Prison Rape Elimination Act (PREA) Audit Report
Juvenile Facilities

☐ **Interim** ☒ **Final**

Date of Interim Audit Report: Click or tap here to enter text. ☒ **N/A**
If no Interim Audit Report, select N/A
Date of Final Audit Report: May 6, 2025

Auditor Information

Name: Ashgar Farooq Mallick	**Email:** afarooq.mallick@gmail.com
Company Name: PREA Juvenile Auditors of America, LLC	
Mailing Address: 79 Jansen Road	**City, State, Zip:** New Paltz, New York 12 561
Telephone: 845-594-8161	**Date of Facility Visit:** April 6-7, 2025

Agency Information

Name of Agency: Department of Youth Services			
Governing Authority or Parent Agency *(If Applicable)*: Massachusetts Department of Youth Services (DYS)			
Physical Address: 600 Washington St. 4th Floor		**City, State, Zip:** Boston, MA 02111	
Mailing Address: 600 Washington St.		**City, State, Zip:** Boston, MA 02111	
The Agency Is:	☐ Military	☐ Private for Profit	☐ Private not for Profit
☐ Municipal	☐ County	☒ State	☐ Federal

Agency Website with PREA Information:
https://hhsvgapps01.hhs.state.ma.us/ehsintranet/community/department-of-youth-services

Agency Chief Executive Officer

Name: Cecely Reardon	
Email: cecely.a.reardon@mass.gov	**Telephone:** 617-960-3330

Agency-Wide PREA Coordinator

Name: Monica King	
Email: monica.l.king@mass.gov	**Telephone:** 774-230-1200
PREA Coordinator Reports to: Nancy Carter	**Number of Compliance Managers who report to the PREA Coordinator:** 24

Facility Information

Name of Facility: Paul T. Leahy Center			
Physical Address: 363 Belmont St.		**City, State, Zip:** Worcester, MA 01949	
Mailing Address (if different from above): Click or tap here to enter text.		**City, State, Zip:** Click or tap here to enter text.	
The Facility Is:	☐ Military	☐ Private for Profit	☐ Private not for Profit
☐ Municipal	☐ County	☒ State	☐ Federal
Facility Type:	☐ Prison	☐ Jail	

Facility Website with PREA Information: **https://hhsvgapps01.hhs.state.ma.us/ehsintranet/community/department-of-youth-services**

Has the facility been accredited within the past 3 years? ☐ Yes ☒ No

If the facility has been accredited within the past 3 years, select the accrediting organization(s) – select all that apply (N/A if the facility has not been accredited within the past 3 years):

☐ ACA

☐ NCCHC

☐ CALEA

☐ Other (please name or describe: Click or tap here to enter text.

☒ N/A

If the facility has completed any internal or external audits other than those that resulted in accreditation, please describe:
N/A

Superintendent/Director/Administrator

Name:	Lisa Astorino		
Email:	lisa.astorino@mass.gov	**Telephone**	774-366-7916

Facility PREA Compliance Manager

Name:	Leonard Beatty		
Email:	Leonard.l.beatty@mass.gov	**Telephone:**	508-368-4217

Facility Health Service Administrator ☐ N/A

Name:	Carol Latino-Mikkelsen		
Email:	carol.latino-mikkelsen@mass.gov	**Telephone:**	508-475-2726

Facility Characteristics

Designated Facility Capacity:	36
Current Population of Facility:	18

Average daily population for the past 12 months:	20
Has the facility been over capacity at any point in the past 12 months?	☐ Yes ☒ No
Which population(s) does the facility hold?	☐ Females ☐ Males ☒ Both Females and Males
Age range of population:	14-21
Average length of stay or time under supervision:	Detention 1-21 days revocation 15-30 days ONA 24 hours or less
Facility security levels/resident custody levels:	Hardware secure

Number of residents admitted to facility during the past 12 months:	284
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for *72 hours or more*:	131
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for *30 days or more:*	100
Does the audited facility hold residents for one or more other agencies (e.g. a State correctional agency, U.S. Marshals Service, Bureau of Prisons, U.S. Immigration and Customs Enforcement)?	☐ Yes ☒ No

Select all other agencies for which the audited facility holds residents: Select all that apply (N/A if the audited facility does not hold residents for any other agency or agencies):	☐ Federal Bureau of Prisons ☐ U.S. Marshals Service ☐ U.S. Immigration and Customs Enforcement ☐ Bureau of Indian Affairs ☐ U.S. Military branch ☐ State or Territorial correctional agency ☐ County correctional or detention agency ☐ Judicial district correctional or detention facility ☐ City or municipal correctional or detention facility (e.g. police lockup or city jail) ☐ Private corrections or detention provider ☐ Other - please name or describe: Click or tap here to enter text. ☒ N/A

Number of staff currently employed by the facility who may have contact with residents:	80
Number of staff hired by the facility during the past 12 months who may have contact with residents:	28
Number of contracts in the past 12 months for services with contractors who may have contact with residents:	1
Number of individual contractors who have contact with residents, currently authorized to enter the facility:	13
Number of volunteers who have contact with residents, currently authorized to enter the facility:	0

Physical Plant

Number of buildings: **Auditors should count all buildings that are part of the facility, whether residents are formally allowed to enter them or not. In situations where temporary structures have been erected (e.g., tents) the auditor should use their discretion to determine whether to include the structure in the overall count of buildings. As a general rule, if a temporary structure is regularly or routinely used to hold or house residents, or if the temporary structure is used to house or support operational functions for more than a short period of time (e.g., an emergency situation), it should be included in the overall count of buildings.**	1
Number of resident housing units: **Enter 0 if the facility does not have discrete housing units. DOJ PREA Working Group FAQ on the definition of a housing unit: How is a "housing unit" defined for the purposes of the PREA Standards? The question has been raised in particular as it relates to facilities that have adjacent or interconnected units. The most common concept of a housing unit is architectural. The generally agreed-upon definition is a space that is enclosed by physical barriers accessed through one or more doors of various types, including commercial-grade swing doors, steel sliding doors, interlocking sally port doors, etc. In addition to the primary entrance and exit, additional doors are often included to meet life safety codes. The unit contains sleeping space, sanitary facilities (including toilets, lavatories, and showers), and a dayroom or leisure space in differing configurations. Many facilities are designed with modules or pods clustered around a control room. This multiple-pod design provides the facility with certain staff efficiencies and economies of scale. At the same time, the design affords the flexibility to separately house residents of differing security levels, or who are grouped by some other operational or service scheme. Generally, the control room is enclosed by security glass, and in some cases, this allows residents to see into neighboring pods. However, observation from one unit to another is usually limited by angled site lines. In some cases, the facility has prevented this entirely by installing one-way glass. Both the architectural design and functional use of these multiple pods indicate that they are managed as distinct housing units.**	**3**
Number of single cell housing units:	30
Number of multiple occupancy cell housing units:	3
Number of open bay/dorm housing units:	0
Number of segregation cells (for example, administrative, disciplinary, protective custody, etc.):	0
In housing units, does the facility maintain sight and sound separation between youthful residents and adult residents? (N/A if the facility never holds youthful residents)	☐ Yes ☐ No ☒ N/A
Does the facility have a video monitoring system, electronic surveillance system, or other monitoring technology (e.g. cameras, etc.)?	☒ Yes ☐ No
Has the facility installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology in the past 12 months?	☒ Yes ☐ No

Medical and Mental Health Services and Forensic Medical Exams

Are medical services provided on-site?	☒ Yes ☐ No
Are mental health services provided on-site?	☒ Yes ☐ No

Where are sexual assault forensic medical exams provided? Select all that apply.	☐ On-site ☒ Local hospital/clinic ☐ Rape Crisis Center ☐ Other (please name or describe: Click or tap here to enter text.)

Investigations

Criminal Investigations

Number of investigators employed by the agency and/or facility who are responsible for conducting CRIMINAL investigations into allegations of sexual abuse or sexual harassment:	0
When the facility received allegations of sexual abuse or sexual harassment (whether staff-on-resident or resident-on-resident), CRIMINAL INVESTIGATIONS are conducted by: Select all that apply.	☐ Facility investigators ☐ Agency investigators ☒ An external investigative entity
Select all external entities responsible for CRIMINAL INVESTIGATIONS: Select all that apply (N/A if no external entities are responsible for criminal investigations)	☐ Local police department ☐ Local sheriff's department ☒ State police ☐ A U.S. Department of Justice component ☐ Other (please name or describe: Click or tap here to enter text.) ☐ N/A

Administrative Investigations

Number of investigators employed by the agency and/or facility who are responsible for conducting ADMINISTRATIVE investigations into allegations of sexual abuse or sexual harassment?	4
When the facility receives allegations of sexual abuse or sexual harassment (whether staff-on-resident or resident-on-resident), ADMINISTRATIVE INVESTIGATIONS are conducted by: Select all that apply	☐ Facility investigators ☒ Agency investigators ☒ An external investigative entity
Select all external entities responsible for ADMINISTRATIVE INVESTIGATIONS: Select all that apply (N/A if no external entities are responsible for administrative investigations)	☐ Local police department ☐ Local sheriff's department ☐ State police ☐ A U.S. Department of Justice component ☒ Other (please name or describe: Depart. of Children & Families) ☐ N/A

Summary of Audit Findings

The summary should include the number and list of standards exceeded, number of standards met, and number and list of standards not met.

Auditor Note: *No standard should be found to be "Not Applicable" or "NA". A compliance determination must be made for each standard.*

Standards Exceeded

Number of Standards Exceeded: 1
List of Standards Exceeded: 115.313

Standards Met

Number of Standards Met: 42

Standards Not Met

Number of Standards Not Met: 0
List of Standards Not Met: Click or tap here to enter text.

Post-Audit Reporting Information

General Audit Information	
Onsite Audit Dates	
1. Start date of the onsite portion of the audit:	April 6, 2025
2. End date of the onsite portion of the audit:	April 7, 2025
Outreach	
3. Did you attempt to communicate with community-based organization(s) or victim advocates who provide services to this facility and/or who may have insight into relevant conditions in the facility?	☒ Yes ☐ No
a. If yes, identify the community-based organizations or victim advocates with whom you corresponded:	UMASS Memorial Hospital**; Central Regional Rape Crisis Center; Massachusetts State Police**
Audited Facility Information	
4. Designated Facility Capacity:	36
5. Average daily population for the past 12 months:	20
6. Number of resident housing units: DOJ PREA Working Group FAQ on the definition of a housing unit: How is a "housing unit" defined for the purposes of the PREA Standards? The question has been raised in particular as it relates to facilities that have adjacent or interconnected units. The most common concept of a housing unit is architectural. The generally agreed-upon definition is a space that is enclosed by physical barriers accessed through one or more doors of various types, including commercial-grade swing doors, steel sliding doors, interlocking sally port doors, etc. In addition to the primary entrance and exit, additional doors are often included to meet life safety codes. The unit contains sleeping space, sanitary facilities (including toilets, lavatories, and showers), and a dayroom or leisure space in differing configurations. Many facilities are designed with modules or pods clustered around a control room. This multiple-pod design provides the facility with certain staff efficiencies and economies of scale. At the same time, the design affords the flexibility to separately house residents of differing security levels, or who are grouped by some other operational or service scheme. Generally, the control room is enclosed by security glass, and in some cases, this allows residents to see into neighboring pods. However, observation from one unit to another is usually limited by angled site lines. In some cases, the facility has prevented this entirely by installing one-way glass. Both the architectural design and functional use of these multiple pods indicate that they are managed as distinct housing units.	3

Audited Facility Population on Day One of the Onsite Portion of the Audit
Residents/Residents/Detainees

8. Enter the total number of residents housed at the facility as of the first day of the onsite portion of the audit:	18
10. Enter the total number of residents with a physical disability housed at the facility as of the first day of the onsite portion of the audit:	0
11. Enter the total number of residents with a cognitive or functional disability (including intellectual disability, psychiatric disability, or speech disability) housed at the facility as of the first day of the onsite portion of the audit:	2
12. Enter the total number of residents who are Blind or have low vision (visually impaired) housed at the facility on the first day of the onsite portion of the audit:	0
13. Enter the total number of residents who are Deaf or hard-of-hearing housed at the facility on the first day of the onsite portion of the audit:	0
14. Enter the total number of residents who are Limited English Proficient (LEP) housed at the facility as of the first day of the onsite portion of the audit:	1
15. Enter the total number of residents who identify as lesbian, gay, or bisexual housed at the facility as of the first day of the onsite portion of the audit:	0
16. Enter the total number of residents who identify as transgender, or intersex housed at the facility as of the first day of the onsite portion of the audit:	0
17. Enter the total number of residents who reported sexual abuse in this facility who are housed at the facility as of the first day of the onsite portion of the audit:	0
18. Enter the total number of residents who reported sexual harassment in this facility who are housed at the facility as of the first day of the onsite portion of the audit:	0
19. Enter the total number of residents who disclosed prior sexual victimization during risk screening housed at the facility as of the first day of the onsite portion of the audit:	0
20. Enter the total number of residents who are or were ever placed in segregated housing/isolation for risk of sexual victimization housed at the facility as of the first day of the onsite portion of the audit:	0
21. Enter the total number of residents who are or were ever placed in segregated housing/isolation for having reported sexual abuse in this facility as of the first day of the onsite portion of the audit:	0
22. Enter the total number of residents detained solely for civil immigration purposes housed at the facility as of the first day of the onsite portion of the audit:	0
23. Provide any additional comments regarding the population characteristics of residents in the facility as of the first day of the onsite portion of the audit (e.g., groups not tracked, issues with identifying certain populations). *Note: as this text will be included in the audit report, please do not include any personally identifiable information or other information that could compromise the confidentiality of any persons in the facility.*	Youth were interviewed from two housing units (ONA was closed). They consisted of youth aged 15-18, all males, length of stay was 10 days to 2 years, majority of the residents were from the Boston area. They were Caucasian, Black, and Hispanic.
Staff, Volunteers, and Contractors *Include all full- and part-time staff employed by the facility, regardless of their level of contact with residents/residents/detainees*	
24. Enter the total number of STAFF, including both full- and part-time staff employed by the facility as of the first day of the onsite portion of the audit:	50

25. Enter the total number of CONTRACTORS assigned to the facility as of the first day of the onsite portion of the audit who have contact with residents:	2
26. Enter the total number of VOLUNTEERS assigned to the facility as of the first day of the onsite portion of the audit who have contact with residents:	0
27. Provide any additional comments regarding the population characteristics of staff, volunteers, and contractors who were in the facility as of the first day of the onsite portion of the audit. *Note: as this text will be included in the audit report, please do not include any personally identifiable information or other information that could compromise the confidentiality of any persons in the facility.*	**Staff were interviewed from all 3 shifts. They were male and female; Caucasian, Hispanic, and African-American. Staff from all departments were interviewed. Their length of employment ranged from 8 months to 30 years. Contractors interviewed were medical staff and educational staff**

Interviews

Resident/Resident/Detainee Interviews

Random Resident Interviews

28. Enter the total number of RANDOM RESIDENTS who were interviewed:	10
29. Select which characteristics you considered when you selected random resident interviewees:	☒ Age ☒ Race ☒ Ethnicity (e.g., Hispanic, Non-Hispanic) ☒ Length of time in the facility ☒ Housing assignment ☐ Gender ☐ Other (describe) Click or tap here to enter text. ☐ None (explain) Click or tap here to enter text.
30. How did you ensure your sample of random resident interviewees was geographically diverse?	Looked at the resident census which had their city of origin.
31. Were you able to conduct the minimum number of random resident interviews?	☒ Yes ☐ No
a. If no, explain why it was not possible to interview the minimum number of random resident interviews:	Click or tap here to enter text.

32. Provide any additional comments regarding selecting or interviewing random residents (e.g., any populations you oversampled, barriers to completing interviews, barriers to ensuring representation, etc.). *Note: as this text will be included in the audit report, please do not include any personally identifiable information or other information that could compromise the confidentiality of any persons in the facility.*	**Youth were interviewed from two housing units (ONA was closed). They consisted of youth aged 15-18, all males, length of stay was 10 days to 2 years, majority of the residents were from the Boston area. They were Caucasian, Black, and Hispanic. Youth were interviewed from all parts of the state.**

Targeted Resident/Resident/Detainee Interviews

33. Enter the total number of TARGETED RESIDENTS who were interviewed:	3

As stated in the PREA Auditor Handbook, the breakdown of targeted interviews is intended to guide auditors in interviewing the appropriate cross-section of residents/residents/detainees who are the most vulnerable to sexual abuse and sexual harassment. When completing questions regarding targeted resident/resident/detainee interviews below, remember that an interview with one resident/resident/detainee may satisfy multiple targeted interview requirements. These questions are asking about the number of interviews conducted using the targeted resident/resident/detainee protocols. *For example, if an auditor interviews an resident who has a physical disability, is being held in segregated housing due to risk of sexual victimization, and disclosed prior sexual victimization, that interview would be included in the totals for each of those questions. Therefore, in most cases, the sum of all the following responses to the targeted resident/resident/detainee interview categories will exceed the total number of targeted residents/residents/detainees who were interviewed.* *If a particular targeted population is not applicable in the audited facility, enter "0".*	
35. Enter the total number of interviews conducted with residents with a physical disability using the "Disabled and Limited English Proficient Residents" protocol:	0

a. If 0, select why you were unable to conduct at least the minimum required number of targeted residents in this category:	☒ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these residents. ☐ The residents in this targeted category declined to be interviewed.
b. If 0, discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other residents).	This auditor reviewed resident case files, clinical, and medical files in JJEMS to confirm there were no physically disabled residents at the facility. This was also confirmed during interviews with Program Director, Clinical Director, Nurse Practitioner, PREA Compliance Manager, teachers, random staff, and residents.
36. Enter the total number of interviews conducted with residents with a cognitive or functional disability (including intellectual disability, psychiatric disability, or speech disability) using the "Disabled and Limited English Proficient Residents" protocol:	2
a. If 0, select why you were unable to conduct at least the minimum required number of targeted residents in this category:	☐ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these residents. ☐ The residents in this targeted category declined to be interviewed.

b. If 0, discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other residents).	Click or tap here to enter text.
37. Enter the total number of interviews conducted with residents who are Blind or have low vision (visually impaired) using the "Disabled and Limited English Proficient Residents" protocol:	0
a. If 0, select why you were unable to conduct at least the minimum required number of targeted residents in this category:	☒ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these residents. ☐ The residents in this targeted category declined to be interviewed.
b. If 0, discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other residents).	This auditor reviewed resident case files, clinical, and medical files in JJEMS to confirm there were no visually impaired residents at the facility. This was also confirmed during interviews with Program Director, Clinical Director, Nurse Practitioner, PREA Compliance Manager, teachers, random staff, and residents.
38. Enter the total number of interviews conducted with residents who are Deaf or hard-of-hearing using the "Disabled and Limited English Proficient Residents" protocol:	0
a. If 0, select why you were unable to conduct at least the minimum required number of targeted residents in this category:	☒ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these residents. ☐ The residents in this targeted category declined to be interviewed.
b. If 0, discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other residents).	This auditor reviewed resident case files, clinical, and medical files in JJEMS to confirm there were no deaf residents at the facility. This was also confirmed during interviews with Program Director, Clinical Director, Nurse Practitioner, PREA Compliance Manager, teachers, random staff, and residents.
39. Enter the total number of interviews conducted with residents who are Limited English Proficient (LEP) using the "Disabled and Limited English Proficient Residents" protocol:	1
a. If 0, select why you were unable to conduct at least the minimum required number of targeted residents in this category:	☐ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these residents. ☐ The residents in this targeted category declined to be interviewed.
b. If 0, discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other residents).	Click or tap here to enter text.

40. Enter the total number of interviews conducted with residents who identify as lesbian, gay, or bisexual using the "Transgender and Intersex Residents; Gay, Lesbian, and Bisexual Residents" protocol:	0
a. If 0, select why you were unable to conduct at least the minimum required number of targeted residents in this category:	☒ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these residents. ☐ The residents in this targeted category declined to be interviewed.
b. If 0, discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other residents).	This auditor reviewed resident case files, clinical, risk-assessments, and medical files in JJEMS to confirm there were no gay, bisexual, transgender, or intersex residents at the facility. This was also confirmed during interviews with Program Director, Clinical Director, Nurse Practitioner, PREA Compliance Manager, teachers, random staff, and residents.
41. Enter the total number of interviews conducted with residents who identify as transgender or intersex "Transgender and Intersex Residents; Gay, Lesbian, and Bisexual Residents" protocol:	0
a. If 0, select why you were unable to conduct at least the minimum required number of targeted residents in this category:	☒ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these residents. ☐ The residents in this targeted category declined to be interviewed.
b. If 0, discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other residents).	This auditor reviewed resident case files, clinical, risk-assessments, and medical files in JJEMS to confirm there were no gay, bisexual, transgender, or intersex residents at the facility. This was also confirmed during interviews with Program Director, Clinical Director, Nurse Practitioner, PREA Compliance Manager, teachers, random staff, and residents.
42. Enter the total number of interviews conducted with residents who reported sexual abuse in this facility using the "Residents who Reported a Sexual Abuse" protocol:	0
a. If 0, select why you were unable to conduct at least the minimum required number of targeted residents in this category:	☒ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these residents. ☐ The residents in this targeted category declined to be interviewed.
b. If 0, discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other residents).	This auditor reviewed resident case files, clinical, risk-assessments, and medical files in JJEMS to confirm no residents reported sexual abuse in the facility. This was also confirmed during interviews with Program Director, Clinical Director, Nurse Practitioner, PREA Compliance Manager, teachers, random staff, and residents.

43. Enter the total number of interviews conducted with residents who disclosed prior sexual victimization during risk screening using the "Residents who Disclosed Sexual Victimization during Risk Screening" protocol:	0
a. If 0, select why you were unable to conduct at least the minimum required number of targeted residents in this category:	☒ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these residents. ☐ The residents in this targeted category declined to be interviewed.
b. If 0, discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other residents).	This auditor reviewed resident case files, clinical, risk-assessments, and medical files in JJEMS to confirm there were no residents who disclosed prior victimization during risk screening at the facility. This was also confirmed during interviews with Program Director, Clinical Director, Nurse Practitioner, PREA Compliance Manager, teachers, random staff, and residents.
44. Enter the total number of interviews conducted with residents who are or were ever placed in segregated housing/isolation for risk of sexual victimization using the "Residents Placed in Segregated Housing (for Risk of Sexual Victimization/Who Alleged to have Suffered Sexual Abuse)" protocol:	0
a. If 0, select why you were unable to conduct at least the minimum required number of targeted residents in this category:	☒ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these residents. ☐ The residents in this targeted category declined to be interviewed.
b. If 0, discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other residents).	This auditor reviewed resident case files, clinical, risk-assessments, and medical files in JJEMS to confirm there were no residents placed in segregation at the facility. This was also confirmed during interviews with Program Director, Clinical Director, Nurse Practitioner, PREA Compliance Manager, teachers, random staff, and residents. This auditor toured the entire facility to confirm there were no rooms used for segregation or isolation.
45. Provide any additional comments regarding selecting or interviewing random residents (e.g., any populations you oversampled, barriers to completing interviews, barriers to ensuring representation, etc.). *Note: as this text will be included in the audit report, please do not include any personally identifiable information or other information that could compromise the confidentiality of any persons in the facility.*	**Youth were interviewed from two housing units (ONA was closed). They consisted of youth aged 15-18, all males, length of stay was 10 days to 2 years, majority of the residents were from the Boston area. They were Caucasian, Black, and Hispanic. Youth were interviewed from all parts of the state.**
Staff, Volunteer, and Contractor Interviews	
Random Staff Interviews	
46. Enter the total number of RANDOM STAFF who were interviewed:	12
47. Select which characteristics you considered when you selected RANDOM STAFF interviewees (select all that apply):	☒ Length of tenure in the facility ☒ Shift assignment

	☒ Work assignment ☒ Rank (or equivalent) ☐ Other (describe) Click or tap here to enter text. ☐ None (explain) Click or tap here to enter text.
48. Were you able to conduct the minimum number of RANDOM STAFF interviews?	☒ Yes ☐ No
a. If no, select the reasons why you were not able to conduct the minimum number of RANDOM STAFF interviews (select all that apply):	☐ Too many staff declined to participate in interviews ☐ Not enough staff employed by the facility to meet the minimum number of random staff interviews (Note: select this option if there were not enough staff employed by the facility or not enough staff employed by the facility to interview for both random and specialized staff roles). ☐ Not enough staff available in the facility during the onsite portion of the audit to meet the minimum number of random staff interviews. ☐ Other (describe) Click or tap here to enter text.
b. Describe the steps you took to select additional RANDOM STAFF interviewees and why you were still unable to meet the minimum number of random staff interviews:	Click or tap here to enter text.
49. Provide any additional comments regarding selecting or interviewing random staff (e.g., any populations you oversampled, barriers to completing interviews, etc.). *Note: as this text will be included in the audit report, please do not include any personally identifiable information or other information that could compromise the confidentiality of any persons in the facility.*	Staff are Caucasian, African American, Hispanic, and Asian; males and females. Staff ranged from 8 months of services to 25 years of service. The majority of the staff live in close proximity to the facility, but one traveled from another state. Staff were interviewed from all 3 shifts and all ranks.
Specialized Staff, Volunteers, and Contractor Interviews *Staff in some facilities may be responsible for more than one of the specialized staff duties. Therefore, more than one interview protocol may apply to an interview with a single staff member and that interview would satisfy multiple specialized staff interview requirements.*	
50. Enter the total number of staff in a SPECIALIZED STAFF role who were interviewed (excluding volunteers and contractors):	13
51. Were you able to interview the Agency Head?	☒ Yes ☐ No
a. If no, explain why it was not possible to interview the Agency Head:	Click or tap here to enter text.
52. Were you able to interview the Superintendent/Director or their designee?	☒ Yes ☐ No
a. If no, explain why it was not possible to interview the Superintendent/Director or their designee:	Click or tap here to enter text.
53. Were you able to interview the PREA Coordinator?	☒ Yes ☐ No
a. If no, explain why it was not possible to interview the PREA Coordinator:	Click or tap here to enter text.
54. Were you able to interview the PREA Compliance Manager?	☒ Yes ☐ No ☐ N/A (N/A if the agency is a single facility agency or is otherwise not required to have a PREA Compliance Manager per the Standards)
a. If no, explain why it was not possible to interview the PREA Compliance Manager:	Click or tap here to enter text.

55. Select which SPECIALIZED STAFF roles were interviewed as part of this audit (select all that apply):	☐ Agency contract administrator ☒ Intermediate or higher-level facility staff responsible for conducting and documenting unannounced rounds to identify and deter staff sexual abuse and sexual harassment ☐ Line staff who supervise youthful residents (if applicable) ☒ Education and program staff who work with youthful residents (if applicable) ☒ Medical staff ☒ Mental health staff ☐ Non-medical staff involved in cross-gender strip or visual searches ☒ Administrative (human resources) staff ☐ Sexual Assault Forensic Examiner (SAFE) or Sexual Assault Nurse Examiner (SANE) staff ☒ Investigative staff responsible for conducting administrative investigations ☐ Investigative staff responsible for conducting criminal investigations ☒ Staff who perform screening for risk of victimization and abusiveness ☐ Staff who supervise residents in segregated housing/residents in isolation ☒ Staff on the sexual abuse incident review team ☒ Designated staff member charged with monitoring retaliation ☒ First responders, both security and non-security staff ☒ Intake staff ☐ Other (describe) Click or tap here to enter text.
56. Did you interview VOLUNTEERS who may have contact with residents in this facility?	☐ Yes ☒ No
a. Enter the total number of VOLUNTEERS who were interviewed:	0
b. Select which specialized VOLUNTEER role(s) were interviewed as part of this audit (select all that apply):	☐ Education/programming ☐ Medical/dental ☐ Mental health/counseling ☐ Religious ☐ Other
57. Did you interview CONTRACTORS who may have contact with residents in this facility?	☒ Yes ☐ No
a) Enter the total number of CONTRACTORS who were interviewed:	2
b) Select which specialized CONTRACTOR role(s) were interviewed as part of this audit (select all that apply):	☐ Security/detention ☒ Education/programming ☒ Medical/dental

	☐ Food service ☐ Maintenance/construction ☐ Other
58. Provide any additional comments regarding selecting or interviewing specialized staff (e.g., any populations you oversampled, barriers to completing interviews, etc.). *Note: as this text will be included in the audit report, please do not include any personally identifiable information or other information that could compromise the confidentiality of any persons in the facility.*	The 2 contracts were a Teaching Coordinator and a Nurse Practitioner; one was male and one female; they length of employment ranged from 18 to 20 years.

Site Review and Documentation Sampling

Site Review

PREA Standard 115.401(h) states, "The auditor shall have access to, and shall observe, all areas of the audited facilities." In order to meet the requirements in this Standard, the site review portion of the onsite audit must include a thorough examination of the entire facility. The site review is not a casual tour of the facility. It is an active, inquiring process that includes talking with staff and residents to determine whether, and the extent to which, the audited facility's practices demonstrate compliance with the Standards. Note: discussions related to testing critical functions are expected to be included in the relevant Standard-specific overall determination narratives.

59. Did you have access to all areas of the facility?	☒ Yes ☐ No
a. If no, explain what areas of the facility you were unable to access and why.	Click or tap here to enter text.
Was the site review an active, inquiring process that included the following:	
60. Reviewing/examining all areas of the facility in accordance with the site review component of the audit instrument?	☒ Yes ☐ No
a. If no, explain why the site review did not include reviewing/examining all areas of the facility.	Click or tap here to enter text.
61. Testing and/or observing all critical functions in the facility in accordance with the site review component of the audit instrument (e.g., intake process, risk screening process, PREA education)?	☒ Yes ☐ No
a. If no, explain why the site review did not include testing and/or observing all critical functions in the facility.	Click or tap here to enter text.
62. Informal conversations with residents during the site review (encouraged, not required)?	☒ Yes ☐ No
63. Informal conversations with staff during the site review (encouraged, not required)?	☒ Yes ☐ No

64. Provide any additional comments regarding the site review (e.g., access to areas in the facility, observations, tests of critical functions, or informal conversations). *Note: as this text will be included in the audit report, please do not include any personally identifiable information or other information that could compromise the confidentiality of any persons in the facility.*	This auditor had access to the entire facility and during the tour observed residents on housing floors, in the kitchen, and in classrooms. This auditor observed numerous PREA boxes for staff, visitors, and residents throughout the facility. Also observed were PREA posters with the hotline number and the Rape Crisis number posted throughout the facility. The Institutional Plan was in binder in the staff office.

Documentation Sampling

Where there is a collection of records to review—such as staff, contractor, and volunteer training records; background check records; supervisory rounds logs; risk screening and intake processing records; resident education records; medical files; and investigative files—auditors must self-select for review a representative sample of each type of record.

65. In addition to the proof documentation selected by the agency or facility and provided to you, did you also conduct an auditor-selected sampling of documentation?	☒ Yes ☐ No
66. Provide any additional comments regarding selecting additional documentation (e.g., any documentation you oversampled, barriers to selecting additional documentation, etc.). *Note: as this text will be included in the audit report, please do not include any personally identifiable information or other information that could compromise the confidentiality of any persons in the facility.*	This auditor reviewed all resident case files and risk assessments in JJEMS. Reviewed logbooks, unannounced rounds log, training logs, blank SAIR form, blank monitor retaliation form, staffing plan, staff schedules, staff background checks, and training curriculum. Resident PREA educational forms on intake and Day 7 that were signed by the residents were reviewed.

Sexual Abuse and Sexual Harassment Allegations and Investigations in this Facility

Sexual Abuse and Sexual Harassment Allegations and Investigations Overview

Remember the number of allegations should be based on a review of all sources of allegations (e.g., hotline, third-party, grievances) and should not be based solely on the number of investigations conducted.
Note: For question brevity, we use the term "resident" in the following questions. Auditors should provide information on resident, resident, or detainee sexual abuse allegations and investigations, as applicable to the facility type being audited.

67. Total number of SEXUAL ABUSE allegations and investigations overview during the 12 months preceding the audit, by incident type:

Instructions: If you are unable to provide information for one or more of the fields below, enter an "X" in the field(s) where information cannot be provided.

	# of sexual abuse allegations	# of criminal investigations	# of administrative investigations	# of allegations that had both criminal and administrative investigations
Resident-on-resident sexual abuse	0	0	0	0
Staff-on-resident sexual abuse	0	0	0	0
Total	0	0	0	0

a. If you were unable to provide any of the information above, explain why this information could not be provided.	Click or tap here to enter text.

68. Total number of SEXUAL HARASSMENT allegations and investigations overview during the 12 months preceding the audit, by incident type:

Instructions: If you are unable to provide information for one or more of the fields below, enter an "X" in the field(s) where information cannot be provided.

	# of sexual harassment allegations	# of criminal investigations	# of administrative investigations	# of allegations that had both criminal and

				administrative investigations
Resident-on-resident sexual harassment	0	0	0	0
Staff-on-resident sexual harassment	0	0	0	0
Total	0	0	0	0

a. If you were unable to provide any of the information above, explain why this information could not be provided.	Click or tap here to enter text.

Sexual Abuse and Sexual Harassment Investigation Outcomes

Sexual Abuse Investigation Outcomes

Note: these counts should reflect where the investigation is currently (i.e., if a criminal investigation was referred for prosecution and resulted in a conviction, that investigation outcome should only appear in the count for "convicted.") Do not double count. Additionally, for question brevity, we use the term "resident" in the following questions. Auditors should provide information on resident, resident, and detainee sexual abuse investigation files, as applicable to the facility type being audited.

69. Criminal SEXUAL ABUSE investigation outcomes during the 12 months preceding the audit:

Instructions: If you are unable to provide information for one or more of the fields below, enter an "X" in the field(s) where information cannot be provided.

	Ongoing	Referred for Prosecution	Indicted/Court Case Filed	Convicted/Adjudicated	Acquitted
Resident-on-resident sexual abuse	0	0	0	0	0
Staff-on-resident sexual abuse	0	0	0	0	0
Total	0	0	0	0	0

a. If you were unable to provide any of the information above, explain why this information could not be provided.	Click or tap here to enter text.

70. Administrative SEXUAL ABUSE investigation outcomes during the 12 months preceding the audit:

Instructions: If you are unable to provide information for one or more of the fields below, enter an "X" in the field(s) where information cannot be provided.

	Ongoing	Unfounded	Unsubstantiated	Substantiated
Resident-on-resident sexual abuse	0	0	0	0
Staff-on-resident sexual abuse	0	0	0	0
Total	0	0	0	0

a. If you were unable to provide any of the information above, explain why this information could not be provided.	Click or tap here to enter text.

Sexual Harassment Investigation Outcomes

Note: these counts should reflect where the investigation is currently. Do not double count. Additionally, for question brevity, we use the term "resident" in the following questions. Auditors should provide information on resident, resident, and detainee sexual harassment investigation files, as applicable to the facility type being audited.

71. Criminal SEXUAL HARASSMENT investigation outcomes during the 12 months preceding the audit:

Instructions: If you are unable to provide information for one or more of the fields below, enter an "X" in the field(s) where information cannot be provided.

	Ongoing	Referred for Prosecution	Indicted/Court Case Filed	Convicted/Adjudicated	Acquitted

Resident-on-resident sexual harassment	0	0	0	0	0
Staff-on-resident sexual harassment	0	0	0	0	0
Total	0	0	0	0	0

a. If you were unable to provide any of the information above, explain why this information could not be provided.	Click or tap here to enter text.

72. Administrative SEXUAL HARASSMENT investigation outcomes during the 12 months preceding the audit:

Instructions: If you are unable to provide information for one or more of the fields below, enter an "X" in the field(s) where information cannot be provided.

	Ongoing	Unfounded	Unsubstantiated	Substantiated
Resident-on-resident sexual harassment	0	0	0	0
Staff-on-resident sexual harassment	0	0	0	0
Total	0	0	0	0

a. If you were unable to provide any of the information above, explain why this information could not be provided.	Click or tap here to enter text.

Sexual Abuse and Sexual Harassment Investigation Files Selected for Review

Sexual Abuse Investigation Files Selected for Review

73. Enter the total number of SEXUAL ABUSE investigation files reviewed/sampled:	0
a. If 0, explain why you were unable to review any sexual abuse investigation files:	There were no sexual abuse allegations that were reported during the past 12 months. This was confirmed during interviews with DYS investigator, PREA Coordinator, and Facility Administrator.
74. Did your selection of SEXUAL ABUSE investigation files include a cross-section of criminal and/or administrative investigations by findings/outcomes?	☐ Yes ☒ No ☐ N/A (N/A if you were unable to review any sexual abuse investigation files)
Resident-on-resident sexual abuse investigation files	
75. Enter the total number of RESIDENT-ON-RESIDENT SEXUAL ABUSE investigation files reviewed/sampled:	0
76. Did your sample of RESIDENT-ON-RESIDENT SEXUAL ABUSE investigation files include criminal investigations?	☐ Yes ☒ No ☐ N/A (N/A if you were unable to review any resident-on-resident sexual abuse investigation files)

77. Did your sample of RESIDENT-ON-RESIDENT SEXUAL ABUSE investigation files include administrative investigations?	☐ Yes ☒ No ☐ N/A (N/A if you were unable to review any resident-on-resident sexual abuse investigation files)
Staff-on-resident sexual abuse investigation files	
78. Enter the total number of STAFF-ON-RESIDENT SEXUAL ABUSE investigation files reviewed/sampled:	0
79. Did your sample of STAFF-ON-RESIDENT SEXUAL ABUSE investigation files include criminal investigations?	☐ Yes ☒ No

	☐ N/A (N/A if you were unable to review any staff-on-resident sexual abuse investigation files)
80. Did your sample of STAFF-ON-RESIDENT SEXUAL ABUSE investigation files include administrative investigations?	☐ Yes ☒ No ☐ N/A (N/A if you were unable to review any staff-on-resident sexual abuse investigation files)
Sexual Harassment Investigation Files Selected for Review	
81. Enter the total number of SEXUAL HARASSMENT investigation files reviewed/sampled:	0
a. If 0, explain why you were unable to review any sexual harassment investigation files:	There were no sexual harassment allegations that were reported during the past 12 months. This was confirmed during interviews with DYS investigator, DCF investigator, PREA Coordinator, and Facility Administrator.
82. Did your selection of SEXUAL HARASSMENT investigation files include a cross-section of criminal and/or administrative investigations by findings/outcomes?	☐ Yes ☒ No ☐ N/A (N/A if you were unable to review any sexual harassment investigation files)
Resident-on-resident sexual harassment investigation files	
83. Enter the total number of RESIDENT-ON-RESIDENT SEXUAL HARASSMENT investigation files reviewed/sampled:	0
84. Did your sample of RESIDENT-ON-RESIDENT SEXUAL HARASSMENT investigation files include criminal investigations?	☐ Yes ☒ No ☐ N/A (N/A if you were unable to review any resident-on-resident sexual harassment investigation files)
85. Did your sample of RESIDENT-ON-RESIDENT SEXUAL HARASSMENT investigation files include administrative investigations?	☐ Yes ☒ No ☐ N/A (N/A if you were unable to review any resident-on-resident sexual harassment investigation files)
Staff-on-resident sexual harassment investigation files	
86. Enter the total number of STAFF-ON-RESIDENT SEXUAL HARASSMENT investigation files reviewed/sampled:	0
87. Did your sample of STAFF-ON-RESIDENT SEXUAL HARASSMENT investigation files include criminal investigations?	☐ Yes ☒ No ☐ N/A (N/A if you were unable to review any staff-on-resident sexual harassment investigation files)
88. Did your sample of STAFF-ON-RESIDENT SEXUAL HARASSMENT investigation files include administrative investigations?	☐ Yes ☒ No ☐ N/A (N/A if you were unable to review any staff-on-resident sexual harassment investigation files)
89. Provide any additional comments regarding selecting and reviewing sexual abuse and sexual harassment investigation files. *Note: as this text will be included in the audit report, please do not include any personally identifiable information or other information that could compromise the confidentiality of any persons in the facility.*	There were no sexual abuse or sexual harassment allegations that were reported during the past 12 months. This was confirmed during interviews with DYS investigator, DCF investigator, PREA Coordinator, and Facility Administrator.
Support Staff Information	
DOJ-certified PREA Auditors Support Staff	

90. Did you receive assistance from any DOJ-CERTIFIED PREA AUDITORS at any point during this audit? *Remember: the audit includes all activities from the pre-onsite through the post-onsite phases to the submission of the final report. Make sure you respond accordingly.*	☐ Yes ☒ No
a. If yes, enter the TOTAL NUMBER OF DOJ-CERTIFIED PREA AUDITORS who provided assistance at any point during the audit:	Click or tap here to enter text.
Non-certified Support Staff	
91. Did you receive assistance from any NON-CERTIFIED SUPPORT STAFF at any point during this audit? *Remember: the audit includes all activities from the pre-onsite through the post-onsite phases to the submission of the final report. Make sure you respond accordingly.*	☐ Yes ☒ No
a. If yes, enter the TOTAL NUMBER OF NON-CERTIFIED SUPPORT STAFF who provided assistance at any point during the audit:	Click or tap here to enter text.
Auditing Arrangements and Compensation	
92. Who paid you to conduct this audit?	☒ The audited facility or its parent agency ☐ My state/territory or county government (if you audit as part of a consortium or circular auditing arrangement, select this option) ☐ A third-party auditing entity (e.g., accreditation body, consulting firm) ☐ Other

PREVENTION PLANNING

Standard 115.311: Zero tolerance of sexual abuse and sexual harassment; PREA coordinator

All Yes/No Questions Must Be Answered by The Auditor to Complete the Report

115.311 (a)

- Does the agency have a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment? ☒ Yes ☐ No
- Does the written policy outline the agency's approach to preventing, detecting, and responding to sexual abuse and sexual harassment? ☒ Yes ☐ No

115.311 (b)

- Has the agency employed or designated an agency-wide PREA Coordinator? ☒ Yes ☐ No
- Is the PREA Coordinator position in the upper-level of the agency hierarchy? ☒ Yes ☐ No
- Does the PREA Coordinator have sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards in all of its facilities? ☒ Yes ☐ No

115.311 (c)

- If this agency operates more than one facility, has each facility designated a PREA compliance manager? (N/A if agency operates only one facility.) ☒ Yes ☐ No ☐ NA
- Does the PREA compliance manager have sufficient time and authority to coordinate the facility's efforts to comply with the PREA standards? (N/A if agency operates only one facility.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The Massachusetts Department of Youth Services (DYS) Policy and Procedures 01.05.07(c) is committed to the prevention and elimination of sexual abuse and sexual harassment within their facility/facilities through compliance with the Prison Rape Elimination Act of 2003. DYS is committed to the equal opportunity to participate in and benefit from all aspects of the agency's effort to prevent, detect and respond to sexual abuse and sexual harassment. Violations of this policy may result in disciplinary sanctions for staff and youth perpetrators and/or criminal prosecution as authorities deem appropriate. This policy contains the necessary definitions, sanctions, and descriptions of the agency strategies and with residents, staff, volunteers, and contractors.

DYS has a designated PREA Coordinator who reports directly to the Senior Director of Residential Operations. The Agency PREA Coordinator oversees twenty-four (24) PREA Compliance Managers. This auditor reviewed the Agency Organizational Chart, confirmed the Agency PREA Coordinator's position, and noted that she reports directly to the Senior Director of Residential Operations for any PREA related issues within the agency. She is knowledgeable of the PREA standards and has stated that she is committed to PREA and implementing PREA in both facilities. The Agency PREA Coordinator also reported that she has the support needed and sufficient time to develop, implement, and oversee the agency's efforts towards PREA compliance in both agency facilities and to fulfill the PREA responsibilities. She was interviewed by this auditor on April 6, 2025.

Paul T. Leahy Center has a designated PREA Compliance Manager. His official title is Facility Administrator of Metro Youth Service Center. The Facility PREA Compliance Manager has served in this role for twelve (12) years and is knowledgeable of the PREA standards. This is his fourth PREA audit as the Facility PREA Compliance Manager. He was interviewed by this auditor during the on-site portion of this audit on April 6, 2025 and stated he has sufficient time and authority to develop, implement, and oversee the facility's efforts to comply with the PREA standards.

Paul T. Leahy Center is a 36-bed facility with three (3) housing units of 15-15-6 beds respectively. The two (2) 15-bed housing units are boys' residential programs and the 6-bed housing unit is a boys' and girls' overnight arrest program (ONA). The ONA program (4 boys' beds and 2 girls' beds) is located on the opposite side of the boys' program and has its own entrance from the outside.

Reviewed documentation to determine compliance:

- DYS Policy 01.05.07(c) - Preventing and Responding to Sexual Abuse, Sexual Exploitation and Sexual Harassment of Youth
- Agency and Facility Organizational Charts
- Pre-audit Questionnaire

Interviews:

- Interview with Agency PREA Coordinator
- Interview with Facility PREA Compliance Manager
- Interview with Facility Administrator

Standard 115.312: Contracting with other entities for the confinement of residents

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.312 (a)

- If this agency is public and it contracts for the confinement of its residents with private agencies or other entities including other government agencies, has the agency included the entity's obligation to comply with the PREA standards in any new contract or contract renewal signed on or after August 20, 2012? (N/A if the agency does not contract with private agencies or other entities for the confinement of residents.) ☒ Yes ☐ No ☐ NA

115.312 (b)

- Does any new contract or contract renewal signed on or after August 20, 2012 provide for agency contract monitoring to ensure that the contractor is complying with the PREA standards? (N/A if the agency does not contract with private agencies or other entities for the confinement of residents.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Paul T. Leahy Center does not contract for the confinement of its residents with other private agencies/entities. This was confirmed during interview with the Regional Director. As a result of Paul T. Leahy Center not contracting for the confinement of its residents with other agencies/entities, there were no contracts for this auditor to review.

Reviewed documentation to determine compliance:

- Pre-Audit Questionnaire

Interviews:

- Interview with Regional Director
- Interview with Facility Administrator

- Interview with Facility PREA Compliance Manager

Standard 115.313: Supervision and monitoring

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.313 (a)

- Does the facility have a documented staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse?

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Generally accepted juvenile detention and correctional/secure residential practices? ☒ Yes ☐ No

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Any judicial findings of inadequacy? ☒ Yes ☐ No

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Any findings of inadequacy from Federal investigative agencies? ☒ Yes ☐ No

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Any findings of inadequacy from internal or external oversight bodies? ☒ Yes ☐ No

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: All components of the facility's physical plant (including "blind-spots" or areas where staff or residents may be isolated)? ☒ Yes ☐ No

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: The composition of the resident population? ☒ Yes ☐ No

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: The number and placement of supervisory staff? ☒ Yes ☐ No

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: The institution programs occurring on a particular shift? ☐ Yes ☒ No ☐ NA

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Any applicable State or local laws, regulations, or standards? ☒ Yes ☐ No

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: The prevalence of substantiated and unsubstantiated

incidents of sexual abuse? ☒ Yes ☐ No

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Any other relevant factors? ☒ Yes ☐ No

115.313 (b)

- In circumstances where the staffing plan is not complied with, does the facility document and justify all deviations from the plan? (N/A if no deviations from staffing plan.)
  ☒ Yes ☐ No ☐ NA

115.313 (c)

- In the past 12 months, has the facility maintained staff ratios of a minimum of 1:8 during resident waking hours and 1:16 during resident sleeping hours, except during limited and discrete exigent circumstances? ☒ Yes ☐ No

- In the past 12 months, if the facility has not maintained staff ratios of a minimum of 1:8 during resident waking hours and 1:16 during resident sleeping hours has the facility, has the facility fully documented each instance? ☒ Yes ☐ No

115.313 (d)

- In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: The staffing plan established pursuant to paragraph (a) of this section? ☒ Yes ☐ No

- In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: The facility's deployment of video monitoring systems and other monitoring technologies? ☒ Yes ☐ No

- In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: The resources the facility has available to commit to ensure adherence to the staffing plan? ☒ Yes ☐ No

115.313 (e)

- Has the facility/agency implemented a policy and practice of having intermediate-level or higher-level supervisors conduct and document unannounced rounds to identify and deter staff sexual abuse and sexual harassment? ☒ Yes ☐ No

- Is this policy and practice implemented for night shifts as well as day shifts? ☒ Yes ☐ No

- Does the facility/agency have a policy prohibiting staff from alerting other staff members that these supervisory rounds are occurring, unless such announcement is related to the legitimate operational functions of the facility? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☒ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

a) Massachusetts DYS Policy and Procedures 01.05.07(c) requires the facility to develop, implement and document a staffing plan that provides for adequate levels of staffing, and where applicable, video monitoring to protect youth against sexual abuse. The Video Surveillance and Staffing Plan was reviewed by the Facility Administrator on February 5, 2025. This plan is reviewed on an annual basis but assessed on a regular basis. In determining adequate staffing levels and the need for video monitoring, facilities must take into consideration:

1. Generally accepted juvenile detention and correctional/secure residential practices;
2. Any judicial findings of inadequacy;
3. Any findings of inadequacy from federal investigative agencies;
4. Any findings of inadequacy from internal or external oversight bodies;
5. All components of the facility's physical plant (including "blind spots" and/or areas where staff or youth may be isolated);
6. Composition of the different facilities;
7. Number and placements of supervisory staff;
8. Programs occurring on each shift;
9. Relevant laws, regulations, and standards;
10. Prevalence of substantiated and unsubstantiated incidents of sexual abuse; and
11. Minimum staff to youth ratios must be 1 to 8 during waking hour and 1 to 16 during sleeping hours.

Any deviations from the plan due to limited and discrete exigent circumstances must be documented on the Video Surveillance and Staffing Plan. Only security staff must be included in those reports.

There were eighteen (18) residents (9 on Leahy Detention and 9 on Sharp Unit) residing at Paul T. Leahy Center during the on-site portion of this audit. The average daily population at these facilities during the past twelve (12) months has been twenty (20) residents.

The annual Video Surveillance and Staffing Plan at Paul T. Leahy Center addresses the facility staffing plan and requirements. The plan is reviewed on an annual basis and was reviewed by the PREA Coordinator. The facility is currently budgeted for eighty-two (82) direct care staff; eighty (80) positions are currently filled, with two (2) vacant positions.

The Paul T. Leahy Center facility is equipped with 99 video surveillance cameras (73 indoor cameras and 26 outdoor cameras); Recordings from these devices remain on a secure server for approximately thirty (30) days. There were six (6) workstations and thirteen (13) monitors in the facility. In addition, the Facility Administrator and Program Directors have access to the video surveillance system on their

computers in their office which can be viewed and/or reviewed at any point during the day. Video from all major incidents is reviewed by the Facility Administrator and retained on a flash drive. It was noted during interview with the Facility Administrator / Program Directors that random video surveillance is reviewed on a weekly basis by the Supervisors at Paul T. Leahy Center. It was noted that the video surveillance system was installed in 2000 and upgraded in January 2025. Interview the Facility Administrator confirmed the video surveillance system is inspected on an annual basis.

b) Massachusetts DYS Policy and Procedures 01.05.07(c) states "minimum staff to youth ratios must be 1 to 8 during waking hours and 1 to 16 during sleeping hours. Any deviations from the plan due to limited and discrete exigent circumstances must be documented on the Video Surveillance and Staffing Plan."

This auditor observed staffing ratios of 1:1 during the on-site portion of the audit. This exceeds the standard during program hours. This auditor observed nine (9) staff on each unit during the on-site portion of the audit.

The Facility Administrator reported that there have been no deviations from the staffing plan during the past 12 months. She also reported that in the event administrative staff at Paul T. Leahy Center feel staffing ratios cannot be maintained during an upcoming shift, staff would be held over and paid overtime to meet the ratios. Interviews with the Facility Administrators and Facility PREA Compliance Manager revealed that staffing is monitored shift to shift by the Assistant Program Directors and that adjustments are made as needed to ensure the ratios are met. Staff schedules and resident rosters were also reviewed by this auditor and confirmed the facility is exceeding minimum ratios daily.

c) The Massachusetts DYS Policy and Procedures 01.05.07(c) states, "minimum staff to youth ratios must be 1 to 8 during waking hours and 1 to 16 during sleeping hours. Any deviations from the plan due to limited and discrete exigent circumstances must be documented in the Video Surveillance and Staffing Plan and is also communicated to the Regional Director and the Facility Administrator."

The Massachusetts DYS Policy and Procedures 01.05.07(c) states the facility runs at a minimum of 1:7 staff to resident ratio during Shift 3 (11:00pm to 7:00am) and a minimum of 1:5 staff to resident ratio during Shift 1 (7:00am to 3:00pm) and Shift 2 (3:00pm to 11:00pm). Paul T. Leahy Center' policy requires 1:5 during live shifts and 1:7 during the overnight shift. Both the DYS and Paul T. Leahy Center ratios exceed the requirements for this standard. It was confirmed by this auditor after reviewing population reports for the past 12 months, staff schedules, and observations made during the tour of the facility that these ratios were being exceeded on a regular basis at the facility. During the on-site portion of the audit, there were a total of eighteen (18) residents residing at the facility. There have been a minimum five (5) staff assigned to each living unit during Shift 1 and Shift 2, and a minimum of three (3) staff assigned to each living unit during Shift 3 to ensure proper supervision of the residents.

d) The Massachusetts DYS Policy and Procedures 01.05.07(c) requires each facility's PREA Compliance Manager to schedule and conduct an annual (or more frequently, as necessary) facility review using the Video Surveillance and Staffing Plan.

A review of the Video Surveillance and Staffing Plan confirmed this plan is reviewed on an annual basis and was reviewed by the Facility Administrator on February 5, 2025. The Video Surveillance and Staffing Plan was also reviewed and approved by the Agency PREA Coordinator February 5, 2025.

e) The Massachusetts DYS Policy and Procedures 01.05.07(c) states, "A residential member of administration shall conduct and document unannounced rounds, at a minimum of twice each month (one during waking shift and one during sleeping shift) at each facility, to identify and deter staff sexual

abuse and/or sexual harassment. All rounds shall be documented in the Unannounced Visit Form, the unit log, and emailed to the Facility Administrator and Program Director. The Facility Administrator / Program Directors carry a radio during the unannounced rounds to ensure staff are not alerting each other. They also review video footage to verify this. Staff is prohibited from alerting other staff members or residents that rounds are occurring."

A review of Unannounced Visit Form and staff interviews confirmed that unannounced rounds are conducted by the Program Director and Assistant Program Director at Paul T. Leahy Center. The Assistant Program Director who conducted unannounced rounds was interviewed and was able to discuss how they complete the unannounced rounds, assure minimum ratios were being met, and their inspections of the facility are completed. The Program Director and the Assistant Program Director said that they enter the facility from various entrances and listen to radio transmissions to see if staff members alert each other. They look for staff positioning, read logbooks for accuracy, and note the tone of the unit. The unannounced rounds are random by selecting different times of day/night and days of the week. This auditor was able to review the Unannounced Visit to confirm that unannounced rounds were being completed minimum of three times per month (once per each shift) during the past 12 months.

Review of documentation and proof to determine compliance:

- Massachusetts DYS Policy and Procedures 01.05.07(c) -Preventing and Responding to Sexual Abuse, Sexual Exploitation and Sexual Harassment of Youth
- Paul T. Leahy Center staff schedules
- Unannounced Visit Form
- Resident Roster
- 2025 Video Surveillance and Staffing Plan
- Residential Staff/Youth Ratios Policy
- Locations of video surveillance cameras (interior and exterior)
- Tour of the facilities

Interviews:

- Interview with Facility Administrator
- Interview with Program Director
- Interview with Assistant Program Director
- Interview with Facility PREA Compliance Manager
- Interviews with twelve (12) randomly selected staff from all three (3) shifts
- Interviews with ten (10) randomly selected residents

Standard 115.315: Limits to cross-gender viewing and searches

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.315 (a)

- Does the facility always refrain from conducting any cross-gender strip or cross-gender visual body cavity searches, except in exigent circumstances or by medical practitioners?
  ☒ Yes ☐ No

115.315 (b)

- Does the facility always refrain from conducting cross-gender pat-down searches, except in exigent circumstances?
  ☒ Yes ☐ No

115.315 (c)

- Does the facility document all cross-gender strip searches and cross-gender visual body cavity searches? ☒ Yes ☐ No

115.315 (d)

- Does the facility have policies that enables residents to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks? ☒ Yes ☐ No

- Does the facility have procedures that enables residents to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks? ☒ Yes ☐ No

- Does the facility require staff of the opposite gender to announce their presence when entering a resident housing unit? ☒ Yes ☐ No

115.315 (e)

- Does the facility always refrain from searching or physically examining transgender or intersex residents for the sole purpose of determining the resident's genital status? ☒ Yes ☐ No

- If an resident's genital status is unknown, does the facility determine genital status during conversations with the resident, by reviewing medical records, or, if necessary, by learning that information as part of a broader medical examination conducted in private by a medical practitioner? ☒ Yes ☐ No

115.315 (f)

- Does the facility/agency train security staff in how to conduct cross-gender pat down searches in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs? ☒ Yes ☐ No

- Does the facility/agency train security staff in how to conduct searches of transgender and intersex residents in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

a-c) Massachusetts DYS Policy and Procedures 03.01.02(a) – Searches in Secure Facilities states that youth may only be searched by staff of the same gender. The facility does not conduct full strip searches. The facility conducts pat searches and clothing searches; the youth is never completely naked. All searches must be conducted with a witness. The policy prohibits the search or physical examination of a Transgender or Intersex resident for the sole purpose of determining that resident's genital status. Residents state that they have never been subject to a cross-gender pat down search. All staff have received training regarding the search of a Transgender or Intersex resident in a respectful and dignified manner and could candidly discuss the search policy for such a resident. All random staff that were interviewed confirmed that cross-gender searches do not occur. DYS "Guidelines for Practice with LGBTQI – GMC Youth" prohibits searching youth for the purpose of determining if a youth is Transgender or Intersex. According to the Pre-Audit Questionnaire, there were no cross-gender strip searches or cross-gender pat searches during the past twelve (12) months.

Staff and residents interviewed supported that cross-gender strip searches and cross-gender pat searches are prohibited and do not occur at Paul T. Leahy Center. During interviews, staff could describe what an exigent circumstance would be. During the past 12 months, there have been no cross-gender strip searches or cross-gender visual body cavity searches of residents performed by medical staff or non-medical staff at Paul T. Leahy Center.

Interviews with residents, Facility PREA Compliance Manager, Clinical Director, and the Program Director confirmed there have been no cross-gender pat searches of residents during the past 12 months at Paul T. Leahy Center. Staff interviewed understood what an exigent circumstance would be and that this is the only time they would be permitted to conduct a cross-gender pat search.

Staff interviewed reported that it is against DYS policy to conduct a cross-gender pat search. Staff and residents interviewed confirmed there have been no cross-gender pat searches conducted at Paul T. Leahy Center during the past 12 months.

d) Massachusetts DYS Policy and Procedures 03.04.09 – Prevention of Harassment and Discrimination Against Youth enables all residents to shower, perform bodily functions, and change without non-medical staff of the opposite gender viewing their breasts, buttocks, or genitalia. There are no cameras in the bathrooms, showers, youth rooms, or anywhere youth are permitted to change their clothes. All youth interviewed acknowledged that they have privacy when showering, using the bathroom, and changing their clothes. All bathrooms are single-user bathrooms with a sink, toilet, and shower. Staff close the door and it is locked from the outside, when the resident is finished, he knocks

on the door and staff unlock from the outside. Staff monitor this area from the hallway. All staff interviewed stated that their presence is announced when they enter a housing unit of the opposite gender youth. There are signs at the entrances to the housing units requiring opposite gender to announce their presence upon entering the unit. All youth interviewed acknowledged that the opposite gender staff announce their presence when entering the housing units. This auditor observed this practice throughout the facility during the on-site portion of the audit.

This policy states that all DYS locations shall have access to LGBTQI and GNC related resources, including booklist, website list of community resource supports, and other appropriate materials. This well be provided in resources other than English; as needed.

The policy states that upon conducting intake of a youth, staff shall ask the youth in accordance with the provided intake questions, how they identify by gender. A youth that identifies as a transgender or intersex youth shall be placed in a location consistent with the stated gender identity. Placement decisions for youth, especially transgender or intersex youth, shall be reassessed at least at the Monthly Treatment Meeting or as needed to review any threats to safety experienced by the youth.

e) Massachusetts DYS Policy and Procedures 03.01.02(a) – Searches in Secure Facilities states, "Staff are prohibited from searching or physically examining a Transgender or Intersex resident for the sole purpose of determining the resident's genital status."

Staff interviewed understood that they are prohibited from searching or physically examining a transgender or intersex resident for the sole purpose of determining the resident's genital status. Staff interviewed stated that if a resident's genital status is unknown, they would attempt to determine the genital status by having a conversation with the resident, reviewing medical records, and reviewing the case history of the resident. There were no transgender residents admitted into the facility during the past 12 months. There were no transgender residents residing at Paul T. Leahy Center during the on-site portion of this audit.

According to the Pre-Audit Questionnaire, there were no cross-gender strip searches or cross-gender pat searches during the past 12 months. This was confirmed during interviews with the Program Director, Facility PREA Compliance Manager, staff, and residents during the on-site portion of this audit.

f) The staff PREA training curriculum includes the searching of residents, including cross-gender pat searches and searches of transgender and intersex residents in a professional and respectful manner. All staff are required to participate in and complete these trainings upon hire. Staff interviewed were able to describe these trainings to this auditor and discuss key points covered during the trainings during interviews with this auditor.

Reviewed documentation to confirm compliance:

- Massachusetts DYS Policy and Procedures 03.01.02(a) – Searches in Secure Facilities
- Massachusetts DYS Policy 03.04.09 – Prevention of Harassment and Discrimination Against Youth
- Staff Training Curriculum
- Staff Training Logs
- Tour of Facility

Interviews:

- Interview with the Program Director
- Interview with the Facility PREA Compliance Manager
- Interview with Clinical Director
- Interviews with twelve (12) randomly selected staff
- Interviews with ten (10) randomly selected residents

Standard 115.316: Residents with disabilities and residents who are limited English proficient

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.316 (a)

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: residents who are deaf or hard of hearing? ☒ Yes ☐ No

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: residents who are blind or have low vision? ☒ Yes ☐ No

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: residents who have intellectual disabilities? ☒ Yes ☐ No

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: residents who have psychiatric disabilities? ☒ Yes ☐ No

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: residents who have speech disabilities? ☒ Yes ☐ No

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Other (if "other," please explain in overall determination notes)? ☒ Yes ☐ No

- Do such steps include, when necessary, ensuring effective communication with residents who are deaf or hard of hearing? ☒ Yes ☐ No

- Do such steps include, when necessary, providing access to interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary? ☒ Yes ☐ No

- Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Have intellectual disabilities? ☒ Yes ☐ No

- Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Have limited reading skills? ☒ Yes ☐ No

- Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Are blind or have low vision? ☒ Yes ☐ No

115.316 (b)

- Does the agency take reasonable steps to ensure meaningful access to all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment to residents who are limited English proficient? ☒ Yes ☐ No

- Do these steps include providing interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary? ☒ Yes ☐ No

115.316 (c)

- Does the agency always refrain from relying on resident interpreters, resident readers, or other types of resident assistance except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the resident's safety, the performance of first-response duties under §115.64, or the investigation of the resident's allegations? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

a) Massachusetts DYS Policy and Procedures 01.05.07(c) – Preventing and Responding to Sexual Abuse, Sexual Exploitation and Sexual Harassment of Youth states that all residents that are admitted with disabilities (physical or mental) will be instructed on the facility's efforts to prevent, detect, and respond to sexual abuse and sexual harassment. The policy further states that use of youth-to-youth interpreters is prohibited. The facility has multiple Spanish speaking staff. This auditor received copies of intake material in Spanish. Special Education teachers are available for youth with learning disabilities. A language interpretation service is available for other languages should the need arise. They also provide Braille for the blind residents and a hearing specialist for the deaf residents.

This auditor interviewed two (2) cognitively disabled residents during the on-site portion of this audit. These residents confirmed their needs are being met and an intake staff took the time to explain the materials and answer any questions that they had, and anytime they do not comprehend something, they know they can seek assistance from a staff, and they will take the time to review the material they do not understand to ensure they are able to comprehend that material. During an interview with the Facility PREA Compliance Manager, he noted any disabled resident residing in the facility, receives an equal opportunity to participate in and benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse. It was noted while reviewing the resident roster and resident files with the Facility PREA Compliance Manager that there were two (2) youth residing at the facility during the on-site portion of this audit who had some sort of cognitive disability (including residents identified as Special Education or having a learning disability). Two (2) youth were interviewed during the on-site portion of this audit.

b) Massachusetts DYS Policy and Procedures 01.05.07(c) – Preventing and Responding to Sexual Abuse, Sexual Exploitation and Sexual Harassment of Youth states, "Residents, who are limited in English proficiency, shall have equal opportunity to all aspects of DYS's services.

The PREA brochure is available to residents in both English and Spanish. Both versions of this brochure were reviewed by this auditor prior to the on-site portion of this audit. PREA posters are in the living units, all common areas, hallways, and the area where family visits take place. These posters are also in both English and Spanish.

There was one (1) limited English proficient residents residing at Paul T. Leahy Center during the on-site portion of this audit. This resident was interviewed by this auditor. He stated that he spoke very little English when he arrived at the facility. He said that staff spoke Spanish to him and translated everything during his Intake on the first day. He said that the staff member has taught him English during his stay, and helps him with his school work and everything he has a problem with. The facility has numerous staff members that speak Spanish that work with him.

c) Massachusetts DYS Policy and Procedures 01.05.07(c) – Preventing and Responding to Sexual Abuse, Sexual Exploitation and Sexual Harassment of Youth states, "DYS shall not rely on resident interpreters, resident readers, or other types of resident assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise a resident's safety, the performance of first response duties, or the investigation of the resident's allegations."

Interviews with staff confirmed that residents are not used as interpreters. Staff stated that they have not used the interpreting service but have witnessed clinical staff use the service for family meetings. In addition, it was confirmed during interviews with staff, the Program Director, and Facility PREA Compliance Manager that there have been no circumstances during the past 12 months at Paul T. Leahy Center where resident interpreters, readers, or other types of resident assistants have been

used. Staff interviewed all understood there are interpreters and resources available for the residents through the interpreting service. They also provide Braille for the blind residents and a hearing specialist for the deaf residents. There is a MOU with Interpreters and Translators Inc. for interpreting services.

Reviewed documentation to determine compliance:

- Massachusetts DYS Policy and Procedures 01.05.07(c) - Preventing and Responding to Sexual Abuse, Sexual Exploitation and Sexual Harassment of Youth
- MOU with Interpreters and Translators Inc.
- English and Spanish Reporting Posters
- PREA Brochures (English and Spanish)
- Tour of the facility

Interviews:

- Interview with Program Director
- Interview with Facility PREA Compliance Manager
- Interviews with twelve (12) randomly selected staff
- Interviews with two (2) cognitively disabled residents
- Interviews with ten (10) randomly selected residents
- Interview with one (1) LEP resident

Standard 115.317: Hiring and promotion decisions

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.317 (a)

- Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997)? ☒ Yes ☐ No

- Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse? ☒ Yes ☐ No

- Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who has been civilly or administratively adjudicated to have engaged in the activity described in the question immediately above? ☒ Yes ☐ No

- Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997)? ☒ Yes ☐ No

- Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse? ☒ Yes ☐ No

- Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who has been civilly or administratively adjudicated to have engaged in the activity described in the question immediately above? ☒ Yes ☐ No

115.317 (b)

- Does the agency consider any incidents of sexual harassment in determining whether to hire or promote anyone who may have contact with residents? ☒ Yes ☐ No

- Does the agency consider any incidents of sexual harassment in determining whether to enlist the services of any contractor who may have contact with residents? ☒ Yes ☐ No

115.317 (c)

- Before hiring new employees, who may have contact with residents, does the agency perform a criminal background records check? ☒ Yes ☐ No

- Before hiring new employees who may have contact with residents, does the agency, consistent with Federal, State, and local law, make its best efforts to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse? ☒ Yes ☐ No

115.317 (d)

- Does the agency perform a criminal background records check and consult applicable child abuse registries before enlisting the services of any contractor who may have contact with residents? ☒ Yes ☐ No

115.317 (e)

- Does the agency either conduct criminal background records checks at least every five years of current employees and contractors who may have contact with residents or have in place a system for otherwise capturing such information for current employees? ☒ Yes ☐ No

115.317 (f)

- Does the agency ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in written applications or interviews for hiring or promotions? ☒ Yes ☐ No

- Does the agency ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in any interviews or written self-evaluations conducted as part of reviews of current employees? ☒ Yes ☐ No

- Does the agency impose upon employees a continuing affirmative duty to disclose any such misconduct? ☒ Yes ☐ No

115.317 (g)

- Does the agency consider material omissions regarding such misconduct, or the provision of materially false information, grounds for termination? ☒ Yes ☐ No

115.317 (h)

- Does the agency provide information on substantiated allegations of sexual abuse or sexual harassment involving a former employee upon receiving a request from an institutional employer for whom such employee has applied to work? (N/A if providing information on substantiated allegations of sexual abuse or sexual harassment involving a former employee is prohibited by law.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

a-b) Massachusetts DYS Policy 01.05.06(a) – Hiring of Staff (criminal history screening) states, "DYS shall not hire or promote anyone who may have contact with residents, and shall not enlist the services of any contractor who may have contact with residents who:

1. Has engaged in sexual abuse in prison, jail, lockup, community confinement facility, juvenile facility, or other institution.
2. Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force or coercion; or if the victim did not consent or was unable to consent or refused; or
3. Has been civilly or administratively adjudicated to have engaged in the activity described above

DYS shall consider any incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of a contractor, that may have contact with residents."

The practice of conducting background checks for all prospective employees prior to employment was confirmed during an interview with a representative from HR Office as well as reviewing twelve (12) randomly selected employee files. All employee files reviewed by this auditor had the appropriate background checks.

c) Massachusetts DYS Policy and Procedures 01.05.06(a) – Hiring Staff states, "Before hiring new employees who may have contact with residents, DYS shall:

1. Perform a criminal offender record information (CORI) at the Criminal History System's Board (CHSB) including out of state inquiries
2. Perform abuse and neglect records of the Department of Children and Families (DCF)
3. Perform sex offender registry information (SORI) of the Sex Offender Registry Board (SORB)
4. Conduct driving records background checks from the Registry of Motor Vehicles

During the past 12 months, there were twenty-eight (28) employees hired at Paul T. Leahy Center who may have contact with residents. This auditor reviewed twelve (12) randomly selected staff files contained in the above-mentioned background information. This was also confirmed during an interview with a representative from the HR Office. In addition, the Agency PREA Coordinator was able to describe the agency's hiring and promotion process in detail to this auditor.

d) Massachusetts DYS Policy 01.10.01 – Volunteer Services states, "Contractor agencies shall ensure all criminal background checks are conducted and documented prior to service for employees who may have contact with residents. Additionally, background checks will be completed no less than every five years."

This auditor verified proof of criminal background checks.

During the past 12 months, there were thirteen (13) contractors approved to enter Paul T. Leahy Center to have contact with residents. Two (2) contractors were interviewed, and they stated that they received the PREA training for contractors and signed the acknowledgement form stating they received and understood the training. During interviews with the contractors, they were able to describe the PREA reporting responsibilities, and the zero-tolerance policy. A review of the signed acknowledgement forms confirmed that they did receive the PREA training in November 2024. They also stated that DYS conducted background checks prior to entering the facility.

e) Massachusetts DYS Policy 01.05.06(a) – Hiring of Staff states, "DYS shall conduct all criminal background checks no less than every two years for current employees."

Background checks will be completed no less than every five years.

During interviews with a representative from the HR Office and the Agency PREA Coordinator, it was noted that when a person is hired at DYS, their name is entered into the Criminal Offender Record Information at the Criminal History System's Board. If an employee is arrested, it is their duty to report, and it will show up in the Criminal History System Board. Checks are made to the Department of Children and Families for abuse and neglect every two years for current employees and any employee eligible for promotion. This auditor was able to review twelve (12) randomly selected staff files to confirm the above-mentioned practice has been implemented and is being adhered to.

f) Massachusetts DYS Policy 01.05.06(a) – Hiring of Staff notes applicants are required to report their application for employment any arrests that may impact their ability to work with youth. Applicants are asked if they have had a felony conviction of a sex offense at any time.

g) Massachusetts DYS Policy and Procedures 01.05.06(a) – Hiring of Staff states, “Material omission regarding such misconduct or the provision of materially false information shall be grounds for termination.”

This screening process noted above was confirmed during an interview with a representative from the Personnel Office as well as reviewing twelve (12) randomly selected employees background checks. The employment application allows prospective employees to disclose their criminal history prior to a background check being completed.

A representative from the Personnel Office noted that when requested, DYS does provide information on substantiated or allegations of sexual abuse or sexual harassment involving a former employee upon receiving a request from an institutional employer for whom such employee has applied to work.

Reviewed documentation to determine compliance:

- Massachusetts DYS Policy 01.05.06(a) – Hiring of Staff
- Massachusetts DYS Policy 01.10.01 – Volunteer Services
- Review of twelve (12) randomly selected staff files
- Review of contractors (teachers) background checks
- DYS CORI Regulations
- CMR 12.00 et seq
- CORI Clearance Forms

Interviews:

- Interview with the Agency PREA Coordinator
- Interview with the Human Resource staff
- Interview with DYS Regional Director
- Interview with Facility Administrator
- Interview with Program Director
- Interviews with contractors (teacher/medical)

Standard 115.318: Upgrades to facilities and technologies

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.318 (a)

- If the agency designed or acquired any new facility or planned any substantial expansion or modification of existing facilities, did the agency consider the effect of the design, acquisition, expansion, or modification upon the agency’s ability to protect residents from sexual abuse? (N/A if agency/facility has not acquired a new facility or made a substantial expansion to existing facilities since August 20, 2012, or since the last PREA audit, whichever is later.)
  ☐ Yes ☐ No ☒ NA

115.318 (b)

- If the agency installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology, did the agency consider how such technology may enhance the agency's ability to protect residents from sexual abuse? (N/A if agency/facility has not installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology since August 20, 2012, or since the last PREA audit, whichever is later.)
  ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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a) Paul T. Leahy Center develops a Video Surveillance and Staffing Plan on an annual basis (updated on February 5, 2025, by the Facility Administrator). Any expansion or modification at Paul T. Leahy Center is noted on this plan. The facility's most recent Video Surveillance and Staffing Plan was provided to this auditor prior to the on-site portion of this audit and was confirmed during the interview with the Facility Administrator during the on-site portion of this audit.

There have been no expansion or modification projects completed at Paul T. Leahy Center since the last PREA audit in 2022. The facility's video surveillance system provides a camera view of every door in the area where youth are permitted as well as doors to enter the area where they are not permitted. The Video Surveillance and Staffing Plan clearly addresses the use of technology to improve the safety of the youth.

Through interviews with the DYS Regional Director, Agency PREA Coordinator, and the Facility Administrator, it was confirmed that if there are any additional plans for expansion or modifications at Paul T. Leahy Center, the agency will take into consideration the possible need to increase video monitoring and to further review monitoring technology to protect residents from sexual abuse.

Paul T. Leahy Center currently has 99 cameras of which are 73 interior and 26 exterior cameras. The Program Directors, Assistant Program Directors, and the Facility Administrator have access to the system via their office laptop/computer.

Reviewed documentation to determine compliance:

- 2025 Video Surveillance and Staffing Plan
- Tour of the facility

Interviews:

- Interview with DYS Regional Director
- Interview with Agency PREA Coordinator
- Interview with Facility Administrator

RESPONSIVE PLANNING

Standard 115.321: Evidence protocol and forensic medical examinations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.321 (a)

- If the agency is responsible for investigating allegations of sexual abuse, does the agency follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.) ☒ Yes ☐ No ☐ NA

115.321 (b)

- Is this protocol developmentally appropriate for youth where applicable? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.) ☒ Yes ☐ No ☐ NA

- Is this protocol, as appropriate, adapted from or otherwise based on the most recent edition of the U.S. Department of Justice's Office on Violence Against Women publication, "A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents," or similarly comprehensive and authoritative protocols developed after 2011? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.) ☒ Yes ☐ No ☐ NA

115.321 (c)

- Does the agency offer all victims of sexual abuse access to forensic medical examinations, whether on-site or at an outside facility, without financial cost, where evidentiarily or medically appropriate? ☒ Yes ☐ No

- Are such examinations performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) where possible? ☒ Yes ☐ No

- If SAFEs or SANEs cannot be made available, is the examination performed by other qualified medical practitioners (they must have been specifically trained to conduct sexual assault forensic exams)? ☒ Yes ☐ No

- Has the agency documented its efforts to provide SAFEs or SANEs? ☒ Yes ☐ No

115.321 (d)

- Does the agency attempt to make available to the victim a victim advocate from a rape crisis center? ☒ Yes ☐ No

- If a rape crisis center is not available to provide victim advocate services, does the agency make available to provide these services a qualified staff member from a community-based organization, or a qualified agency staff member? (N/A if the agency *always* makes a victim advocate from a rape crisis center available to victims.) ☐ Yes ☐ No ☒ NA

- Has the agency documented its efforts to secure services from rape crisis centers? ☒ Yes ☐ No

115.321 (e)

- As requested by the victim, does the victim advocate, qualified agency staff member, or qualified community-based organization staff member accompany and support the victim through the forensic medical examination process and investigatory interviews? ☒ Yes ☐ No

- As requested by the victim, does this person provide emotional support, crisis intervention, information, and referrals? ☒ Yes ☐ No

115.321 (f)

- If the agency itself is not responsible for investigating allegations of sexual abuse, has the agency requested that the investigating agency follow the requirements of paragraphs (a) through (e) of this section? (N/A if the agency/facility is responsible for conducting criminal AND administrative sexual abuse investigations.) ☒ Yes ☐ No ☐ NA

115.321 (g)

- Auditor is not required to audit this provision.

115.321 (h)

- If the agency uses a qualified agency staff member or a qualified community-based staff member for the purposes of this section, has the individual been screened for appropriateness to serve in this role and received education concerning sexual assault and forensic examination issues in general? (N/A if agency *always* makes a victim advocate from a rape crisis center available to victims.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

a-b) Massachusetts DYS Policy and Procedures 01.05.07(c) – Preventing and Responding to Sexual Abuse, Sexual Exploitation and Sexual Harassment of Youth addresses the availability of Rape Crisis Centers and DCF Child at Risk Hotline services to youth, that services will be provided to the youth at no cost. The Memorandum of Understanding (MOU) with Massachusetts Department of Public Health (DPH); and the Memorandum of Understanding with the Massachusetts State Police were reviewed by this auditor. The MOU clearly stated that the Emergency Department at UMASS Memorial Hospital will provide forensic examination conducted by the Sexual Assault Nurse Examiner (SANE) or other similarly credentialed forensic examiner, collect and maintain the integrity of the evidence collected during the examination for law enforcement. Facility staff does not conduct physical evidence collection of criminal acts or forensic examinations. All staff are trained to preserve incident scenes and measures to prevent evidence from being destroyed. This was confirmed via interviews with staff and DYS Investigator. DYS investigators conduct administrative investigations along with DCF investigators. The Massachusetts State Police conduct criminal investigations. There is a statewide MOU for evidence collection and forensic examinations in place. There were no reported incidents of sexual abuse or sexual assault during this audit period. This was confirmed via interview with the DYS Investigator.

c) The Program Director, Facility PREA Compliance Manager, Nurse Practitioner, and Assistant Program Director stated during their interviews that UMASS Memorial Hospital is where a resident would be transported for a forensic examination by a SANE/SAFE. DYS has a Memorandum of Understanding with UMASS Memorial Hospital that confirms UMASS Memorial Hospital will provide a forensic examination conducted by a Sexual Assault Nurse Examiner or a similarly credentialed examiner with the patient's consent. This examiner will collect and maintain the integrity of evidence collected during the examination for law enforcement. UMASS Memorial Hospital will also contact Central Region Rape Crisis Center to send an advocate.

Massachusetts DYS Policy and Procedures 01.05.07(c) – Preventing and Responding to Sexual Abuse, Sexual Exploitation and Sexual Harassment of Youth states, that DYS "offers residents who experience sexual abuse access to forensic medical examination, without financial cost, where evidentiary or medically appropriate."

In reviewing documentation, there were no incidents of sexual abuse at Paul T. Leahy Center during the past 12 months that involved penetration and required a resident to be transported to UMASS Memorial Hospital for a forensic examination by a SANE/SAFE.

d) The Agency PREA Coordinator provided this auditor with a Memorandum of Agreement with Central Region Rape Crisis Center that states a victim advocate would be dispatched to UMASS Memorial Hospital to provide rape crisis counseling and advocacy services to the victim.

A representative from Central Region Rape Crisis Center was interviewed via phone by this auditor and confirmed an advocate would respond to UMASS Memorial Hospital to provide rape counseling, emotional support, and advocacy services to any victim of sexual abuse.

e) DYS has a Memorandum of Agreement with Central Region Rape Crisis Center which states an advocate would be contacted to accompany and support the victim through the forensic medical examination process and investigatory interviews. This advocate would also provide emotional support, crisis intervention, information, and referrals. This auditor was provided a copy of the Memorandum of Agreement with Central Region Rape Crisis Center to review prior to the on-site portion of this audit. In addition, this auditor was able to interview a representative from Central Region Rape Crisis Center to confirm the services listed in the Memorandum of Agreement are available to any resident victim of sexual abuse at Paul T. Leahy Center.

f) DYS investigators and the Department of Children and Families (DCF) conduct sexual abuse and sexual harassment administrative investigations. All alleged incidents of sexual abuse and sexual harassment which may be criminal in nature are reported to the Massachusetts State Police investigators.

An interview with an investigator/representative from Massachusetts State Police confirmed this agency complies with all PREA investigative standards when completing an investigation at Paul T. Leahy Center.

Reviewed documentation to determine compliance:

- Massachusetts DYS Policy and Procedures 01.05.07(c) - Preventing and Responding to Sexual Abuse, Sexual Exploitation and Sexual Harassment of Youth
- MOU with Massachusetts Department of Public Health
- MOU with Central Region Rape Crisis Center
- MOU with UMASS Memorial Hospital
- MOU with Massachusetts State Police

Interviews:

- Interview with Agency PREA Coordinator
- Interview with Facility Administrator
- Interview with the Facility PREA Compliance Manager
- Interview with Nurse Practitioner
- Interview with representative from UMASS Memorial Hospital
- Interview with representative from Central Region Rape Crisis Center
- Interview with investigator/representative from Massachusetts State Police

Standard 115.322: Policies to ensure referrals of allegations for investigations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.322 (a)

- Does the agency ensure an administrative or criminal investigation is completed for all allegations of sexual abuse? ☒ Yes ☐ No

- Does the agency ensure an administrative or criminal investigation is completed for all allegations of sexual harassment? ☒ Yes ☐ No

115.322 (b)

- Does the agency have a policy and practice in place to ensure that allegations of sexual abuse or sexual harassment are referred for investigation to an agency with the legal authority to conduct criminal investigations, unless the allegation does not involve potentially criminal behavior? ☒ Yes ☐ No

- Has the agency published such policy on its website or, if it does not have one, made the policy available through other means? ☒ Yes ☐ No

- Does the agency document all such referrals? ☒ Yes ☐ No

115.322 (c)

- If a separate entity is responsible for conducting criminal investigations, does the policy describe the responsibilities of both the agency and the investigating entity? (N/A if the agency/facility is responsible for criminal investigations. See 115.21(a).) ☒ Yes ☐ No ☐ NA

115.322 (d)

- Auditor is not required to audit this provision.

115.322 (e)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

a) Massachusetts DYS Policy and Procedures 01.05.07(c) - Preventing and Responding to Sexual Abuse, Sexual Exploitation and Sexual Harassment of Youth states that any reports (direct, indirect, third party) received involving sexual abuse and sexual harassment shall be reviewed by the Program Director and either the Facility PREA Compliance Manager or one of the members of the administrative team. It requires that the allegation be reported to DCF Child at Risk Hotline (1-800-792-5200) for administrative investigation. The DYS Director of Investigations will be notified for a DYS investigator to conduct an administrative investigation. Allegations that may be criminal in nature will be referred to the Massachusetts State Police. All DYS staff are mandated reporters of abuse and all staff interviewed were aware of their obligations to report abuse under Massachusetts law.

b) As noted in the Massachusetts DYS Policy and Procedures 01.05.07(c), all allegations of sexual abuse and sexual harassment are referred to DCF and DYS for administrative investigation; and Massachusetts State Police for criminal investigation. Interviews with the Facility Administrator, Program Director, and DYS Investigator confirmed that during an open investigation, communication is maintained between DCF and Paul T. Leahy Center through telephone calls, emails, and on-site visits. An interview with a representative from DCF also confirmed these statements.

Information regarding the referral of allegations of sexual abuse and sexual harassment for investigation and other PREA related information is posted on the agency website. PREA related information is also posted in the facility in each living unit, common areas, and visiting areas. These posters were observed by this auditor during the tour of the facility.

All allegations are referred to DCF Child at Risk Hotline within 24 hours and are documented on an Incident Report. There were no allegations of sexual abuse or sexual harassment during the past 12 months at Paul T. Leahy Center.

c) The Massachusetts DYS Policy and Procedures 01.05.07(c) states that the agency shall request the investigating agency conduct investigations in compliance with PREA standards.

A representative from the Department of Children and Families (DCF) was contacted and stated her agency completes thorough investigations on each incident and sends a detailed report to the Facility Administrator noting their findings, determinations, and recommendations at the completion of each investigation. The Facility PREA Compliance Manager noted that following the facility receiving an investigative report from the Department of Children and Families indicating an Unsubstantiated or Substantiated determination regarding a sexual abuse investigation, a PREA Abuse Incident Review is conducted by the Incident Review Team and documented by the Facility Administrator.

During the past 12 months, there were no allegations of sexual abuse or sexual harassment at Paul T. Leahy Center that were investigated by a DCF investigator, or the Massachusetts State Police. Therefore, there were no investigative reports to review or residents and staff to interview by this auditor.

Reviewed documentation to determine compliance:

- Massachusetts DYS Policy and Procedures 01.05.07(c) - Preventing and Responding to Sexual Abuse, Sexual Exploitation and Sexual Harassment of Youth
- Pre-Audit Questionnaire
- MOU with Massachusetts State Police
- MOU with Massachusetts Department of Public Health
- DYS Website

Interviews:

- Interview with Facility Administrator
- Interview with Program Director
- Interview with Facility PREA Compliance Manager
- Interview with representative from the Department of Children and Families
- Interview with DYS Investigator
- Interview with representative from Massachusetts State Police

TRAINING AND EDUCATION

Standard 115.331: Employee training

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.331 (a)

- Does the agency train all employees who may have contact with residents on its zero-tolerance policy for sexual abuse and sexual harassment? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on how to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on residents' right to be free from sexual abuse and sexual harassment ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on the right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on the dynamics of sexual abuse and sexual harassment in confinement? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on the common reactions of sexual abuse and sexual harassment victims? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on how to detect and respond to signs of threatened and actual sexual abuse and how to distinguish between consensual sexual contact and sexual abuse between residents? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on how to avoid inappropriate relationships with residents? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on how to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on how to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities? ☒ Yes ☐ No

- Does the agency train all employees on all relevant laws regarding the applicable age of consent? ☒ Yes ☐ No

115.331 (b)

- Is such training tailored to the gender of the residents at the employee's facility? ☒ Yes ☐ No

- Have employees received additional training if reassigned from a facility that houses only male residents to a facility that houses only female residents, or vice versa? ☒ Yes ☐ No

115.331 (c)

- Have all current employees who may have contact with residents received such training? ☒ Yes ☐ No

- Does the agency provide each employee with refresher training every two years to ensure that all employees know the agency's current sexual abuse and sexual harassment policies and procedures? ☒ Yes ☐ No

- In years in which an employee does not receive refresher training, does the agency provide refresher information on current sexual abuse and sexual harassment policies? ☒ Yes ☐ No

115.331 (d)

- Does the agency document, through employee signature or electronic verification, that employees understand the training they have received? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

a) Massachusetts DYS Policy and Procedures 01.05.07(c) - Preventing and Responding to Sexual Abuse, Sexual Exploitation and Sexual Harassment of Youth; Policy 01.05.08 - Prohibition of Sexual Harassment in the Workplace; and Policy 03.04.09 – Prohibition of Harassment and Discrimination Against Youth require all employees to receive training that is specific to juveniles and the gender of the population they are working with. Employees must sign an acknowledgement verifying that they understand the training they received. Current employees must receive this training and receive refresher training annually. This training must include the following critical subjects:

1. The agency's policy on zero tolerance for sexual abuse and sexual.
2. How to fulfill their responsibilities under agency sexual misconduct prevention, detecting, reporting, and response policy and procedures.
3. Residents' right to be free from sexual abuse and sexual harassment.
4. The right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment in juvenile facilities.
5. Dynamics of sexual abuse and sexual harassment in confinement.
6. Common reactions of sexual abuse and sexual harassment of juvenile victims.
7. How to detect and respond to signs of threatened and actual sexual misconduct.
8. How to avoid inappropriate relationships with residents.
9. How to communicate effectively and professionally with residents, including those who identify as lesbian, gay, transgender, intersex, or gender non-conforming.
10. How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities.
11. Relevant laws regarding the applicable age of consent.

All employees receive an initial training through a DYS Power Point presentation (DYS Policy Training for State and Provider Employees on LGBTQI and GNC Youth). This training is conducted during the initial training at the Academy to all staff. This states that DYS staff will support LGBTQI and GNC youth in a positive and proactive way, such as acceptance of gender identity and using correct pronouns. Staff also review the LGBTQI MaeBright Slides during this training which covers topics of gender identity, sexual orientation, biological sex, gender expression, bisexuality, and asexuality aromanticism. Current employees, who received this training, receive refresher training annually.

All staff interviewed reported that they received initial PREA training/annual refresher on all areas noted in this standard. All staff interviewed were aware of their obligations related to PREA, their obligations as mandated reporters of abuse, their duties as first responders, and the facility protocols related to evidence collection. Interviews with staff members also confirmed they receive the training and understood the material that was covered in the training they received. This auditor was able to review

the Training Roster and confirmed they had appropriate staff members signatures and noted if they understood the training they received and completed a post-training test.

b) PREA training is provided specific to the facility annually.

In addition to the above-mentioned trainings, staff also received mandated reporter trainings as per the DYS Mandatory Training Curriculum. Staff were able to discuss their mandated reporter responsibilities as well as their first responder responsibilities.

During the on-site portion of this audit, it was noted that posters are posted throughout the facility to educated both staff and residents on agency PREA policies. Brochures noting PREA requirements are given to residents, staff, volunteers, and contractors.

c) Massachusetts DYS Policy and Procedures 01.05.07(c) - Preventing and Responding to Sexual Abuse, Sexual Exploitation and Sexual Harassment of Youth states, "Current employees must receive the initial PREA training and refresher training annually." This auditor reviewed training records and confirmed all staff completed the annual trainings/refreshers on a yearly basis. Interviews with staff also confirmed they receive the trainings/refreshers on an annual basis and understood the material that was covered in the trainings/refreshers they received.

d) All staff who successfully completed the annual PREA training must document through employee signature that employees understand the training they have received. This auditor was able to review the Training Roster and confirmed they had the appropriate staff signatures and noted if they understood the training they received.

Interviews with randomly selected staff confirmed they are knowledgeable of PREA. Staff demonstrated their knowledge of PREA, the Massachusetts DYS Policy and Procedures 01.05.07(c) - Preventing and Responding to Sexual Abuse, Sexual Exploitation and Sexual Harassment of Youth, and the residents' and staff's rights to be free from retaliation for reporting allegations of sexual abuse and sexual harassment during interviews. Staff were also able to note the appropriate steps they would take to protect residents of imminent sexual abuse as well as their role as a first responder.

Reviewed documentation to determine compliance:

- Massachusetts DYS Policy and Procedures 01.05.07(c) - Preventing and Responding to Sexual Abuse, Sexual Exploitation and Sexual Harassment of Youth
- Massachusetts DYS Policy 01.05.08 - Prohibition of Sexual Harassment in the Workplace
- Massachusetts DYS Policy 03.04.09 – Prohibition of Harassment and Discrimination Against Youth
- Pre-Audit Questionnaire
- PREA Training Curriculum including DYS Power Point
- DYS – Policy Training for State and Provider Employees on LGBTQI and GNC Youth
- LBTQI MaeBright Slide Show
- Mandated Reporter Curriculum: Recognizing Signs of Child Abuse Curriculum
- Training Roster
- Training file of contractor
- Random employee files

Interviews:

- Interview with Agency PREA Coordinator

- Interview with the Facility PREA Compliance Manager
- Interviews with random staff

Standard 115.332: Volunteer and contractor training

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.332 (a)

- Has the agency ensured that all volunteers and contractors who have contact with residents have been trained on their responsibilities under the agency's sexual abuse and sexual harassment prevention, detection, and response policies and procedures? ☒ Yes ☐ No

115.332 (b)

- Have all volunteers and contractors who have contact with residents been notified of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents (the level and type of training provided to volunteers and contractors shall be based on the services they provide and level of contact they have with residents)? ☒ Yes ☐ No

115.332 (c)

- Does the agency maintain documentation confirming that volunteers and contractors understand the training they have received? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

a) Massachusetts DYS Policy and Procedures 01.05.07(c) - Preventing and Responding to Sexual Abuse, Sexual Exploitation and Sexual Harassment of Youth pg. 14 states that volunteers and interns who have contact with youth shall receive training on this policy either through Basic Training or on the Volunteer Orientation Training. The PREA training is a review of the DYS PREA Policy. They shall receive instructions regarding facility policy, prohibited contact, prevention, detection, response, and reporting of sexual misconduct prior to assuming responsibilities that include contact with youth. Volunteers, interns,

and contractors will receive PREA brochures, and must sign an acknowledgement that they received and understood the training.

Paul T. Leahy Center reported that there were six (6) contractors and zero (0) volunteers currently approved to enter the facility. During the past 12 months, there have been thirteen (13) contractors and zero (0) volunteers approved to enter the facility.

During an interview with the Facility PREA Compliance Manager, it was noted that prior to entering the facility, all volunteers, interns, and contractors receive training on the DYS Policy 01.05.07(c) through Basic Training or on the Volunteer/Contractor Orientation Training. They also receive an acknowledgement to review and sign off indicating they have received the training and understood it.

b) Massachusetts DYS Policy and Procedures 01.05.07(c) states that DYS shall ensure that all contracting entities have received and understood their responsibilities with respect to prevention, detection, and response to sexual abuse and/or sexual harassment.

c) Massachusetts DYS Policy and Procedures 01.05.07(c) states that the volunteer and contractor acknowledgement shall be completed; documentation shall be maintained by the Facility PREA Compliance Manager.

The Facility PREA Compliance Manager was able to explain the process of educating a volunteer/contractor prior to them entering the facility to ensure they are aware of the agency zero-tolerance policy, their duty to report, and the importance of appropriate interactions with the residents.

There have been thirteen (13) contractors approved to enter the facility during the past 12 months. This auditor requested and received signed Volunteer/Contractor Training and Acknowledgement Forms for all thirteen (13) contractors approved to enter Paul T. Leahy Center during the past 12 months to confirm they received training prior to entering the facility and having contact with residents. Two (2) contractors were interviewed by this auditor during the on-site portion of the audit. The contractors were able to articulate the PREA training they received in November 2024 which included reporting requirements, how to detect for signs of sexual abuse and sexual harassment, how to avoid inappropriate relationships with residents, and how to preserve physical evidence. This auditor received their training file to confirm that they received and understood their PREA training.

Interviews with contracted employees, reported that they would report any allegation of sexual abuse and/or sexual harassment to their supervisor and/or Facility Administrator. They would also report to DCF Child at Risk Hotline either by phone or email. The contracted employee acknowledged receiving PREA training annually. This auditor was able to verify this through training records.

Reviewed documentation to determine compliance:

- Massachusetts DYS Policy and Procedures 01.05.07(c) - Preventing and Responding to Sexual Abuse, Sexual Exploitation and Sexual Harassment of Youth
- Pre-Audit Questionnaire
- PREA Brochure for Contractors and Volunteers
- Training logs
- Signed Training Acknowledgements for Contractors
- Educational Signed Acknowledgement for all Teachers
- Volunteer Orientation Training Curriculum

Interviews:

- Interview with Facility PREA Compliance Manager
- Interviews with contracted employees (teacher/medical)

Standard 115.333: Resident education

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.333 (a)

- During intake, do residents receive information explaining, in an age-appropriate fashion, the agency's zero-tolerance policy regarding sexual abuse and sexual harassment? ☒ Yes ☐ No

- During intake, do residents receive information explaining how to report incidents or suspicions of sexual abuse or sexual harassment? ☒ Yes ☐ No

115.333 (b)

- Within 10 days of intake, does the agency provide comprehensive education to residents either in person or through video regarding: Their rights to be free from sexual abuse and sexual harassment? ☒ Yes ☐ No

- Within 10 days of intake, does the agency provide comprehensive education to residents either in person or through video regarding: Their rights to be free from retaliation for reporting such incidents? ☒ Yes ☐ No

- Within 10 days of intake, does the agency provide comprehensive education to residents either in person or through video regarding: Agency policies and procedures for responding to such incidents? ☒ Yes ☐ No

115.333 (c)

- Have all residents received the comprehensive education referenced in 115.333(b)? ☒ Yes ☐ No

- Do residents receive education upon transfer to a different facility to the extent that the policies and procedures of the resident's new facility differ from those of the previous facility? ☒ Yes ☐ No

115.333 (d)

- Does the agency provide resident education in formats accessible to all residents including those who are limited English proficient? ☒ Yes ☐ No

- Does the agency provide resident education in formats accessible to all residents including those who are deaf? ☒ Yes ☐ No

- Does the agency provide resident education in formats accessible to all residents including those who are visually impaired? ☒ Yes ☐ No

- Does the agency provide resident education in formats accessible to all residents including those who are otherwise disabled? ☒ Yes ☐ No

- Does the agency provide resident education in formats accessible to all residents including those who have limited reading skills? ☒ Yes ☐ No

115.333 (e)

- Does the agency maintain documentation of resident participation in these education sessions? ☒ Yes ☐ No

115.333 (f)

- In addition to providing such education, does the agency ensure that key information is continuously and readily available or visible to residents through posters, resident handbooks, or other written formats? ☒ Yes ☐ No

Auditor Overall Compliance Determination

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☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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Massachusetts DYS Policy and Procedures 01.05.07(c) - Preventing and Responding to Sexual Abuse, Sexual Exploitation and Sexual Harassment of Youth states that all juveniles, upon intake, shall receive verbal and written information about sexual misconduct during their orientation. The information shall address:

1. Their right to have confidential access to their attorney or other legal representation;
2. Their right to have reasonable access to parents or legal guardians;
3. How to report incidents or suspicions of sexual abuse or sexual harassment;
4. The facility's process and procedure for a resident to file a grievance;
5. The facility's process and procedure for accessing the facility's client advocate;
6. How to access outside victim advocates for emotional support services related to sexual abuse (this information shall include mailing addresses and telephone numbers, including toll-free numbers of available local, state and/or national victim advocacy or rape crisis organizations);

7. For individuals being admitted to the facility solely for civil immigration purposes, mailing addresses, telephone numbers (including toll-free hotlines were available) of immigrant service agencies;
8. The extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws;
9. Information related to the DYS Massachusetts DYS Policy and Procedures 01.05.07(c);
10. Information related to the agency's policy against for reporting sexual abuse, sexual harassment or cooperating with an investigation;
11. For transgender and intersex youth, information related to their right to shower separately and;
12. Comprehensive education in person:
    a. Their right to be free from sexual abuse and sexual harassment
    b. Their right to be free from retaliation for reporting sexual abuse or harassment
    c. The agency's response policies and procedures for responding to reports of sexual abuse or sexual harassment

a) Massachusetts DYS Policy and Procedures 01.05.07(c) requires that all youth be informed of the DYS Policy 01.05.07(c) - Preventing and Responding to Sexual Abuse, Sexual Exploitation and Sexual Harassment of Youth on excessive use of force, sexual abuse, and sexual harassment. In addition, within 10 days of intake, DYS shall provide age-appropriate education to residents, either in person or video, about their rights to be free from sexual abuse and sexual harassment, and free from retaliation for reporting allegations of sexual abuse and sexual harassment. Youth must be provided information concerning prevention, intervention, self-protection, reporting of sexual abuse and the agency's zero tolerance policy.

This auditor was able to review copies of PREA pamphlets. All residents receive these pamphlets upon admission to Paul T. Leahy Center. They are available in both English and Spanish. Upon receiving the pamphlets at intake, each resident signs an acknowledgement form noting they received these pamphlets. This auditor was able to review all resident files to confirm each resident received the PREA education pamphlets and signed an acknowledgement form noting they received the pamphlets. Residents interviewed were knowledgeable of PREA and were able to articulate ways they can report sexual harassment and sexual abuse. In addition, all residents interviewed confirmed they received PREA education during their intake and comprehensive PREA education within the first week of admission.

b) Paul T. Leahy Center reports there were two hundred and eighty-four (284) residents admitted to the facility whose stay was 10 days or longer during the past 12 months. Two hundred and eighty-four (284) residents received comprehensive PREA education following their intake into the facility. The facility delivers comprehensive PREA education to each resident following the intake process (during their first week at the facility). This education included their right to be free from both sexual abuse and sexual harassment and retaliation for reporting such incidents. This auditor reviewed ten (10) resident files and confirmed all of the files noted these residents received their comprehensive PREA education within 10 days of being admitted to the facility. All residents interviewed confirmed they received PREA education during their first day of being admitted into the facility, and each resident's file had a signed acknowledgement form noting they received the PREA education on day of admission and comprehensive PREA education on day seven.

c) Massachusetts DYS Policy and Procedures 01.05.07(c) requires youth who are transferred to another facility must receive this information again to the extent that the information from the previous facility differs from their new facility.

In addition, Massachusetts DYS Policy and Procedures 01.05.07(c) states that youth must be informed of the zero-tolerance policy on excessive force, sexual abuse, and sexual harassment.

Intake staff interviewed reported each resident admitted into Paul T. Leahy Center receives PREA education during the intake process. They were able to describe reviewing the agency zero tolerance policy and receiving and providing each with PREA pamphlets. In addition to providing each resident with these

pamphlets during intake, a staff completes a comprehensive PREA education session and answers any questions they may have on day seven. This auditor reviewed all ten (10) resident files during the on-site portion of this audit and all resident files reviewed contained a signed copy of the acknowledgement form noting the resident received both PREA education at intake and the comprehensive PREA education per policy noted above.

All residents interviewed confirmed they received comprehensive PREA education during their intake at the facility. They also acknowledged reviewing and receiving the PREA pamphlets upon intake.

d) Massachusetts DYS Policy and Procedures 01.05.07(c) states DYS shall provide residents education in formats accessible to all residents, including those who are limited English proficient or otherwise disabled, as well as to residents who have limited reading skills.

Language assistance resources are available through a contracted interpreting service called Interpreters and Translators Inc. They also provide Braille for the blind and a hearing specialist for the deaf. Facilities must not rely upon youth interpreters, youth readers or other types of youth assistants except in limited circumstances where are an extended delay in obtaining an effective interpreter could jeopardize a youth's safety, the performance of first responder duties subject to section 115.364 of the PREA Juvenile Standards, or the investigation of the youth's allegations. All education and information must be made available in formats accessible to all youth (limited English, deaf, visually impaired, or otherwise disabled, as well as limited reading skills).

Interviews with Intake staff at Paul T. Leahy Center confirmed all PREA education information is communicated orally and in writing and in a language clearly understood by the resident, during the intake process and during the resident's first day at the facility. Language assistance resources are available through a contracted interpreter service. The facility also ensures that key information about PREA is continuously and readily available or visible through posters, the Resident Handbook, and PREA pamphlets in both English and Spanish. This auditor was able to confirm this material was available in both English and Spanish during the tour of the facility and by reviewing the Resident Handbook and PREA pamphlets that all residents receive.

This auditor interviewed two (2) cognitively disabled residents residing at Paul T. Leahy Center during the on-site portion of this audit. These residents confirmed all PREA education materials were explained to them in a language they understood, and the staff took the time to answer any questions they had. There was one (1) limited English proficient resident residing at the facility during the on-site portion of this audit who was interviewed by this auditor during the on-site portion of the audit. He stated that he knew very little English upon his admission and a Spanish speaking staff translated everything to him, and continued to work with him. He said that this staff member has taught him the English he speaks today. It was noted there has been one (1) limited-English proficient resident admitted into Paul T. Leahy Center during the past 12 months.

e) Massachusetts DYS Policy and Procedures 01.05.07(c) states, "receipt of the above (PREA) education and information must be documented for each youth."

All resident intake and comprehensive PREA education are documented on acknowledgment forms. These acknowledgement forms are signed and dated by the resident upon receiving the intake and comprehensive PREA education information and is also signed and dated by the staff who delivered the education. In addition, each resident receives the PREA education pamphlets and Resident Handbook upon intake into the facility. Each resident signs an acknowledgment form noting they received these pamphlets. These acknowledgement forms are kept in the resident's file. This auditor was able to review ten (10) resident files and each file contained the above-mentioned documentation confirming the resident received the PREA pamphlets during and the comprehensive PREA education within 24 hours of being admitted into the facility.

f) At intake, all residents receive PREA pamphlets and the Resident Handbook. These pamphlets include information about the agency's zero tolerance policy and reporting information noting ways to report an allegation of sexual abuse or sexual harassment. In addition, there were visible posters (in both English and Spanish) in the hallways, all common areas, visiting areas, and in the living units of the facility that were viewed by this auditor during the on PREA during the first day and provided comprehensive PREA education on the seventh day of admission and on a regular basis during their stay at the facility. All residents interviewed stated they have been educated on PREA during their first day and provided comprehensive PREA education during the first 10 days. Each resident interviewed was knowledgeable of PREA standards, their rights not to be sexually abused or sexually harassed by staff or residents, how to make a report by telling a trusted staff, use a grievance form, call the hotline, or tell their parents. All residents were also provided with a Resident Handbook that has telephone numbers to report any sexual abuse or sexual harassment.

Reviewed documentation to determine compliance:

- Massachusetts DYS Policy and Procedures 01.05.07(c) - Preventing and Responding to Sexual Abuse, Sexual Exploitation and Sexual Harassment of Youth
- Pre-Audit Questionnaire
- PREA Brochures in English and Spanish
- Youth PREA Education Program Curriculum
- Posters for Reporting Sexual Abuse and Sexual Harassment in English and Spanish
- PREA Education and Comprehensive PREA Education Acknowledgement Forms
- Resident Handbook
- MOU with Interpreters and Translators Inc.
- Ten (10) youth files

Interviews:

- Interview with Facility PREA Compliance Manager
- Interview with Intake staff
- Interview with Clinical Director that provides PREA Education
- Interviews with ten (10) randomly selected residents
- Interviews with two (2) cognitively disabled residents
- Interview with one (1) LEP resident

Standard 115.334: Specialized training: Investigations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.334 (a)

- In addition to the general training provided to all employees pursuant to §115.31, does the agency ensure that, to the extent the agency itself conducts sexual abuse investigations, its investigators receive training in conducting such investigations in confinement settings? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).) ☒ Yes ☐ No ☐ NA

115.334 (b)

- Does this specialized training include techniques for interviewing sexual abuse victims? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).) ☒ Yes ☐ No ☐ NA

- Does this specialized training include proper use of Miranda and Garrity warnings? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).) ☒ Yes ☐ No ☐ NA

- Does this specialized training include sexual abuse evidence collection in confinement settings? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).) ☒ Yes ☐ No ☐ NA

- Does this specialized training include the criteria and evidence required to substantiate a case for administrative action or prosecution referral? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).) ☒ Yes ☐ No ☐ NA

115.334 (c)

- Does the agency maintain documentation that agency investigators have completed the required specialized training in conducting sexual abuse investigations? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).) ☒ Yes ☐ No ☐ NA

115.334 (d)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

a) The Department of Children and Families (DCF) is the state entity outside of the agency responsible for the investigation of all allegations of sexual abuse and sexual harassment. The Department of Children and Families has responsibility for investigation of all PREA related allegations and incidents."

b-d) The Department of Children and Families (DCF) is responsible for the investigation of all allegations of sexual abuse and sexual harassment at Paul T. Leahy Center. A representative from the Department of Children and Families (DCF) was interviewed and confirmed all investigators complete the PREA training. This training covers the topics of interviewing juvenile sexual abuse victims; proper use of Miranda and Garrity warnings; sexual abuse evidence collection in confinement settings; and the criteria and evidence required to substantiate a case for administrative action or prosecution referral.

DYS maintains that agency investigators have completed the required specialized training in conducting sexual abuse investigations. There are signed acknowledgment forms with their signatures.

In addition, the Agency PREA Coordinator and Facility Administrator were able to confirm all allegations of sexual abuse and sexual harassment are referred to Massachusetts State Police for investigation. There were no allegations of sexual abuse or sexual harassment during the past twelve (12) months at Paul T. Leahy Center. This was confirmed during interviews with the DYS Investigator and the DCF representative.

Reviewed documentation to determine compliance:

- Massachusetts DYS Policy and Procedures 01.05.07(c)
- MOU with the Massachusetts Department of Public Health
- Investigative Report

Interviews:

- Interview with Agency PREA Coordinator
- Interview with Facility Administrator
- Interview with representative from the Massachusetts Department of Public Health
- Interview with DYS Investigator
- Interview with DCF representative

Standard 115.335: Specialized training: Medical and mental health care

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.335 (a)

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in how to detect and assess signs of sexual abuse and sexual harassment? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.) ☒ Yes ☐ No ☐ NA

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in how to preserve physical evidence of sexual abuse? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.) ☒ Yes ☐ No ☐ NA

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in how to respond effectively and professionally to victims of sexual abuse and sexual harassment? (N/A if the agency does not

have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.) ☒ Yes ☐ No ☐ NA

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in how and to whom to report allegations or suspicions of sexual abuse and sexual harassment? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.) ☒ Yes ☐ No ☐ NA

115.335 (b)

- If medical staff employed by the agency conduct forensic examinations, do such medical staff receive appropriate training to conduct such examinations? (N/A if agency medical staff at the facility do not conduct forensic exams *or* the agency does not employ medical staff.) ☐ Yes ☐ No ☒ NA

115.335 (c)

- Does the agency maintain documentation that medical and mental health practitioners have received the training referenced in this standard either from the agency or elsewhere? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.) ☒ Yes ☐ No ☐ NA

115.335 (d)

- Do medical and mental health care practitioners employed by the agency also receive training mandated for employees by §115.331? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners employed by the agency.) ☒ Yes ☐ No ☐ NA

- Do medical and mental health care practitioners contracted by or volunteering for the agency also receive training mandated for contractors and volunteers by §115.332? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners contracted by or volunteering for the agency.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

a) Massachusetts DYS Policy and Procedures 01.05.07(c) require all full time and part time medical and mental health practitioners who work within DYS facilities shall be trained in no less than: detecting and assessing signs of sexual abuse and harassment; preserving physical evidence of sexual abuse; responding effectively and professionally to victims of sexual abuse and harassment; and how and to whom to report allegations or suspicions of sexual abuse and sexual harassment.

There are currently five (5) medical staff and six (6) mental health staff employed at Paul T. Leahy Center. Training records reviewed by this auditor confirmed all mental health staff at the facility completed the required specialized trainings. Medical and mental health staff confirmed they received the trainings and understood the material specific to their job title.

b) Paul T. Leahy Center does not conduct forensic examinations. In the event of an allegation of sexual abuse with penetration, forensic examinations are conducted at UMASS Memorial Hospital by SANE/SAFE. A Memorandum of Understanding (MOU) is in place with UMASS Memorial Hospital that confirms UMASS Memorial Hospital will provide a forensic rape examination conducted by a Sexual Assault Nurse Examiner (SANE) or other similarly credentialed examiner. This auditor was provided with a copy of the Memorandum of Understanding with UMASS Memorial Hospital to confirm compliance.

c) This auditor received and reviewed medical and mental health staff training records, training certificates, and sign off/acknowledgement forms at DYS. In addition, interviews with medical and mental health staff confirmed they had received and understood the specialized trainings they received specific to their job title.

d) As noted in the Massachusetts DYS Policy and Procedures 01.05.07(c), mental health staff also receive the PREA training all staff at the facility are required to complete on an annual basis. Medical and mental health staff interviewed were knowledgeable of the PREA standards and their roles regarding sexual abuse and sexual harassment prevention, detection, and response at Paul T. Leahy Center. This auditor was able to review medical and mental health staff training records to confirm they received and successfully completed the annual PREA training that all staff at Paul T. Leahy Center are required to complete. This was also confirmed during interviews with medical and mental health staff at the facility.

Reviewed documentation to determine compliance:

- Massachusetts DYS Policy and Procedures 01.05.07(c) – Preventing and Responding to Sexual Abuse, Sexual Exploitation and Sexual Harassment of Youth
- MOU with UMASS Memorial Hospital
- Employee Training Curriculum
- Documentation of PREA Training for Medical and Mental Health Staff

Interviews:

- Interview with DYS Investigator
- Interview with representative from UMASS Memorial Hospital
- Interview with Clinical Director
- Interview with Nurse Practitioner

SCREENING FOR RISK OF SEXUAL VICTIMIZATION AND ABUSIVENESS

Standard 115.341: Screening for risk of victimization and abusiveness

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.341 (a)

- Within 72 hours of the resident's arrival at the facility and periodically throughout the resident's confinement, are all residents assessed during an intake screening for their risk of being sexually abused by other residents or sexually abusive toward other residents? ☒ Yes ☐ No

- Are all residents assessed upon transfer to another facility for their risk of being sexually abused by other residents or sexually abusive toward other residents? ☒ Yes ☐ No

115.341 (b)

- Are all PREA screening assessments conducted using an objective screening instrument? ☒ Yes ☐ No

115.341 (c)

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: (1) Whether the resident has a mental, physical, or developmental disability? ☒ Yes ☐ No

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: (2) The age of the resident? ☒ Yes ☐ No

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: (3) The physical size and stature of the resident? ☒ Yes ☐ No

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: (3) The resident's level of emotional and cognitive development? ☒ Yes ☐ No

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: (4) Whether the resident has previously been incarcerated? ☒ Yes ☐ No

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: (5) The resident's current charges and offense history? ☒ Yes ☐ No

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: (7) Whether the resident is or is perceived to be gay, lesbian, bisexual, transgender, intersex, or gender nonconforming (the facility affirmatively asks the resident about his/her sexual orientation and gender identity AND makes a subjective determination based on the screener's perception whether the resident is gender non-conforming or otherwise may be perceived to be LGBTI)? ☒ Yes ☐ No

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: (8) Whether the resident has previously experienced sexual victimization? ☒ Yes ☐ No

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: (9) The resident's own perception of vulnerability? ☒ Yes ☐ No

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: (10) Any other specific information about individual residents that may indicate heightened needs for supervision, additional safety precautions, or separation from certain other residents? ☒ Yes ☐ No

115.341 (e)

- Has the agency implemented appropriate controls on the dissemination within the facility of responses to questions asked pursuant to this standard in order to ensure that sensitive information is not exploited to the resident's detriment by staff or other residents? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

a) The Massachusetts DYS Policy and Procedures 01.05.07(c) - Preventing and Responding to Sexual Abuse, Sexual Exploitation and Sexual Harassment of Youth and DYS Policy and Procedures 03.01.04 – Searches in Community Programs address the standards related to screening youth for risk of victimization and abusiveness. These address the use of the Vulnerability Assessment Instrument: Risk of Victimization and/or Sexually Aggressive Behavior in that it is administered within seventy-two

(72) hours of intake to obtain information about each resident's personal history and behavior to reduce the risk of sexual abuse by or towards a resident, and every six (6) months throughout a resident's placement. The two practices utilized by DYS far exceed the seventy-two (72) hours allocated to the standard. Youth are administered the "Dialogue Tree" immediately upon admission by intake staff. Within twenty-four (24) hours, but usually the day of admission, clinical staff perform the full screening of youth using the Vulnerability Assessment Instrument.

The policy states that the results of the Vulnerability Assessment (VAI) are utilized when making bed assignments and determining the appropriate level of supervision necessary.

This auditor discussed the Vulnerability Assessment Instrument (VAI) with a staff who completes the form and the Facility PREA Compliance Manager. The Vulnerability Assessment Instrument (VAI) is completed by a clinician upon intake. Residents are reassessed periodically (a minimum of every 6 months) after the initial screening by clinical staff. All staff interviewed were aware this screening is used to protect residents from sexual abuse while being housed at Paul T. Leahy Center.

During the past 12 months, there were 284 residents admitted to Paul T. Leahy Center whose length of stay in the facility was for 72 hours or longer. All Paul T. Leahy Center residents admitted to the facility were screened for risk of sexual victimization or risk of sexually abusing other residents upon intake by being administered the Vulnerability Assessment Instrument. This auditor was able to confirm the Vulnerability Assessment Instrument is completed upon intake by interviewing a clinician who completes the assessment and by reviewing the database that logs the Vulnerability Assessment Instrument with the Facility PREA Compliance Manager.

Interviews with residents confirmed the Vulnerability Assessment Instrument (VAI) is completed as noted in the above-mentioned policy as all residents interviewed stated they were asked questions when they first arrived as to whether they had ever been sexually abused, if they had any disabilities, or if they were fearful of sexual abuse while at Paul T. Leahy Center. Ten (10) resident files were reviewed for documentation verifying the risk assessments were being completed as per the above-mentioned policy. All the files reviewed had the above-mentioned screening (VAI) completed within 72 hours of intake and periodically throughout the resident's stay at the facility. This auditor did review six-months of reassessments of five (5) residents that were interviewed and had been in the facility from six months to two years. All residents stated that the clinician met with them and conducted the risk assessments several times. This was verified by reviewing the residents' files in JJEMS.

b) The Vulnerability Assessment Instrument (VAI) is an objective screening assessment commonly used to conduct risk assessments of each resident upon admission to the facility and periodically throughout their stay at the facility. The Clinical Director, who competes the VAI, was interviewed and understood how to administer this screening and was aware of its importance in keeping residents safe from sexual abuse. The Clinical Director interviewed was able to explain how he reviews case history notes and behavior records of the resident prior to intake and then administers the VAI to the resident by completing a one-on-one interview during the intake process.

c) The Vulnerability Assessment Instrument attempts to ascertain information about: prior sexual victimization or abusiveness; any gender non-conforming appearance or manner of identification as lesbian, gay, bisexual, transgender, or intersex, and whether the youth may therefore be vulnerable to sexual abuse; current charges and offense history; age; level of emotional and cognitive development; physical size and stature; mental illness or mental disabilities; physical disabilities; the youth's own perception of vulnerability; and any other specific information about the individual youth that may indicate needs for heightened supervision, additional safety precautions, or separation from certain other youth.

This auditor was able to review the VAI that is used to screen residents at Paul T. Leahy Center and confirms this tool captures the information required in this standard. A review of all resident files confirmed

the VAI is being completed within 72 hours of intake and periodically throughout the resident's stay at Paul T. Leahy Center after the initial screening is completed.

d) Interviews with the Facility PREA Compliance Manager and Clinical Director revealed that clinicians interview each resident face to face upon admission. Each resident is then reassessed periodically throughout their stay by a clinical staff. It was noted that the initial screening is completed during the resident's intake on their first day at the facility (no later than 72 hours after their admission). During an interview, the Clinical Director that completes the VAI also stated he uses case history notes and behavioral record when completing the initial VAI during intake.

e) All completed VAIs are securely kept in a statewide database known as JJEMS and the only persons with access are clinicians and administrative staff at Paul T. Leahy Center. All pertinent necessary information is recorded and communicated to staff for housing and bedroom assignments or additional supervision purposes only to ensure sensitive information is not exploited to the resident's detriment by staff or other residents. During an interview with the Facility PREA Compliance Manager, this auditor was able to view the database to confirm confidentiality of the documents. In addition, interviews with staff confirmed all pertinent information is communicated to them verbally and via log entries to ensure all staff are aware of any precautions implemented to protect the resident(s) at the facility.

Reviewed documentation to determine compliance:

- Massachusetts DYS Policy and Procedures 01.05.07(c) - Preventing and Responding to Sexual Abuse, Sexual Exploitation and Sexual Harassment of Youth
- Massachusetts DYS Policy 03.01.04 – Searches in Community Program
- Pre-Audit Questionnaire
- Vulnerability Assessment Instrument: Risk of Victimization and/or Sexually Aggressive Behavior
- Completed Vulnerability Assessment Instruments for ten (10) residents
- Six-month Reassessment
- Review of ten (10) resident files

Interviews:

- Interview with Facility PREA Compliance Manager
- Interview with Clinical Director that perform the screening for risk of victimization and abusiveness
- Interviews with ten (10) randomly selected residents

Standard 115.342: Use of screening information

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.342 (a)

- Does the agency use information from the risk screening required by § 115.41, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Housing Assignments? ☒ Yes ☐ No

- Does the agency use information from the risk screening required by § 115.41, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Bed assignments? ☒ Yes ☐ No

- Does the agency use information from the risk screening required by § 115.41, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Work Assignments? ☒ Yes ☐ No

- Does the agency use information from the risk screening required by § 115.41, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Education Assignments? ☒ Yes ☐ No

- Does the agency use information from the risk screening required by § 115.41, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Program Assignments? ☒ Yes ☐ No

115.342 (b)

- Does the agency isolate residents from others only as a last resort when less restrictive measures are inadequate to keep them and other residents safe, and then only until an alternative means of keeping all residents safe can be arranged? ☒ Yes ☐ No
- During any period of isolation, does the agency refrain from denying residents daily large-muscle exercise and any legally required educational programming or special education services? ☒ Yes ☐ No
- Does the agency allow residents in isolation to receive daily visits from a medical or mental health care clinician? ☒ Yes ☐ No
- Does the agency allow residents access to other programs and work opportunities to the extent possible? ☒ Yes ☐ No

115.342 (c)

- Does the agency house lesbian, gay bisexual, transgender, or intersex residents solely on the basis of such identification or status? ☒ Yes ☐ No
- Does the agency consider lesbian, gay, bisexual, transgender, or intersex identification or status as an indicator of likelihood of being sexually abuse? ☒ Yes ☐ No

115.342 (d)

- When deciding whether to assign a transgender or intersex resident to a facility for male or female residents, does the **agency** consider, on a case-by-case basis whether a placement would ensure the resident's health and safety, and whether a placement would present management or security problems (NOTE: if an agency by policy or practice assigns residents to a male or female facility on the basis of anatomy alone, that agency is not in compliance with this standard)? ☒ Yes ☐ No

- When making housing or other program assignments for transgender or intersex residents, does the agency consider on a case-by-case basis whether a placement would ensure the

resident's health and safety, and whether a placement would present management or security problems? ☒ Yes ☐ No

115.342 (e)

- Are placement and programming assignments for each transgender or intersex resident reassessed at least twice each year to review any threats to safety experienced by the resident? ☒ Yes ☐ No

115.342 (f)

- Are each transgender or intersex resident's own views with respect to his or her own safety given serious consideration when making facility and housing placement decisions and programming assignments? ☒ Yes ☐ No

115.342 (g)

- Are transgender and intersex residents given the opportunity to shower separately from other residents? ☒ Yes ☐ No

115.342 (h)

- If residents are isolated pursuant to 115.342(b), does the facility clearly document: (1) The basis for the facility's concern for the resident's safety; and (2) The reason why no alternative means of separation can be arranged? ☒ Yes ☐ No

115.342 (i)

- Every 30 days, does the facility afford each resident described in paragraph (h) of this section a review to determine whether there is a continuing need for separation from the general population? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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The Massachusetts DYS Policy and Procedures 01.05.07(c) - Preventing and Responding to Sexual Abuse, Sexual Exploitation and Sexual Harassment of Youth, Treatment Plans, and DYS Policy and

Procedures 03.04.09 – Prohibition of Harassment and Discrimination Against Youth pertain to screening/assessing residents at intake states that a member of the clinical team will obtain information about each resident's personal history and behavior to reduce the risk of sexual abuse by or to a resident and their behavior will be evaluated throughout their stay. Housing/room decisions for each youth will be based on the risks determined by the intake screen and Assessment Instrument, as well as any information ascertained through conversations during the intake process and medical and mental health screenings with the goal of keeping all residents safe and free from sexual abuse.

a. Lesbian, gay, bisexual, transgender, or intersex residents shall not be placed in a particular housing, bed, or other assignments solely on the basis of such identification or status, nor shall agencies consider lesbian, gay, bisexual, transgender, or intersex identification or status as an indicator of likelihood of being sexually abusive.
b. All housing placements will be made with the sole intention of ensuring the resident's health and safety.
c. Transgender or Intersex resident's safety evaluation shall be reassessed at a minimum of every six (6) months (twice each year) to review any threats to safety and each transgender or intersex's own views, with respect to his or her own safety, shall be given serious consideration.
d. Transgender or Intersex residents shall follow the DYS, Inc. -Providing Non-Discriminatory Services to LGBT Residents Policy operating procedures regarding showering separately.

Isolation is not practiced and is prohibited by DYS and was not used during the past twelve (12) months.

a) Massachusetts DYS Policy and Procedures 02.02.01(b) – Treatment Plans require that youth at Paul T. Leahy Center are screened for potential vulnerabilities to victimize others with sexually aggressive behavior upon arrival/intake. This screening will be documented using the Vulnerability Assessment Instrument and entered into JJEMS within 72 hours of admission. Living unit and room assignments must be made accordingly.

Interviews with the Facility Administrator and the Clinical Director confirmed the Vulnerability Assessment Instrument is completed by the clinical therapist within 72 hours of intake and living units and bedroom assignments are made accordingly to keep all residents at Paul T. Leahy Center free from sexual abuse and sexual harassment. Both were able to discuss how the Vulnerability Assessment Instrument (VAI) is used to place all residents in appropriate living units and bedroom assignments to ensure residents are kept safe at all times.

A review of the Vulnerability Assessment Instrument (VAI) supported this policy. Residents confirmed through interviews that screenings are being administered as per policy. Any residents who were identified as sexually vulnerable from the information noted on the VAI, had a Safety Plan developed for them and communicated to all staff to keep them safe at Paul T. Leahy Center. There were no residents residing at Paul T. Leahy Center that were deemed to be sexually aggressive during the on-site portion of this audit. Safety Plans included increased supervision during waking hours.

b) The Massachusetts DYS Policy and Procedures 03.03.01(a) – Involuntary Room Confinement require that residents only be isolated from others only as a last resort when less restrictive measures are inadequate to keep them and other residents safe, and then only until an alternative means of ensuring residents' safety can be arranged. During any period of isolation, Paul T. Leahy Center shall not deny residents daily large muscle exercise and are legally required educational programming or special education services. Residents that are isolated shall receive daily visits from a medical and/or mental health provider. Isolation, as it relates to this standard, is not authorized under DYS Policy, and was not used during this audit period. Involuntary room confinements, as isolation referred to in DYS is not authorized for the purposes described in this standard.

It was documented on the PAQ that there were no residents in isolation during the past 12 months at Paul T. Leahy Center. Interviews with the Facility Administrator and the Clinical Director confirmed Paul T. Leahy

Center has not used isolation to protect any resident at risk for sexual victimization during the past 12 months as the use of isolation is prohibited in DYS. During the four of the facility, this auditor did not notice any areas where a resident could be isolated.

c) The Massachusetts DYS Policy and Procedures 03.04.09 – Prohibition of Harassment and Discrimination Against Youth states that lesbian, gay, transgender, bisexual, or intersex youth shall not be placed in a particular housing, bed, or other assignments solely on the basis of such identification, or status, nor shall DYS consider lesbian, gay, transgender, bisexual, transgender, or intersex identification or status as an indicator of likelihood of being sexually abusive."

There were no residents residing at Paul T. Leahy Center who identified as LGBTI during the time of the on-site portion of this audit. Interviews with the Facility Administrator and Clinical Director confirmed that under no circumstance would a resident be placed in a specific bedroom based solely on their sexual identification. The Clinical Director stated residents are placed in appropriate living units and bedrooms by using the results from the Vulnerability Assessment Instrument to ensure safety.

d) The Massachusetts DYS Policy and Procedures 03.04.09 – Prohibition of Harassment and Discrimination Against Youth states that in reaching a determination of whether to assign a transgender or intersex youth to a facility for male residents, as well as making other housing and programing assignments, Paul T. Leahy Center must consider on a case-by-case basis whether the placement would ensure the resident's health and safety, and whether the placement would present programmatic management and/or security problems.

There were no transgender residents admitted to Paul T. Leahy Center during the past 12 months. An interview with the Facility PREA Compliance Manager and the Pre-Audit Questionnaire confirmed that there were no transgender residents admitted at Paul T. Leahy Center in the past 12 months.

e) The Massachusetts DYS Policy and Procedures 03.04.09 – Prohibition of Harassment and Discrimination Against Youth states, "Placement and programming for transgender and intersex youth must be reassessed at least twice a year or sooner if a complaint has been made, to review any threat to safety experienced by the youth."

There were no transgender residents admitted to Paul T. Leahy Center during the past 12 months. Therefore, there were no transgender or intersex residents to interview.

f) The Massachusetts DYS Policy and Procedures 03.04.09 – Prohibition of Harassment and Discrimination Against Youth states, "Transgender and intersex youth's own views with respect to their own safety must be given serious consideration."

g) The Massachusetts DYS Policy and Procedures 03.04.09 – Prohibition of Harassment and Discrimination Against Youth states, "Transgender and youth must be given the opportunity to shower separately from other youth."

There were no transgender residents admitted to Paul T. Leahy Center during the past 12 months. Interviews with the Facility PREA Compliance Manager and staff confirmed any transgender resident residing in the facility would be given the opportunity to shower separately from the other residents. All staff interviewed stated that all residents in the facility shower separately as only one resident is permitted to use the restroom at a time to shower. The bathroom is a single user bathroom, with one (1) shower, one (1) toilet and one (1) sink. When the resident enters the bathroom, the staff close the door which locks from the outside. When the resident is finished using the bathroom they knock on the door and staff unlock the door for them from the outside. Staff monitor this area from the hallway. This practice was observed by this auditor during the tour of the facility.

h-i) The Massachusetts DYS Policy and Procedures 03.03.01(a) says that residents may be isolated from others only as a last resort when less restrictive measures are inadequate to keep them and other residents safe, and then only until an alternative means of ensuring residents' safety can be arranged.

- The basis for the facility's concern for the resident's safety;
- The reason why no alternative means of separation can be arranged."

There were no residents at Paul T. Leahy Center who were at risk of sexual victimization held in isolation during the past 12 months. The use of isolation is prohibited by DYS. Therefore, there was no documentation for this auditor to review.

Reviewed documentation to determine compliance:

- Massachusetts DYS Policy and Procedures 02.02.01(b) – Treatment Plans
- Massachusetts DYS Policy and Procedures 03.03.01(a) – Involuntary Room Confinement
- Massachusetts DYS Policy and Procedures 03.04.09 – Prohibition of Harassment and Discrimination Against Youth
- Vulnerability Assessment of ten (10) residents
- Housing Log
- Review of 10 resident files
- Tour of facility

Interviews:

- Interview with Agency PREA Coordinator
- Interview with Facility Administrator
- Interview with Assistant Program Director
- Interview with Facility PREA Compliance Manager
- Interview with Clinical Director who conduct risk screening
- Interviews with ten (10) randomly selected residents

REPORTING

Standard 115.351: Resident reporting

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.351 (a)

- Does the agency provide multiple internal ways for residents to privately report sexual abuse and sexual harassment? ☒ Yes ☐ No

- Does the agency provide multiple internal ways for residents to privately report retaliation by other residents or staff for reporting sexual abuse and sexual harassment? ☒ Yes ☐ No

- Does the agency provide multiple internal ways for residents to privately report staff neglect or violation of responsibilities that may have contributed to such incidents? ☒ Yes ☐ No

115.351 (b)

- Does the agency also provide at least one way for residents to report sexual abuse or sexual harassment to a public or private entity or office that is not part of the agency? ☒ Yes ☐ No

- Is that private entity or office able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials? ☒ Yes ☐ No

- Does that private entity or office allow the resident to remain anonymous upon request? ☒ Yes ☐ No

- Are residents detained solely for civil immigration purposes provided information on how to contact relevant consular officials and relevant officials at the Department of Homeland Security? (N/A if the facility *never* houses residents detained solely for civil immigration purposes) ☐ Yes ☐ No ☒ NA

115.351 (c)

- Does staff accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously, and from third parties? ☒ Yes ☐ No

- Does staff promptly document any verbal reports of sexual abuse and sexual harassment? ☒ Yes ☐ No

115.351 (d)

- Does the agency provide a method for staff to privately report sexual abuse and sexual harassment of residents? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

a) Massachusetts DYS Policy and Procedures 01.05.07(c) - Preventing and Responding to Sexual Abuse, Sexual Exploitation and Sexual Harassment of Youth has established procedures for allowing multiple internal methods for residents to privately report sexual abuse and/or sexual harassment, retaliation by other residents or staff for reporting sexual abuse and sexual harassment and/or staff neglect or violation of responsibilities that may have contributed to such incidents. These methods include but are not limited to:

1. Direct reporting to an employee, educational staff, or contracted entity;
2. Private reporting to a public or private entity, or an office that is not part of the agency;
3. The grievance process;
4. Parents

Reporting information is delivered to the residents through the intake process, Resident Handbook, PREA pamphlets, and posters. Numerous posters (in both English and Spanish) were observed throughout the facility by this auditor during the tour. These posters highlighted the various ways residents and staff can report incidents of sexual abuse and sexual harassment.

Interviews with residents confirmed they were educated on how to report allegations of sexual abuse, sexual harassment, retaliation, and neglect. All residents interviewed were able to note several ways to report allegations to facility staff, administrative staff, the DCF Child at Risk Hotline, their parents, POs, or attorneys.

b) Massachusetts DYS Policy and Procedures 01.05.07(c) - Preventing and Responding to Sexual Abuse, Sexual Exploitation and Sexual Harassment of Youth states that DYS shall provide at least one method for residents to report sexual abuse and/or sexual harassment to a public or private entity or office that is not part of DYS and that is able to receive and immediately forward resident reports of sexual abuse and/or sexual harassment to DYS officials allowing the resident to remain anonymous upon request. These methods include, but are not limited to:

1. Private reporting to a public or private entity, or an office that is not part of the agency;
2. Staff shall provide residents with access to call the DCF Child at Risk Hotline upon request.

Reporting information is delivered to the residents through the intake process, Resident Handbook, PREA pamphlets, and posters. Numerous posters (in both English and Spanish) were observed throughout the facility by this auditor during the tour. These posters highlighted the various ways residents and staff can report incidents of sexual abuse and sexual harassment.

In addition, the pamphlets at Paul T. Leahy Center were reviewed by this auditor and they contained telephone numbers and addresses for residents to report allegations of sexual abuse and sexual harassment to offices outside of the facility. In this case, the pamphlets contain the toll-free telephone numbers and addresses to Rape Crisis Centers, DFC Child at Risk Hotline (1-800-792-5200).

The primary reporting mechanism is to an outside agency, DFC Child at Risk Hotline. This allows for receipt of the report and transmission to the facility anonymously if requested. Prior to the on-site visit, this auditor did a telephone interview with a representative from the Department of Children and Families (DCF) and she confirmed the services. This reporting method is posted throughout the facility.

There were no current residents that reported sexual abuse or sexual harassment while at Paul T. Leahy Center. This was confirmed by this auditor during interviews with the DYS Investigator and DCF representative.

All residents interviewed were aware of their right to contact outside agencies including DCF. Residents interviewed also confirmed they received this information through posters in their living units and around the facility, PREA pamphlets, and PREA education received at intake.

There were no residents placed at Paul T. Leahy Center solely for civil immigration purposes. However, during interviews with agency management, it was determined they would provide these residents information on how to contact consular officials and relevant officials at the Department of Homeland Security to report sexual abuse and/or sexual harassment.

c) Massachusetts DYS Policy and Procedures 01.05.07(c) - Preventing and Responding to Sexual Abuse, Sexual Exploitation and Sexual Harassment of Youth states, “Staff shall accept reports made verbally, in writing, anonymously and from third parties. These reports shall be immediately processed according to child abuse regulations.”

Staff interviewed were knowledgeable of the various ways residents and staff can report incidents of sexual abuse, sexual harassment, or retaliation. In addition, staff interviewed stated they would immediately document a verbal report by notifying their supervisor and contacting DCF hotline immediately to report the allegation.

d) Massachusetts DYS Policy and Procedures 01.05.07(c) requires DYS to provide residents with access to tools necessary to create a written report. There shall be grievance forms located in all common areas to allow the residents to create written reports.

Youth also have the option of reporting allegations to DCF hotline via their respective toll-free numbers posted on all living units. Additionally, youth, their families, and the public have the ability to report allegations outside the agency/facility via the toll-free number for DCF Child at Risk Hotline.

Interviews with residents confirmed they are educated on ways to report allegations of sexual abuse or sexual harassment upon intake into the facility. In addition, the residents were able to note ways they could report allegations of sexual harassment, sexual abuse, and retaliation to DCF Child at Risk Hotline either in writing or by calling the toll-free telephone numbers listed in their Resident Handbook, PREA pamphlets, and on posters throughout the facility. Residents also stated that they could tell a staff they trust, use the grievance form, or tell their family. Staff interviewed also understood the ways a resident can privately report allegations of sexual harassment, sexual abuse, and retaliation.

e)Massachusetts DYS Policy and Procedures 01.05.07(c) states staff shall provide the ability to privately report sexual abuse and/or sexual harassment of residents.

There is a PREA box located in the front entrance as well as outside of the visiting room for parents to submit forms pertaining to any abuse allegation. Forms are available in English and Spanish. The box is checked on a daily basis. The box is accessible to staff, visitors, and contractors. There are also PREA boxes on each residential unit, dining room, and educational floor for residents, staff, volunteers, and contractors.

Interviews with staff confirmed they are aware that they are permitted to privately report allegations of sexual abuse and sexual harassment. All staff interviewed stated they could report the allegation to an administrative staff at the facility or by reporting the allegation to DCF Child at Risk Hotline via the toll-free hotline.

Reviewed documentation to determine compliance:

- Massachusetts DYS Policy and Procedures 01.05.07(c) - Preventing and Responding to Sexual Abuse, Sexual Exploitation and Sexual Harassment of Youth
- Massachusetts DYS Policy and Procedures 03.04.01 – Youth Grievance Process
- Massachusetts DYS Policy and Procedures 03.04.04(c) – Residential Visitation Policy Incorporating Family Engagement Principles

- Pre-Audit Questionnaire
- Resident Handbook in Spanish and English
- Mandated Reporter Training Curriculum
- Telephone Policy
- Posters in facility in English and Spanish
- MOU with Central Region Rape Crisis Center

Interviews:

- Interview with Facility Administrator
- Interview with Facility Compliance Manager
- Interview with DYS Investigator
- Interview with DCF representative
- Interviews with twelve (12) randomly selected staff
- Interviews with ten (10) randomly selected residents

Standard 115.352: Exhaustion of administrative remedies

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.352 (a)

- Is the agency exempt from this standard? NOTE: The agency is exempt ONLY if it does not have administrative procedures to address resident grievances regarding sexual abuse. This does not mean the agency is exempt simply because an resident does not have to or is not ordinarily expected to submit a grievance to report sexual abuse. This means that as a matter of explicit policy, the agency does not have an administrative remedies process to address sexual abuse. ☒ Yes ☐ No

115.352 (b)

- Does the agency permit residents to submit a grievance regarding an allegation of sexual abuse without any type of time limits? (The agency may apply otherwise-applicable time limits to any portion of a grievance that does not allege an incident of sexual abuse.) (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- Does the agency always refrain from requiring a resident to use any informal grievance process, or to otherwise attempt to resolve with staff, an alleged incident of sexual abuse? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

115.352 (c)

- Does the agency ensure that: A resident who alleges sexual abuse may submit a grievance without submitting it to a staff member who is the subject of the complaint? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- Does the agency ensure that: Such grievance is not referred to a staff member who is the subject of the complaint? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

115.352 (d)

- Does the agency issue a final agency decision on the merits of any portion of a grievance alleging sexual abuse within 90 days of the initial filing of the grievance? (Computation of the 90-day time period does not include time consumed by residents in preparing any administrative appeal.) (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- If the agency claims the maximum allowable extension of time to respond of up to 70 days per 115.52(d)(3) when the normal time period for response is insufficient to make an appropriate decision, does the agency notify the resident in writing of any such extension and provide a date by which a decision will be made? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- At any level of the administrative process, including the final level, if the resident does not receive a response within the time allotted for reply, including any properly noticed extension, may an resident consider the absence of a response to be a denial at that level? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

115.352 (e)

- Are third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, permitted to assist residents in filing requests for administrative remedies relating to allegations of sexual abuse? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- Are those third parties also permitted to file such requests on behalf of residents? (If a third-party files such a request on behalf of an resident, the facility may require as a condition of processing the request that the alleged victim agree to have the request filed on his or her behalf, and may also require the alleged victim to personally pursue any subsequent steps in the administrative remedy process.) (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- If the resident declines to have the request processed on his or her behalf, does the agency document the resident's decision? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- Are parents or legal guardians of a juvenile allowed to file grievances regarding allegations of sexual abuse, including appeals, on behalf of residents? ☒ Yes ☐ No

- Are such grievances conditioned upon the juvenile agreeing to have the request filed on his or her behalf? ☒ Yes ☐ No

115.352 (f)

- Has the agency established procedures for the filing of an emergency grievance alleging that an resident is subject to a substantial risk of imminent sexual abuse? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- After receiving an emergency grievance alleging an resident is subject to a substantial risk of imminent sexual abuse, does the agency immediately forward the grievance (or any portion thereof that alleges the substantial risk of imminent sexual abuse) to a level of review at which immediate corrective action may be taken? (N/A if agency is exempt from this standard.). ☒ Yes ☐ No ☐ NA

- After receiving an emergency grievance described above, does the agency provide an initial response within 48 hours? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- After receiving an emergency grievance described above, does the agency issue a final agency decision within 5 calendar days? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- Does the initial response and final agency decision document the agency's determination whether the resident is in substantial risk of imminent sexual abuse? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- Does the initial response document the agency's action(s) taken in response to the emergency grievance? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- Does the agency's final decision document the agency's action(s) taken in response to the emergency grievance? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

115.352 (g)

- If the agency disciplines a resident for filing a grievance related to alleged sexual abuse, does it do so ONLY where the agency demonstrates that the resident filed the grievance in bad faith? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

a-h) Massachusetts DYS Policy and Procedures 03.04.01 – Youth Grievance Process complies fully with this standard. There were no incidents of sexual abuse, sexual harassment, or retaliation filed using the grievance process in the past twelve (12) months. No grievances by third parties were filed alleging sexual

abuse, harassment, or retaliation. The policy requires that grievances can be used to report sexual abuse or harassment, but residents are not required to use a grievance. If they do, they can do so without having to submit or refer to the staff involved in the grievance. Residents cannot be disciplined for filing a grievance. The policy contains all necessary provisions and timelines. I reviewed ten (10) resident files, and all contained notification of the grievance process.

PREA pamphlets describe various ways a resident can report sexual abuse and sexual harassment. Each resident receives a copy of these pamphlets at intake and a clinician/intake worker reviews these pamphlets during the intake process with each resident. The grievance process is not listed as a formal mechanism to report sexual abuse or sexual harassment in either of these pamphlets.

All residents interviewed were aware of the grievance procedure. All the resident files reviewed contained notification of the grievance process. In addition, all staff interviewed could describe the steps they would take to protect a resident from imminent sexual abuse. These steps included separating the alleged victim from the alleged aggressor, increasing supervision, contacting their supervisor and documenting the threats in writing.

There were no grievances filed by third parties alleging sexual abuse, sexual harassment, or retaliation at Paul T. Leahy Center during the past 12 months. This was confirmed by reviewing resident files and grievance records with the Facility PREA Compliance Manager during the on-site portion of this audit.

Reviewed documentation to determine compliance:

- Massachusetts DYS Policy and Procedures 03.04.01 – Youth Grievance Process
- Pre-Audit Questionnaire
- Resident Handbook
- Facility grievance records
- Grievance form in Spanish and English
- Files of ten (10) residents

Interviews:

- Interview with Facility PREA Compliance Manager
- Interviews with twelve (12) randomly selected staff
- Interviews with ten (10) randomly selected residents

Standard 115.353: Resident access to outside confidential support services

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.353 (a)

- Does the facility provide residents with access to outside victim advocates for emotional support services related to sexual abuse by giving residents mailing addresses and telephone numbers, including toll-free hotline numbers where available, of local, State, or national victim advocacy or rape crisis organizations? ☒ Yes ☐ No

- Does the facility provide persons detained solely for civil immigration purposes mailing addresses and telephone numbers, including toll-free hotline numbers where available of local, State, or national immigrant services agencies? (N/A if the facility *never* has persons detained solely for civil immigration purposes.) ☐ Yes ☐ No ☒ NA

- Does the facility enable reasonable communication between residents and these organizations and agencies, in as confidential a manner as possible? ☒ Yes ☐ No

115.353 (b)

- Does the facility inform residents, prior to giving them access, of the extent to which such communications will be monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws? ☒ Yes ☐ No

115.353 (c)

- Does the agency maintain or attempt to enter into memoranda of understanding or other agreements with community service providers that are able to provide residents with confidential emotional support services related to sexual abuse? ☒ Yes ☐ No

- Does the agency maintain copies of agreements or documentation showing attempts to enter into such agreements? ☒ Yes ☐ No

115.353 (d)

- Does the facility provide residents with reasonable and confidential access to their attorneys or other legal representation and reasonable access to parents or legal guardians? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

a) Massachusetts DYS Policy and Procedures 01.05.07(c) - Preventing and Responding to Sexual Abuse, Sexual Exploitation and Sexual Harassment of Youth ; DYS Policy an Procedures 03.04.04(c) – Residential Visitation Policy Incorporating Family Engagement Principles state that residents will be provided access to outside support services and legal representation related to sexual abuse, by providing, posting, or otherwise making accessible mailing addresses and telephone numbers of local, state, and/or national victim advocacy organizations. DYS shall enable reasonable communication between residents and these organizations and agencies, in as confidential a manner as possible."

PREA pamphlets contain telephone numbers and addresses for victim advocates from a rape crisis center. All residents receive a copy of these pamphlets at intake. In addition to residents receiving a copy of the above-mentioned pamphlets, there are numerous posters posted around the facility with telephone numbers and addresses to Central Region Rape Crisis Center. This information is available in both English and Spanish and was reviewed by this auditor and noted during the tour of the facility. Paul T. Leahy Center also has a Memorandum of Agreement with Central Region Rape Crisis Center. This Memorandum of Agreement states Central Region Rape Crisis Center will provide any victim of sexual abuse a victim advocate.

Interviews with residents confirmed they are educated and aware of the services that are available to them in the event they are a victim of sexual assault at Paul T. Leahy Center.

b) Most of the residents interviewed were aware of the services available to them from Central Region Rape Crisis Center in the event they are a victim of sexual abuse. Residents interviewed also stated they were educated that any correspondence with Central Region Rape Crisis Center is confidential and private. In addition, the residents understood the responsibility of the victim advocate to report new information of sexual abuse to the authorities as they are mandated to report that information. Residents noted during interviews this information is provided to them during their intake, is noted in pamphlets they receive during their intake into the facility and is posted throughout the facility. A few residents, during their interview, pointed out the posters with the Central Region Rape Crisis Center telephone number.

There were no allegations of sexual abuse or sexual harassment at during the past 12 months. This was confirmed during interviews with the DYS Investigator and the Facility PREA Compliance Manager.

c) Paul T. Leahy Center has a MOU with Central Region Rape Crisis Center and the services they offer through the Massachusetts Department of Public Health. The MOU was reviewed; and this auditor spoke to a representative via telephone prior to the on-site audit. She confirmed the services offered in MOU.

A Memorandum of Agreement is in place with Central Region Rape Crisis Center in accordance with this standard. The Memorandum of Agreement confirms each party's responsibilities regarding this standard. The Agency PREA Coordinator and the Facility PREA Compliance Manager both describe this Memorandum of Agreement and the services that are provided by Central Region Rape Crisis Center (to provide advocacy services to any victims of assault at Paul T. Leahy Center.

d) Visitation and contact with legal representation and family members is outlined in the Visitation Policy. Paul T. Leahy Center provides residents with reasonable and confidential access to their attorneys and/or legal representation as well as parents or legal guardians. Attorneys can also visit whenever it is convenient for them to do so, and these visits/conversations would be in a private setting. Parents or legal guardians are permitted to visit on a weekly basis and residents also receive telephone calls to family members on a weekly basis. All residents interviewed stated they receive weekly telephone calls to their families and weekly visits (if the family is able to visit). Some of the residents stated that they have received visits from their attorney as well as received phone calls from them. They said they are offered a private office to meet with them and have privacy during their phone call. All of the residents stated that they have received family visits and speak to their family on a regular basis.

Reviewed documentation to determine compliance:

- Massachusetts DYS Policy and Procedures 01.05.07(c) - Preventing and Responding to Sexual Abuse, Sexual Exploitation and Sexual Harassment of Youth
- Massachusetts DYS Policy and Procedures 03.04.04(c) – Resident Visitation Policy Incorporating Family Engagement Principles
- Pre-Audit Questionnaire

- Telephone and Visitation Policy
- MOU with Massachusetts Department of Public Health
- MOU with Central Region Rape Crisis Center
- Resident Handbook
- English and Spanish PREA posters in the facility
- Resident PREA Brochures

Interviews:

- Interview with the Agency PREA Coordinator
- Interview with the Program Director
- Interview with Facility PREA Compliance Manager
- Interview with DYS Investigator
- Interviews with twelve (12) randomly selected staff
- Interviews with ten (10) randomly selected residents
- Interview with representative from the Central Region Rape Crisis Center

Standard 115.354: Third-party reporting

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.354 (a)

- Has the agency established a method to receive third-party reports of sexual abuse and sexual harassment? ☒ Yes ☐ No

- Has the agency distributed publicly information on how to report sexual abuse and sexual harassment on behalf of a resident? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

a) Massachusetts DYS Policy and Procedures 01.05.07(c) - Preventing and Responding to Sexual Abuse, Sexual Exploitation and Sexual Harassment of Youth describes multiple methods used to receive third party reports of sexual abuse or sexual harassment and is posted on the agency's website to inform the public about reporting resident sexual abuse and sexual harassment on behalf of residents. Third party reports can also be made to any staff, the Facility Administrator, DCF Hotline, attorneys, or parents.

This auditor was able to review the agency's website and confirm multiple methods to file a third-party report are posted on the website. In addition to being posted on the agency website, multiple methods to file a third-party report are posted in the visiting area of the facility and were observed by this auditor during the tour of the facility. There is a PREA box located at the entrance and one in the visiting room for parents, visitors, staff, and contractors, as well as one on each resident unit, dining room, and school floor for residents.

Interviews with residents confirmed they are aware of who third parties are. They were also aware that these individuals can report allegations or incidents of sexual abuse or sexual harassment on their behalf. 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. Staff interviewed noted they would document the allegation and report the allegation to DCF Hotline for investigation.

There were no allegations of sexual abuse or sexual harassment filed by a third party at Paul T. Leahy Center during the past 12 months. This was confirmed during interviews with the Facility Administrator and DYS Investigator.

Reviewed documentation to determine compliance:

- Massachusetts DYS Policy and Procedures 01.05.07(c) - Preventing and Responding to Sexual Abuse, Sexual Exploitation and Sexual Harassment of Youth
- Pre-Audit Questionnaire
- DYS public website
- PREA posters
- PREA boxes

Interviews:

- Interview with Facility Administrator
- Interview with DYS Investigator
- Interviews with twelve (12) randomly selected staff
- Interviews with ten (10) randomly selected residents

OFFICIAL RESPONSE FOLLOWING AN RESIDENT REPORT

Standard 115.361: Staff and agency reporting duties

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.361 (a)

- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency? ☒ Yes ☐ No

- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding retaliation against residents or staff who reported an incident of sexual abuse or sexual harassment? ☒ Yes ☐ No

- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding any staff neglect or violation of responsibilities that may have contributed to an incident of sexual abuse or sexual harassment or retaliation? ☒ Yes ☐ No

115.361 (b)

- Does the agency require all staff to comply with any applicable mandatory child abuse reporting laws? ☒ Yes ☐ No

115.361 (c)

- Apart from reporting to designated supervisors or officials, does staff always refrain from revealing any information related to a sexual abuse report to anyone other than to the extent necessary, as specified in agency policy, to make treatment, investigation, and other security and management decisions? ☒ Yes ☐ No

115.361 (d)

- Are medical and mental health practitioners required to report sexual abuse to designated supervisors and officials pursuant to paragraph (a) of this section, as well as to the designated State or local services agency where required by mandatory reporting laws? ☒ Yes ☐ No

- Are such practitioners required to inform residents at the initiation of services of their duty to report and the limitations of confidentiality? ☒ Yes ☐ No

- Are medical and mental health practitioners required to inform residents of the practitioner's duty to report, and the limitations of confidentiality, at the initiation of services? ☒ Yes ☐ No

115.361 (e)

- Upon receiving any allegation of sexual abuse, does the facility promptly report the allegation to the appropriate agency office and to the alleged victim's parents or legal guardians, unless the facility has official documentation showing the parents or legal guardians should not be notified? ☒ Yes ☐ No
- If the alleged victim is under the guardianship of the child welfare system, does the facility submit the report to the alleged victim's caseworker instead of the parents or legal guardians? ☒ Yes ☐ No
- If a juvenile court retains jurisdiction over the alleged victim, does the facility head or designee report the allegation to the juvenile's attorney or other legal representative of record within 14 days of receiving the allegation? ☒ Yes ☐ No

115.361 (f)

- Does the facility report all allegations of sexual abuse and sexual harassment, including third-party and anonymous reports, to the facility's designated investigators? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

a) Massachusetts DYS Policy and Procedures 01.05.07(c) - Preventing and Responding to Sexual Abuse, Sexual Exploitation and Sexual Harassment of Youth states that all staff must immediately report any known or suspected act or allegation of sexual misconduct or retaliation to administration. They must treat all reported incidents or prohibited conduct seriously and ensure that known or suspected acts or allegations of sexual misconduct are reported immediately.

All staff members interviewed were aware that any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment, staff neglect, or any violation of responsibilities that may have contributed to an incident or retaliation, must be reported to DCF Child at Risk Hotline. All staff members interviewed were aware that they must immediately contact their supervisor to report the allegation of sexual abuse and/or sexual harassment. Interviews with staff members (including mental health staff) confirmed they are aware of their obligations to protect the confidentiality of the information they obtain from a report of sexual abuse.

b) Massachusetts DYS Policy and Procedures 01.05.07(c) - Preventing and Responding to Sexual Abuse, Sexual Exploitation and Sexual Harassment of Youth requires all staff to comply with mandated reporter laws.

All staff interviewed were aware of their responsibility to report any allegations of sexual abuse or sexual harassment to DCF Child at Risk Hotline for investigation. The staff were able to describe their role as Mandated Reporters to this auditor during the interviews and were aware of the DCF hotline to report allegations of sexual abuse and sexual harassment.

c) Massachusetts DYS Policy and Procedures 01.05.07(c) states, "Apart from reporting to designated supervisors, and State or local service agencies, all DYS staff are prohibited from revealing any information related to a sexual abuse report to anyone other than to the extent necessary to make treatment, investigation, and other security and management decisions."

Interviews with staff, including mental health, confirmed they are aware of their obligations to protect the confidentiality of the information they obtained from a report of sexual abuse.

d) Massachusetts DYS Policy and Procedures 01.05.07(c) states, “medical and mental health practitioners shall be required to report sexual abuse to designated supervisors and officials, as well as to designated State of local service agencies where required by mandated reporting laws.”

Medical and mental health staff interviewed indicated that disclosure is provided to residents regarding the limitation of confidentiality and their duty to report at the initiation of treatment services. In addition, these staff are required to report any knowledge, suspicion, or information regarding any allegation of sexual abuse or sexual harassment to their direct supervisor immediately upon learning of the allegation. This information is also reported to DCF hotline for investigation. Staff interviewed also discussed completing Mandated Reporter trainings on an annual basis and were able to discuss their role as mandated reporters during interviews.

e) Massachusetts DYS Policy and Procedures 01.05.07(c) states, “Upon receiving any allegation of sexual abuse, facility administration shall promptly report the allegation to the DCF Child at Risk Hotline.”

All staff interviewed also stated that in addition to reporting the allegation to their direct supervisor; and are required to report the allegation to DCF hotline and document the allegation/incident.

f) All allegations of sexual abuse, sexual harassment, neglect, and retaliation are reported to DCF Child at Risk Hotline for investigation. DCF Child at Risk Hotline will determine if the information meets the requirements to register a report for investigation.

It should be noted: all staff (including medical and mental health staff) are trained to treat third party reports the same as if they witnessed the incident themselves when receiving a report from a third party.

Interviews with the Facility Administrator, Facility PREA Compliance Manager, and staff (including medical and mental health staff) confirmed they are aware of how to report an allegation and were aware all allegations are investigated by DCF, DYS investigators, and State Police. The Facility Administrator and the Facility PREA Compliance Manager were able to describe the reporting process as well as the investigative process once the allegation is referred to DCF Child at Risk Hotline.

There were no allegations of sexual abuse or sexual harassment that was reported during the past twelve (12) months at Paul T. Leahy Center. This was confirmed during interviews with Facility Administrator and DYS Investigator. All staff interviewed were aware of their responsibility to report allegations as they are mandated reporters.

Reviewed documentation to determine compliance:

- Massachusetts DYS Policy and Procedures 01.05.07(c) - Preventing and Responding to Sexual Abuse, Sexual Exploitation and Sexual Harassment of Youth
- Pre-Audit Questionnaire
- Training Logs
- PREA posters

Interviews:

- Interview with the Facility Administrator
- Interview with the Facility PREA Compliance Manager
- Interview with DYS Investigator

- Interview with Nurse Practitioner
- Interview with Clinical Director
- Interviews with twelve (12) randomly selected staff

Standard 115.362: Agency protection duties

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.362 (a)

- When the agency learns that a resident is subject to a substantial risk of imminent sexual abuse, does it take immediate action to protect the resident? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

a) Massachusetts DYS Policy and Procedures 01.05.07(c) - Preventing and Responding to Sexual Abuse, Sexual Exploitation and Sexual Harassment of Youth addresses the requirements of this standard. The policy and the facility's Institutional Plan require an immediate response should a youth be determined to be at imminent risk of sexual abuse or assault; it shall take immediate action to protect the youth.

The Regional Director was interviewed regarding the protective action the agency takes when learning that a resident is subject to substantial risk of imminent sexual abuse. The Regional Director reported the agency would ensure steps are taken to remove the risk to the resident which could include separation of the resident from the potential abuser, either by transferring the resident to another facility or making a living unit change if the potential abuser is a staff working at the facility. The staff could also be removed from the living unit or placed on administrative leave pending an investigation. The Regional Director stressed the safety of the resident is the agency's utmost priority.

Staff interviewed stated they would immediately separate the resident at risk from the potential abuser, increase supervision, call for additional staff assistance if needed, and report the incident to their direct supervisor and DCF Child at Risk Hotline. Their direct supervisor would then determine the best course of action to ensure the safety of the resident. In addition, staff interviewed stated they would also document the incident.

Interview with the Facility Administrator confirmed staff members would be expected to act immediately to separate the resident at risk from a potential abuser. In addition, they reported a Safety Plan would be developed and implemented to ensure the safety of the resident at risk. The Safety Plan would include increased supervision/monitoring, separation from the potential abuser, and making a housing unit and/or room change as necessary.

There were no residents that the facility determined were subject to substantial risk of sexual abuse during the past 12 months.

Reviewed documentation to determine compliance:

- Massachusetts DYS Policy and Procedures 01.05.07(c) - Preventing and Responding to Sexual Abuse, Sexual Exploitation and Sexual Harassment of Youth
- Institutional Plan for Paul T. Leahy Center
- Pre-Audit Questionnaire

Interviews:

- Interview with Regional Director
- Interview with the Facility Administrator
- Interview with Facility PREA Compliance Manager
- Interviews with twelve (12) randomly selected staff

Standard 115.363: Reporting to other confinement facilities

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.363 (a)

- Upon receiving an allegation that a resident was sexually abused while confined at another facility, does the head of the facility that received the allegation notify the head of the facility or appropriate office of the agency where the alleged abuse occurred? ☒ Yes ☐ No

115.363 (b)

- Is such notification provided as soon as possible, but no later than 72 hours after receiving the allegation? ☒ Yes ☐ No

115.363 (c)

- Does the agency document that it has provided such notification? ☒ Yes ☐ No

115.363 (d)

- Does the facility head or agency office that receives such notification ensure that the allegation is investigated in accordance with these standards? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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a) Massachusetts DYS Policy and Procedures 01.05.07(c) Preventing and Responding to Sexual Abuse, Sexual Exploitation and Sexual Harassment of Youth states that any DYS state or contracted provider, employee, intern, or volunteer in an Alternative LOCKUP Program (ONA), residential or community placement who learns of or suspects alleged sexual boundaries violations, sexual abuse, or sexual harassment within an ONA or residential placement shall immediately report the information to their Facility Administrator and either the PREA Compliance Manager or one of the members from the administrative team where the allegation occurred. Such initial report may be verbal, but the reporter must also complete a written incident report prior to the end of the shift. Such notification shall be provided as soon as possible, but no later than seventy-two (72) hours after receiving the allegation. All allegations will be reported to the Department of Children and Families (DCF).

Interview with the Facility Administrator confirmed this reporting process and noted that there has not been a report in the last 12 months of any allegations of sexual abuse or sexual harassment occurring to a resident while in another facility.

b) Massachusetts DYS Policy and Procedures 01.05.07(c) notes the Program Director of the facility that receives the allegation must notify the Facility Director of the other facility or appropriate office of the agency where the alleged abuse occurred and must also notify the appropriate investigative agency. Such notifications must be provided as soon as possible, but no later than 72 hours after receiving the allegation.

Interview with the Facility Administrator confirmed he understood the timeframe to notify the agency/facility where the alleged abuse occurred. After interviewing the Facility Administrator, it was confirmed that Paul T. Leahy Center did not receive any allegations that a resident was abused while residing in another facility.

c) Massachusetts DYS Policy and Procedures 01.05.07(c) notes notifications to the facility where the alleged abuse occurred must be documented and reported to the Department of Children and Families.

Interview with the Facility Administrator confirmed he would document any notification of alleged abuse using an Incident Report. He also stated an email would also be sent to the Facility Director of the facility where the alleged abuse occurred (after contacting this person by telephone) to provide further documentation. In addition to documenting the allegation, the Facility Administrator noted he would immediately report the allegation of abuse to DCF hotline for investigation. If the allegation occurred in a facility outside of the state, he stated she would contact the proper investigative agency in the state where the allegation occurred.

d) The Facility Administrator was able to articulate what his responsibilities would be if he received an allegation from another facility that a resident was sexually abused or sexually harassed while residing at Paul T. Leahy Center. He stated he would immediately generate an Incident Report and contact DCF hotline to report the allegation of abuse for investigation. He stated if the alleged abuser was still residing or

employed at Paul T. Leahy Center, a Safety Plan would be developed immediately to ensure the safety of all residents.

The facility did not receive any allegations/notifications from other facilities that a resident was sexually abused or sexually harassed while residing at Paul T. Leahy Center during the past 12 months. This was confirmed by this auditor by reviewing Incident Reports that were filed during the past 12 months and interview with the DYS Investigator.

Reviewed documentation to determine compliance:

- Massachusetts DYS Policy and Procedures 01.05.07(c) - Preventing and Responding to Sexual Abuse, Sexual Exploitation and Sexual Harassment of Youth
- Pre-Audit Questionnaire
- Incident Reports

Interviews:

- Interview with Facility Administrator
- Interview with Facility PREA Compliance Manager
- Interview with DYS Investigator

Standard 115.364: Staff first responder duties

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.364 (a)

- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Separate the alleged victim and abuser? ☒ Yes ☐ No

- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Preserve and protect any crime scene until appropriate steps can be taken to collect any evidence? ☒ Yes ☐ No

- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Request that the alleged victim not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating, if the abuse occurred within a time period that still allows for the collection of physical evidence? ☒ Yes ☐ No

- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Ensure that the alleged abuser does not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating, if the abuse occurred within a time period that still allows for the collection of physical evidence? ☒ Yes ☐ No

115.364 (b)

- If the first staff responder is not a security staff member, is the responder required to request that the alleged victim not take any actions that could destroy physical evidence, and then notify security staff? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

a) Massachusetts DYS Policy and Procedures 01.05.07(c) - Preventing and Responding to Sexual Abuse, Sexual Exploitation and Sexual Harassment of Youth states that upon learning of an allegation that a resident was sexually abused, the first staff member to respond shall act in accordance with the policies. The first staff member to respond to the scene shall be required to:

1. Separate the victim and alleged abuser
2. Preserve and protect the scene until appropriate steps can be taken to collect any evidence
3. Request that alleged victim not take any actions that could destroy physical evidence, including as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, swimming, drinking, or eating
4. Take steps to prevent the alleged abuser from destroying evidence, such as washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating
5. Notify the Program Director or designee and document the incident
6. Transport to UMASS Memorial Hospital

There were no allegations that were reported during the past twelve (12) months required first responder actions.

All staff interviewed could articulate the steps they would take as a first responder. Their responses were consistent with the Massachusetts DYS Policy and Procedures 01.05.07(c) - Preventing and Responding to Sexual Abuse, Sexual Exploitation and Sexual Harassment of Youth.

b) Massachusetts DYS Policy and Procedures 01.05.07(c) notes first responder duties for non-security staff are the same as security staff. Non-security staff have been trained appropriately in the above-mentioned duties as a first responder.

Non-security staff interviewed were educated in their role as first responders and were able to articulate exactly what they would be expected to do in the event they were the first responder to an incident of sexual

abuse. They stated they would immediately call for assistance so security staff would be able to report to the area of the incident and assist with securing the scene.

Reviewed documentation to determine compliance:

- Massachusetts DYS Policy and Procedures 01.05.07(c) - Preventing and Responding to Sexual Abuse, Sexual Exploitation and Sexual Harassment of Youth
- Pre-Audit Questionnaire

Interviews:

- Interview with Facility Administrator
- Interview with the Facility PREA Compliance Manager
- Interview with the Agency PREA Coordinator
- Interviews with twelve (12) randomly selected staff

Standard 115.365: Coordinated response

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.365 (a)

- Has the facility developed a written institutional plan to coordinate actions among staff first responders, medical and mental health practitioners, investigators, and facility leadership taken in response to an incident of sexual abuse? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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a) Massachusetts DYS Policy and Procedures 01.05.07(c) - Preventing and Responding to Sexual Abuse, Sexual Exploitation and Sexual Harassment of Youth requires each facility to have an institutional plan for a coordinated response. The plans provide clear and concise directions for response to any alleged PREA violation. Interviews with the Facility Administrator, direct care staff, medical staff, and mental health staff indicated that each is knowledgeable of his/her responsibilities in regard to an incident or allegation of

sexual assault. All staff interviewed were aware of their program's Institutional Plan and where to locate the document.

This auditor was able to review the Institutional Plan to confirm this document described the role of the administrative staff, direct care staff, medical staff, and mental health staff. The plan is detailed and notes the roles of all staff at Paul T. Leahy Center.

Reviewed documentation to determine compliance:

- Massachusetts DYS Policy and Procedures 01.05.07(c) - Preventing and Responding to Sexual Abuse, Sexual Exploitation and Sexual Harassment of Youth
- Pre-Audit Questionnaire
- Facility Institutional Plan

Interviews:

- Interview with Facility Administrator
- Interview with Nurse Practitioner
- Interview with Clinical Director
- Interviews with twelve (12) randomly selected staff

Standard 115.366: Preservation of ability to protect residents from contact with abusers

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.366 (a)

- Are both the agency and any other governmental entities responsible for collective bargaining on the agency's behalf prohibited from entering into or renewing any collective bargaining agreement or other agreement that limits the agency's ability to remove alleged staff sexual abusers from contact with any residents pending the outcome of an investigation or of a determination of whether and to what extent discipline is warranted? ☒ Yes ☐ No

115.366 (b)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The Massachusetts DYS Policy and Procedures 01.05.04(d) – Code of Employee Conduct states that effective August 20, 2012 DYS will not enter into or renew any collective bargaining unit agreement that limits the ability to remove alleged staff sexual abusers from contact with any residents pending the outcome of an investigation or a determination of whether and to what extent discipline is warranted. There have been no new collective bargaining agreements entered into by DYS that would violate this standard. The Massachusetts DYS Policy and Procedures 01.05.04(d) authorizes DYS to protect youth from contact with alleged abusers up to and including suspending staff without pay. There were no reported allegations of staff sexual misconduct during this audit period.

During the interview with the Facility Administrator, he stated that any time there is an allegation, a safety plan for the specific resident, and all the residents, is put into place. This always includes removing the staff person from contact with the resident or residents and depending upon the allegation, placing the staff member on Administrative Leave until the investigation is completed.

Reviewed documentation to determine compliance:

- Massachusetts DYS Policy and Procedures 01.05.04(d) – Code of Employee Conduct Union Contract with AFSCOME, NAGE, MNA, SEIU

Interview:

- Interview with Regional Director
- Interview with Facility Administrator

Standard 115.367: Agency protection against retaliation

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.367 (a)

- Has the agency established a policy to protect all residents and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other residents or staff? ☒ Yes ☐ No

- Has the agency designated which staff members or departments are charged with monitoring retaliation? ☒ Yes ☐ No

115.367 (b)

- Does the agency employ multiple protection measures, such as housing changes or transfers for resident victims or abusers, removal of alleged staff or resident abusers from contact with victims, and emotional support services, for residents or staff who fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations? ☒ Yes ☐ No

115.367 (c)

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor the conduct and treatment of residents or staff who reported the sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor the conduct and treatment of residents who were reported to have suffered sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Act promptly to remedy any such retaliation? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor any resident disciplinary reports? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor resident housing changes? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor resident program changes? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor negative performance reviews of staff? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor reassignments of staff? ☒ Yes ☐ No

- Does the agency continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need? ☒ Yes ☐ No

115.367 (d)

- In the case of residents, does such monitoring also include periodic status checks? ☒ Yes ☐ No

115.367 (e)

- If any other individual who cooperates with an investigation expresses a fear of retaliation, does the agency take appropriate measures to protect that individual against retaliation?
  ☒ Yes ☐ No

115.367 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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a-e) The Massachusetts DYS Policy and Procedures 01.05.07(c) - Preventing and Responding to Sexual Abuse, Sexual Exploitation and Sexual Harassment of Youth shall protect all residents and staff who report sexual abuse or sexual harassment or cooperate with investigators pertaining to sexual abuse and sexual harassment from retaliation by other staff or residents.

DYS employs multiple protective measures which may include housing or room changes, or transfers for residents, (regardless of if they are victims or abuser); removal of alleged staff or resident(s) from contact with victim(s); emotional support services for residents or staff who fear retaliation for reporting abuse or sexual harassment or for cooperating with investigations. Policy requires monitoring for at least 90 days following an allegation of sexual abuse or sexual harassment (or until an allegation is determined to be Unfounded following investigation). Items that may be monitored include any resident disciplinary reports, housing or programming changes, negative performance reviews, and reassignments of staff.

Interview with the Program Director indicated that he and the Assistant Program Directors serve as retaliation monitors at Paul T. Leahy Center. They were educated and trained on signs of retaliation. The Facility Administrator stated during interview that the agency would expect that actions would be taken immediately to ensure the resident was safe. It is the expectation of the agency that any resident who reports an allegation of sexual abuse or sexual harassment would be monitored for at least 90 days or until the allegation is investigated by the Department of Children and Families. He stated they would monitor the resident by completing status checks for at least 90 days per policy. These status checks are made on a daily basis by checking in with the youth and/or reviewing documentation such as resident disciplinary reports, and room or programming changes. They monitor behavioral changes in residents, such as isolating oneself. They monitor work records of staff, including tardiness, and absenteeism. Documentation of retaliation monitoring is kept on a Retaliation Monitoring form. This auditor was able to review a Retaliation Monitoring form.

There were no incidents of retaliation, known or suspected, during the past twelve (12) months.

Reviewed documentation to determine compliance:

- Massachusetts DYS Policy and Procedures 01.05.07(c) - Preventing and Responding to Sexual Abuse, Sexual Exploitation and Sexual Harassment of Youth
- Retaliation Monitoring form

Interview:

- Interview with Facility Administrator
- Interview with Agency PREA Coordinator
- Interview with Program Director
- Interview with DYS Investigator

Standard 115.368: Post-allegation protective custody

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.368 (a)

- Is any and all use of segregated housing to protect a resident who is alleged to have suffered sexual abuse subject to the requirements of § 115.43? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

a) The Massachusetts DYS Policy and Procedures 03.04.09 – Prohibition of Harassment and Discrimination Against Youth states segregated housing of youth to keep them safe from sexual misconduct is not used and is prohibited. The facility did not use segregation or isolation for the purpose of this standard during this audit period. There were no reported instances of sexual abuse during this period.

Interview with the Facility Administrator confirmed the prohibition of segregated housing for this purpose. During the tour of the facility, this auditor did not notice any places where a resident could be segregated or isolated. In addition, interviews with residents at the facility confirmed the prohibition of segregated housing.

Reviewed documentation to determine compliance:

- Massachusetts DYS Policy and Procedures 03.04.09 – Prohibition and Discrimination Against Youth
- Tour of the facility

Interview:

- Interview with Facility Administrator
- Interview with Facility PREA Compliance Manager
- Interviews with ten (10) randomly selected residents

INVESTIGATIONS

Standard 115.371: Criminal and administrative agency investigations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.371 (a)

- When the agency conducts its own investigations into allegations of sexual abuse and sexual harassment, does it do so promptly, thoroughly, and objectively? [N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations. See 115.321(a).] ☒ Yes ☐ No ☐ NA

- Does the agency conduct such investigations for all allegations, including third party and anonymous reports? [N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations. See 115.321(a).] ☒ Yes ☐ No ☐ NA

115.371 (b)

- Where sexual abuse is alleged, does the agency use investigators who have received specialized training in sexual abuse investigations as required by 115.334? ☒ Yes ☐ No

115.371 (c)

- Do investigators gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data? ☒ Yes ☐ No

- Do investigators interview alleged victims, suspected perpetrators, and witnesses? ☒ Yes ☐ No

- Do investigators review prior reports and complaints of sexual abuse involving the suspected perpetrator? ☒ Yes ☐ No

115.371 (d)

- Does the agency terminate investigations solely because the source of the allegation recants the allegation? ☒ Yes ☐ No

115.371 (e)

- When the quality of evidence appears to support criminal prosecution, does the agency conduct compelled interviews only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution? ☒ Yes ☐ No

115.371 (f)

- Do agency investigators assess the credibility of an alleged victim, suspect, or witness on an individual basis and not on the basis of that individual's status as resident or staff? ☒ Yes ☐ No

- Does the agency investigate allegations of sexual abuse without requiring a resident who alleges sexual abuse to submit to a polygraph examination or other truth-telling device as a condition for proceeding? ☒ Yes ☐ No

115.371 (g)

- Do administrative investigations include an effort to determine whether staff actions or failures to act contributed to the abuse? ☒ Yes ☐ No

- Are administrative investigations documented in written reports that include a description of the physical evidence and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings? ☒ Yes ☐ No

115.371 (h)

- Are criminal investigations documented in a written report that contains a thorough description of the physical, testimonial, and documentary evidence and attaches copies of all documentary evidence where feasible? ☒ Yes ☐ No

115.371 (i)

- Are all substantiated allegations of conduct that appears to be criminal referred for prosecution? ☒ Yes ☐ No

115.371 (j)

- Does the agency retain all written reports referenced in 115.71(f) and (g) for as long as the alleged abuser is incarcerated or employed by the agency, plus five years? ☒ Yes ☐ No

115.371 (k)

- Does the agency ensure that the departure of an alleged abuser or victim from the employment or control of the agency does not provide a basis for terminating an investigation?
  ☒ Yes ☐ No

115.371 (l)

- Auditor is not required to audit this provision.

115.371 (m)

- When an outside entity investigates sexual abuse, does the facility cooperate with outside investigators and endeavor to remain informed about the progress of the investigation? (N/A if an outside agency does not conduct administrative or criminal sexual abuse investigations. See 115.21(a).) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

a) The Massachusetts DYS Policy and Procedures 01.05.07(c) - Preventing and Responding to Sexual Abuse, Sexual Exploitation and Sexual Harassment of Youth states, "The DYS Director of Investigations or his/her designed shall investigate all allegations of sexual boundary violations, sexual abuse and/or sexual harassment, and retaliation for reporting such allegations or cooperating with an investigation. The investigation will include an effort to determine whether employee's actions or omissions contributed to the allegation."

Interview with the DYS Investigator confirmed that they would conduct these investigations promptly, thoroughly, and objectively for all allegations, including third-party and anonymous reports.

As noted in the Massachusetts DYS Policy and Procedures 01.05.07(c), DYS does conduct investigations for allegations of sexual abuse or sexual harassment. Investigations may be completed by DCF investigators and Massachusetts State Police.

b) The Massachusetts DYS Policy and Procedures 01.05.07(c) states DYS will "cooperate and consult with law enforcement and the District Attorney's Office conducting the criminal investigation and ensure that the criminal investigation is completed." DYS will contact the law enforcement agency and request that an officer trained in sexual abuse investigations involving juvenile victims be responsible for the investigation.

c-h) Interview with a representative from Massachusetts State Police confirmed that criminal investigations are completed by the local police department and include gathering and preserving direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data; interviewing alleged victims, suspected perpetrators, and witnesses; reviewing prior complaints and reports of sexual abuse involving the suspected perpetrator.

The Massachusetts DYS Policy and Procedures 01.05.07(c) notes the facility will cooperate with outside investigators and will remain informed of the investigative process. During interviews, the Facility Administrator stated that if an investigation is conducted by the State Police, they maintain contact with the Massachusetts State Police investigators during an open investigation via telephone calls, e-mails, and on-site visits by the DYS Investigative Unit. The DYS Investigative Unit is the liaison for the facilities with all DCF, EEC, and State Police investigations. If it is an administrative investigation, they will remain in contact with the investigator from the Department of Children and Families via telephone calls and emails via the DYS Investigative Unit.

i-j) The Massachusetts DYS Policy and Procedures 01.05.07(b) requires that all files are kept as long as the alleged abuser is within DYS custody or employed by the agency, plus five (5) years. This was confirmed by the Agency PREA Coordinator.

k-m) Per the Massachusetts DYS Policy and Procedures 01.05.07(c), the departure of an alleged abuser or victim from their employment or control by the facility/agency does not provide a basis for termination of an investigation. They state the investigation would continue until a determination is made. This was also confirmed by the Agency PREA Coordinator, and the DYS Investigator.

There were no allegations of sexual abuse or sexual harassment during the past twelve months. There were no residents to interview and no files to review. This was confirmed during interview with the DYS Investigator. Interview with the Facility Administrator confirmed that if an allegation of sexual abuse was determined to be Substantiated or Unsubstantiated; and Incident Review would also be conducted after the investigation was completed.

Reviewed documentation to determine compliance:

- Massachusetts DYS Policy and Procedures 01.05.07(c) - Preventing and Responding to Sexual Abuse, Sexual Exploitation and Sexual Harassment of Youth
- Pre-Audit Questionnaire
- MOU with Massachusetts State Police
- Monitoring Retaliation Form
- Review of ten (10) resident files

Interviews:

- Interview with Agency PREA Coordinator
- Interview with Facility Administrator
- Interview with the Facility PREA Compliance Manager
- Interview with DYS Investigator
- Interview with representative from Massachusetts State Police

Standard 115.372: Evidentiary standard for administrative investigations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.372 (a)

- Is it true that the agency does not impose a standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

a) The Massachusetts DYS Policy and Procedures 01.05.07(c) - Preventing and Responding to Sexual Abuse, Sexual Exploitation and Sexual Harassment of Youth states that DYS shall impose no standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated. Interview with the Agency PREA Coordinator and DYS Investigator confirmed the process of investigations involving alleged sexual abuse follow these guidelines.

There were no allegations of sexual abuse and sexual harassment during the past 12 months at Paul T. Leahy Center. There were no administrative investigative reports for alleged sexual abuse and/or sexual harassment to review.

Reviewed documentation to determine compliance:

- Massachusetts DYS Policy and Procedures 01.05.07(c) - Preventing and Responding to Sexual Abuse, Sexual Exploitation and Sexual Harassment of Youth
- Pre-Audit Questionnaire
- Investigative Report

Interviews:

- Interview with Facility Administrator
- Interview with Agency PREA Coordinator
- Interview with DYS Investigator

Standard 115.373: Reporting to residents

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.373 (a)

- Following an investigation into a resident's allegation that he or she suffered sexual abuse in an agency facility, does the agency inform the resident as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded? ☒ Yes ☐ No

115.373 (b)

- If the agency did not conduct the investigation into a resident's allegation of sexual abuse in an agency facility, does the agency request the relevant information from the investigative agency in order to inform the resident? (N/A if the agency/facility is responsible for conducting administrative and criminal investigations.) ☒ Yes ☐ No ☐ NA

115.373 (c)

- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The staff member is no longer posted within the resident's unit? ☒ Yes ☐ No

- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The staff member is no longer employed at the facility? ☒ Yes ☐ No

- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The agency learns that the staff member has been indicted on a charge related to sexual abuse in the facility? ☒ Yes ☐ No

- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility? ☒ Yes ☐ No

115.373 (d)

- Following a resident's allegation that he or she has been sexually abused by another resident, does the agency subsequently inform the alleged victim whenever: The agency learns that the alleged abuser has been indicted on a charge related to sexual abuse within the facility? ☒ Yes ☐ No

- Following a resident's allegation that he or she has been sexually abused by another resident, does the agency subsequently inform the alleged victim whenever: The agency learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility? ☒ Yes ☐ No

115.373 (e)

- Does the agency document all such notifications or attempted notifications? ☒ Yes ☐ No

115.373 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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a-e) The Massachusetts DYS Policy and Procedures 01.05.07(c) - Preventing and Responding to Sexual Abuse, Sexual Exploitation and Sexual Harassment of Youth states that the DYS Director of Investigations or his/her designee shall notify the resident victim by the DYS Investigations unit and law enforcement and anytime extensions from the completion of the decision and document such notifications in JJEMS Progress Notes. Such notifications shall include whether the:

1. Allegation has been determined to be Substantiated, Unsubstantiated, or Unfounded;
2. Employee or youth alleged to have committed the sexual abuse is no longer within the youth's program or facility; and
3. Employee or youth alleged to have committed the sexual abuse is indicated and/or convicted on a charge related to sexual abuse due to the youth's allegation

The Facility Administrator and Agency PREA Coordinator stated that the resident would continuously be informed as to the on-going status of the investigation, whether it involved another resident or a staff member. They also confirmed that the juveniles who are currently in the custody of DYS are entitled to know the outcomes of investigations of their allegations. The facility informs the juvenile whether the allegation was determined to be substantiated, unsubstantiated, or unfounded. All notifications or attempted notifications are documented. If the allegation involved a staff member, the facility informs the juvenile whenever the staff member is no longer posted within the juvenile's unit, when the staff member is no longer employed at the facility, when the staff member has been indicted on a charge related to sexual abuse within the facility, or when the staff member has been convicted on a charge related to sexual abuse within

the facility. If the allegation involved another juvenile, the facility informs the alleged victim when the alleged abuser has been indicted on a charge related to sexual abuse within the facility or when the alleged abuser has been convicted on a charge related to sexual abuse within the facility.

The facility had no allegations of sexual abuse or sexual harassment during the past twelve (12) months. Interview with the DYS Investigator stated that if an investigation was determined to be Substantiated or Unsubstantiated, the resident would be notified and this would be documented in the resident's case file in JJEMS.

Reviewed documentation to determine compliance:

- Massachusetts DYS Policy and Procedures 01.05.07(c) - Preventing and Responding to Sexual Abuse, Sexual Exploitation and Sexual Harassment of Youth
- Massachusetts DYS Grievance Policy

Interview:

- Interview with the Facility Administrator
- Interview with the Agency PREA Coordinator
- Interview with DYS Investigator

DISCIPLINE

Standard 115.376: Disciplinary sanctions for staff

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.376 (a)

- Are staff subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies? ☒ Yes ☐ No

115.376 (b)

- Is termination the presumptive disciplinary sanction for staff who have engaged in sexual abuse? ☒ Yes ☐ No

115.376 (c)

- Are disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) commensurate with the nature and circumstances of the acts committed, the staff member's disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories? ☒ Yes ☐ No

115.376 (d)

- Are all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, reported to: Law enforcement agencies (unless the activity was clearly not criminal)? ☒ Yes ☐ No

- Are all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, reported to: Relevant licensing bodies? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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Instructions for Overall Compliance Determination Narrative

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a) Massachusetts DYS Policy and Procedures 01.05.07(c) - Preventing and Responding to Sexual Abuse, Sexual Exploitation and Sexual Harassment of Youth states DYS employees who violate agency sexual abuse and/or sexual harassment policies or who engage in behavior that contributes to sexual abuse and/or sexual harassment of residents shall be subject to disciplinary sanctions up to and including termination. Sexual misconduct perpetrated by staff is contrary to the policies of DYS and professional ethical principles that all employees are bound to uphold. There is no consensual sex in a custodial or supervisory relationship as a matter of law. A sexual act with a resident by a person in a position of authority over the resident is a felony subject to criminal prosecution. Retaliation against a resident who refuses to submit to sexual activity or retaliation against individuals (including witnesses) because of their involvement in the reporting or investigation of sexual misconduct is also prohibited and grounds for disciplinary action including termination and criminal prosecution.

b-d) Failure of employees to report incidents of sexual misconduct is cause for disciplinary action up to and including termination. All dismissals for violations Massachusetts DYS Policy and Procedures 01.05.07(c) or resignations by staff who would have been dismissed or subject to dismissal proceedings if not for their resignation must be reported to law enforcement agencies unless the activity was clearly not criminal and reported to any relevant licensing bodies.

The Pre-Audit Questionnaire indicated that no staff members were terminated for violating any sexual abuse or sexual harassment policies during the past twelve (12) months. This was confirmed during the interview with the Facility Administrator and interview with the Workforce Coordinator.

Reviewed documentation to determine compliance:

- Massachusetts DYS Policy and Procedures 01.05.07(c) - Preventing and Responding to Sexual Abuse, Sexual Exploitation and Sexual Harassment of Youth

- Pre-Audit Questionnaire
- Twelve (12) randomly selected staff files

Interview:

- Interview with Agency PREA Coordinator
- Interview with Facility Administrator
- Interview with Workforce Coordinator

Standard 115.377: Corrective action for contractors and volunteers

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.377 (a)

- Is any contractor or volunteer who engages in sexual abuse prohibited from contact with residents? ☒ Yes ☐ No

- Is any contractor or volunteer who engages in sexual abuse reported to: Law enforcement agencies (unless the activity was clearly not criminal)? ☒ Yes ☐ No

- Is any contractor or volunteer who engages in sexual abuse reported to: Relevant licensing bodies? ☒ Yes ☐ No

115.377 (b)

- In the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer, does the facility take appropriate remedial measures, and consider whether to prohibit further contact with residents? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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a) Massachusetts DYS Policy and Procedures 01.10.01(a) – Volunteer and Intern Services states DYS shall immediately prohibit youth contact by a contractor, intern, or volunteer, and/or discontinue a volunteer or

intern activity that threatens the security or the safety of the youth, employee, and/or the volunteer including acts that are in violation of this policy or fail to follow applicable training.

The Pre-Audit Questionnaire indicated that there were no contractors or volunteers reported to law enforcement for engaging in sexual abuse or sexual harassment of residents during the past twelve (12) months. At the time of the in-person audit there were seven (7) contractors at the facility. Two (2) contractors were interviewed during the on-site portion of the audit. Both contractors (Teaching Coordinator/medical) stated they received their annual PREA training and this was confirmed by reviewing their training records.

b) The Facility Administrator stated that the facility would immediately remove the contractor or volunteer from the facility, would contact appropriate authorities, and would not allow them to return until the completion of an investigation. There were no reported instances of sexual assault or sexual harassment by the approved contractors during the past twelve (12) months; therefore, there was no documentation to review regarding this standard. This was verified by the Facility Administrator during his interview.

Reviewed documentation to determine compliance:

- Massachusetts DYS Policy and Procedures 01.10.01(a) – Volunteer and Intern Services
- Pre-Audit Questionnaire
- Signed training acknowledgements of contractors

Interview:

- Interview with the Agency PREA Coordinator
- Interview with the Facility Administrator
- Interviews with contractors (Teaching Coordinator/medical)

Standard 115.378: Disciplinary sanctions for residents

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.378 (a)

- Following an administrative finding that a resident engaged in resident-on-resident sexual abuse, or following a criminal finding of guilt for resident-on-resident sexual abuse, are residents subject to disciplinary sanctions pursuant to a formal disciplinary process? ☒ Yes ☐ No

115.378 (b)

- Are disciplinary sanctions commensurate with the nature and circumstances of the abuse committed, the resident's disciplinary history, and the sanctions imposed for comparable offenses by other residents with similar histories? ☒ Yes ☐ No

- In the event a disciplinary sanction results in the isolation of a resident, do agencies deny the resident daily large-muscle exercise or access to any legally required educational programming or special education services? ☒ Yes ☐ No

- Do residents in isolation receive daily visits from a medical or mental health care clinician? ☒ Yes ☐ No

- Do residents have access to other programs and work opportunities to the extent possible? ☒ Yes ☐ No

115.378 (c)

- When determining what types of sanction, if any, should be imposed, does the disciplinary process consider whether an resident's mental disabilities or mental illness contributed to his or her behavior? ☒ Yes ☐ No

115.378 (d)

- If the facility offers therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse, does the facility consider whether to require the offending resident to participate in such interventions as a condition of access to programming and other benefits? ☒ Yes ☐ No

- Do agencies require participation in such interventions as a condition to access general programming or education? ☒ Yes ☐ No

115.378 (e)

- Does the agency discipline a resident for sexual contact with staff only upon a finding that the staff member did not consent to such contact? ☒ Yes ☐ No

115.378 (f)

- For the purpose of disciplinary action does a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred NOT constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation? ☒ Yes ☐ No

115.378 (g)

- If the agency prohibits all sexual activity between residents, does the agency always refrain from considering non-coercive sexual activity between residents to be sexual abuse? (N/A if the agency does not prohibit all sexual activity between residents.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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Instructions for Overall Compliance Determination Narrative

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a-b) Massachusetts DYS Policy and Procedures 01.05.07(c) - Preventing and Responding to Sexual Abuse, Sexual Exploitation and Sexual Harassment of Youth states that after investigation, if it is determined that a youth intentionally made a false allegation and did not act in good faith based upon a reasonable belief, program behavior management systems should be utilized to address the youth's behavior. Consideration will be taken into the nature and circumstances of the incident, resident history, mental health or disabilities, and precedent of sanctions imposed under similar circumstances.

c) Consideration will be taken into the nature and circumstances of the incident, resident history, mental health or disabilities, and precedent of sanctions imposed under similar circumstances. Residents are subjected to disciplinary sanctions for contact with staff, if upon investigation, it is determined that the staff member did not consent to such contact. Disciplinary action must be administered in a fair, impartial, and expeditious manner.

d) Consideration must also be given to providing the offending resident therapy, counseling, or other interventions for the abuse. DYS 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 was therapeutic in nature.

Interview with the Facility Administrator confirmed that a resident's mental health is always considered when discipline is imposed for incidents of sexual abuse. In addition, the Facility Administrator stated the resident's mental health diagnosis is reviewed and considered during Sexual Abuse Incident Reviews following a substantiated or unsubstantiated finding to ensure appropriate discipline was imposed.

Consideration must be given to providing the offending youth therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse. However, the facility may not require participation in such interventions as a condition of access to general programming or education.

Interview with mental health staff was conducted by this auditor during the on-site portion of this audit. The interview confirmed Paul T. Leahy Center does offer mental health services for any resident found to have engaged in resident-on-resident sexual abuse. The mental health staff stated the resident's participation in therapy sessions is not always required as a condition of access to reward-based incentives.

There were no allegations of sexual abuse during the past twelve (12) months.

e) Massachusetts DYS Policy and Procedures 01.05.07(c) states the facility may only discipline a youth for sexual contact with staff upon a finding that the staff member did not consent to such contact. Interviews with the Facility Administrator confirmed a resident would only be disciplined for sexual contact with a staff member upon finding the staff member did not consent to the sexual contact. There were no incidents of resident-on-staff sexual abuse during the past twelve (12) months. The Facility Administrator also confirmed that residents are not disciplined for reports of sexual abuse made in good faith, even if the investigation did not establish evidence sufficient to substantiate the allegation. The Facility Administrator also noted that any suspicion of possible sexual abuse is reported to the DCF hotline immediately for investigation.

There were no allegations of sexual abuse during the past twelve (12) months.

f) Interviews with the Facility Administrator and the Agency PREA Coordinator confirmed that the facility does not use isolation and the underlying issues related to the incident would be addressed in therapy. They also stated that a resident making a report in good faith cannot be disciplined according to the PREA Policy.

g) The DYS Policy 01.05.07(c) - Preventing and Responding to Sexual Abuse, Sexual Exploitation and Sexual Harassment of Youth states that sexual activity between youth is prohibited, however for such activity to constitute sexual abuse, there must be no assent to the activity, or it must be forcible or coerced.

Reviewed documentation to determine compliance:

- Massachusetts DYS Policy and Procedures 01.05.07(c) - Preventing and Responding to Sexual Abuse, Sexual Exploitation and Sexual Harassment of Youth
- Pre-Audit Questionnaire
- Youth Handbook

Interview:

- Interview with Facility Administrator
- Interview with Agency PREA Coordinator
- Interview with Clinical Director

MEDICAL AND MENTAL CARE

Standard 115.381: Medical and mental health screenings; history of sexual abuse

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.381 (a)

- If the screening pursuant to § 115.341 indicates that a prison resident has experienced prior sexual victimization, whether it occurred in an institutional setting or in the community, do staff ensure that the resident is offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening? (N/A if the facility is not a prison.)
  ☒ Yes ☐ No ☐ NA

115.381 (b)

- If the screening pursuant to § 115.341 indicates that a prison resident has previously perpetrated sexual abuse, whether it occurred in an institutional setting or in the community, do staff ensure that the resident is offered a follow-up meeting with a mental health practitioner within 14 days of the intake screening? (N/A if the facility is not a prison.) ☒ Yes ☐ No ☐ NA

115.381 (c)

- Is any information related to sexual victimization or abusiveness that occurred in an institutional setting strictly limited to medical and mental health practitioners and other staff, as necessary, to inform treatment plans and security and management decisions, including housing, bed, work, education, and program assignments, or as otherwise required by Federal, State, or local law?
  ☒ Yes ☐ No

115.381 (d)

- Is any information related to sexual victimization or abusiveness that occurred in an institutional setting strictly limited to medical and mental health practitioners and other staff as necessary to inform treatment plans and security management decisions, including housing, bed, work, education, and program assignments, or as otherwise required by Federal, State, or local law?
  ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

a-c) Massachusetts DYS Policy and Procedures 01.05.07(c) - Preventing and Responding to Sexual Abuse, Sexual Exploitation and Sexual Harassment of Youth requires that if a resident's intake assessment indicates that they have experienced any prior sexual victimization or have perpetrated sexual abuse, whether it occurred in an institution setting or in the community, the resident will be offered a follow-up meeting with the psychologist, psychiatrist, and/or mental health worker within 14 days of the intake screening. Documentation of such shall be noted on the resident's Vulnerability Assessment Instrument. Anytime an allegation of sexual abuse occurs, the youth will be taken to UMASS Memorial Hospital to be seen by a SANE without financial cost to the youth. Upon return from the hospital, the medical staff is to assess for any lingering, acute, or non-acute physical injuries, as well as psychological impact of the victimization.

There were no residents admitted to Paul T. Leahy Center during the past twelve (12) months who disclosed prior sexual victimization during risk screening at intake. Interview with the Clinical Director stated that when a resident discloses prior sexual victimization during screening at intake, they are referred to mental health practitioners or medical staff for follow-up services immediately, but within the required 14 days.

Interviews with the Facility Administrator and Clinical Director confirmed any information from the intake screen is limited to medical, mental health staff, or other staff as necessary to implement treatment plans, security, and management decisions including housing, bed, and program assignments. This information is not accessible to direct care staff.

d) During the interview with the Facility Administrator, it was noted they are mandated reporters and are required by law to report any information they receive from a resident relating to sexual abuse. All staff members interviewed stated they inform the resident upon intake of their reporting duties.

During interview with the Clinical Director, he indicated they are aware that residents reporting prior sexual victimization or prior sexual aggression are to be referred for a follow up meeting with medical and mental health staff within fourteen (14) days of intake. He related that services that are offered include evaluations, developing a treatment plan, and offering on-going services. He was also aware that the residents have the right to refuse a follow-up meeting. All residents received physicals within 14 days of admission.

A review of all resident files noted there were no current residents who had disclosed prior victimization during screening. Per the Clinical Director interview, youth have access to mental health and medical services at the facility. When a disclosure of prior abuse occurs, services are offered by clinical staff and medical staff which are documented in the resident's case file in JJEMS. Access to these files is restricted. All residents interviewed confirmed they were seen by the facility Nurse Practitioner during their intake.

Per the clinical staff interview, youth have access to medical services in the facility. When a disclosure of prior abuse occurs, and services are offered by clinical staff, which is documented in the resident's case file. Access to these files is restricted. All youth interviewed confirmed that they were seen by a Nurse Practitioner shortly after arrival at the facility.

During interviews with the Program Director, Clinical Director, and Intake staff all indicated they are aware that youth reporting prior sexual victimization or prior sexual aggression are to be referred for a follow-up meeting with medical and mental health staff. Interview with medical staff confirmed that screening includes history of sexual abuse. Per medical staff interview, youth have access to all medical services available in the community.

All youth interviewed confirmed that they were seen by medical staff shortly after arrival at the facility. A review of ten (10) youth files noted there were no current youth who disclosed prior victimization during screening.

Reviewed documentation to determine compliance:

- Massachusetts DYS Policy and Procedures 01.05.07(c) - Preventing and Responding to Sexual Abuse, Sexual Exploitation and Sexual Harassment of Youth
- Pre-Audit Questionnaire
- Vulnerability Assessments of ten (10) residents
- Secondary medical documentation
- Files of ten (10) residents

Interviews:

- Interview with Facility Administrator
- Interview with Program Director
- Interview with Facility PREA Compliance Manager
- Interview with Clinical Director

- Interview with Nurse Practitioner
- Interview with mental health staff
- Interview with Intake staff
- Interviews with ten (10) randomly selected residents

Standard 115.382: Access to emergency medical and mental health services

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.382 (a)

- Do resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services, the nature and scope of which are determined by medical and mental health practitioners according to their professional judgment?
  ☒ Yes ☐ No

115.382 (b)

- If no qualified medical or mental health practitioners are on duty at the time a report of recent sexual abuse is made, do security staff first responders take preliminary steps to protect the victim pursuant to § 115.362? ☒ Yes ☐ No

- Do security staff first responders immediately notify the appropriate medical and mental health practitioners? ☒ Yes ☐ No

115.382 (c)

- Are resident victims of sexual abuse offered timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate? ☒ Yes ☐ No

115.382 (d)

- Are treatment services provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident?
  ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

a) Massachusetts DYS Policy and Procedures 01.05.07(c) - Preventing and Responding to Sexual Abuse, Sexual Exploitation and Sexual Harassment of Youth requires resident victims of sexual abuse shall receive timely, unimpeded access to emergency medical treatment and crisis prevention services. It is noted that the resident will be immediately transported to UMASS Memorial Hospital for a forensic medical exam. The outside medical facility's trained Sexual Assault Nurse Examiner (SANE) will make the final determination regarding evidence collection. Staff who can provide support to the victim must accompany the youth. If a youth refuses to be examined at the hospital, such refusal must be properly documented on the appropriate form(s).

Paul T. Leahy Center has a MOU in place with UMASS Memorial Hospital to have a forensic examination completed by a Sexual Assault Nurse Examiner (SANE) and proved medical/mental health services at no cost to the victim. This MOU was provided to this auditor for review. In addition, this auditor contacted a representative from UMASS Memorial Hospital to confirm resident victims are referred to their facility and receive the services noted in the MOU.

There were no residents at the facility who reported sexual abuse involving penetration during the past twelve (12) months. Therefore, there were no residents sent to UMASS Memorial Hospital for a forensic examination. This was confirmed during interviews with the DYS Investigator and the Agency PREA Coordinator.

b) Massachusetts DYS Policy and Procedures 01.05.07(c) requires if no qualified medical or mental health practitioners are on duty at the time of the report of recent abuse is made, staff first responders shall take preliminary steps to protect the victim and shall immediately notify the appropriate medical and mental health practitioner. In addition, first responders will not allow the youth to engage in any activities such as hygiene, washing, bathing, showering, eating, drinking, brushing teeth, chewing gum, and eating or drinking (unless medically necessary). Youth should also be discouraged from urinating or defecating as that may destroy evidence prior to being presented at a hospital for the gathering of such evidence.

All staff members interviewed confirmed the duties of a first responder and were able to describe their responsibilities if they are a first responder to an allegation of sexual abuse.

c) Massachusetts DYS Policy and Procedures 01.05.07(c) states victims of sexual abuse are offered timely information about sexually transmitted infections prophylaxis. This is in accordance with professionally accepted standards of care, where medically appropriate.

This auditor interviewed the Nurse Practitioner, during the on-site portion of the audit, who stated any resident of sexual abuse would be offered information and timely access to sexually transmitted infections prophylaxis while at Paul T. Leahy Center through the community medical provider, UMASS Memorial Hospital .

d) Massachusetts DYS Policy and Procedures 01.05.07(c) states all medical, mental health, and counseling services must be provided at no cost to the youth.

This auditor was able to interview the Facility Administrator and Clinical Director during the on-site portion of this audit and a representative from UMASS Memorial Hospital . All interviewed confirmed that any victim of

sexual assault would be referred to Central Regional Rape Crisis Center and receive medical and mental health treatment at no cost to the victim.

Paul T. Leahy Center has a MOU with the UMASS Memorial Hospital . Central Regional Rape Crisis Center is notified by staff, the hospital, or the facility. They will send an advocate to the hospital and meet with the victim and guide the victim through the SANE examination, investigation process, interviews, and arrange for counseling and support services for the resident. These services will be at no cost to the resident.

Interviews with the Facility Administrator and the Nurse Practitioner confirmed that resident victims of sexual abuse are provided timely and unimpeded access to emergency services at no cost to the victim. This was confirmed by this auditor by reviewing the MOU with UMASS Memorial Hospital , Central Regional Rape Crisis Center, and speaking to a representative from each.

The facility's Institutional Plan fully addresses the requirements of his standard.
Reviewed documentation to determine compliance:

- Massachusetts DYS Policy and Procedures 01.05.07(c) - Preventing and Responding to Sexual Abuse, Sexual Exploitation and Sexual Harassment of Youth
- Pre-Audit Questionnaire
- MOU with UMASS Memorial Hospital
- MOU with Central Regional Rape Crisis Center
- Facility Institutional Plan

Interviews:

- Interview with Facility Administrator
- Interview with Facility PREA Compliance Manager
- Interview with DYS Investigator
- Interview with representative from UMASS Memorial Hospital
- Interview with representative from Central Regional Rape Crisis Center
- Interview with Nurse Practitioner
- Interview with Clinical Director
- Interviews with twelve (12) randomly selected staff

Standard 115.383: Ongoing medical and mental health care for sexual abuse victims and abusers

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.383 (a)

- Does the facility offer medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility? ☒ Yes ☐ No

115.383 (b)

- Does the evaluation and treatment of such victims include, as appropriate, follow-up services, treatment plans, and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody? ☒ Yes ☐ No

115.383 (c)

- Does the facility provide such victims with medical and mental health services consistent with the community level of care? ☒ Yes ☐ No

115.383 (d)

- Are resident victims of sexually abusive vaginal penetration while incarcerated offered pregnancy tests? (N/A if "all-male" facility. *Note: in "all-male" facilities, there may be residents who identify as transgender men who may have female genitalia. Auditors should be sure to know whether such individuals may be in the population and whether this provision may apply in specific circumstances.*) ☒ Yes ☐ No ☐ NA

115.383 (e)

- If pregnancy results from the conduct described in paragraph § 115.383(d), do such victims receive timely and comprehensive information about and timely access to all lawful pregnancy-related medical services? (N/A if "all-male" facility. *Note: in "all-male" facilities, there may be residents who identify as transgender men who may have female genitalia. Auditors should be sure to know whether such individuals may be in the population and whether this provision may apply in specific circumstances.*) ☒ Yes ☐ No ☐ NA

115.383 (f)

- Are resident victims of sexual abuse while incarcerated offered tests for sexually transmitted infections as medically appropriate? ☒ Yes ☐ No

115.383 (g)

- Are treatment services provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident? ☒ Yes ☐ No

115.383 (h)

- If the facility is a prison, does it attempt to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners? (NA if the facility is a jail.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

a) Massachusetts DYS Policy and Procedures 01.05.07(c) - Preventing and Responding to Sexual Abuse, Sexual Exploitation and Sexual Harassment of Youth states if the screening indicates that a resident has previously penetrated or experienced prior sexual victimization, whether it occurred in an institutional setting or in the community, staff shall ensure that the resident is offered a follow-up meeting with a medical or mental health practitioner within 14 days of intake. Massachusetts DYS Policy and Procedures 01.05.07(c) also states that any resident or resident offender will be assessed and offered follow-up counseling that will be on-going within sixty (60) days of learning about the abuse history. However, the counseling usually occurs the same day staff learn about it. In the event a sexual assault incident was to occur, the victim would receive services from the community provider as outlined in the statewide MOU. Treatment services shall be provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperated with any investigation arising out of the incident.

Interviews with the Facility Administrator and interview with Clinical Director confirmed all residents are offered a medical and mental health evaluation upon their arrival to the facility (if they have been a victim of sexual abuse in a residential facility or not). It was noted these evaluations are completed during the resident's first week at the facility.

b) Medical and mental health evaluations completed on each resident at the facility include a diagnosis and recommendation. Clinical Director interviewed noted if a resident was a victim of sexual abuse in a residential facility, follow-up services would occur more frequently, and recommendations would include more specific follow-up services. Medical evaluations are conducted by the medical department of the facility.

c-h) Interview with the Facility Administrator confirmed any resident who is a victim of sexual abuse at the facility would be offered timely follow-up for sexually transmitted diseases as part of the follow-up with the medical department. This would occur if the victim was tested at the hospital or not.

Interviews with the Facility Administrator and Nurse Practitioner confirmed the above-mentioned process occurs as detailed in this standard. In addition, they stated the level of the care that a resident receives is consistent with the community level of care.

There were no incidents of sexual abuse or sexual assault occurring at the facility during the past twelve (12) months. This was confirmed through interviews with Facility Administrator and DYS Investigator. In the event that an incident was to occur, the victim would receive services from the community providers as outlined in the statewide MOU.

Reviewed documentation to determine compliance:

- Massachusetts DYS Policy and Procedures 01.05.07(c) - Preventing and Responding to Sexual Abuse, Sexual Exploitation and Sexual Harassment of Youth
- Pre-Audit Questionnaire
- Files of ten (10) residents

Interviews:

- Interview with Facility Administrator
- Interview with Nurse Practitioner
- Interview with Clinical Director
- Interview with DYS Investigator

DATA COLLECTION AND REVIEW

Standard 115.386: Sexual abuse incident reviews

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.386 (a)

- Does the facility conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation, including where the allegation has not been substantiated, unless the allegation has been determined to be unfounded? ☒ Yes ☐ No

115.386 (b)

- Does such review ordinarily occur within 30 days of the conclusion of the investigation? ☒ Yes ☐ No

115.386 (c)

- Does the review team include upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners? ☒ Yes ☐ No

115.386 (d)

- Does the review team: Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse? ☒ Yes ☐ No
- Does the review team: Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; gang affiliation; or other group dynamics at the facility? ☒ Yes ☐ No
- Does the review team: Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse? ☒ Yes ☐ No
- Does the review team: Assess the adequacy of staffing levels in that area during different shifts? ☒ Yes ☐ No
- Does the review team: Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff? ☒ Yes ☐ No

- Does the review team: Prepare a report of its findings, including but not necessarily limited to determinations made pursuant to §§ 115.386(d)(1) - (d)(5), and any recommendations for improvement and submit such report to the facility head and PREA compliance manager? ☒ Yes ☐ No

115.86 (e)

- Does the facility implement the recommendations for improvement, or document its reasons for not doing so? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

a-e) The Massachusetts DYS Policy and Procedures 01.05.07(c) - Preventing and Responding to Sexual Abuse, Sexual Exploitation and Sexual Harassment of Youth states that within 30 days of the conclusion of every sexual abuse investigation, the facility shall conduct a Sexual Abuse Incident Review of all allegations (Substantiated or Unsubstantiated), unless the allegation has been determined to be Unfounded. The Facility PREA Compliance Manager shall convene a Review Team including upper-level management officials. The Review Team shall obtain input from direct care staff, supervisors, investigators, medical, mental health professionals, and other employees as appropriate. In addition, the Review Team must:

1. Consider whether the allegation or investigation indicated a need to change policy or practice to better prevent, detect, or respond to sexual abuse.
2. Consider whether the incident or allegation was motivated by perceived race, ethnicity, sex, gender identity, sexual orientation, status, gang affiliation, or motivated by other group dynamics at the facility.
3. Examine the area of the facility where the incident allegedly occurred to access whether the physical layout may enable abuse.
4. Assess the adequacy of staffing levels in that area during different shifts.
5. Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff.
6. Prepare a report of its findings, including but not necessarily limited to determinations made pursuant to this section, and any recommendations for improvement and submit such a report to the Facility Director.
7. The facility must implement the recommendations for improvement or must document its reasons for not doing so.

The Facility PREA Compliance Manager stated the Incident Review Team consists of upper-level management officials, medical, clinical, Agency PREA Coordinator, and DYS Investigator. A member of the Incident Review Team was interviewed during the on-site portion of this audit and was able to describe the review process that would take place in the event an allegation of sexual abuse was either Substantiated or Unsubstantiated. He stated the Incident Review Team would convene within thirty (30) days upon the completion of an investigation. Recommendations would include examining the need to change a policy or practice to better prevent, detect, or respond to sexual abuse or sexual harassment. This Sexual Abuse Incident Review is headed by the Facility PREA Compliance Manager.

If there is an incident there is a review process that consists of an upper management team. The Facility Administrator and the Agency PREA Coordinator stated that the team convenes and reviews all reports, reviews video footage, and looks at the physical plant where the incident occurred. The team will make their recommendation in their report to the Agency PREA Coordinator, and Regional Director. All PREA Sexual Abuse Incident Reviews and findings are incorporated into the Annual Report by the Facility Administrator.

There were no incidents within the past twelve (12) months that have required an incident review.

Reviewed documentation to determine compliance:

- Massachusetts DYS Policy and Procedures 01.05.07(c) - Preventing and Responding to Sexual Abuse, Sexual Exploitation and Sexual Harassment of Youth
- Pre-Audit Questionnaire
- Sexual Abuse Incident Review Template

Interviews:

- Interview with Facility Administrator
- Interview with Facility PREA Compliance Manager
- Interview with Agency PREA Coordinator
- Interview with Incident Review Team member

Standard 115.387: Data collection

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.387 (a)

- Does the agency collect accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions? ☒ Yes ☐ No

115.387 (b)

- Does the agency aggregate the incident-based sexual abuse data at least annually? ☒ Yes ☐ No

115.387 (c)

- Does the incident-based data include, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice? ☒ Yes ☐ No

115.387 (d)

- Does the agency maintain, review, and collect data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews? ☒ Yes ☐ No

115.387 (e)

- Does the agency also obtain incident-based and aggregated data from every private facility with which it contracts for the confinement of its residents? (N/A if agency does not contract for the confinement of its residents.) ☒ Yes ☐ No ☐ NA

115.387 (f)

- Does the agency, upon request, provide all such data from the previous calendar year to the Department of Justice no later than June 30? (N/A if DOJ has not requested agency data.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

a-f) The Massachusetts DYS Policy and Procedures 01.05.07(c) - Preventing and Responding to Sexual Abuse, Sexual Exploitation and Sexual Harassment of Youth states that the Director of Investigations in coordination with the Agency PREA Coordinator shall collect uniform data for all allegations of sexual abuse based on incident reports, investigation files, and incident reviews. The Agency PREA Coordinator shall aggregate the incident-based sexual abuse data at least annually. The incident-based data collected shall include, at minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice.

An interview with the Agency PREA Coordinator indicated that she keeps detailed records for all incidents to generate the annual report and/or data required by the United States Department of Justice. These are kept in a secure file in JJEMS which is password protected. There were no allegations of sexual abuse during the past twelve (12) months. Upon request, the facility shall provide all such data from the previous calendar year to the Department of Justice no later than June 30th.

This auditor was able to review the agency website and reviewed the Annual Report that is posted. The Agency PREA Coordinator confirmed that the Survey of Sexual Violence has been requested by DOJ and was completed for 2023. The annual report is prepared by the Agency PREA Coordinator and is approved by the Commissioner for the agency.

Reviewed documentation to determine compliance:

- Massachusetts DYS Policy and Procedures 01.05.07(c) - Preventing and Responding to Sexual Abuse, Sexual Exploitation and Sexual Harassment of Youth
- Pre-Audit Questionnaire
- 2023 Annual PREA Report
- DOJ 2023 Annual Survey
- Agency Website

Interview:

- Interview with Agency PREA Coordinator
- Interview with Facility PREA Compliance Manager

Standard 115.388: Data review for corrective action

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.388 (a)

- Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Identifying problem areas? ☒ Yes ☐ No

- Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Taking corrective action on an ongoing basis? ☒ Yes ☐ No

- Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Preparing an annual report of its findings and corrective actions for each facility, as well as the agency as a whole? ☒ Yes ☐ No

115.388 (b)

- Does the agency's annual report include a comparison of the current year's data and corrective actions with those from prior years and provide an assessment of the agency's progress in addressing sexual abuse ☒ Yes ☐ No

115.388 (c)

- Is the agency's annual report approved by the agency head and made readily available to the public through its website or, if it does not have one, through other means? ☒ Yes ☐ No

115.388 (d)

- Does the agency indicate the nature of the material redacted where it redacts specific material from the reports when publication would present a clear and specific threat to the safety and security of a facility? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

a) Massachusetts DYS Policy and Procedures 01.05.07(c) - Preventing and Responding to Sexual Abuse, Sexual Exploitation and Sexual Harassment of Youth states that they shall meet, no less than annually, to review information collected from all internal investigations and aggregated data included on the Survey of Sexual Violence Summary in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training including:

1. Identifying problem areas
2. Taking corrective action on an on-going basis
3. Preparing an annual report of its findings and corrective actions

Such a report shall include a comparison of the current year's data and corrective actions with those from the prior years and shall provide an assessment of Paul T. Leahy Center's progress in addressing sexual abuse.

b-c) The annual report shall be approved by the Commissioner of DYS and made readily available to the public through the DYS website. Specific material is redacted from the reports when publication would present a clear and specific threat to the safety and security of the facility but must indicate the nature of the material redacted. DYS shall also remove all personal identifiers from the report. The most recent Annual PREA Report (2023) is posted on the agency website and was reviewed by this auditor.

d) Upon request, DYS provides all program specific data from the previous calendar year to the Department of Justice in the form of the Survey of Sexual Victimization. This survey was completed by the Agency PREA Coordinator and posted on the agency website.

Reviewed documentation to determine compliance:

- Massachusetts DYS Policy and Procedures 01.05.07(c) - Preventing and Responding to Sexual Abuse, Sexual Exploitation and Sexual Harassment of Youth
- Massachusetts DYS Policy and Procedures 01.08.02 – Information Security Policy
- Pre-Audit Questionnaire
- PREA Annual Report (2023)
- DYS website

Interviews:

- Interview with Facility Administrator
- Interview with Agency PREA Coordinator

Standard 115.389: Data storage, publication, and destruction

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.389 (a)

- Does the agency ensure that data collected pursuant to § 115.387 are securely retained? ☒ Yes ☐ No

115.389 (b)

- Does the agency make all aggregated sexual abuse data, from facilities under its direct control and private facilities with which it contracts, readily available to the public at least annually through its website or, if it does not have one, through other means? ☒ Yes ☐ No

115.389 (c)

- Does the agency remove all personal identifiers before making aggregated sexual abuse data publicly available? ☒ Yes ☐ No

115.389 (d)

- Does the agency maintain sexual abuse data collected pursuant to § 115.387 for at least 10 years after the date of the initial collection, unless Federal, State, or local law requires otherwise? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

a-d) Massachusetts DYS Policy and Procedures 01.05.07(c) - Preventing and Responding to Sexual Abuse, Sexual Exploitation and Sexual Harassment of Youth requires that aggregated sexual abuse data is made readily available to the public at least annually through the agency website. Data collected is retained for ten (10) years after the initial collection, unless Federal, State, or local law requires otherwise.

The facility's Annual PREA Report is reviewed and approved by the Commissioner of DYS and made available to the public through its website. The Agency PREA Coordinator noted that no personally identifiable information is included in the report. The most recent Annual PREA Report (2023) is posted on the DYS website and was reviewed by this auditor.

Reviewed documentation to determine compliance:

- Massachusetts DYS Policy and Procedures 01.05.07(c) - Preventing and Responding to Sexual Abuse, Sexual Exploitation and Sexual Harassment of Youth
- Massachusetts DYS Policy and Procedures 01.08.02 – Information Security Policy
- Pre-Audit Questionnaire
- PREA Annual Report (2023)
- DYS website

Interviews:

- Interview with Agency PREA Coordinator
- Interview with Facility Administrator

AUDITING AND CORRECTIVE ACTION

Standard 115.401: Frequency and scope of audits

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.401 (a)

- During the prior three-year audit period, did the agency ensure that each facility operated by the agency, or by a private organization on behalf of the agency, was audited at least once? (*Note: The response here is purely informational. A "no" response does not impact overall compliance with this standard.*) ☒ Yes ☐ No

115.401 (b)

- Is this the first year of the current audit cycle? (*Note: a "no" response does not impact overall compliance with this standard*.) ☐ Yes ☒ No

- If this is the second year of the current audit cycle, did the agency ensure that at least one-third of each facility type operated by the agency, or by a private organization on behalf of the agency, was audited during the first year of the current audit cycle? (N/A if this is **not** the *second* year of the current audit cycle.) ☐ Yes ☐ No ☒ NA

- If this is the third year of the current audit cycle, did the agency ensure that at least two-thirds of each facility type operated by the agency, or by a private organization on behalf of the agency, were audited during the first two years of the current audit cycle? (N/A if this is **not** the *third* year of the current audit cycle.) ☒ Yes ☐ No ☐ NA

115.401 (h)

- Did the auditor have access to, and the ability to observe, all areas of the audited facility? ☒ Yes ☐ No

115.401 (i)

- Was the auditor permitted to request and receive copies of any relevant documents (including electronically stored information)? ☒ Yes ☐ No

115.401 (m)

- Was the auditor permitted to conduct private interviews with residents, residents, and detainees? ☒ Yes ☐ No

115.401 (n)

- Were residents permitted to send confidential information or correspondence to the auditor in the same manner as if they were communicating with legal counsel? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

a-n) Paul T. Leahy Center was first audited in 2016, during the third year of the first three-year cycle. The facility was re-audited during the third year of the second three-year cycle on April 30, 2019 and found to be fully compliant. The facility was re-audited again during the third year of third three-year cycle on March 28, 2022 and found to be fully compliant.

The facility provided all requested information via e-mail. The audit notification was posted more than six (6) weeks prior to the on-site portion of this audit (posted on January 10, 2025), and pictures of the notifications posted in all common areas, living units, conference room, staff offices, and the front entrance were submitted to the auditor via email. During the tour of the facility, the notifications were still posted and viewed by this auditor. This auditor did not receive any correspondence from staff or residents. This auditor was permitted to and did tour all areas of the facility and was provided a private and confidential area of the facility to complete interviews of residents and staff.

The facility has met this standard by having its facility audited during the first 3-year cycle. The report is posted on the DYS website.

Reviewed documentation to determine compliance:

- Pre-Audit Questionnaire
- Tour of facility
- DYS website
- PREA Audit Notification
- Photographs of PREA Audit Notification

Standard 115.403: Audit contents and findings

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.403 (f)

- The agency has published on its agency website, if it has one, or has otherwise made publicly available, all Final Audit Reports. The review period is for prior audits completed during the past three years PRECEDING THIS AUDIT. The pendency of any agency appeal pursuant to 28 C.F.R. § 115.405 does not excuse noncompliance with this provision. (N/A if there have been no Final Audit Reports issued in the past three years, or in the case of single facility agencies that there has never been a Final Audit Report issued.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Final PREA audit report from 2022 is posted on the DYS website. The final PREA reports were posted within ninety (90) days of issuance by the auditor. This was confirmed by reviewing the DYS website and an interview with the Agency PREA Coordinator.

Reviewed documentation to determine compliance:

- DYS website

Interview:

- Interview with Agency PREA Coordinator

AUDITOR CERTIFICATION

I certify that:

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

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

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

Auditor Instructions:

Type your full name in the text box below for Auditor Signature. This will function as your official electronic signature. Auditors must deliver their final report to the PREA Resource Center as a searchable PDF format to ensure accessibility to people with disabilities. Save this report document into a PDF format prior to submission.[1] Auditors are not permitted to submit audit reports that have been scanned.[2] See the PREA Auditor Handbook for a full discussion of audit report formatting requirements.

Farooq Mallick /s/ May 6, 2025

Auditor Signature **Date**

[1] See additional instructions here: https://support.office.com/en-us/article/Save-or-convert-to-PDF-d85416c5-7d77-4fd6-a216-6f4bf7c7c110 .

[2] See *PREA Auditor Handbook*, Version 1.0, August 2017; Pages 68-69.