**PREA AUDIT: AUDITOR’S SUMMARY REPORT**

**JUVENILE LOCKUP**

[ ] **INTERIM** [x] **FINAL**

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| **AUDITOR INFORMATION** |
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| **Dates of on-site audit:** | **April 27, 2016** |
| **FACILITY INFORMATION** |
| **Name of Facility:** | **Central Region Alternative Lockup Program** |
| **AGENCY INFORMATION** |
| **Name of Agency:** | **Massachusetts Department of Youth Services** |
| **Governing Authority or Parent Agency:** | **Massachusetts Department of Youth Services** |
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**NARRATIVE:** The Central Region Alternative Lockup Program (ALP) is a staff-secure 8 bed overnight detention facility for female and male adolescents operated by Key Program, Inc. (Key) under contract for the Massachusetts Department of Youth Services (DYS). The on-site portion of the PREA Audit took place April 27, 2016 and covered the audit period of April 27, 2015 to April 27, 2016. On the morning of April 27, 2016 this auditor entered the facility for purposes of conducting an on sight tour of the facility and interviewing youth, staff, volunteers and contractors. The facility provided a list of all staff by shift and employee job categories. Prior to arrival this auditor reviewed pertinent agency policies, procedures, and related documentation used to demonstrate compliance with the Juvenile Facility PREA Standards. The pre-audit review of documents contained in the Pre-Audit Questionnaire submitted by the facility prompted no questions. There was one youth at the program on the date of the audit. Youth are only housed at the program until the courts open for business in the morning.

During the tour, additional questions were answered by executive and upper-level management staff. Staff and youth interviews followed and were conducted privately in a room with a large observation window. There are no SANE or SAFE staff employed at the facility. These services are available at the local hospital through a state-wide Memorandum of Understanding (MOU). This auditor reviewed the MOU to provide SANE and SAFE services, and crisis counseling. This auditor interviewed members of the incident review team and the staff member charged with monitoring retaliation. Administrative investigations (sexual harassment only) are conducted by trained DYS staff and criminal investigations are conducted exclusively by the Massachusetts State Police. There were no volunteers or contractors interviewed as none were at the facility or available during the audit. The agency Executive Director had been previously interviewed by this auditor.

**DESCRIPTION OF FACILITY CHARACTERISTICS:** The Key Program, Inc. (Key) Alternative Lock-Up Program (ALP) provides a placement alternative for juveniles who are arrested on delinquent charges and who would otherwise be held for over six hours in police lock-ups across Worcester County and throughout the Commonwealth. If police departments hold children who are under the age of 18 and under arrest for delinquency for more than six hours in a locked cell, it violates the Juvenile Justice Delinquency Prevention Act (JJDPA), section 123, (a)(14). Key’s Alternative Lock-Up is a DEEC licensed, nine bed program of temporary shelter (1-4 days), for either males or females, at Key’s existing site at 104 Lincoln Street, Worcester. This physically secure site is fully licensed by the Department of Early Education and Care (Department of EEC) and is well known by Police Departments across Worcester County, and throughout the Commonwealth.

Clients are referred to the ALP by various police departments throughout the Commonwealth. Since inception, the ALP has marketed to and trained police departments on its availability and hours of operation. A bed can be accessed during non-court hours by contacting the program. The Key staff person receiving the call will determine the availability of a bed and conduct an initial telephone screening. If a bed is not available, Key staff will locate a placement at another ALP within the Commonwealth. If a bed is available, the police department will transport the youth to the program. Upon arrival, the Key staff person will complete a receiving screening form which, in part, ensures the youth has no medical or mental health problems necessitating immediate treatment or screening. At the intake, the client is searched by a same sex staff person who then completes a DYS Body Map Form indicating if there were any injuries or identification marks on the client. The staff person will sign the Body Map, and if there are no issues warranting further follow-up / attention, the client begins the intake procedure with the ALP staff. The intake procedure will consist of completing a Client Face sheet, which contains pertinent demographic data, along with an Intake Assessment Form, and a Personal Effects Inventory form. If during the intake process, it is determined that the client has any affiliation with a gang, the staff will then complete a DYS Group Affiliation Intake Sheet, in which basic information about the client and the group that the client is affiliated with is gathered. The client is then asked to read the Personal Effects Inventory form, verify that the information listed (inventory) is accurate and then the client is asked to sign the form, indicating that the client acknowledges that the list is accurate. The client is then asked to read and sign a Rules & Regulations form, a Lamb Warning form, and a Prison Rape Elimination Act (PREA) form. By signing the forms, the client is acknowledging that they have read and understand the information, not necessarily that they agree with the information.

Central Region ALP maintains supervisory coverage as well as an On-Call Administrator whenever youth are in the program.

**SUMMARY OF AUDIT FINDINGS:** Auditor arrived at the facility the morning of April 27, 2016. An entrance meeting was held with the Key Program Regional Director, Program Director (who also serves as the PREA Compliance Manager), and the DYS PREA Coordinator.

A complete tour of the facility took approximately 15 minutes. All areas were well maintained. The facility has a video surveillance system. That system provides coverage of the front and rear doors, as well as the intake area. The program is staffed with two employees at all times and if more than one youth is in the program there are three staff on duty. The bathroom is designed for one user at a time. Youth always shower and use the bathroom alone. Sight lines are good throughout the program (there are no unmitigated blind spots on the housing units).

Due to the nature of the program (short-term overnight holds) and the extremely unpredictable nature of admissions, only one youth was available for interview. This youth acknowledged being screened upon admission to the program and that gender identity questions were asked prior to the youth being searched. The youth also acknowledged receiving information on her right to be free from sexual abuse, assault or harassment, and information on multiple means of reporting same. Documentation was provided for the last youth admitted, having been screened and provided with information on their rights to be free from sexual abuse, sexual harassment and sexual assault.

The PREA screening for risk is conducted by trained staff on the date of admission, and documented. All youth acknowledge being screened on the date of admission via signature.

Administrative investigations regarding allegations of sexual harassment are conducted by trained DYS investigators. A review of investigators’ reports confirmed an aggressive response to all allegations of harassment. Criminal investigations of sexual abuse and assault are conducted by the Massachusetts State Police. Telephone and email contact with the DYS General Counsel confirm that there were no incidents of sexual abuse or assault during this audit period. Forensic examinations and evidence collection are performed at UMass Hospital. A state-wide MOU is in place to provide forensic examinations and victims’ services.

This auditor interviewed the following staff titles (number in parentheses indicates more than one staff in that title was interviewed):

* Key Program Regional Director
* Program Director
* DYS PREA Coordinator
* Facility PREA Compliance Manager

Random direct-care staff were not interviewed as there are no staff present when youth are not in the program and there is no way to predict when youth will be there. All employees that were interviewed presented as very knowledgeable about their jobs and highly dedicated to keeping youth safe. The agency’s commitment to PREA was also very evident during interviews. Staff members were not only aware of their agency’s policies and procedures, but were able to discuss PREA and how it related to the overall mission of the program and the agency’s mission as a whole.

All interviewees knew their obligations as mandated reporters and first responders. All felt well supported by DYS, and had no fear regarding retaliation for reporting abuse. All staff have received PREA specific training as first responders and all knew what to do if they were a first responder. All felt empowered to proactively address issues related to sexual violence and were able to describe actions they would take to prevent and/or deter potential and/or imminent threats of sexual violence. Documentation of training for all employees was provided.

As previously stated, there was only one youth in the program at the time of the audit. All references to youth being interviewed in this report are a compilation of information gleaned from the youth satisfaction surveys and information documented in JJEMS. All youth admitted to the program complete an exit interview in the form of a satisfaction survey at the end of their stay. There were no youth currently at the facility that had made an allegation of abuse that occurred at the facility. There were no youth currently at the facility who had reported an allegation of sexual harassment that occurred at the facility. There were no youth at the program who identified as LGBTI or had been identified as gender non-conforming in appearance. All youth acknowledged being asked about sexual orientation upon admission (documented in JJEMS). All youth signed for receipt of written information on their right to be free from sexual abuse, assault or harassment, and the multiple methods for reporting abuse. All youth acknowledge via signature being screened upon admission. Over the course of audit period less than 1% (of 384 admissions) of youth reported ever having fear for their safety while at the facility (confirmed via exit survey database). This is extraordinary considering the number of youth Central Region ALP serves that have never been locked up before (over 56% of the 384 admissions).

The quality and organization of the documentation provided to this auditor was outstanding. The pre-audit questionnaire completed by the DYS State-Wide PREA Coordinator is one of the better ones I have ever received. The referenced documents in the questionnaire were provided electronically.

**STANDARDS DETERMINATION TOTALS:**

**Exceeds Standard – 2 (Two) Standards or approximately 6% of total standards.**

**Meets Standard - 31 (Thirty One) Standards or approximately 94% of total standards.**

**Does Not Meet Standard – 0 (Zero) Standards or 0% of total standards**

**Standard 115.111 Zero tolerance of sexual abuse and sexual harassment; PREA Coordinator**

[ ] Exceeds Standard (substantially exceeds requirement of standard)

[x] 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.**

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| The Massachusetts Department of Youth Services (DYS) Policy and Procedure 01.05.07(B), page 1, clearly articulates the agency’s zero tolerance policy. Agency and facility organization charts clearly depict the roles of State-wide PREA Coordinator and Facility PREA Compliance Manager. Interviews with the PREA Coordinator and Compliance Manager proved their knowledge of the PREA standards and their commitment to the implementation of the PREA standards. Notice of the PREA compliance audit was posted on all living units and other prominent locations throughout the facility. |

**Standard 115.112 Contracting with other entities for the confinement of detainees.**

[ ] Exceeds Standard (substantially exceeds requirement of standard)

[x] 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.**

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| This auditor was provided with copies of contracts the Commonwealth of Massachusetts has for the confinement of juvenile justice youth. The contracts clearly require full compliance with the PREA standards as a condition of the contract. Central Region ALP does not enter into such contracts. |

**Standard 115.113 Supervision and monitoring**

[ ] Exceeds Standard (substantially exceeds requirement of standard)

[x] 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.**

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| DYS Policy and Procedure 01.05.07(B), page 12, was reviewed by this auditor. Policy requires Central Region ALP to have a staffing plan in compliance with the PREA standards and that the plan is reviewed annually. The facility has a staffing plan which was provided to this auditor. Documentation of annual review of the plan was also provided. DYS Policy and Procedure 03.02.02(c), page 1, requires unannounced rounds. This auditor was provided documentation of these rounds and interviews with supervisory staff confirmed that they occur. Documented staffing ratios exceed the standards during all program hours. Over-night staffing, in compliance with the standards was documented on staffing schedules, housing unit logs as well as interviews with staff and youth. There were no instances of deviations from the staffing plan due to training, vacations, Family Medical Leave and other types of leave. Overtime is paid to maintain staffing ratios. |

**Standard 115.114 Juvenile and youthful detainees.**

[ ] Exceeds Standard (substantially exceeds requirement of standard)

[x] 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.**

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| Per DYS Policy and the program contracts, the Alternative Lockup Programs do not serve adult detainees. |

**Standard 115.115 Limits to cross-gender viewing and searches**

[ ] Exceeds Standard (substantially exceeds requirement of standard)

[x] 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.**

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| Per DYS Policy and Procedure 03.01.02(a), page 3, states that youth may only be searched by staff of the same gender. All searches must be conducted with a witness. All staff interviewed confirmed that cross-gender searches do not occur. All youth interviewed denied ever having been searched by an opposite gender staff. DYS “Guidelines for Practices with LGBTQI-GNC Youth” prohibits searching youth for the purpose of determining if the youth is transgender or intersex. All of the youth interviewed denied ever being searched for this purpose. There are no cameras in bathrooms, showers, youth rooms or anywhere youth are permitted to change clothes. DYS Policy and Procedure 03.01.02(a), page provides for all youth to shower privately. All youth interviewed acknowledged that they have privacy when showing, toileting and changing clothes. All showers and bathrooms are for multiple users and are appropriately partitioned and supervised.  |

**Standard 115.116 Detainees with disabilities and residents who are limited English proficient.**

[ ] Exceeds Standard (substantially exceeds requirement of standard)

[x] 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.**

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| DYS Policy and Procedure 01.07.05(b), page 5, requires compliance with this standard. It further states on the same page that the use of resident interpreters is prohibited. This auditor received copies of intake materials in Spanish. The facility has multiple Spanish speaking staff. Special education teachers are available for youth with learning disabilities. A language interpretation service is available for other languages should the need arise. There were no youth currently at the facility that required the services of an interpreter. There were no youth currently at the facility that had disabilities that would require them to receive special services to understand their rights under PREA. All of the above was confirmed via interviews with staff, youth and clinicians. |

**Standard 115.117 Hiring and promotion decisions**

[ ] Exceeds Standard (substantially exceeds requirement of standard)

[x] 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.**

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| The Massachusetts DYS CORI regulations embodied in CMR 12.00 et seq, require background checks every three years for State employees and every two years for contract vendor employees. These checks include clearance through the Commonwealth’s child abuse registry. Material omissions of sexual abuse or harassment incidents or the provision of materially false information are grounds for termination. Documentation of CORI clearances was provided to this auditor. Interviews with the Facility Administrator, DYS Director of Residential Operations and the DYS State-Wide PREA Coordinator confirmed the practice. |

**Standard 115.118 Upgrades to facilities and technologies**

[ ] Exceeds Standard (substantially exceeds requirement of standard)

[x] 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.**

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| There have been no physical plant upgrades or renovations during this audit period. The Annual Review of Staffing, Monitoring Technology and Facility Resources Report clearly addresses the use of technology to improve the safety of youth. |

**Standard 115.121 Evidence protocol and forensic medical examinations**

[ ] Exceeds Standard (substantially exceeds requirement of standard)

[x] 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.**

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| Massachusetts DYS Policy and Procedure 01.05.07(b), page 10; the Memorandum of Understanding with Massachusetts Department of Early Education and Care; and the Memorandum of Understanding with the Massachusetts State Police were reviewed by this auditor. The policy addresses all aspects of this standard. There were no instances of sexual abuse or assault during this audit period, and therefore there was no documentation to review. Physical evidence collection of criminal acts and forensic examinations are not conducted by facility staff. All staff are trained to preserve incident scenes and measures to prevent evidence from being destroyed. This was confirmed via interviews with staff. Criminal investigations are conducted by the Massachusetts State Police. There is a state-wide MOU for evidence collection and forensic examinations in place. There were no instances of sexual abuse or assault during this audit period. This was confirmed via email conversation with the DYS General Counsel. |

**Standard 115.122 Policies to ensure referrals of allegations for investigations**

[x] 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.**

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| Massachusetts DYS Policy and Procedure 01.05.07(b) was reviewed by this auditor. The policy meets all the requirements of this standard. It requires that all allegations of sexual harassment and sexual abuse be investigated. It requires that allegations that may be criminal in nature be referred to law enforcement and provides clear guidance for when DYS may conduct an administrative investigation once a referral to law enforcement has been made. All DYS staff are mandated reporters of abuse and all staff interviewed were aware of their obligations to report abuse under Massachusetts law. The facility reported zero allegations of sexual harassment during this audit period. Central Region ALP, and DYS as a whole, is intentionally reporting and investigating single occurrences of sexual harassment (standard states “repeated” in the definition) in order to improve the conditions of confinement at the facility as they relate to PREA compliance, and they should be applauded for their efforts. This practice clearly exceeds the requirements of this standard. |

**Standard 115.131 Employee and volunteer training**

[ ] Exceeds Standard (substantially exceeds requirement of standard)

[x] 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.**

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| DYS Policy and Procedures 01.05.07(b), 01.05.08, and 03.04.09 meet all aspects of this standard and are incorporated into the DYS power-point training received by all staff. All staff interviewed acknowledged that they had received the initial training and refresher training. Documentation was provided to this auditor confirming staff completes a post training test to confirm understanding of the material presented. Contract employees and volunteers complete the training. All staff interviewed were aware of their obligations related to the agency’s PREA policy, their obligations as mandated reporters of abuse, their duties as a first responder and agency protocols related to evidence collection.The training curriculum utilized by the facility meets all aspects of this standard as follows: |
| [x]  (1) Agency’s zero tolerance policy for sexual abuse and sexual harassment. | 01.05.07(b); Pg. 1-2 |
| [x]  (2) How to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures. | 01.05.07(b); Pg. 1-2 |
| [x]  (3) Residents’ right to be free from sexual abuse and sexual harassment. | 01.05.07(b); Pg. 5-6 |
| [x]  (4) The right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment. | 01.05.07(b); Pg. 1 |
| [x]  (5) The dynamics of sexual abuse and sexual harassment in juvenile facilities. | 01.05.07(b); Pg. 3-5 |
| [x]  (6) The common reactions of sexual abuse and sexual harassment juvenile victims. | 01.05.07(b); Pg. 5-9 |
| [x]  (7) How to detect and respond to signs of threatened and actual sexual abuse. | Throughout the slides |
| [x]  (8) How to avoid inappropriate relationships with residents. | 01.05.07(b); Pg. 2, 12-13 |
| [x]  (9) How to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents. | 01.05.07(b); Pg. 13 |
| [x]  (10) How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities. | 01.05.07(b); Pg. 5 |
| [x]  (11) Relevant laws regarding the applicable age of consent. | 01.05.07(b); Pg. 1 |

**Standard 115.132 Detainee, contractor, and inmate worker notification of the agency’s zero-tolerance policy.**

[ ] Exceeds Standard (substantially exceeds requirement of standard)

[x] 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.**

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| All youth receive written notice of the DYS zero tolerance policy upon admission. A signed acknowledgement by the youth is maintained in JJEMS. Per the DYS Volunteer/Intern Orientation Handbook all volunteers and interns must receive PREA training. The PREA training is a review of the DYS PREA policy. Volunteers and interns must sign an acknowledgement that they have received and understood the training. There are no inmate workers, contractors or volunteers utilized at the program. |

**Standard 115.134 Specialized training: Investigations**

[ ] Exceeds Standard (substantially exceeds requirement of standard)

[x] 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.**

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| Per DYS Policy 01.05.07(b), page 8, DYS does not conduct investigations of sexual abuse. Such investigations are conducted by the Massachusetts State Police and the Department of Early Education and Care (EEC). A Memorandum of Understanding is in place with the EEC and the MOU specifically requests that the agency comply with the relevant PREA standards. Documentation was provided of efforts to enter into an MOU with the State Police. Documentation of training for DYS Investigators was provided to this auditor. DYS investigators have completed the NIC PREA Investigators training. |

**Standard 115.141 Screening for risk of victimization and abusiveness**

[ ] Exceeds Standard (substantially exceeds requirement of standard)

[x] 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.**

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| DYS Policy and Procedure 03.01.04, pages 2-3 and 01.05.07(b), page 8 address the standards related to screening youth for risk of victimization and abusiveness. Youth are administered the “Dialogue Tree” immediately upon admission by intake staff. Within 24 hours, but usually on date of admission clinical staff perform the full screening of youth using a standardized instrument. This screening is documented in the Juvenile Justice Enterprise Management System (JJEMS). JJEMS is state-wide database of information on all youth committed to DYS and is available to contract vendors as well as state operated programs. Access to screening information is limited to clinical staff and a limited number of upper level administrators. All of the youth interviewed stated that screening occurred shortly after admission. The screening instrument addresses all required elements of the standard.  |

**Standard 115.151 Detainee reporting**

[ ] Exceeds Standard (substantially exceeds requirement of standard)

[x] 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.**

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| DYS Policy and Procedure 01.05.07(b), page 6, appropriately addresses this standard. All youth interviewed knew multiple means (tell staff, DCF Hotline, tell parent, call lawyer, file grievance) to report abuse of any kind. All knew where to find the DCF Hotline number to report abuse outside the agency. None of the youth interviewed had ever reported sexual harassment, sexual abuse or any form of abuse while in DYD custody. Youth receive a handout at admission regarding how to report abuse and there are posters throughout the facility and on all housing units (in English and Spanish) with the information. All staff are mandated reporters of abuse per DYS Policy and Procedure 01.05.04(d), page 6, and the laws of the Commonwealth of Massachusetts. All staff interviewed were aware of their obligations as mandated reporters.  |

**Standard 115.154 Third-party reporting**

[ ] Exceeds Standard (substantially exceeds requirement of standard)

[x] 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.**

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| DYS’s public website lists the hotline number to call if sexual abuse or harassment is suspected. All youth interviewed acknowledged that they knew they could report abuse via a third party. All staff interviewed acknowledged that they would accept a third party report of abuse and respond in the same manner as if they had witnessed the abuse themselves. |

**Standard 115.161 Staff and agency reporting duties**

[ ] Exceeds Standard (substantially exceeds requirement of standard)

[x] 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.**

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| DYS Policy and Procedure 01.05.07(b) address the requirements of this standard. All staff and volunteers are mandated reporters of child abuse. All staff and volunteers receive training as to how to fulfill their obligations as mandated reporters (what to report and how to report it). All staff interviewed were aware of the obligations as mandated reporters.  |

**Standard 115.162 Agency protection duties**

[ ] Exceeds Standard (substantially exceeds requirement of standard)

[x] 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.**

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| DYS Policy and Procedure 01.05.07(b), pages 6 and 10 addresses the requirements of this standard. There were no instances of a youth being determined to be in substantial risk of imminent sexual abuse. All staff interviewed were able to articulate means that they would use to protect youth should this occur. |

**Standard 115.163 Reporting to other confinement facilities**

[ ] Exceeds Standard (substantially exceeds requirement of standard)

[x] 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.**

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| DYS Policy and Procedure 01.05.07(b), pages 6 complies with this standard. Central Region ALP did not receive any reports of youth being sexually abused at another confinement facility during this audit period and therefore had no documentation to show this auditor regarding such actions.  |

**Standard 115.164 Staff first responder duties**

[ ] Exceeds Standard (substantially exceeds requirement of standard)

[x] 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.**

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| All staff, volunteers and contractors receive training regarding first responder duties. Documentation of training was provided to this auditor. DYS Policy and Procedure 01.05.07(a), complies with this standard. Central Region ALP has an institutional plan that meets the requirements of this standard. There were no instances of sexual assault during this audit period, therefore there is no documentation of staff performing these duties. All staff interviewed were able to articulate their first responder duties. |

**Standard 115.165 Coordinated response**

[ ] Exceeds Standard (substantially exceeds requirement of standard)

[x] 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.**

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| A copy of Central Region ALP’s institutional plan was provided to this auditor. The plan provides clear and concise direction for response to any alleged PREA violation. There were no instances of sexual assault during this audit period and therefore there was no documentation of the plans use available for review. All staff interviewed were aware of their program’s institutional plan and where to locate the document. |

**Standard 115.166 Preservation of ability to protect detainees from contact with abusers**

[ ] Exceeds Standard (substantially exceeds requirement of standard)

[x] 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.**

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| There have been no new collective bargaining agreements entered into by Central Region ALP or DYS on behalf of Central Region ALP that would violate this standard. DYS Policy and Procedure 01.05.04(d) specifically authorizes DYS to protect youth from contact with alleged abusers up to and including suspending staff without pay. |

**Standard 115.167 Agency protection against retaliation**

[ ] Exceeds Standard (substantially exceeds requirement of standard)

[x] 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.**

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| DYS Policy and Procedure 01.05.07(b), pages 8 names the Program Director as the person responsible for monitoring for retaliation against staff or youth. There were no allegations of sexual abuse or assault during this audit period and therefore there was no document of monitoring to be reviewed. |

**Standard 115.171 Criminal and administrative agency investigations**

[ ] Exceeds Standard (substantially exceeds requirement of standard)

[x] 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.**

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| DYS and Central Region ALP do not conduct investigations of allegations that rise to the level of criminal behavior. These are conducted by the Massachusetts State Police. DYS Policy and Procedure 01.05.07(b), pages 9-10 complies with this standard relative to administrative investigations. DYS investigators completed PREA investigations training through the NIC and follow the protocols there in when conducting investigations related to allegations of sexual harassment. A review of prior sexual harassment investigation reports confirmed the investigators’ understanding of this policy and their training. DYS has made documented efforts to advise the Massachusetts State Police of the requirements of this standard. |

**Standard 115.172 Evidentiary standard for administrative investigations**

[ ] Exceeds Standard (substantially exceeds requirement of standard)

[x] 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.**

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| Per DYS Policy and Procedure 01.05.07(b), page 10, section E(2), a preponderance of evidence is the standard. There were no allegations of sexual harassment during this audit period. A review of two administrative investigation reports for alleged sexual harassment (occurring at another program) confirmed the evidentiary standard is being followed. |

**Standard 115.176 Disciplinary sanctions for staff**

[ ] Exceeds Standard (substantially exceeds requirement of standard)

[x] 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.**

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| DYS Policy and Procedure 01.05.04(d), page 4 addresses the requirements of this standard. There were no substantiated instances of sexual abuse, assault or harassment by Central Region ALP staff occurring during this audit period, and therefore there was no documentation to review for compliance. |

**Standard 115.177 Corrective action for contractors and volunteers**

[ ] Exceeds Standard (substantially exceeds requirement of standard)

[x] 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.**

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| DYS Policy and Procedure 01.10.01(a), page 1 addresses the requirements of this standard. There were no instances of sexual abuse, assault or harassment by Central Region ALP contractors or volunteers occurring during this audit period, and therefore there was no documentation to review for compliance. |

**Standard 115.178 Referrals for prosecution for detainee-on-detainee sexual abuse.**

[ ] Exceeds Standard (substantially exceeds requirement of standard)

[x] 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.**

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| Central Region ALP has a youth handbook that outlines the behavioral treatment program response for such violations. Based upon the therapeutic nature of these programs the general tenor of responses are therapeutic in nature. In other words, behavioral change is the goal versus punitive actions. Based upon the fact that Central Region ALP’s primary goal related to disciplinary sanctions in response to rule violations is treatment oriented this auditor finds this standard to be in compliance.  |

**Standard 115.182 Access to emergency medical and mental health services**

[ ] Exceeds Standard (substantially exceeds requirement of standard)

[x] 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.**

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| The program’s Institutional Plan addresses the requirements of this standard. DYS Policy and Procedure 01.05.07(b) also requires that the youth’s medical and mental health needs are met. The state-wide MOU clearly states that services will be provided to the youth free of charge. There were no incidents of sexual abuse or sexual assault occurring at Central Region ALP during this audit period, and therefore there was no documentation to be reviewed. |

**Standard 115.186 Sexual abuse incident reviews**

[x] 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.**

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| There were no incidents of sexual abuse or sexual assault occurring at Central Region ALP during this audit period. DYS Policy and Procedure 01.05.07(b), page 11 complies with this standard. Due to the lack of sexual abuse incidents there was no documentation for this auditor to review. |

**Standard 115.187 Data collection**

[ ] Exceeds Standard (substantially exceeds requirement of standard)

[x] 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.**

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| DYS Policy and Procedure 01.05.07(b), page 12 complies with this standard. DYS also maintains electronic records for youth and staff. Combined these systems allow DYS to access data sufficient to complete the annual survey of sexual violence. The agency’s public website was reviewed by this auditor. Aggregate data for all contract and DYS operated facilities is posted. |

**Standard 115.188 Data review for corrective action**

[ ] Exceeds Standard (substantially exceeds requirement of standard)

[x] 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.**

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| The agency’s public website was reviewed by this auditor. The most recent, available annual PREA report was posted. The annual report addresses all elements of this standard. DYS Policy and Procedure 01.08.02 addresses the retention requirements of this standard. |

**Standard 115.189 Data storage, publication, and destruction**

[ ] Exceeds Standard (substantially exceeds requirement of standard)

[x] 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.**

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| The DYS Policy and Procedure 01.08.02 addresses the data storage requirements of this standard. A review of the data available on the DYS website supports full compliance for this standard. There is no individual identifying information contained in the aggregate data or the reports related to the data posted. |

**AUDITOR CERTIFICATION**

This auditor certifies that no conflict of interest exists with respect to his ability to conduct an audit of the Massachusetts Department of Youth Services, the Central Region ALP Center or its vendor providers.

\_\_**Kurt Pfisterer/s/**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ May 26, 2016

Kurt Pfisterer, Dual Certified PREA Auditor Date