of cross gender searches and as a result no logs or incident reports to review for justifications. Compliance was determined through the interview result of staff and residents as well as the staff knowledge of the training materials. Though there was no transgender or intersex resident to interview, the agency policy prohibits strip searches of any type and specifically addresses the language in indicator (e) on page 9 in section F7b. During the corrective action period the facility received a transgender resident. The facility made an initial plan to accomodate and modified the plan once the intake and screening process was complete. The facility and Agency reached out for assistance to ensure that they were acting in compliance with the standard expectations. The facility had made plans focused on providing a safe and comfortable environment for her including separate bathroom facilities and consideration of the resident preference in pat searches. There are no strip searches permitted at Coolidge House. Compliance was based on the initial information, the discussions with CRJ around the planning for the transgender resident and the policy and interviews completed.

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.

The Coolidge House facility has posters and brochures English and Spanish, the second most common language spoken by residents. As part of the audit, the auditor was able to speak with a resident with disabilities. The auditor was able to speak with a resident for whom English was there second language as well as other bilingual residents. The agency did not have a handbook in Spanish, the second most common spoken language, at the time of the audit that addressed PREA. Policy 900.00 Section IF2 outline the agency's requirements in this standard including equal opportunity and access to information for those residents who are disabled or have limited English proficiency as well as the protection of confidentiality through the prohibition of resident interpreters. Residents interviewed understood PREA and the ability and means of reporting a concern. The Coolidge House program has the ability to provide other aides to disabled residents or those with low vision to ensure they have an understanding of PREA and the services and protections available. The agency has interpretive services available to staff and a TTY machine for hearing impaired residents. Interview with staff revealed that they knew it was not appropriate to use resident interpreters except in exigent circumstances. Staff were less consistent in their understanding of the interpretive services available. The audit team was able to determine they had bilingual staff who could provide assistance to ESL residents.The auditor was able to see signage on the tour of the facility in a second language. Interview with the Agency's Head confirms the commitment to provide whatever resources are need to help clients succeed in their facilities including the understanding of PREA. The Director reports than it is rare that they have received residents who do not speak English but acknowledged that some may converse better in Spanish.

As part of the corrective measures all staff recieved retraining on the use of interpretive services including language line. The facility also completed the translation of the handbook to Spanish which includes the facility rules, zero tolerance stance toward sexual misconduct, and information on how to report PREA concerns. As a result of the corrective measures the

auditor has determined the standard is now in compliance

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.

The Community Resources for Justice is compliant with the hiring and promotion decisions required by PREA. The agency has policies (900.00 and HR hiring policy) in place to address the requirements of the standard including the screening of individuals for sexual abuse or harassment histories. The agency has all staff working in their Social Justice Services Division undergo criminal background checks. Interviews with HR staff and documentation supports that systems are being completed across the agency. Coolidge House has hired and promoted one staff in the last year. On the second day of the audit the staff personnel records were reviewed at the CRJ administrative offices. The auditor was able to review a random sample of seven current employees. These records were in addition to staff records provided in the standard documentation files. Documentation from the personnel files supported the requirements of this standard including a form in which employees are asked about the past sexual misconduct in indicators and the requirements in indicators (f) and are given notice of (g) the continued disclosure requirements. All staff of Coolidge House have their information forwarded prior to hire to the Federal Bureau of Prisons (FBOP) for criminal background checks. All contract renewals of the FBOP require the resubmission of names for criminal background checks which puts them in compliance with the five-year requirement. Only five of the 27 full and part time employees have been in the facility over 5 years. The files reviewed contained the acknowledgement the criminal background checks were completed. File review of an employee who had previously worked in another correctional setting showed the agency had completed the institutional check required by PREA. The agency has limited contractors, food service vendors and pest control vendors who do not provide direct services to clients but still undergo employee criminal background checks. The agency was able to provide documentation of contractors who have also completed a background check as well as documentation of Interns who also had the required background checks completed by FBOP. The agency also showed the required PREA pre-employment form was completed on the college intern. The agency has not had a request for information on a prior Coolidge House employee by another institution. The agency and facility compliance was determined by the review of the staff files, the policy supporting the completion of the effort required in standard 115.217 and the interview with CRJ human resource staff, as well as interviews with the agency PREA Coordinator.

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.

Coolidge House underwent some minor renovations that improved the safety of the facility. The facility had a lighting upgrade to all rooms of the facility. The lighting improvement increased the foot candles in each space significantly, making supervision easier. The facility added a new space in which residents to provide urinalysis samples. The improvements allowed for better supervision by staff through improved lines of sight including on cameras. Compliance is based on the statements of the Director, Assistant Director, PREA Coordinator documentation of the lighting improvements and observations made by the auditor on the tour.

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)

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The Coolidge House has not had a sexual assault case requiring evidence protocols or forensic medical exams. In the event of a sexual assault, the criminal investigation would be completed by the Boston Police Department in conjunction with the Federal Bureau of Prisons. Coolidge House has had communications with the Boston Police Department about PREA requirements in investigation at their facilities, a letter was provided to document the parties' agreement.

Coolidge House has trained their staff about measures to preserve evidence. This was evident in the staff interviews and training logs. All residents who are victims of sexual assault will be sent to Brigham and Women's Hospital, who has SAFE and SANE examiners available 24 hours per day, at no cost to the resident. A letter of agreement between the hospital and Community Resources for Justice (CRJ) was provided to confirm this; as does information from the Hospital website. The Auditor also spoke with a representative from the hospital emergency room . The Hospital reportedly has Sexual Assault Nurse Examiners available on staff or oncall.

The agency provided a letter documenting the support of the local rape crisis organization, the Boston Area Rape Crisis Center (BARCC). A victim's advocate could, as part of this agreement, accompany the resident victim of sexual assault as they undergo forensic exams and investigatory interviews. Hospital representatives also confirm it is their policy to call for an advocate from the local rape crisis organization.

The Massachusetts Department of Public Health oversees the training of forensic nurses. This state agency certifies and sets protocols with SANE Advisory Board to ensure up to date practices are maintained. The SANE Advisory Board consists of representatives from the Attorney General's Office, State police and Boston Crime Labortory personnel, Governors task force on Sexual and Domestic Violence, SANEs, law enforcement, health care organizations, advocacy organizations, as well as other disciplines efforts to ensure standardized practices in the collection of forensic evidence. The state is also divided into regions; in Boston BARCC is the lead Rape Crisis Agency and there are seven hospital with certified SANE Nurses including Brigham and Women's Hospital.

Compliance is determined based on facts stated above addressed all the standard indicators. Since there were no sexual assaults requiring forensic evidence, the auditor considered in determining compliance access to qualified SANEs, the preparation of the staff in handling a PREA Event and the interview of the agency PREA Coordinator. Interviews with other agencies also gave an understanding of the state's system and their willingness to work with individuals from Coolidge House if an incident was to occur.

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.

Community Recourses for Justice agency policy 900.00 Staff and Resident Sexual Abuse and Harassment (PREA), page 19, sets forth obligations that all Sexual Harassment and Sexual Assault cases are investigated. Since the agency did not have a sexual assault incident there was no referral for investigation to the Boston Police Department. The Agency has posted onto its website, its PREA policy which sets forth obligations for referring incidents for criminal and administrative investigations that could be done by either the contracting agency or the CRJ. The referring agencies and the Boston Area Rape Crisis Center (BARCC) domestic and sexual violence support unit confirm they have not had any reported incidents of sexual abuse or harassment in the past year and that the agency is good at communicating issues of concerns. The Director reported, and a file review was presented, on an administrative investigation that was completed. The report documented the claim, and steps taken to determine the validity of the claim. Interview results and video surveillance that was used to determine the findings was described in the report. Compliance was determined based on the interviews with the Facility Director who completed the administrative investigation, Agency Head, the review of the administrative investigation from April of 2016. Interviews with the residents were consistent as they all denied having made any complaints on PREA related incidents.

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)

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The Coolidge House policy 900.00 addresses the requirements of the standard in Section D pages 5 and 6 including the required areas of education and the frequency of training. All employees have received PREA training with an agency staff member with whom the Auditor interviewed as part of a previous audit. A copy of the slide show portion was reviewed by this Auditor for content and consistency with the required elements in indicator (a). Formal and informal interview with staff during the tour confirm the PREA training is offered at a minimum of one time per year. All staff interviewed confirmed the 10 required areas were covered in the training often by giving examples.

Training sign-in logs have staff acknowledge their understanding of PREA. indicator (d). Coolidge House is a male facility, no staff have been transferred from the female facility, but all the staff are exposed in the training how females may react to abuse in different ways from male residents (indicator (b)). Training on both male and female issues prepare staff who may choose to transfer to other co-correctional facilities in the Greater Boston area that CRJ runs. In addition to the PREA specific training the agency provides employees with training on boundaries, search training, and ethical practices. Standard compliance was determined using the information provided here and the random staff interviews in which they were able to give different examples of the training program. In addition to the file review of staff personnel records, the facility provided training records on several areas including sign in forms where employees, confirm by signature, their understanding of the content. The auditor was also able to see documentation of the new employee training before they could work as staff in the facility.

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.

At Coolidge House the contracted service providers do not provide any direct services to clients. The contractors who drop off prepared food do so under staff supervision. As contractors have limited contact with residents they are provided information at entry to the facility about PREA and the agency's efforts to keep residents safe. Upon signing into the facility visitors are offered a copy of the agency's brochure on PREA. The agency has created a log that individuals acknowledge the receipt of PREA information. The Facility PREA brochure (located at the front desk) tells of the zero tolerance policy of CRJ and Coolidge House. The brochure notifies individuals on how to report an incident. The agency has created a three level education program for people who enter the facility. The one-time staff supervised visitors are given basic knowledge about PREA, the routine visitor who though does not provide direct service get an expanded meeting with the facility administrator to review the requirerments of PREA and the protections in place for residents. If Coolidge House had contractors providing direct services, including Interns, they would receive the same PREA training as Coolidge House staff. The facility provided documentation of PREA education to the individuals who drop off food and the individual who provides a community education program.The agency provided documentation of a sign in logs for one time visitors, that explained PREA and encouraged visitors to take and read the brochure. There were no current contractors or interns available at this CRJ facility but the auditor previously interviewed a intern at a previous facility under the direction of Director LeFrancois.

Compliance is determined based on policy , the reported and documented efforts to ensure individual entering the facility are aware of PREA and the Auditors observation. The auditor was given a brochure on PREA upon signing into the facility and withness other individual also going through the same process during the audit dates.

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.

Residents of Coolidge House report receiving PREA education at prior federal correctional settings. Residents also reported they were educated upon admission to the facility. Residents report receiving PREA education during their admission meeting with the Intake/Release Coordinator. Individuals who had reported not being oriented had their files reviewed to confirm that they had signed the they were educated on PREA. Interviews and file reviews support resident education occurred in the first 24 hours. A checklist of information is reviewed, signed and placed in their case record. Residents reported that their Case Managers, consistent with policy, also reviewed PREA related information in their orientation meetings. The facility has PREA educational materials available to residents in the form of brochures and posters in addition to the client handbook. The Resident handbook describes at length what PREA is, their rights to be free from abuse, various ways to report concern internally and externally, as well as information on medical and Mental Health treatment and that all claims will be investigated. Residents were able to confirm they knew the agencies Zero Tolerance stance on sexualized behaviors, how to report a concern about sexual assault or harassment, their right to be free from abuse and their right to be protected from retaliation if they report a concern. Random files of active clients and some closed files were reviewed to ensure timeliness and consistency of the education. There were no instances in which a resident was transferred into Coolidge House from another CRJ facility. Compliance was determined utilizing the information from the client files, the interview results of the person completing intake, the residents interviews and the materials available to the residents about PREA.

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.

Coolidge House and Community Resources for Justice will only complete administrative investigations. The facility will work to support criminal justice agencies investigations of sexual assault cases. Coolidge House has not had to complete an administrative investigation related to a sexual assault case in the last three years and completed one investigation in the last year on sexual harreassment. Policy 900.00 page 18 requires CRJ to have staff trained investigators including interviewing potential victims of sexual abuse, requirements of substantiation of a case and the issuance of Garrity warnings. The facility Director and several administrative staff of Community Resources for Justice completed the National Institute of Corrections online training program on PREA related investigations. The NIC training PREA: Investigating Sexual Abuse in a Confinement Setting addresses the requirement of (b) including the issuance for Garrity warnings, evidence requirements for substantiating a case. Those individuals who completed the course were Matt LeFrancois, Director; Joe Jarvis Program Administrator, Frank Kenyon Assistant Director, Susan Jenness Phillips, PREA Coordinator Community Resources for Justice; Dick Guy, Deputy Director Social Justice Services; and Maria Alexson, Employee Benefits/Training and Development Manager. Director LeFrancois has used the administrative investigation and has documented the steps consistent with the standards. The standard is deemed compliant as the agency has obtained appropriate training, and documentation to support staff had completed it. Interviews with staff also supported compliance with the standard in indicator B by the staff's knowledge of interview considerations when talking with victims and when Garrity verses Miranda warnings are given.

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.

N/A Coolidge House does not employ or contract for medical or mental health services on site. The facility uses community based services for those resident who are in need of routine or emergent care.

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.

Coolidge House policy 900.00 page 7 and 8 requires screening of all residents upon admission within 72 hours. File review shows, by practice, the facility completes screening usually within hours but not longer than 24 hours of admission. The auditor looked at a sample of both current and former resident files as part of the onsite visit. All residents are screened using an objective tool. The staff person responsible for screening reports the tool is used as a questionnaire and the majority of information required is done through direct interview with the residents. Balance of information comes from the records review of the residents. Residents confirmed in interviews that the staff asked them questions that would be part of the tool within the first 24 hours of their admission. Residents reported inconsistently about being asked at admission about their history of sexual abuse victimization, their sexuality and their perception of safety. File reviews is confirmed in the documentation reviewed by the auditor that the residents signed that they were asked these questions as part of the PREA Intake Orientation Checklist. The questions are part of the orientation checklist on PREA that the resident and Intake Officer signs. Residents support the case manager reassesses them and asks about the safety in the environment and if they choose to not answer questions about sexuality or victimization they would not be punished. The PREA Coordinator has worked with administration to improve the level and consistency of documentation of the reassessment questioning of residents in the first 30 days.
A review of files on the date of the site visit showed that not all case management staff were reassessing residents within the timeline. All information on the resident's screening is kept in the resident's case file which is locked when not with the case managers. Sensitive information is not available to other residents and there is no labeling system that would lead to exploitation by fellow residents. A corrective action period was required to ensure that all resident were reassessed as part of this process the facility will forward intake and reassessment documentation including notations showing all questions were asked. The Community Resources of Justice Quality Assurance Department has also implemented a system on ongoing review of this information that will be done in all agency facilities. During the corrective action period the facility sent the auditor documentation of initial and follow up screenings in the first 30 days. The auditor was also provided with case notes documenting that residents are routinely asked about safety, history of abuse and their sexuality subsequent to the initial screening and within the first 30 days. As a result of the corrective measures the auditor has determined the standard is now in compliance

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.

Coolidge House policy 900.00 page 8 and 9 describes the use of the screening tool in the development of plans for programming, employment and the assignment of roomates. All residents who are screened as potential sexual predators will be roomed by themselves or with those who are not potential victims. As a community release facility the residents are approved to move into the community to seek and obtain employment. Residents who have been identified with either abuse or perpetrator histories can be refereed out to BARCC or the local Mental Health clinics with whom the facility has developed relationships or has contracts with through the Federal Bureau of Prisons. Transgender and intersex resident's own views of safety would be taken into consideration in the implementation of housing. The facility does not employ the use of separate housing rooms based on LGBTI identification consistent with agency policy which prohibits this practice (pg8 #4f). The agency has considered housing and private bathroom use accommodations for Transgender and Intersex residents at Coolidge House. Bedrooms in Coolidge House near staff offices and near camera positions could provide close observation for transgender or intersex residents. Each room would also offer the resident with private bathroom facilities. Policy and staff training require all staff to take seriously any room change request by a resident and ask them about their feeling of safety. As there was no transgender or intersex to interview at the time of the audit residents compliance determination was reliant on the interview of the screening officer and the Agency PREA Coordinator. Since the facility had no LGBTI identified residents, indicator (f) compliance determination (that LGBTI resident are not segregated as a practice) was based on questioning of random staff on the tour in addition to the interviews with the screening officer and the facility Director. During the corrective action period the facility received a transgender resident. The staff and administration began planning prior to the resident's arrival for providing accomodations consistent with the 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.

Coolidge House Policy 900.00 addresses the requirements of this standard in Section K page 15 and Section H page 10 addresses the staff responsibility to accept all forms of resident reported Sexual Abuse and Harassment claims and the mechanism for residents to report. The facility Sexual Assault Brochure, the Resident Handbook and posters throughout the facility all give direction on the importance and

methods of reporting Sexual Assault and Sexual Harassment. In interviews with the residents, the auditor received multiple way in which residents felt they could report concerns regarding sexual assault or Sexual Harassment. Residents consistently reported comfort in speaking with staff and/or the Program Director. They were able to identify the posted hotline information (BARCC and the CRJ PREA Coordinators numbers) and the ability to speak to the Federal Bureau of Prisons or the Federal Probation Office, or family members who come to the facility if they had any concerns in speaking with the facility staff.

Interviews with staff were consistent in their understanding of their duties of accepting and responding to all reports of Sexual Assault or Sexual Harassment whether it was done verbally, in writing, anonymously, or by a third party. Staff knew their duties also included the documentation of all claims and immediately reporting them up the chain of command. Documents reviewed prior to site visit, observed on tour, and interviews with the PREA Coordinator, staff and residents supported compliance.

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.

Community Resources for Justice and the Coolidge House policies including policy 900 (pages 16-17) covered the various requirements of the standards relating to grievance procedures in a PREA event. The agency also defines the process for general grievances in policy 1.1.8 Resident Grievance and Appeal Process. The Director reports there had been one grievances related to a PREA issue filed. The administration was aware of the requirements of the standard: including (b) no time limits on submission of grievances or requirements of informal resolution meetings with staff member. The policy also states residents do not have to submit grievances to any staff person who is subject of the complaint (c) and covers the obligation for timely responses (d). The policy also set forth a process for emergency grievances (f) and the right to hold residents accountable when they can be proven to have filed knowing the information was not true. Since the resident was no longer at the facility the determination of compliance was based on policy and administrative interviews and review of the investigative file and the original grievance. Residents who were interviewed were aware of the grievance process and knew they could only be held accountable for an unfounded complaint if it is proven that the report was filed in bad faith. Compliance was based on the resident's knowledge of the grievance process as a potential source to express concerns related to PREA. Residents were aware of how to file a grievance or a BP8. Compliance was also based on the information obtained in the investigative file.

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.

Community Resources for Justice entered into an agreement with BARCC to provide outside confidential counseling and support services to resident victims of sexual abuse in Coolidge House. Information about the service is available in pamphlets and on posters in the facility. Residents are also made aware of the services via their case management staff. Residents can also seek assistance through the local mental

health clinics that are part of the services provided by the Bureau of Prisons. Resident are aware that these services are confidential up to the point that someone was being hurt or mistreated. Residents from Coolidge House go into the community frequently so if they were not comfortable making the call while in the facility, even though it is not monitored, they could call when out at the job site. Residents also have access to a cellular phone and can make calls to Rape Crisis agency if they choose not to use the facility phones. Both residents and staff understood mandatory reporting requirements and the level of confidentiality consistent with maintaining a safe environment. Agency administration is committing to increasing the resident and staff overall knowledge of rape crise services. The Auditor encouraged them to increase resource information to residents about Rape Crisis Service providers throughout New England as FBOP residents, upon discharge will be returning to several of the New England states.

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)

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.

Coolidge House policy 900.00 page 15 describes the requirements of the standard as it relates to third party reporting. The agency website provides information on PREA and how an individual could file a Third Party Report. The person can phone or email (PREA@CRJ.org) the agency PREA Coordinator or the website includes a form that could be printed and mailed. The facility's brochure on PREA also provides the public with information on how to report a concern. As noted in standard 115.232 the brochures are available to all visitors entering the facility. The Director, Assistant Directors, nor the Agency PREA Coordinator Susan Jenness Philips reports receiving any third party notifications. Compliance is based on the interview answers which staff and residents alike were aware of the ability to make third party complaints. A determination of compliance was also supported by the materials found on the agency's website. The auditor confirmed that the phone number also went to the PREA Coordinator

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.

Coolidge House policy (900.00 Staff and Resident Sexual Abuse and Sexual Harassment (PREA)) requires, and staff interviews confirm, that staff are aware of the immediate need to report all accusations or knowledge of Sexual Assault, Sexual Harassment or retaliation including third party and anonymous complaints.(page 16) Staff interviews support they are aware of the importance of timely

reporting and the need to provide confidentiality about information except when reporting to supervisory, investigative staff or information needed to secure treatment or provide for the safety/security of others. The facility does not employ Medical staff or mental health clinicians (indicator c) and does not service individuals under the age of 18 (indicator d). Staff are aware of mandated reporting and their legal responsibility to report all PREA events or any concerns of retaliation of those individuals who have reported such events. Staff are to report to the facility Director immediately or the on-call administrator. The Director will notify Boston Police if the event appears to be criminal. The agency PREA Coordinator, the Director and Deputy Director of Social Services and the referral sources of the residents informed immediately on all complaints. CRJ would investigate events administratively including to determine if staff inaction led to the incident. Even though the agency does not employ any mental health staff, residents felt the local mental health provider would be required to inform the facility and local authorities of any incident of sexual abuse. Compliance is based on staff interviews and policy requirements. Since the agency does not service resident under 18 the requirement to report to the state Department of Children and Families is not applicable. Compliance with all applicable portions of the standard were determined through review of policy, interview with staff and their knowledge of reporting all knowledge, suspicion, or information of sexual abuse, sexual harassment and any form of retaliation.

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)

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 Coolidge House facility has not had to protect a resident in imminent risk of sexual abuse. In interviews with random staff they were able to identify what to do to provide immediate safety. Effort would include immediate separation of parties, increasing contact and support to the residents. Agency policy requires staff to take all concerns seriously and immediately notify administration. The Director of Social Justice Services, Elizabeth Curtin, and Matt LeFrancois, Director of Coolidge House both acknowledge that the agency response would be swift and the efforts would include both facility based changes to increase safety and contacting the referral source. The agency PREA Coordinator, Susan Jenness Phillips, would also be notified of these events. CRJ Administration was able to give examples of how, in non PREA related situations, in which a resident has felt threatened, they were able to protect residents. Their planned efforts include change of rooms, housing floors or facilities if needed. In each situation requiring transfer to other CRJ facilities the Bureau of Prison would also be informed. CRJ runs two other Bureau of Prison programs within a 40 minute drive of the Coolidge House facility. The referring authority may order a resident to be removed. The perceived aggressor, by practice may be removed to a higher level of custody after discussions with the referring authority. Compliance was determined by the consistent plan to protect residents that was voiced by both staff and administration. The auditor also took into consideration the agency and facility's prior experience in implementing protective measures similar non PREA incidents.

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)

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.

Coolidge House Policy 900 Staff and Resident Sexual Abuse and Sexual Harassment (PREA) page 15 covers the requirements of reporting abuse to other confinement facilities including the timing (within 72 hours), that the notification is to the Director of the other facility and documentation of such incidents. Director Matt LeFrancois reports not having had any resident disclose any prior institutional abuse which required them to put these steps into action. Director Francois was aware of the time line requirements of the standard and his obligation to similarly investigate all allegations he receives from other institutions. Since Coolidge House serves FBOP inmates there are multiple facilities in which notice may come from or be required to be made. Director of Social Justice Services and the Agency PREA Coordinator were able to share how notification was handled in the last year at another CRJ facility to a FBOP Prison. In preparation for the audit the Auditor spoke with the regional ReEntry Manager of FBOP who was not aware of any instances in which accusations were made by residents of Coolidge House or by residents who had returned to federal custody. Since there were no incidents at Cooldige House compliance was determined based on policy requirements consistent with standards and the administration's knowledge of the requirements. Agency PREA Coordinator and Director of Social Justice Services pointed to notification made within the required time period at another CRJ facility to support compliance.

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.

Coolidge House Policy 900.00 Staff and Resident Sexual Abuse and Sexual Harassment (PREA) (pages 11-12) addresses the requirements of the First Responder Standard. The facility trains its entire staff as potential first responders. Staff training and policy describes efforts to: 1) support the alleged victim, 2) provide quick access to medical services at a hospital with SANE nursing, 3) steps to protect crime scene and potential evidence on those involved. Interviews with random staff supports they know the steps required to ensure quick access to care while protecting potential evidence. Staff were all able to provide examples of what they had learned about protecting evidence including closing off the area the assault happened, not allowing the individuals involved in the incident to eat, drink, smoke, brush, use the toilet, shower or change clothing. The Coolidge House facility has not had a sexual assault incident so there was no staff to interview who had responded as a first responder. The agency has developed a quick reference guide staff could refer to to ensure the first responder duties are met. This is kept in the Program Monitors office at Coolidge House. Since there was no incident, no resident was interviewed who had reported sexual abuse. Compliance for this standard was based on staff knowledge of expectations, policy requirements and the aides put in place to help guide staff in the event of an incident.

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.

Community Resources for Justice and Coolidge House policy 900.00 (pages 11-12) has extensive directions for staff on the steps for responding to a sexual assault and providing a coordinated effort. A quick reference guide was also created to ensure that staff know the appropriate steps and phone numbers to contact outside agencies, such as the Brigham and Women's Hospital and (BARCC) Boston Area Rape Crisis Center. A copy of this document is available in the Program Monitors station on the first floor of the facility. The facility Director was able to describe the plan and communication efforts that would occur. His expected notifications also include the local service providers mentioned, the local police, the funding authority FBOP, and the agency management including the PREA Coordinator should an incident occur. Compliance is based on the consistent understanding of the plan by administrative staff and their having reached out to other agencies, such as local hospitals and BARCC, for support. The auditor also found the direct care staff were aware of who to call in the event of a sexual assault and if they were not certain of all the steps there was a document for them to reference.

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.

Coolidge House is part of Community Resources for Justice which does not employ individuals as part of a collective bargaining agreement. The agency policy 900.00 section IH7 and prior practice allows for the removal or reassignment of staff to no contact positions while an investigation occurs. This practice was confirmed by Director Matt Francois and Director of Social Justice Services Elizabeth Curtin. The Agency was able to provide an example in which the agency suspended an employee while investigating a harassment complaint. Compliance is based on the interview with Director of Social Justice Services (for the Agency Head) and the agency's prior track record handling similar situations.

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.

Coolidge House and Community Resources for Justice policy 900.00 on PREA (Pages 3-4) addresses the agency's commitment to protect residents and staff who report PREA Incidents from retaliation. As part of the prevention steps the policy outlines the agency efforts to protect staff and residents who report a PREA incident. The policy outlines multiple steps taken to insure safety and requires active monitoring and communication with those involved for at least 90 days (indicators c and d). Since there has not been an incident of sexual abuse there is no documentation to review. The Director of Social Justice Services on behalf of the Agency head and the Program Director, both described multiple mechanisms that would be put in place to protect individuals who report sexual assaults which include changing housing, preventing contact between the accused and the victim, monitoring reports about the resident or staff to see if there is any change in frequency or tone. Matt LeFrancois, the Coolidge House Director, or Joe Jarvis the Assistant Director would lead the monitoring of these events and PREA Coordinator Susan Jenness Philips would get updates about the resident's progress. The monitoring of the resident or staff who reported a concern would be at a minimum 90 days. The auditor based compliance on information given at the interviews consistent with policy, since there were no files to review for periodic status checks. Those interviews include the Director and Assistant Director of Coolidge House as well as the Director of Social Justice for CJR and the Agency PREA Coordinator.

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.

Community Resources for Justice would only complete administrative investigations at the Coolidge House facility. Agency policy requires that administrative investigations will be completed by CRJ or the residents referring authority. At Coolidge House the referring authority would be the Federal Bureau of Prisons. All criminal investigations would be done through the local law enforcement agencies. To date the facility has not had an incident requiring a criminal investigation. Agency Policy 900.00 (page 19-20) addresses the standards expectations. Indicator (c) on collection of DNA evidence would be completed by the Boston Police Investigators. Coolidge House staff are aware of how to protect evidence by closing off the area in which the assault occurred and giving specific directions to the resident victim and perpetrator to limit evidence destruction. Indicator (d) would be determined by the criminal investigation team of the Boston Police Department. The facility does not require the use of polygraph examination or other truth telling devises. Agency policy states that record retention rules require PREA investigation files be retained for a minimum of five years from the date the alleged abuser is released from the custody or employed by the Community Resources for Justice. The facility had one PREA related administrative investigation and no criminal investigation for sexual assault. The steps of the administrative investigations were reviewed with the Director, including the interview process, factors considered in determining credibility, and the process he would enact to ensure communication is maintained with the local police investigators and the Federal Bureau of Prisons. The Director was also aware that investigations must be completed even if the alleged abuser is released from custody or terminates employment. Compliance determination was made based on interview with the Director who would lead Investigations at Coolidge House, the prior experience he has in performing investigations, the example of prior investigation at the facility into a significant event and the staff knowledge of protecting a crime scene and DNA evidence.

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.

Facility Director and the Community Resource for Justice PREA Coordinator confirm that agency and Coolidge House policy 900.00 (page 19) requires that no greater standard than the preponderance of evidence be used in determining whether an allegation of sexual assault or harassment can be substantiated. Administrative staff have taken the NIC training "PREA: Investigating Sexual Abuse in a Confinement Setting" course which covers this topic. For compliance determination, the auditor had to rely on the interviews with the Director and PREA Coordinator, training records supporting the investigators were trained (115.234) and the administrative investigation file of a PREA complaint of harassment.

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.

The Coolidge House policy 900.00 Staff and Resident Sexual Abuse and Sexual Harassment (PREA) goes beyond the expectation of the standard in 115.273 as it puts forth requirements for reporting to residents victims of Coolidge House on the outcome of all investigations of Sexual Abuse and Sexual Harassment. Agency policy requires notification be made to residents who not only report sexual abuse but also requires notification on claims of sexual harassment. In determining compliance the auditor took into consideration the Director's knowledge in his interview that communication lines between the facility and the investigative agency must be open to allow him to make the appropriate notifications of the victim resident. Since there was no sexual assault by either staff or residents, there was no documentation to review to support indicator (c) and (d). The Coolidge House facility is a contractor of the Federal Bureau of Prisons and as such the Director is aware that he would have to work with FBOP to obtain information if the victim was to stay in the facility. It is believed, given the setting, once the aggressor is identified, FBOP would remove them to a higher custody during the investigation. If the reported victim remained in custody at Coolidge House the Director would inform the resident in writing of the progress of the case when referred for prosecution and at disposition.

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.

Community Resources for Justice agency policy and Coolidge House policy 900 (pages 18 and 19) states that staff who violate agency sexual abuse or sexual harassment policies are subject to disciplinary action. Disciplinary actions, including termination, which will be presumed consequence for a substantiated finding of sexual abuse. Discipline according to policy will be commensurate to the nature and circumstances of the acts committed and comparable to other staff with similar histories. Coolidge House requires all allegations of sexual abuse be reported to the Boston Police regardless of whether the staff resigns or is terminated. No staff has been disciplined for a PREA related violation in the past year as a result of an administrative investigation. As a result, there was no incident in which a criminal act was determined to have occurred which would have resulted in the case being referred to the Boston Police for a criminal investigation. Compliance for this standard was based on policy, past practice of the agency at other CRJ facilities and the interview with the Director.

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.

Coolidge House has limited contractors, including no direct service contractors, who would be unescorted in the facility. The facility also had, at the time of the audit, no volunteers or interns. The facility has no contracted staff who perform services directly to clients and educates those who enter the facility on PREA. The CRJ and Coolidge House policy 900.00 allows the program to bar entry to prevent contact with potential victims in incidents of sexual abuse or harassment. The policy requires the agency to refer incidents involving these individuals for investigation by law enforcement agencies. To date the agency reports it has not had to enact any of these measures to protect the residents. Compliance was determined based on the facility having the necessary procedures in place to be compliant with the standards expectations should a situation arise. As an example, the administration described how similar actions were taken for non PREA events at other CRJ facilities.

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.

Coolidge and Community Resources for Justice Policy 900.00 Staff and Resident Sexual Abuse and Sexual Harassment (PREA) page 20 addresses the requirements of this standard including the nature of the offense, the resident disciplinary history, and the mental health of the resident. Policy also requires, in discipline events involving sexual contact with staff, the resident can only be disciplined if it is found the staff did not consent. The agency prohibits consensual relationships between residents and, according to policy, will not consider this abuse unless there is evidence to the contrary but the residents would be subjected to discipline. Residents are reminded of this by case managers during orientation and it is also stated in the resident handbook. The facility staff monitor relationships closely and residents are subject to formal discipline following any abuse incident. Residents will have access to appropriate counseling services if they remain in the facility. Depending on the offense counseling may become part of their requirements to continue in the Coolidge House program. Residents report staff address all sexualized behaviors including the topics of conversations. The residents acknowledge that this action by staff make the environment safe and ensures that things do not escalate. Both staff and residents talked about required separation in the common areas that prevents males and females from sitting together. As a community confinement facility all disciplinary findings are relayed to the referring authority who reserves the right to remove residents. If a disciplinary incident was to occur the Federal Bureau of Prison would also be involved in the Disciplinary process. The agency provided the auditor with a list of federal violations and the corresponding range of sanctions. The facility is determined to be in compliance with the standards based on the policy, interviews with the facility Director, agency PREA Coordinator, as well as consistent statements from resident and staff on the level of behavioral expectations in the facility.

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.

The Coolidge House facility has not experienced an incident of sexual assault and as such has not sent a resident out for services. Since Coolidge House does not employ medical or mental health staff they have directed all staff on first responder duties. This training includes the process of sending residents out as soon as possible to the Brigahm and Womens Hospital in Boston and notifying the Boston Area Rape Crisis Center (BARCC). The hospital has the appropriate SANE nursing services and will be provided treatment without cost to victims of Sexual Assault. The auditor spoke with representatives of the hospital and reviewed the hospital and state public health websites on Sexual Assault protocols. The Massachucetts Department of Public Health certifies the SANE services in the state including treatment requirements which includes HIV, STD, Pregnancy testing and prophylaxis treatments. The SANE Advisory panel help to insure services are consistent and available throughout the state. The neighborhood medical and mental health services, from the auditor's literature reviews and interviews, appear to be comprehensive. FBOP contracted services can also provide follow up Mental Health treatment if needed, free of charge, to the residents of Coolidge House. Coolidge House Policy 900 page 14 confirms that any service related to examinations, transportation and prophylactic and emergency contraception are done free of charge to the victim. Compliance is based on discussions with case management staff, the Director and the Agency PREA Coordinator. The auditor also took into consideration the agency policy and a literature review of the areas available services.

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.

Coolidge House is committed to ensuring residents have ongoing access to services if they have been a victim of sexual abuse in any criminal justice setting. Agency Policy 900.00 Page 14 speaks to each aspect of this standard. The availability of BARCC and the local mental health clinics provided by the FBOP allows for ongoing treatment services. Ongoing health services for victims of sexual assault could be provided at Brigham and Woman's Hospital or care can be transferred to the local health services organization the residents go to for routine care and mental health services. In each case the resident can be treated free of charge including STD and HIV testing and treatment. Indicators d and e are not applicaple as the facility is all male. The residents of Coolidge house have access to community based health services. The services are the same as any other Boston resident who use these facilities. Resident on resident abuser would be evaluated with-in 60 days by a Mental Health provider according to policy. This is if the resident has not been removed to a higher level of custody. Though the agency has not had to put to use the requirement of this standard it appears to have the plan to initiate services if needed. The auditor also relied on conversations with community hospitals and service providers to gain a understanding of services available. The auditor also completed internet research on the various health service agencies to further support the finding of compliance.

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.

Coolidge House and CRJ Policy 900.00 p Staff and Resident Sexual Abuse and Sexual Harassment (PREA) pages 19 and 20 requires the completion of the steps outlined in this policy. The policy described who should be part of the review and the timeline for completion of the review. As there were no incidents of sexual abuse, there is no incident reviews required and no documentation to review. Interviews with Coolidge House Director Matt LeFrancois and the agency PREA Coordinator Susan Jenness Phillips support they are reportedly aware of the requirements of sexual assault incident reviews. Policy and interviews support that the facility is prepared to meet the requirements of this standard if an incident was to occur. The auditor encouraged the development of a report form to ensure consistent documentation of the standard element described in indicator d.

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.

Community Resources for Justice has collected data related to PREA in all of its facilities. Since all CRJ Social Justice facilities use the same policy the definitions are uniform. Coolidge House staff have been tracking a variety of information related to PREA that includes information for the Survey of Sexual Violence and other PREA related measures. The agency tracks, by facility through the PREA Coordinator's office, monthly and aggregate data relating to twenty-one (21) different PREA standards. Since the PREA Coordinator also oversees quality assurance for the agency she has access to all incidents, investigations and is a member of all review teams. The agency does not subcontract for confinement therefore indicator (e) is not applicable. The Department of Justice had not requested the facilities data in the last year making indicator (f) also not applicable. Compliance is based on the information provided and documentation of the data. Interview with the agency's PREA Coordinator was also considered in determining compliance. As the agency's Director of Standards and Accreditation she has the responsibility for evaluating data and working with programs to assist in improvement efforts.

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.

Community Resources for Justice policy 900.00 Staff and Resident Sexual Abuse and Sexual Harassment (PREA) pg. 22 addresses the standard's requirements. The data elements have been collected for the past year. The management teams on the facility level and the agency level will utilize data to make informed decisions on programmatic and policy needs. Though there were no incidents at Coolidge House, the agency still looks at ways to improve the safety of the facility. With the PREA Coordinator overseeing the agency's Standards and Accreditation Unit the parent agency CRJ has created a system in which problem areas can be identified and a corrective action plan monitored. The agency publishes data in an annual report of its programs. The agency also has put completed PREA reports on its website from CRJ Community Confinement facilities. The annual report does not have identifying information. The compliance with the standard is based on information provided and the interviews with the Director of Social Justice Services for the Agency Head and the Agency PREA Coordinator.

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.

Coolidge House and Community Resources for Justice Policy 900 addresses the requirements of this standard. All facility data is provided to the agency PREA Coordinator who is responsible for maintaining and securing all data. If the facility had an incident, all identifying information would be removed before any information is made public. As the Agency PREA Coordinator is also responsible for Quality Assurance she is aware of the requirerments including the security of information and how long the information is required to be held. The PREA Coordinator also works with the Social Justice Management Team on studying the data, and with the agency's head in the development of a annual report. Compliance is based on the information provided in the annual report, the policy indications on how to handle information and interview with the agency's 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.

Jack Fitzgerald – Certified Auditor – Fitzgerald Correctional Consulting LLC. 11/19/2016

Auditor Signature Date