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

**JUVENILE FACILITIES**

**INTERIM** **FINAL**

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| **Dates of on-site audit:** | **May 12, 2016** | |
| **FACILITY INFORMATION** | | |
| **Name of Facility:** | **Fall River LEAD 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 Fall River LEAD Program is a staff secure 10 bed facility for male adolescents operated by the Old Colony YMCA (OCY) under contract with the Massachusetts Department of Youth Services (DYS). The on-site portion of the PREA Audit took place May 12, 2016 and covered the audit period of May 12, 2015 to May 12, 2016. On the morning of May 12, 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 and a list of all youth by housing unit. 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 few questions. Answers to those questions were submitted to this auditor by the facility staff and any additional remaining questions were resolved during the audit. This auditor interviewed all of the current seven youth. The youth interviewed represented 100% of the current population. Length of stay for those interviewed ranged from four days to seven months. There were no youth who identified themselves as lesbian, bisexual, gay, transgender or intersex and no youth who needed translation services. No youth had specifically requested to speak with this auditor nor had this auditor received any written correspondence from youth or staff. There were no youth currently in the program who made an allegation of sexual abuse or sexual harassment.

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 video surveillance. 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 for 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.Emails were sent to Just Detention International and the Director of the Massachusetts SANE Programs in an effort to determine if the organizations had any relevant information regarding the facility. Just Detention International responded and had no reports regarding the program.

**DESCRIPTION OF FACILITY CHARACTERISTICS:** The Fall River DYS Learn Educate Appreciate and Develop (LEAD) Program, located Fall River, MA, provides services to youth placed in its care by the Massachusetts Department of Youth Services using effective, evidence-based treatment strategies. These services include dialectical behavioral therapy, substance abuse prevention and treatment, behavior management and family involvement with the goal of community reintegration. Community reintegration is accomplished through partnerships with various external entities. These entities include the Fall River Workforce Investment Board (WIB), Fall River Youth Build, Bristol Community College and the local DYS Community Reentry Centers (CRC). The overarching philosophy of the program is positive youth development. The goal is to help transform the life circumstances of youth and guide them into safe and productive futures.

The LEAD Program is a ten bed staff-secure residential treatment program adolescent males, between the ages of sixteen and twenty one, committed to the Department of Youth Services for grid level offenses ranging from grid levels one to four. The educational program is provided by the Collaborative for Educational Services (CES), while vocational services that focus on skill development, practical certifications and the establishment of linkages leading to employee placement, is provided in-house by the Youth Build program. Due to the OCY's unique relationship with Youth Build, its clients have the ability to draw upon this nationally recognized program that provides vocational services and in-house GED services. OCY's Youth Build program in Brockton has been serving at-risk inner city youth since 1998, while the Fall River location was established in 2005. Youth Build's model has been tested with DYS youth. Approximately 20% of Youth Build clients have been court or DYS-involved. Youth participate in a blend of onsite instruction to support their educational/vocational plan, including GED preparatory services, and they will also participate in offsite training, education and employment activities. The Youth Build instructors work hand in hand with the program CES teachers to develop the linkages to support training, certifications and career track employment placements.

In the vocational component, students earn their OSHA-10 certification, a nationally recognized 10- hour safety course. In addition, they complete an in-house, 40-hour construction certificate that introduces the student to basic tool safety and usage. After completion of these requirements, the students is enrolled in the Home Builders Institute Pre-Apprenticeship Certificate Training program (HBI-PACT). This curriculum is the building industry-validated construction curriculum specifically designed to teach at-risk and underserved populations including academically-challenged individuals. PACT features techniques and practices based on the National Association of Home Builders (NAHB), Model Green Home Building Guidelines and aligns with the ICC-700 2008 National Green Building Standard™, the building industry's rating system approved by the American National Standards Institute (ANSI). PACT relies on a time-honored apprenticeship approach to learning craft skills, combining classroom instruction and hands-on training on a job site. Skill Achievement Records (SARs) track competencies and contextual learning specific to carpentry and safety; construction math and tool and material identification are also part of the curricula.

Youth Build has built and maintains a network of local employers who have hired DYS youth in the past. These employers are sensitive to CORI issues and will support the goal of employment. LEAD clients are able to access employers in this network upon release.

The LEAD Program accepts clients referred by the Department of Youth Services Director of Placement Services for the Southeast Region, with the understanding that referrals may potentially come from other areas. Clients admitted to the program are males between the ages of sixteen to twenty with grid level charges ranging from one to four, with an anticipated length of stay between four to six months.

The program has a combination of single and double bedrooms. Bathrooms are designed for multiple users. There are separate bathrooms for staff and youth. The program has a video surveillance system which provides coverage to 95% of the program areas youth are permitted in.

There were seven youth in the program on the first day of the audit.

The Fall River LEAD Program maintains 24 hour supervisory coverage as well as an On-Call Administrator.

**SUMMARY OF AUDIT FINDINGS:** Auditor arrived at the facility the morning of May 12, 2016. An entrance meeting was held with the 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 which provides coverage for 95% of the facility. The system provides coverage of the recreation areas, dining hall, all housing units, hallways and education areas. There are no cameras in the youths’ rooms. There is a camera view of all doors in areas where youth are permitted. The system has a 60 day retention time for recorded images. Observed staffing (four staff to seven youth), while this auditor was on site exceeds the standards requirement of 8: 1. Bathrooms are for multiple users. Showers and toilets are appropriately partitioned. When more than one youth is in the bathroom a staff is posted inside the room. Youth are allowed to shower one at a time if they so desire. All youth interviewed confirmed that they have adequate privacy when more than one youth is in the bathroom and that when the bathrooms are in use a staff is posted in the bathroom. Sight lines were excellent in all housing areas.

Youth were observed in school, recreation, during movement, and at meals. Observations of staff supervision practices were consistent with the agencies policies.

The PREA screening for risk is conducted by the clinical staff on the date of admission, and documented. All youth interviewed acknowledged being screened on the date of admission as well as being seen by medical staff within 24 hours of admission.

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

This auditor interviewed the following staff titles:

* Program
* Clinical Director
* Clinician
* DYS PREA Coordinator
* Nurse
* Shift Administrator
* Supervisor
* Assistant Supervisor
* Youth Care Advocate
* Facility PREA Compliance Manager

The staff interviewed accounted for all available staff at the program on the date of the on-site audit and were representative of all shifts. Experience levels ranged from one and a half to over 20 years. All 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 staff members knew their obligations as mandated reporters and first responders. All felt well supported by facility management, 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.

A total of five youth at the facility were interviewed (which represented 71% of the population). Ages ranged from 17 to 19 years. There were no youth currently at the facility that had made an allegation of abuse. There were no youth currently at the facility who had reported an allegation of sexual harassment. 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. All youth interviewed had extensive knowledge of the right to be free from sexual abuse, assault or harassment. All youth were aware of multiple methods for reporting abuse. All youth acknowledged being screened upon admission (screening actually occurs on date of admission, which far exceeds the standard) and receiving information upon admission on their right to be free from abuse in any form. Youth also receive the PREA education program on the date of admission. No youth reported ever having fear for their safety while at the facility or at any time during commitment with DYS. All said they currently felt safe at the facility.

The quality and organization of the documentation provided to this auditor was outstanding. This auditor received a three-ring binder which contained specific documentation (training, CORI clearances, etc.) for the program. 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.

The organized manner in which the interviews were facilitated by the PREA Compliance Manager and the DYS State-Wide PREA Coordinator made the process go very smoothly with no wasted time in between interviews.

**STANDARDS DETERMINATION TOTALS:**

**Exceeds Standard – 2 (Two) Standards or approximately 4% of total standards.**

**Meets Standard - 40 (Forty) Standards or approximately 96% of total standards.**

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

**Standard 115.311 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.**

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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 115.312 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.**

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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. The Fall River LEAD Program does not enter into such contracts. |

**Standard 115.313 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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| DYS Policy and Procedure 01.05.07(B), page 12, was reviewed by this auditor. Policy requires the facility 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. The plan addresses prior incidents, finding from external and internal monitoring, judicial findings, technology and staffing needs. 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. There is a video surveillance system which provides video coverage of all housing units, program areas and hallways. The system has a video retention period of at least 60 days. Unannounced rounds are supplemented with mandatory video reviews by supervisors. Observed staffing ratios of four staff to seven youth during the on-site audit exceeded the standards during 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 115.315 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.**

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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. The facility conducts pat searchers and clothing searches (the youth remains in their under garments, they are never completely naked). The facility does not conduct full strip searches. All searches must be conducted with a witness. All random 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 (again, full strip searches are not performed). 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 03.04.09, pages 11 provides for all youth to shower privately. All youth interviewed acknowledged that they have privacy when showing, toileting and changing clothes. Excellent supervision practices mitigate any concerns regarding the bathroom facilities. All staff interviewed stated that their presence is announced when they enter a housing unit of opposite gender youth. There are signs at the entrances to the living areas requiring opposite gender staff to announce their presence upon entering the unit. All youth interviewed acknowledged that opposite gender staff announces their presence when entering the living areas. This practice was also observed throughout the on-site audit. |

**Standard 115.316 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)

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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 115.317 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)

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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 115.318 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.**

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| There have been no physical plant upgrades or renovations during this audit period. The facility’s video surveillance system provides a camera view of every door in areas where youth are permitted as well as doors to enter areas where they are not permitted. The Annual Review of Staffing, Monitoring Technology and Facility Resources Report clearly addresses the use of technology to improve the safety of youth. |

**Standard 115.321 Evidence protocol and forensic medical examinations**

Exceeds Standard (substantially exceeds requirement of standard)

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

Does Not Meet Standard (requires corrective action)

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

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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 115.322 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.**

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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 no allegations of sexual harassment, sexual abuse or sexual assault during this audit period. There were no allegations to refer to the law enforcement for investigation. DYS policy requires reporting of sexual harassment allegations that do not rise to the level of sexual harassment as defined by the PREA standards (the standards specifically state “repeated” as a condition of the definition). While there were no allegations of sexual harassment DYS as a whole, is intentionally reporting and investigating single occurrences of sexual harassment 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 115.331 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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| 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: | |
| (1) Agency’s zero tolerance policy for sexual abuse and sexual harassment. | 01.05.07(b); Pg. 1-2 |
| (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 |
| (3) Residents’ right to be free from sexual abuse and sexual harassment. | 01.05.07(b); Pg. 5-6 |
| (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 |
| (5) The dynamics of sexual abuse and sexual harassment in juvenile facilities. | 01.05.07(b); Pg. 3-5 |
| (6) The common reactions of sexual abuse and sexual harassment juvenile victims. | 01.05.07(b); Pg. 5-9 |
| (7) How to detect and respond to signs of threatened and actual sexual abuse. | Throughout the slides |
| (8) How to avoid inappropriate relationships with residents. | 01.05.07(b); Pg. 2, 12-13 |
| (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 |
| (10) How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities. | 01.05.07(b); Pg. 5 |
| (11) Relevant laws regarding the applicable age of consent. | 01.05.07(b); Pg. 1 |

**Standard 115.332 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)

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| 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. Documentation of contractors or volunteers training and signed acknowledgements were provided to this auditor. |

**Standard 115.333 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)

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| DYS’s resident education program, referred to as the “slide show” is provided to youth by their assigned clinician within 24 hours of admission. This is documented in the youth’s electronic case file. Copies of all youths’ signed acknowledgements were provided to this auditor. Youth receive materials about PREA and their rights to be free from abuse and how to report abuse upon admission. This document is available in English and Spanish. This initial handout is reviewed with youth by intake staff and the youth signs an acknowledgement that they understood the material presented. All youth interviewed were aware of the right to be free from abuse and multiple means of reporting allegations of abuse. All youth entering any DYS operated or contracted facility receives the education. All youth interviewed reported having received the education slide show on multiple occasions, equal to the number of programs they were admitted to. Posters, in both English and Spanish were clearly visible on all living units and throughout the facility. |

**Standard 115.334 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.**

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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 115.335 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.**

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| DYS Policy and Procedure 01.05.07(b), page 13 mandates specialized training for medical and mental health staff as per the PREA standards. Documentation of this training, including training for contract providers was provided to this auditor. Three OYC medical staff members have been interviewed by this auditor and all acknowledged receiving specialized training. Facility medical staff does not conduct forensic examinations or collect evidence. The agency’s protocol is to preserve/avoid destruction of evidence and then transport to the designated medical facility (Charlton Memorial Hospital). |

**Standard 115.341 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.**

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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 115.342 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.**

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| DYS Policy and Procedure 02.02.01(b)addresses how the information obtained during screening is utilized to inform programming and housing decisions. Isolation, as it relates to this standard, is not authorized under DYS policy and was not used during this audit period. There is a policy, DYS Policy and Procedure 03.03.01(a), in place to cover this standard. Involuntary room confinement, as isolation is referred to in DYS, is not authorized for the purposes described in this standard. Interviews with all staff and youth confirmed compliance with this standard. DYS Policy and Procedure 03.04.09 prohibits youth from being assigned to a housing unit based on gender identity and prohibits gender identity from being used as a risk factor for abusiveness. DYS has a policy in place that allows for youth to be assigned to male and female facilities regardless of birth gender. |

**Standard 115.351 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.**

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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 115.352 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.**

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| DYS Policy and Procedure 03.04.01, complies in full with this standard. Although the policy complies with the standard, a grievance filed that alleges that sexual abuse occurred or alleges an imminent threat would immediately trigger the agency’s PREA response procedures. A review of grievance records and interview with the PREA Compliance Manager confirm that there were no grievances filed related to sexual abuse during this audit period. All youth interviewed were aware of the grievance procedures. All staff interviewed were able to describe steps they would take to protect a youth from threatened abuse. |

**Standard 115.353 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.**

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| A state-wide Memorandum of Understanding exits for the provision of these services. DYS Policy and Procedure 03.04.04(b), addresses access to these services. Interviews with medical and clinical staff confirmed that youth would be advised about confidentiality prior to accessing the services. Information is provided to youth via Department of Public Health posters that are on display in all living units and common areas throughout the Facility. These display the telephone number and mailing address for juveniles to contact. All youth interviewed acknowledged ready access to contact with their families (free telephone calls) and the ability to contact their lawyer if they so desired. |

**Standard 115.354 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.**

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| There were no reported instances of third-party reporting during this audit period. DYS’s public website lists the Department of Child and Families (DCF) 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 115.361 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.**

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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. According to the program there were no allegations of sexual abuse, assault or harassment reported by staff during this audit period. None of the staff interviewed reported making such a report. |

**Standard 115.362 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.**

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| DYS Policy and Procedure 01.05.07(b), pages 6 and 10 addresses the requirements of this standard. The policy and the facility’s institutional plan require and immediate response should a youth be determined to be at imminent risk of sexual abuse or assault. There were no reported instances of a youth being determined to be in substantial risk of imminent sexual abuse. All staff interviewed were able to articulate immediate means that they would use to protect youth should this occur. These included immediately calling for a supervisor to respond to the location; keeping the youth under arms-length supervision until the supervisor arrives; and, if necessary based on the imminent nature of the threat, securing the youth alone in a room. |

**Standard 115.363 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.**

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| DYS Policy and Procedure 01.05.07(b), pages 6 complies with this standard. The facility advised that it 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 115.364 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.**

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| All staff, volunteers and contractors receive training regarding first responder duties. DYS Policy and Procedure 01.05.07(a), complies with this standard. The facility has an institutional plan that meets the requirements of this standard. There were no reported 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 115.365 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.**

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| A copy of the facility’s institutional plan was provided to this auditor. The plans provide clear and concise direction for response to any alleged PREA violation. There were no reported 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 115.366 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.**

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| There have been no new collective bargaining agreements entered into by the facility or DYS on behalf of the facility 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 115.367 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.**

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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 reported allegations of sexual abuse or assault during this audit period and therefore there was no document of monitoring to be reviewed. This was confirmed via email conversation with DYS General Counsel. |

**Standard 115.368 Post-allegation protective custody**

Exceeds Standard (substantially exceeds requirement of standard)

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

Does Not Meet Standard (requires corrective action)

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

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| DYS policy does not permit the use of segregation as meant in this standard. There were no reported instances of sexual abuse during this audit period. The facility did not use segregation or isolation for the purpose of this standard during this audit period. |

**Standard 115.371 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.**

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| DYS and the facility 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 115.372 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.**

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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 administrative investigation reports for alleged sexual harassment to confirm the evidentiary standard is being followed. Reports from other DYS investigations confirm compliance by DYS investigators. |

**Standard 115.373 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.**

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| There were no reported instances of sexual abuse alleged to have occurred during this audit period. DYS Policy and Procedure 01.05.07(b), page 10 meets the requirements of this standard. No youth made an allegation of sexual abuse during this audit period and therefore there was no documention to review. |

**Standard 115.376 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.**

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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 facility staff occurring during this audit period, and therefore there was no documentation to review for compliance. |

**Standard 115.377 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.**

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

**Standard 115.378 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.**

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| There were no reported incidents of youth on youth sexual abuse, assault or harassment. The facility 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 the facility’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 115.381 Medical and mental health screenings; history of sexual abuse**

Exceeds Standard (substantially exceeds requirement of standard)

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

Does Not Meet Standard (requires corrective action)

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

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| DYS Policy and Procedure 01.05.07(b), page 8 addresses the requirements of this standard. Youth admitted to the facility are seen by medical staff within 24 hours of arrival. Staff performing the youth’s intake utilize a standardized screening tool to determine if a youth has any immediate and/or emergency medical or mental health needs. All youth interviewed confirmed that they were seen by medical staff shortly after arrival at the facility. Interview with medical staff confirmed that screening includes history of sexual abuse. Per medical staff interview, youth have access to all the same medical services available to youth in the community. When a disclosure of prior abuse occurs, and services are offered by Medical and Mental Health staff, this is documented in JJEMS. |

**Standard 115.382 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.**

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| The facility’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 reported incidents of sexual abuse or sexual assault occurring at the facility during this audit period, and therefore there was no documentation to be reviewed. |

**Standard 115.383 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.**

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| There were no reported incidents of sexual abuse or sexual assault occurring at the facility during this audit period and therefore there was no documentation to review. In the event that an incident was to occur the victim would receive services from the community provider as outlined in the state-wide MOU. As previously noted, services from these providers are at no cost to the victim. All ongoing medical care beyond the scope of facility medical staff would be provided by community providers. The youth would have the option of facility clinical staff or community providers for ongoing mental health services. |

**Standard 115.386 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.**

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| There were no incidents of sexual abuse or sexual assault occurring at the facility 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 115.387 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.**

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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 115.388 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.**

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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 115.389 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.**

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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 Fall River LEAD Program or its vendor providers.

\_\_**Kurt Pfisterer/s/**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ June 1, 2016

Kurt Pfisterer, Dual Certified PREA Auditor Date