# PREA Facility Audit Report: Final

**Name of Facility:** Stevenson House Detention Center
**Facility Type:** Juvenile
**Date Interim Report Submitted:** 06/04/2018
**Date Final Report Submitted:** 07/18/2018

| Auditor Certification | |
|---|---|
| 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. | ☑ |
| I have not included in the final report any personally identifiable information (PII) about any inmate/resident/detainee or staff member, except where the names of administrative personnel are specifically requested in the report template. | ☑ |
| **Auditor Full Name as Signed:** Tammy A. Hardy-Kesler | **Date of Signature:** 07/18/2018 |

| AUDITOR INFORMATION | |
|---|---|
| **Auditor name:** | Hardy-Kessler, Tammy |
| **Address:** | |
| **Email:** | codyemomma@msn.com |
| **Telephone number:** | |
| **Start Date of On-Site Audit:** | 04/02/18 |
| **End Date of On-Site Audit:** | 04/04/18 |

| FACILITY INFORMATION | |
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| **Facility name:** | Stevenson House Detention Center |
| **Facility physical address:** | Route 113 Box 278, Milford, Delaware - 19963 |
| **Facility Phone** | 302-424-8100 |
| **Facility mailing address:** | |
| **The facility is:** | ○ County<br>○ Municipal<br>◉ State<br>○ Private for profit<br>○ Private not for profit |
| **Facility Type:** | ◉ Detention<br>○ Correction<br>○ Intake<br>○ Other |

| Primary Contact | | | |
|---|---|---|---|
| **Name:** | Kevin.Solomon | **Title:** | PREA Compliance Manager |
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| Warden/Superintendent | | | |
|---|---|---|---|
| **Name:** | Katherine Kenney | **Title:** | Suptintendent |
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| Facility PREA Compliance Manager | | | |
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| **Name:** | Kevin Solomon | **Email Address:** | Kevin.Solomon@state.de.us |

| Facility Health Service Administrator | | | |
|---|---|---|---|
| **Name:** | Barbara Stewart-Boyles | **Title:** | Nursing Manager |
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| Facility Characteristics | |
|---|---|
| **Designed facility capacity:** | 77 |
| **Current population of facility:** | 12 |
| **Age range of population:** | 12-18 |
| **Facility security level:** | Level V |
| **Resident custody level:** | s/a |
| **Number of staff currently employed at the facility who may have contact with residents:** | 111 |

| AGENCY INFORMATION | |
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| **Name of agency:** | Division of Youth Rehabilitative Services |
| **Governing authority or parent agency (if applicable):** | Department of Children, Youth And Their Families |
| **Physical Address:** | 1825 Faulkland Road , Wilmington , Delaware - 19805 |
| **Mailing Address:** | |
| **Telephone number:** | 302-633-2620 |

| Agency Chief Executive Officer Information: | | | |
|---|---|---|---|
| **Name:** | John Stevenson | **Title:** | Director |
| **Email Address:** | John.Stevenson@state.de.us | **Telephone Number:** | 302-633-2620 |

| Agency-Wide PREA Coordinator Information | | | |
|---|---|---|---|
| **Name:** | Darryl Dawson | **Email Address:** | darryl.dawson@state.de.us |

## AUDIT FINDINGS

**Narrative:**
The auditor's description of the audit methodology should include a detailed description of the following processes during the pre-audit, on-site audit, and post-audit phases: documents and files reviewed, discussions and types of interviews conducted, number of days spent on-site, observations made during the site-review, and a detailed description of any follow-up work conducted during the post-audit phase. The narrative should describe the techniques the auditor used to sample documentation and select interviewees, and the auditor's process for the site review.

The Prison Rape Elimination Act onsite audit was conducted on April 2-4, 2018 for the W.M. Stevenson House Detention Center (SHDC). The facility is in the jurisdiction of the Delaware Department of Services for Children, Youth, and Their Families (DSCYF) and is operated by the Division of Youth Rehabilitative Services (DYRS). It should be noted that DSYCF which operates SHDC is the state's child welfare agency. The audit was completed by Tammy A. Hardy-Kesler and the Auditor's Assistant, Renee McKellar of TAHK Consultants. All necessary clearances were completed for entry to the facility. Contract procurement was executed and finalized on March 9, 2018 with TAHK Consultants. Previous onsite audit was completed on July 1, 2015. The designated Auditor was Charles J. Kehoe of Midlothian, Virginia. Initially, SHDC was deemed non-compliant on the following PREA standard 115.316 which pertains to the PREA Brochure/Resident Handbook, and PREA standard 115.341 which pertains to PREA Risk Assessments being completed within 72 hours. The corrective action plan was completed, and the facility was found to comply with all the PREA standards on December 31, 2015 by Mr. Kehoe.

The PREA Coordinator and the Auditor decided to utilize the Online Audit System due to the ability of the system to maintain secured information between both parties. Additionally, the Auditor and the PREA Coordinator were both familiar with the system from a previous audit. There were no barriers that existed to completion of the audit by the Auditor, DSCYF, DYRS or SHDC.

The audit method utilized was practice based with collection of findings utilizing observation of practice, random document review of staff and resident files, review of policy and procedure as pertains to Prison Rape Elimination Act (PREA), and interviews of specialized staff, a volunteer, identified targeted youth, random staff, and random youth.

Research was completed by the Auditor prior to the onsite audit facilitating the Auditor's familiarity with the facility and agency. An online news agency, Delaware Online an affiliate of USA Today Network published an article entitled "Staffing issues impacting Delaware child abuse investigations, juvenile detention." The article mentions that DSCYF asked the Delaware lawmakers to increase funding for DSCYF to increase staffing. In the case of the 2 state operated detention centers, the article details the use of mandatory overtime and the utilization of temporary and part-time employees to cover shifts at the detention facilities. Also, the article mentions that the department is holding job fairs as well as seeking pay increases for its staff in the hopes of filling vacant positions. Further research established that SHDC is not operating under any federal consent decrees.This was further confirmed by the PREA Coordinator.

Found on DSCYF's website was a comprehensive section dedicated to PREA and reporting sexual abuse and sexual harassment. The following was available on the website:

- All Final Reports of audited state operated facilities from 2015-2017
- Survey of Sexual Victimization Report from 2008-2016

• DYRS PREA Annual Report from 2012-2017
• PREA Risk Assessment Report from 2015-2017
• Mandatory Reporting Laws Information with form that must accompany the call

The website also available was the Mandatory Reporting Laws requirement which states that law enforcement, educators, and medical personnel are required to report incidences of any abuse to the Child Abuse Hotline, and they are required within 72 hours of the call to complete the mandatory reporting form that must be mailed or faxed to the Delaware Division of Family Services.

The Auditor had not received any confidential correspondence prior to the onsite audit from either residents or staff prior to the onsite audit. The timeframe being referred to was from February 27, 2018 to April 2, 2018.

Prior to the onsite visit, the Professional Standards Manager/PREA Coordinator provided the Auditor with the completed Pre-Audit Questionnaire (PAQ) through the PREA Online Audit System (OAS). The PREA Coordinator began preparing the PAQ on 1/26/18, and the Auditor received access to the PAQ through the Online Automated System on 3/16/18. The completed PAQ contained the policies that pertained to PREA, agency wide policies, blueprints, forms, meeting documents, emails, brochures, Spanish and English student handbook, specialized PREA training certificates, an invoice, response plan checklist, memorandum of agreements, memorandum of understandings, affirmations, and operating guidelines for residential contracts funded by DYRS. Prior to the onsite audit, documents were reviewed to establish the level of compliance to the PREA standards.

On February 27, 2018, the PREA Compliance Manager posted notifications throughout SHDC of the upcoming onsite audit scheduled for April 2-4, 2018. The Compliance Manager provided a time stamped photograph of when the notifications were posted. Notifications were provided to inform residents and staff of the onsite audit as well as the information to send confidential notification to the Auditor. During the onsite audit tour of the facility, the notifications were found to be located at the entry of the facility and continued throughout the building, including all housing units. The postings were placed on a light green paper which were highly visible in comparison to other papers posted in the facility. The text was typed in a large and simple font. When the posting was sent to the PREA Coordinator, it was explained by the Auditor that staff and detainees should be allowed to communicate with the Auditor in the same manner that legal mail is handled.

Prior to the onsite audit, the Auditor compared the PREA Compliance Audit Tool to the Pre-Audit Questionnaire that was provided by the PREA Coordinator. The comparison revealed that there was some missing information. During the first day of the onsite audit the PREA Coordinator was provided a list which detailed the information needed to complete the audit. Additionally, this list was utilized during interviews of specialized staff to ascertain further information as well as the needed documentation. The information requested included updated policies since the submission of the Pre-Audit Questionnaire, staff list, resident list, staffing plan, PREA related logs and footage of rounds, documentation if any exigent circumstances, training curriculum, proof of background checks both criminal and child abuse registry, PREA Risk Assessment, and all documentation related to sexual abuse and sexual harassment allegations. Additionally, there were communications between the PREA Coordinator and the Auditor throughout all the phases of auditing. Lines of communication were done through telephone and email. The PREA Coordinator always provided information that was requested immediately.

Conversations occurred between the Auditor and the PREA Coordinator frequently via telephone and

email. It was understood between the Auditor and the PREA Coordinator that the goal of the audit was to ascertain compliance to the PREA standards and ensure the sexual safety of both residents and staff at SHDC. The expectation of the Auditor is that the facility allows unimpeded access to staff, residents, documentation, and the facility plant. The Auditor explained the common practice for new auditors which entails a probationary review. This review will slightly extend the timetables for the documentation being dispersed to SHDC.

Prior to the onsite audit, the PREA Coordinator and the Auditor discussed how the Auditor could interview 9 of the specialized staff that were at the DSYCF Main campus located in Wilmington, Delaware which is approximately 70 miles North of SHDC. Since the Auditor was traveling southbound to Milford, Delaware, the Auditor recommended that those staff would be done at the DSYCF Main Campus in Wilmington, Delaware. During the first day of the onsite audit, the confidential interviews with specialized staff convened in the conference room at the DSYCF Main Campus Office.

Preceding the interviews, there was an opening meeting with the Agency Head, PREA Coordinator, PREA Compliance Manager for SHDC, Auditor, and the Auditor's Assistant. During this meeting, a checklist was given to the PREA Coordinator which listed items that were needed to complete the audit. Items on the list included, but was not limited to, the roster of residents as well as a roster of staff according to shift. All items requested were given immediately to the Auditor upon arrival at SHDC the next day. During the onsite audit, all request for access to detainees, staff, and documents was unimpeded, and met with immediate action.

Further, the Auditor explained the task of collecting evidence of PREA compliance by the review of documentation, interviews, and the facility's practices. Prior to the audit and during the initial meeting, the Auditor explained that the probationary status that is required of all new Auditors which meant that the timelines that are customary will be longer. During the closing meeting, the Auditor requested a copy of the previously viewed footage of the unannounced search by the Superintendent and the Assistant Superintendent which was provided within a week of request via email. Business cards by administrators were exchanged so that all means of communication were made available.

Inquiry was made with Just Detention International (JDI) to obtain if any allegations of sexual harassment or sexual abuse had been reported for the SHDC in Milford Delaware. On March 27, 2018, a message was received from JDI stating there were no reports of sexual harassment and sexual abuse made within the last 12 months. The Auditor contacted a local community-based advocacy group and the local hospital. Survivors of Abuse in Recovery (SOAR) was contacted as well as the local medical center, Milford Hospital. Both agencies concurred that they had not received any correspondence of any sort by youth detained at SHDC.

Prior to the onsite audit, the Auditor compared the PREA Compliance Audit Tool to the Pre-Audit Questionnaire that was provided by the PREA Coordinator. The comparison revealed that there was some missing information. During the first day of the onsite audit the PREA Coordinator was provided a check list which detailed the information needed to complete the audit. Additionally, this checklist was utilized during interviews of specialized staff to ascertain further information as well as the needed documentation. The information requested included updated policies since the submission of the Pre-Audit Questionnaire, staff list, resident list, staffing plan, logs/footage of rounds, documentation of exigent circumstances, training curriculum, proof of background checks both criminal and child abuse registry for staff and volunteers, PREA risk assessment tool, and all documentation related to sexual abuse and sexual harassment allegations.

During the first day of the onsite audit, the Auditor met on campus at the DYRS Administration Building in Wilmington, Delaware. At that time, it was established that the Auditor would be centralized in the conference room to conduct the opening meeting and confidential interviews with administrative specialized staff. Brief introductions were made between the Auditor, the Auditor's Assistant, Director of the Agency, PREA Coordinator, and the PREA Manager. The PREA Coordinator gave a summary of the DSCYF, DYRS, and SHDC. Further, there was a discussion regarding the interview schedule and the onsite tour of the facility.
For the remainder of the audit, the Auditor was located at SHDC. Within the facility the Auditor conducted confidential interviews with randomly selected staff and additional specialized staff in the administrative conference room. Confidential interviews with randomly selected residents was held in the library. Upon arrival to the facility the following day, the PREA Manager made available the list of staff and residents. At that time, random staff and random residents based on the length of stay were selected for interviews. The file review of residents was based on the youth interviewed. The staff files were selected from various shifts and diversity in the length of employment. The remainder of the specialized staff list and schedule for interviews were already prepared by the PREA Coordinator. Staff from all three shifts were representative of random staff interviewed. The Auditor also interviewed staff that were hired within the year as well as staff that were at the facility for over 10 years. Additionally, a non-custody staff member was also interviewed. When interviewing the staff that held the position as YCR, it was found that the position encompassed at least two responsibilities identified as specialized staff according to PREA. The position required first responder duties and intake responsibilities.

The Auditor interviewed the following positions that were in alignment with the required specialized staff list:

Agency Head
PREA Coordinator
PREA Compliance Manager services as YCR Supervisor and Incident Review Team
Assistant Superintendent-Administrative Investigator, Retaliation Monitor, and PREA rounds
Standards Manager
Contracts Manager
Criminal History Unit Representatives
Human Resource Representatives
Management Analyst
SHDC Nursing Supervisor
SHDC Psychologist serves
Training Manager
Institutional Abuse Investigators
Volunteer
Milford Hospital Representative
Representative of SOARS
2 Institutional Abuse Investigators

Following the introductory meeting, the Auditor began interviews of specialized staff. Specialized staff interviews provided details of operational processes and practices within the agency and the facility. To ascertain evidence of compliance to the PREA standards, the PREA Resource Center Interview Protocols were utilized as well as additional questioning when necessary. Interviews included 8 random residents, 2 residents of a target group, 10 random staff, and 18 specialized staff.

At the time of the onsite audit, there were 18 residents detained at SHDC. Out of the 18 residents, there were 10 residents interviewed. There were no open allegations of sexual abuse or sexual harassment and no youth that were still available from earlier allegations of sexual abuse and sexual harassment. All allegations were made prior to July 2017, and the average length of stay at SHDC is very low so these factors impeded the ability to interview residents that were either victims or perpetrators of sexual abuse or sexual harassment at SHDC. During the opening meeting and the individualized interviews with the PREA Compliance Manager, Nurse Supervisor, and Psychologist, they were asked for the identification of any residents on the roster that were identified as a member of a target group. There were two residents that were identified as members of a target group. The target groups identified were during the PREA Risk Assessment which resulted in a youth that reported prior sexual victimization and a youth that identified as LGBQTI. Both youth were identified during the risk assessment. During the interview process with the youth, one resident identified as a member of the target group and the other did not corroborate belonging to target, but was willing to participate in the remainder of the interview process. At the time of the onsite audit, there were no residents identified as disabled, isolation or limited English proficient. During the onsite tour, there were no residents found in isolation and according to all interviews, the facility does not practice isolation. All residents that were interviewed were asked if they identified with any of the target groups.

DYRS has a process to collect all data pertaining to any sexual harassment and sexual abuse that occurs at either a state operated facility or a contracted residential facility. The Management Analyst is responsible for maintaining the documentation. The agency makes all aggregated reporting available to the public on the agency's website without disclosing any personal identifiers.
Staff were asked questions pertaining to the DYRS PREA Policy 2.13, which indicates zero-tolerance for any incidences of sexual activity, definitions of terms utilized in the policy, procedures, prevention, reporting by staff, reporting by youth, investigations, victim services, and data collection, training, forms, and first responder responsibility.

During the interviews with randomly selected residents, the PREA Resource Interview Protocols were utilized as well as other PREA related questions. Inquiry of randomly selected residents included their understanding of zero tolerance for any sexual activity; their knowledge of mechanisms to report incidences of sexual abuse and sexual harassment; the right to be free of sexual harassment, abuse, and retaliation; discipline associated with sexual harassment, abuse and retaliation; and access to medical and counseling services in the instances of sexual harassment and sexual abuse.

Interviews with staff and residents both revealed high levels of proficiency in retention of information pertaining to PREA. The staff could recall first responder responsibilities, methods to report for both residents and staff, and the agency's stance on zero tolerance for sexual abuse and sexual harassment. Youth could recall methods to report incidents of sexual abuse and sexual harassment, their right to be free from sexual abuse and sexual harassment, and when they received their trainings. Review of training records proved that both staff and residents had signed that they had received training and received documentation on the PREA standards. In the case of the residents, the records revealed that they received an initial introduction to PREA at intake and within 10 days they were given a comprehensive orientation to PREA.

The remainder of the specialized staff was interviewed at the facility. At the time of the audit, school was not in session. PREA Compliance Manager provided the youths daily schedule as well as various programs and treatments that were provided to youth. The Auditor had the opportunity to interview a non-custodial staff at SHDC. The staff member could share their responsibility in the case of sexual

abuse or sexual harassment. It was further disclosed in the interview that this staff member's interaction with youth was always with the presence of custodial staff.

SHDC has 3 volunteers that provide life skills and faith-based services. There was 1 volunteer that was interviewed. Based on responses from questions, the volunteer comprehended the responsibilities under PREA. During the last 12 months the facility has not been in contract with Christiana Care Hospital for medical services.

In corroboration with the DYRS Policy #2.13, each department provided detailed samples of practice that demonstrated the facility's ability to prevent, detect, and respond to allegations of sexual harassment, sexual abuse, and retaliation. Staff that was responsible for direct care and medical/mental health professionals explained their role in completing risk assessments as well as mandatory reporting and responding to incidents of sexual harassment and sexual abuse. Further, there was collaboration with the medical and mental health personnel regarding the formal agreements with the Milford Hospital for forensic medical examination and Survivors of Abuse in Recovery (SOAR).

The Investigator's interviews were done by telephone. During the interviews, there was a detailed account of the process by which investigations are handled in the case of allegations of sexual harassment and sexual abuse within the SHDC. Both the Institutional Abuse Unit (IA) of the Division of Services for Children, Youth, and Their Families (DSCYF), the Delaware State Police (DSP) and/or the Milford Police Department (MPD) investigates allegations of sexual abuse at SHDC. Further, there was a discussion of the process in the preservation of evidence. Towards the end of the interview, there was a dialogue surrounding the case if a victim recants, and it was found that if a victim recants, it is the obligation of the investigator to continue the investigation. The Institutional Abuse Investigators of DSYFC disclosed that there were allegations of sexual abuse and sexual harassment by both youth and staff. It was found by the IA that the allegations did not reach the level of an investigation by IA so the investigation was turned over to the facility's Administrative Investigators. The Auditor reviewed the incident reports and documentation pertaining to sexual abuse and sexual harassment allegations from the Management Analyst. The Auditor reviewed all documentation utilizing the PREA Audit-Juvenile Facilities Documentation Review-Investigations.

The administrative investigations are the responsibility of the DYRS Administration Investigator, and civil investigations are the responsibility of IA. All criminal investigations are investigated by DSP and/or MPD. Within the last 12 months of reporting there was 5 allegations of sexual abuse and sexual harassment at SHDC. The Auditor reviewed 5 Sexual Abuse Incident Review Forms, and it was found that there was 4 unsubstantiated and 1 unfounded claim of sexual harassment and sexual abuse within the 12-month reviewing period. These findings were in alignment with the interviews of the Investigators, Assistant Superintendent, Management Analyst, PREA Coordinator, and the PREA Compliance Manager. At the time of the audit, the youth that were involved in the allegations were no longer detained at the facility. Following information was ascertained upon review of the documentation provided on the sexual abuse and sexual harassment allegations:

1. Youth on Youth Abusive Sexual Act Unsubstantiated
2. Youth on Youth Abusive Sexual Act Unfounded
3. Staff on Youth Sexual Harassment Unfounded
4. Staff on Youth Sexual Harassment Unsubstantiated
5. Staff on Youth Staff Sexual Misconduct Unsubstantiated

It was further established that there were no sexual abuse or sexual harassment allegations in progress with the Management Analyst, PREA Coordinator or the PREA Compliance Manager. All the cases were investigated by the administrative investigators. The allegations were not investigated further by IA or the criminal investigators of DSP or MPD. During the interview with IA, the process of referral of investigations was to follow the protocol that the Child Abuse Hotline was to be contacted initially, and then the caseworker from the Child Abuse Hotline would in turn contact IA. Once IA received the information, they would determine whether the investigation necessitated the involvement of IA and MPD/DSP. If it was found that those investigative bodies were not necessary, the responsibility of investigation would be finalized with the administrative investigators and the Human Resource Department. In total, there were 5 administrative investigations completed. During the last 12 months, there were no criminal cases of sexual abuse or sexual harassment referred to prosecution, indicted, acquitted, or convicted.

The onsite tour was completed over 3 days for the Auditor to see all aspects of operation from agency level on the main campus to the facility operation, physical layout, and central command video monitoring configuration. During the tour of the facility, the Auditor was accompanied by either the PREA Coordinator and/or the PREA Compliance Manager. The facility was toured internally and externally to observe for areas of concern for sexual safety. The Auditor insured that the blueprints provided were in alignment with the actual physical structure. During the onsite audit, the Auditor requested the fire drill blueprints, because the blueprint provided was not comprehensive. During the onsite tour, the Auditor observed that the building was well maintained, organized, walls were without defacing, classrooms were up to date with interactive whiteboards, and rapport between staff and residents was satisfactory. There are 3 shifts that operate within the facility. It should be noted that the Auditor met with staff from all 3 shifts. Upon review of staffing plan for 2017, the plan exceeded requirements of the PREA standards. There was no deviation of the staffing plan, confirmed by random review of staff post assignments and random log review. The Residential SHDC enforces the freeze or retention of staff if there is any risk of possible staff shortage on a shift. According to random staff, freeze is the procedure that is utilized if there is a potential of staff shortage.

During the first day of touring the facility, the location of video monitoring, Child Abuse Hotline Phones, and PREA related posters were determined. Also, practices and procedures were monitored as well. On the second day of the tour video monitoring was operated to locate any blind spots and areas of concern. There was one blind spot that was identified which entailed further discussion with PREA Coordinator and PREA Compliance Manager. The blind spot was in the Intake Sally Port in which youth enter and exit facility. Additionally, the law enforcement weapons box is at that point of entry and exit.

When entering the facility, there is an atrium which is monitored by video and personnel. Upon entering the secured area, sits Central Command which has 2 video monitoring areas with 3 monitors each and 1 control touch screen each. Alongside of the atrium is the swiped secured administrative offices. Within that area, resident administrative records were secured in a file room. The Auditor found the records to be secured.

Further, on the opposite hallway is the visitation room. According to the PREA Compliance Manager, this room is utilized for visitation by family, movie night, program interviews, and there are 2 attached rooms for private attorney consultation. Also, there is another visitation room that the original intent was for no touch visitation. The area is commonly used for canteen.

Next to the visitation area is the gym which contains a restroom as well as a large outside recreation

yard. Both areas have video monitoring. The youth use the bathrooms located in the hallway outside of the gym. Next to the gym is the library which has video monitoring. Additionally, the library is the area in which the residents receive comprehensive PREA orientation. Posted on the walls were several PREA related posters and on the table, there were student handbooks and PREA related material. During the facility tour, the PREA Compliance Manager gave a mock demonstration of the comprehensive PREA training given to youth which included a lecture, distribution of literature, and a video. The video was from the Moss Group PREA training materials. Additionally, it was found by Auditor that there were interpreter services available through a contract for several languages as well as sign language. According to the PREA Compliance Manager, SHDC has not sought any of the translation or interpretive services in the last 12 months. Additionally, it was disclosed that the Spanish language is the second predominant language spoken in the geographic area.

There are several areas that are not accessible to youth. These areas do not have video monitoring. One of the areas is the Education Suite in which teachers prepare lessons and complete education related documentation. Another area is the maintenance laundry area which has swipe access. The kitchen is also swipe access, and the youth do not assist with meal preparation. The loading dock area is accessed by Central Command, and it has video monitoring.

Further in the facility, there was a large medical suite with an attached dental suite. There were 2 cameras in the hallways of the suite. The Auditor observed where medical and mental health files were located and stored. All files were locked at the time of tour. The Auditor briefly questioned the Nurse Supervisor on the posting of staff during medical services. During examinations, there are two medical personnel available in the examining room. The youth are always accompanied by custody staff when coming to the medical suite. While Auditor was present, there was custody staff in the suite with a youth. During the interview with the Nurse Supervisor and the Psychologist and the onsite tour of the medical/mental health suite, the Auditor was given a detail account of the PREA Risk Assessment Process by the Nurse Supervisor. Due to the infrequency of new admits, the Auditor had to rely on the interviews by residents that verified that the Nurse Supervisor or the Psychologist completed the PREA Risk Assessments in the medical/mental health suite.

In as far as classification of youth, the medical or mental health staff provides an email to administration regarding gender conforming or non-conforming and the classification of youth into housing units based on PREA Risk Assessment. While onsite, the Auditor reviewed correspondence between the medical and mental health personnel and administration.

Throughout the facility, there were PREA posters in both English and Spanish. Within the library where the comprehensive PREA training occurs for youth, there were copies of informational and training materials that were easily accessible to youth. At the entryway of SHDC, there were PREA related brochures and materials for third-party reporters to access.

In total, there are 6 housing units at SHDC, and there are 3 housing units that are in operation as living units. There is 1 female unit and 2 male units. All units have staff offices attached to the activity area. The only exception is the intake unit which does not have an activity area or classrooms. All the units at SHDC have exceptional observational qualities. All areas are easily visible, and the video monitoring can view all angles of the housing unit’s activity areas including outside recreation yards. There is no visibility into youth’s cells.

Upon entering a housing unit, the Auditor observed the PREA Compliance Manager announce a opposite

gender presence before entering the unit. The cross-gender announcement was made twice. First announcement was made on the radio, and the next announcement was made at doorway. This practice of announcing opposite gender presence was further confirmed by the interviews with random staff and youth.

On the housing units, the Auditor located the grievance collection areas for each unit. Within each location was a writing utensil as well as blank grievance sheets. Based on the information obtained during the tour and the interviews, residents can complete a grievance sheet regarding sexual abuse and sexual harassment, and the information is immediately called into the Child Abuse Hotline.

Additionally, each housing unit has individualized bathing stalls which is secured by a door. The individualized bathing stalls are sectioned so that a youth could bath in one section and dress in another without being viewed by staff or other youth. According to residents and staff, the door is unlocked and youth is granted entry. The door is secured on the outside by staff, and when the youth is finished grooming and fully dressed, the youth can exit. After interviewing both random residents and random staff, it was corroborated that residents undress, shower, and re-dress prior to coming out of individualized bathing stalls. The units are equipped with wet rooms. The Auditor checked the configuration of the wet room to see if a youth could be viewed toileting by staff on unit or by video monitoring. After looking at footage and standing in cell, it was found that residents could not be viewed toileting.

One of the housing units is specifically designed for intake. During the onsite tour, the PREA Compliance Manager demonstrated the intake process. The demonstration included the unclothed search and the initial information given to youth regarding PREA. During the mock unclothed search, the Auditor was shown the positioning of intake worker at the door and the verbal commands given to youth during the search. Also, the positioning of the witnessing staff of the unclothed search was also shown. Due to the infrequency of new admits, the Auditor had to rely on the demonstration as well as random staff, youth, and targeted groups interviews to corroborate that this is in fact the process completed for each new admit.

The Auditor located the phones utilized to contact the Child Abuse Hotline to report all allegations of sexual harassment, abuse, and retaliation. Youth at SHDC can report instances of sexual abuse and sexual harassment on the phones located on the housing units. The Auditor randomly checked the Child Abuse Hotline phones on each housing unit, and all phones that were checked were in working order and dialed directly to the Child Abuse Hotline. The Auditor spoke to the operator within several seconds of placing call. Each unit except Intake was equipped with at least one Child Abuse Hotline Phone that dialed directly to the dispatcher. Random phones were checked by Auditor for operation. All phones that were checked were operational and the Auditor could connect to the dispatcher within seconds of the call being placed. Dispatchers were aware of PREA and the Auditors responsibility to check that phones were accessible and operational for youth if the need arose to report allegations of sexual harassment and sexual abuse.

Additionally, housing units that are not being utilized are used as storage and there is one that is utilized for indoor recreation purposes. According to PREA Compliance Manager if there becomes a need for more housing units, the units can be easily converted to housing units by storing items in another location. Adjacent to housing units are classrooms which are all equipped with video monitoring. At this time, classrooms that are not utilized for educational purpose are being utilized as offices.

During the tour of SHDC, it was noted that there were no isolation rooms in any of the 3 occupied living units. If necessary, the other unoccupied units can be utilized if a need arose in which a youth needed to be placed for protective custody or quarantined due to a communicable disease. According to the random youth interviewed, they have not witnessed or been placed in isolation. During the tour of facility, there was a mobile bed that was used when a youth had to be in close proximity to staff. Additionally, this practice was observed from footage reviewed from C shift.

On the initial day of the onsite visit there were 18 residents at the SHDC. There were 2 females and 16 males. There were 8 residents selected for random interview, and two youth that identified in a targeted group interviewed. During the onsite visit, there were no youth that identified to the Auditor as LGBQTI, but was identified from the PREA Risk Assessment. There was a youth that disclosed victimization during the PREA risk assessment. There were no youth that identified as limited English proficient, physically or cognitively disabled, blind, deaf, or hard of hearing. It was disclosed to the Auditor by the IA and an administrative investigator, there were no residents residing at the facility that had allegations or open investigations in process of sexual harassment, sexual abuse, or retaliation. There were no barriers by SHDC in obtaining information about the identification of youth in targeted groups.

During the onsite audit, there was a review of resident and staff files pertaining to PREA required mandates as well as electronic training files and criminal background checks. Additionally, there was a review of all documentation pertaining to the 5 allegations of sexual harassment and sexual abuse. The selection of 5 youth files that were interviewed included the 2-youth identified in the target population. The youth files included signed documentation of the completed initial and comprehensive PREA trainings. There were 4 PREA Risk Assessments reviewed. There were 2 assessments which indicated that there were 2 youth identified at risk of victimization or at risk of victimizing others.

Staff personnel files selected were 5 of the random staff interviewed. Staff files had all signatures indicating that training was attended and comprehended. Also, the files contained a yearly affirmation/promotion form signed by staff that they had not participated in, were convicted of or adjudicated of any sexual abuse or sexual harassment within the previous year.

The electronic database training files indicated that all staff at SHDC were trained and in compliance with required trainings pertaining to PREA mandates. Additionally, the PREA training curriculum was reviewed, and found to contain the agency's policy of zero-tolerance for sexual abuse, sexual harassment and retaliation. Training also included reporting, first responder's responsibilities, how to prevent sexual abuse and sexual harassment, juvenile sexual violence, and how to prevent, deter, and detect sexual abuse, and sexual harassment.

There was a review of staff electronic criminal background checks, and they were confirmed to be in complete compliance of being done within the last 5 years. In the case of the 5-sexual abuse and sexual harassment allegation files, the notification form to the youth was missing. The facility was made aware of the missing documentation.

Upon completion of the on-site audit on April 4, 2018 there was an exit meeting held at 2:30 p.m. with the Auditor, Auditor's Assistant, Agency Director, Deputy Director, PREA Coordinator, PREA Compliance Manger and the Assistant Superintendent of SHDC. During the meeting, the Auditor mentioned that according to all random youth interviewed that the youth felt safe from sexual harassment and sexual abuse at SHDC. The Auditor continued with a summary of the audit and a short check list of documents that needed to be made available to complete report. Lastly, the Auditor thanked the administrators and

the residential staff for their continued efforts in maintaining the implementation of the Prison Rape Elimination Act at SHDC.

During the post audit, PREA standard 115.373(a) which mandates the notification of youth of outcomes of PREA investigations was determined to be in need of corrective action. After completing the corrective action, SHDC was found to meet compliance. Initially, SHDC lacked documentation on reporting outcomes of investigations to residents, and it was determined by the Auditor that SHDC did not meet compliance in notifying residents of PREA Investigation findings. After review of investigative files, the Auditor only located 1 Notification of Investigation Form. In total, there were 5 sexual abuse and sexual harassment investigations that occurred in the previous 12 months.

DYRS has a policy that requires youth to be notified of the outcome of sexual abuse and sexual harassment allegations. Cited within DYRS Policy #2.13.IV.D.1.i is a clause that states that upon notification from IA or law enforcement, the program administrator will ensure that the youth is notified of the outcome of the case via the Notification of Investigation Form. In order to reinforce the practice of completing and maintaining notification documentation, SHDC was required to complete the following task for corrective action:

1. DYRS must provide professional development on the notification process based on the requirement set by DYRS Policy #2.13. The policy requires that youth are notified of outcomes of unsubstantiated, substantiated, and unfounded allegations of sexual abuse and sexual harassment investigations. The participants in the professional development should include SHDC administrators and the PREA Compliance Manager. Information that should be included in the professional development are as follows:

a. Notification process
b. Roles of the administrators
c. Notification form completion
d. Timeframes

2. Due to the infrequency of allegations of sexual abuse and sexual harassment allegations at SHDC, the facility was required to provide the Auditor with scenario based tasks which included utilizing past allegations to complete mock notification forms as well as an additional created mock notification. In total, there were six mock notifications forms completed.

SHDC provided the Auditor with the following documentation for verification of completion of corrective action:

a. Training Agenda from the Professional Development on the Notification Process
b. Handouts
c. Sign in Roster with the following signatures
Superintendent
Assistant Superintendent
PREA Compliance Manager
d. Copies of six completed mock notifications

During the post onsite audit phase, there was continued communication to obtain documentation as well as answer any questions pertaining to the audit. The Auditor received the revised copy of the DYRS

PREA Policy #2.13 from June 2017. The Auditor continued to check for any communication from P.O. Box from SHDC staff and/or residents. The Auditor had not received any confidential correspondence from either residents or staff from February 27, 2018 to July 18, 2018.

## AUDIT FINDINGS

**Facility Characteristics:**
The auditor's description of the audited facility should include details about the facility type, demographics and size of the inmate or resident population, numbers and type of staff positions, configuration and layout of the facility, numbers of housing units, description of housing units including any special housing units, a description of programs and services, including food service and recreation. The auditor should describe how these details are relevant to PREA implementation and compliance.

W. M. Marion Stevenson House Detention Center (SHDC) is a juvenile detention facility located on the main business corridor within Milford, Delaware. The facility is operated within the state jurisdiction of the Division of Youth Rehabilitative Services which is under the umbrella of the Department of Services for Children, Youth and Their Families. Youth are detained at the facility until resolution of their cases within family court or superior court. Majority of youth are detained by either Sussex County's or Kent County's Family or Superior Court. Upon release youth can be further adjudicated to another juvenile setting, therapeutic program, adult facility, electronic monitoring, or parent/guardian. Average length of stay for youth is 24 days. While detained at the facility, youth are provided risk and needs assessments, education, medical care, and Cognitive Behavioral Therapy (CBT).

In 2003, SHDC was constructed to replace a previous detention center on the property. The capacity of the facility is 77 youth, but at the time of the onsite audit there were 18 detained youth. Over the last 12 months, the average daily population has been 34 youth. There were 2 female youth and 16 male youth at time of audit.

Race and ethnicity as follows:
White Hispanic or Latino-2
White Not Hispanic or Latino-4
Black or African American Not Hispanic or Latino-11
American Indian or Alaskan Native Not Hispanic or Latino-1

Within the last year, the facility has been operating significantly below capacity. At the time of the onsite audit, there were 110 staff members.
Staff Positions Number of Staff in Position
Administrative Positions including Support Staff-5
YRC Supervisors*-7
YRC *-38
Casual/ Seasonal YRC Staff*-24
Medical (contracted)-5
Mental Health Personnel-2
Family Services Specialist-4
Chaplain-1
Food Service Staff-7
Educational Staff-12
Maintenance Staff-4
Laundry-1
Total Staff-100
*Indicates Custodial Position

The facility employs direct supervision with real time video monitoring with the capability of obtaining footage for up to 30 days. SHDC operates three shifts. There is a total of 69 custody staff. The staff to youth ratio exceeds the PREA standards. The facility has a protocol of mandatory overtime to prevent staff shortage which insures PREA ratio compliance. The following is the staffing minimums for each shift:
Shifts Number of Custody Staff including Supervisors
A 21
B 16
C 8

There are 3 faith-based organizations that provide volunteer services to the youth at the SDHC. The medical services for the direct care of youth is contracted with Christiana Care Health Services. There were no interns disclosed during the audit.

The facility sits several hundred yards from the main corridor. Upon entry to the property, there is a large parking lot. The visitor parking is located on the outer perimeter, and employee parking is located closer to the facility. Intake is within the secured fenced rear of the facility.

The entrance of the facility has a waiting area where PREA related information is available to parents, guardians, and any other third-party reporters of sexual abuse and sexual harassment. Beyond the entrance, there is an entrance to both the secured facility and the administrative offices.

Upon clearance into the secured facility, there is central command which houses 2 desks for monitoring the facility. The design of SHDC allows for exceptional visibility. This factor is seen throughout the facility. Cameras are adequately placed to ensure that sight lines are captured so that any allegation of sexual abuse or sexual harassment can be easily prevented, detected, and if necessary captured for evidence. The resolution of video monitoring is very clear, and individuals and situations can easily be identified.

Across from Central Command, there is a visitation area which has a section for family visits and two private rooms for attorney visits or program interviews. Youth are also availed opportunities to have visits with family, case workers, and their attorney. This area is also utilized for indoor family events. The private rooms allow for confidential meetings if a youth needs to report to a third-party regarding sexual abuse and sexual harassment. If a youth is seeking outside agency counseling or victim support for sexual abuse and sexual harassment, the private rooms allow for confidentiality. Next to the visitation area, there is an area that was intended for a non-contact visitation now it is used for canteen. Further in SHDC, there is a fully stocked library with books and computers. Additionally, this room serves as an orientation area to the facility, and youth are given comprehensive PREA training and orientation to SHDC.

Youth that need medical or mental health services are provided services in the medical suite at the facility. The medical staff is a contracted service with Christiania Care Health Services. Basic medical services are available such as the administering of medication and first aid for minor injuries. All other medical services are provided at the local hospital. Within the medical suite, there is a dental office. The medical, dental, and mental health services are all provided at the facility. The mental health and medical department work in conjunction to complete PREA Risk Assessments. Additionally, the mental health and medical personnel recommend the best options and practices for placement of a resident considering the factors that were identified in the PREA Risk Assessment from the interview with the youth. The goal is to prevent a youth from being victimized or being a perpetrator of sexual abuse and sexual harassment.

SHDC has a food service department which is state operated. Youth do not assist with the preparation of meals. In the cafeteria, there is direct supervision and video monitoring which assist in the prevention, detection, and deterrence of sexual abuse and sexual harassment. Also, staff members sit in close proximity of each unit during meal times.

There are 6 housing units at SHDC. Due to the number of youth detained, there are three units in operation. There is a female unit, and 2 male units. The other units are being utilized as an extra indoor recreation area and storage. If necessary, these units can be operational very quickly with the stored items relocated. Each unit has an activity room and outside recreation yard. Additionally, staff offices are adjacent to the youth activity area. All units are directly supervised and video monitored which assist with the prevention, detection, and deterrence of sexual abuse and sexual harassment.

On the housing units, there is an individualized showering configuration which allows youth to be secure while grooming. Staff must unlock door for youth to enter the single shower. The door is secured once in the bathroom. Within the bathroom is a dressing area and a shower. The facilities protocols are that youth must undress, shower, and re-dress within the confines of the individualized shower. The likelihood of youth being sexually harassed and sexually abused is greatly diminished with the configuration of the showers. Additionally, the PREA standards require that residents that identify as LGBTQI must be given an opportunity to shower by themselves. This configuration allows for that mandate to be met. According to PREA mandates youth cannot be viewed while grooming or toileting. The configuration of the facility individualized showers and the wet rooms and the protocols meet the PREA standards, because there is no visibility of residents while grooming or toileting.

Attached to each unit except intake are classrooms. Educational programming is provided Monday through Friday, and the services are provided 12 months a year. Student's educational records are obtained from school districts. Each student is provided educational services based on academic ability and graduation requirements. The non-operational classrooms are utilized as offices for electronic monitoring unit and bail bond review unit. Education is provided coed. All educational areas that service youth are video monitored to detect, prevent, and deter sexual abuse and sexual harassment. The educational suite is not video monitored, but youth are not allowed access. To enter, education staff must utilize a swipe.

The facility has a large gymnasium and attached is a large fenced outdoor recreation yard. Outdoor family day events occur in this area. Both areas are directly supervised and video monitored to prevent, detect, and deter sexual abuse and sexual harassment.

Since the last audit, the facility has upgraded several internal and external cameras to 360 degree capability. According to an administrator at the facility, these upgrades have shown significant improvement, and the decision to make improvements were in response to PREA standards.

Youth are provided several services while being detained at SHDC. Besides educational programming, youth obtain medical and mental health equivalent to the care that is provided in the community. Youth participate in faith-based programming provided by a volunteer which specifically addresses life skills. In the instance of sexual abuse or sexual harassment, through a formal affirmation with the Milford Hospital, youth would be provided SAFE or SANE examinations as well as timely access to emergency contraception and sexual transmitted infections prophylaxis without cost at Milford Hospital. Also, youth are referred by the local hospital to community based counseling services. Specifically, SOARS has an existing formal affirmation with DCYSF for victim support and counseling services. If there is an instance

of sexual abuse or sexual harassment, a youth can request to have victim support or counselor visit them at SHDC.

## AUDIT FINDINGS

**Summary of Audit Findings:**
The summary should include the number of standards exceeded, number of standards met, and number of standards not met, along with a list of each of the standards in each category. If relevant, provide a summarized description of the corrective action plan, including deficiencies observed, recommendations made, actions taken by the agency, relevant timelines, and methods used by the auditor to reassess compliance.

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

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|---|---|
| **Number of standards exceeded:** | 4 |
| **Number of standards met:** | 39 |
| **Number of standards not met:** | 0 |

Exceeds Compliance 4
Met Compliance 39
Not Met Compliance 0

After completing corrective action, SHDC was found to meet compliance for the standard of reporting to youth the outcomes of PREA investigations. Initially, SHDC was found to have lacked documentation on reporting outcomes of investigations to residents, and it was determined by the Auditor that SHDC did not meet compliance in notifying residents of PREA Investigation findings. After review of investigative files, the Auditor only located 1 Notification of Investigation Form. In total, there were 5 sexual abuse and sexual harassment investigations that occurred in the previous 12 months.

DYRS has a policy that requires youth to be notified of the outcome of sexual abuse and sexual harassment allegations. Cited within DYRS Policy #2.13.IV.D.1.i is a clause that states that upon notification from IA or law enforcement, the program administrator will ensure that the youth is notified of the outcome of the case via the Notification of Investigation Form. In order to reinforce the practice of completing and maintaining notification documentation as well as reporting outcomes to victims, SHDC was required to complete the following task for corrective action:

1. DYRS must provide professional development on the notification process based on the requirement set by DYRS Policy #2.13. The policy requires that youth are notified of outcomes of unsubstantiated, substantiated, and unfounded allegations of sexual abuse and sexual harassment investigations. The participants in the professional development should include SHDC administrators and the PREA Compliance Manager. Information that should be included in the professional development are as follows:

a. Notification process
b. Roles of the administrators
c. Notification form completion
d. Timeframes

2. Due to the infrequency of allegations of sexual abuse and sexual harassment allegations at SHDC, the

facility was required to provide the Auditor with scenario based tasks which included utilizing past allegations to complete mock notification forms as well as an additional created mock notification. In total, there were six mock notifications forms completed.

SHDC provided the Auditor with the following documentation for verification of completion of corrective action:

a. Training Agenda from the Professional Development on the Notification Process
b. Handouts
c. Sign in Roster with the following signatures
Superintendent
Assistant Superintendent
PREA Compliance Manager
d. Copies of six completed mock notifications

On July 13, 2018, it was determined by the Auditor that SHDC was in full compliance with all PREA standards upon the completion of the corrective action.

## Standards

**Auditor Overall Determination Definitions**

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

**Auditor Discussion Instructions**

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

| 115.311 | Zero tolerance of sexual abuse and sexual harassment; PREA coordinator |
|---|---|
| | **Auditor Overall Determination:** Exceeds Standard |
| | **Auditor Discussion** |
| | DYRS Policy #2.13 Prison Rape Elimination Act (PREA)<br>Interviews with Random Staff and Youth, Specialized Staff, PREA Coordinator, and PREA Compliance Manager<br>Training Logs of Staff and Youth<br>Youth Rehabilitative Services Director's Office Organizational Chart<br>Stevenson House Detention Center Organizational Staffing Chart<br>The State of Delaware Employee Performance Plan for both PREA Coordinator and PREA Compliance Manager<br><br>The facility was found to exceed the PREA Standard 115.311 for several reasons. DYRS Policy #2.13 is a comprehensive PREA policy which clearly states the agency's zero tolerance for sexual abuse and sexual harassment. The policy details the agency's approach in preventing, detecting, and responding to sexual abuse and sexual harassment. The policy defines prohibited behaviors regarding sexual abuse and sexual harassment, but it additionally defines all vocabulary used within the policy. Sanctions are stated within the policy for acts of sexual misconduct for both residents and staff. Also, the policy states the description of the strategies and responses employed by the agency to comply with the PREA standards. During the interviews with staff and residents, it was found that procedures discussed were aligned with the policy. The PREA Coordinator position is within the job responsibilities of the Professional Standards Manager as documented in both the definition of the position as well as the Job Performance Plan. Also, the PREA Compliance Manager is within the scope of the YRS Supervisor as documented in the Stevenson House Organizational Plan and the Job Performance Plan. Interviews of personnel for both positions collaborated that they were given sufficient time, authority to develop, implement, and oversee the agency's efforts to comply with the PREA standards.<br><br>115.311 (a)<br>Documented within DYRS Policy #2.13 Section II, is a comprehensive statement that documents the agency's position on zero tolerance for sexual harassment and sexual abuse with youth in the care of the facility. The policy reads, "DYRS has a zero-tolerance for any incidence of sexual activity with youth in our care. DYRS commits to full compliance with the Prison Rape Elimination Act (PREA). Any type of forced or unwanted sexual activity, touching or sexual harassment between youth or any type of sexual activity or sexual harassment between staff and youth (including consensual) is criminal and prohibited.<br>Further in the policy section IV Procedures, the agency outlines the approach to preventing, detecting, and responding to sexual abuse and sexual harassment. Specifically, the policy addresses training for both staff and residents on the PREA mandates. Additionally, time tables for training is also outlined. In the section labeled prevention, the policy addresses the responsibility of administration to adhere to the facility staff to youth ratio. It also describes the use of assessment tools to determine supervision needs of youth for the protection of victims and those known to be perpetrators. Within the policy, supervisors and program managers are to conduct unannounced and announced rounds to deter sexual abuse and sexual harassment. The policy establishes protocols for staff of the opposite gender to alert and |

announce their gender prior to entering a housing unit.
In section III Definitions, there is a comprehensive list of all vocabulary utilized in the policy. The list includes the definition of who is considered staff, which includes department employees, volunteers, contractors, official visitors, and other agency representatives. The definition does not include family, friends, and other visitors. Additionally, there is extensive definitions for non-consensual sexual act, abusive sexual act, and sexual harassment. Included in the list are the job duties as it relates to the PREA Compliance Manager and PREA Coordinator. Contained in the list of definitions is the following designations: gay, gender expression, gender identity, gender nonconforming, intersex, lesbian, LGBTI youth, sexual orientation, and transgender.
Present in Section IV.C,D & E of Policy #2.13, there are specific details to the sanctions imposed for staff misconduct which would include a report to the Child Abuse Hotline. Additionally, it is stated in the policy that for all incidents occurring in Delaware's operated facilities the State will pursue personnel actions that honor due process and decision making that is in the best interest of the youth. After consulting with the Human Resource Unit, the facility administrator will make a recommendation for training and/or disciplinary action. If the action is deemed a criminal offense it would be referred to the Delaware State Police (DSP) or Milford Police Department (MPD). In the case of residents, the policy states that sexual abuse, sexual harassment, consensual activity between youth and bad faith allegations are addressed in the behavioral management program. The behavioral management program utilized at Stevenson House Detention Center (SHDC) is Cognitive Behavioral Therapy (CBT). The description of the strategies and responses to sexual abuse and sexual harassment are highlighted in the training and the prevention section of the policy. The training section states that staff working directly with or monitoring programs and services of youth in secure care and community services must receive PREA training. During the orientation, new employees will be provided training through the Center for Professional Development. Every two years, DYRS employees will receive refresher training in PREA. Likewise, the policy details the curriculum for PREA training. Youth training is also outlined in the policy. Youth are to receive training during intake, and a more comprehensive training within 10 days of intake.
During all interviews with staff and residents at SHDC, it was clear that everyone was very knowledgeable on DYRS policy on a zero tolerance for sexual abuse and sexual harassment. Staff and residents gave detailed accounts of being trained on DYRS Policy #2.13. Residents and staff interviews collaborated with the policy as well as the training logs and documents that were reviewed of both residents and staff.

115.311 (b & c)
During the interview with the PREA Coordinator, it was found that the position of PREA Coordinator was within the umbrella of the Office of Professional Standards. The actual position that is held by the PREA Coordinator is the Professional Standards Manager. As listed on the Employee Performance Plan for this position, one of the duties of this position is accountability of policies and procedures. The position entails knowledge of policies and procedures as well as measuring compliance. Additionally, the position is to assist in policy development, risk management, collect performance data, as well as complete program and incident reviews of state managed facilities. The position of Professional Standards Manager and PREA Coordinator are two parallel positions. As defined in DRYS Policy #2.13 - PREA Coordinator: the DYRS position acts as an agency representative on PREA related issues, attends national or regional PREA meetings or training opportunities and provide assistance to the PREA Compliance Managers. The coordinator is to develop, implement and oversee

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| | agency efforts to comply with the PREA standards in all of its facilities. According to the PREA Coordinator, he is afforded sufficient time, authority, and oversight of the agency's efforts to comply with PREA standards in all of the facilities of DYRS.<br>After reviewing the organizational chart of SHDC and interviewing the PREA Compliance Manager, it was found that the PREA Compliance Manager's state titled position is a YRC Supervisor. The PREA Compliance Manager is supervised by the Superintendent. The position requires knowledge of and the ability to implement policies and procedures. Additionally, the position requires that YRC Supervisor train staff in all policies and procedures. According to DYRS Policy #2.13 the definition for PREA Compliance Manager - each administrative unit shall have a designated person that ensures PREA compliance operationally and its readiness for all related PREA standards. According to the PREA Compliance Manager he is given sufficient time to coordinate the facility's efforts to comply with the PREA standards. |

| 115.312 | Contracting with other entities for the confinement of residents |
|---|---|
| | **Auditor Overall Determination:** Exceeds Standard |
| | **Auditor Discussion** |
| | DYRS Residential Contracts Table<br>Department of Services for Children, Youth and their Families - Operating guidelines For Contracted Children and Family Programs and Services Section V.D.<br>Interview with Contract Manager<br>Review of Residential Contracts<br>Department of Services for Children, Youth and their Families -Operating Guidelines For Contracted Children and Family Programs and Services Section V.D. DYRS Residential Contracts Table<br>Interview with Contract Manager<br><br>Based on the information obtained from the Residential Contracts table, DSCYF Operating Guidelines, and the interview with the Contract Manager, the facility is found to exceed the PREA standard in contracting with other entities for the confinement of youth. The facilities documentation was easily accessible, and the documentation provided by the Contract Manager exceeded the requirement of the PREA standard. During the interview with Contract Manager, it was found that a facility that did not comply with PREA standards contract was terminated. DSCYF will not contract with a facility if they are not PREA compliant or actively seeking PREA compliance. The DSCYF Operation Guidelines are very clear, and sections of the guidelines are dedicated to insuring contractors are compliant with the mandates of PREA. Within the guidelines, the handling of reportable events protocols is described in the case of sexual abuse and sexual harassment.<br><br>115.312 (a)<br>DSCYF has contracts with several contractors for the confinement of youth. In total there are 22 contracts for the confinement of youth. Out of the 22 contracts held by DYRS, there were 12 facilities that are mandated to be PREA compliant based on the composition of the population that is served at these facilities. The remaining 10 facilities populations were less than 51% juvenile justice. As of this audit, 11 of the 12 facilities that are required to be PREA compliant have received PREA Audits, and the one facility which has recently opened is scheduled to be audited in August of 2018. This information was obtained from the DYRS Residential Contracts Table as well as from the interview with the Contract Manager.<br><br>115.312 (b)<br>In accordance with the DSCYF operating guidelines, providers shall comply with all applicable PREA standards and any DSCYF policies and procedures related to PREA for preventing, detecting, monitoring, investigating, and eradicating any form of sexual abuse within DSCYF contracted or subcontracted facilities/programs/offices. Specifically, providers will allow DSCYF announced and unannounced, compliance monitoring to include onsite monitoring. It further states that failure to comply with PREA, including PREA standards and DSCYF PREA related policies or standards, may result in a loss of business until the provider comes into compliance with PREA standards and/or subsequent contract termination. At the time of the onsite audit, there were only 10 contracts that did not require the agency to monitor contractor's compliance to PREA Standards. |

| 115.313 | Supervision and monitoring |
|---|---|
| | **Auditor Overall Determination:** Exceeds Standard |
| | **Auditor Discussion** |
| | Interview with Agency Director, Assistant Superintendent, PREA Coordinator, PREA Compliance Manager, Nurse Supervisor & Random Staff<br>Policy #2.13 Prison Rape Elimination Act Section IV-B-1<br>PREA Policy #2.13 Section IV.B<br>Policy SHDC-102 Organizational Staffing Chart<br>Review of Post Assignments<br>Secure Care Staffing Minimums 2/2/17<br>Annual Staffing Plan Review Documentation-DYRS Director's Team Meeting 6/5/17<br>Staffing Plan<br>Stevenson House Detention Center Workload Assessment<br>Labor Management Meeting Local 2004/117 - 4/9/18<br>Labor/Management Meeting Local 3384 - 4/9/18<br>Minutes-NCCDC & Stevenson House DC Pre-Construction Meeting<br>Footage of PREA Rounds Both Announced and Unannounced<br>Copy of Logs Documenting the PREA Rounds<br>Workload Assessment-Staffing Plan Development for Staff Increase<br>6/17 Annual Meeting Document -Staffing Plan Process<br>Incident Report Review<br>Review of Post Assignments<br>Workload Assessment<br>Delaware Article on Staffing Increases<br><br>For the standard of supervision and monitoring, SHDC exceeds the standard. Based on the facility's diligence in creating and maintaining a staff plan that significantly exceeds the PREA ratios as well as the protocol of mandatory overtime to maintain the staffing ratios. Additionally, the facility completed a Workload Assessment which assisted in the further planning of duties and plans for increased personnel to further service youth in the facility. During the specialized and random staff interviews, it was found that statements were in collaboration with procedures and policies at SHDC in as far as the practice of freeze and mandatory overtime. The agency and facility has documented in the policies requiring there be an assessment on an annual basis, and revisions are to be reported to the Director of the agency. This was collaborated with the agendas provided from the Director's Meeting 6/2017 and the Workload Assessment. Though SHDC is exceeding the PREA ratios, the facility is in the process of adding 29 more positions to improve services to the youth as well as ensure their sexual safety. The increase was further researched by the Auditor, an article was located that stated in fact the lawmakers of Delaware have increased the budget to provide for more positions in SHDC. Also, high-level management and mid-level management are making unannounced and announced PREA rounds which are documented in the shift logs as well as within the 30-day footage that was requested by Auditor. Recently, SHDC has upgraded cameras to improve visibility.<br><br>115.313 (a)<br>PREA Policy 2.13.IV.B.1 states that it is the responsibility of the program administration and |

shift supervisors to maintain facility staff to student ratios in accordance with the individual facility policies. In Policy SHDC-102 Section III Procedures, it states that the organizational chart shall be reviewed annually by the Superintendent and revisions shall be made, if appropriate, and forwarded to the Director. There was a Director's Meeting on 6/2017 in which the staffing plan was developed. Prior to the last audit, SHDC population has been decreasing. The facility has not met capacity of 77 for many years. During the last 12 months, the average daily population was 34. The facility's existing staffing plan allows for the instance of an increase of population, and still maintain necessary ratios in accordance to the PREA mandates. Recently, the lawmakers of Delaware have signed a budget which will increase the staffing at SHDC. During the interview with the Agency Director, the auditor ascertained that the facility is in the process of preparing to increase the staffing at SHDC.
According to the PREA Coordinator, the average daily number of youth was 34 for the past 12 months, and the staffing plan was based on 34 youth. This plans ratio allows for the following coverage:

A Shift staff to youth ratios is 15 to 34
B Shift staff to youth ratios is 15 to 34
C Shift staff to youth ratios is 11 to 34

The above ratios constitute only custody staff. With the staffing increase approved by the lawmakers, the ratios will be even more favorable in maintaining the staff to youth ratio. The PREA mandates require staffing to youth ratios be 1:8 during waking hours and 1:16 during sleeping hours. As can be seen from the above ratios of SHDC, the facility significantly exceeds the staff to youth ratio required by PREA mandates. Based on the information obtained from Review Forms in the instances of allegations of sexual abuse and sexual harassment, the staff to youth ratio exceeded compliance of the PREA standards.
In the case of video monitoring, there were several meetings prior to the improvement to several cameras. According to the Incident Review Forms of allegations of sexual abuse and sexual harassment, it was documented that the monitoring technology in the facility could review allegations in areas that monitoring is permitted.

115.313(b)
During the interview with the PREA Coordinator and PREA Compliance Manager, the initial staffing plan was completed in June 2017. SHDC further completed a workload assessment on 8/2017 to further maximize services to youth at the facility. Further, there was discussion surrounding the staff to youth ratios. It was found by the Auditor through review of Post Assignments that there were no deviations from the staffing plan. Additionally, the PREA Coordinator and PREA Compliance Manager was questioned regarding deviation of the staffing plan. It was stated by both that there was no deviations.
Further, the PREA Coordinator explained that he was part of the Emergency Response Team for DSYCF, and the agency and SHDC did not have any exigent circumstances. The term of exigent circumstance was defined by the PREA Coordinator as an instance that was unknowing and temporary that must be responded to promptly to eliminate a threat to the safety and security of the facility. This definition is in alignment with the PREA definition of exigent circumstance which is any set of temporary or unforeseen circumstances that require immediate action in order to combat a threat to the security or institutional order of a facility.

115.313(c)

In reviewing the organizational chart and the post assignment, the staff to resident ratio is significantly above the PREA mandated ratios. Located on the Secure Care Staffing Minimums document, SHDC schedules 15 staff on Shift A, 15 staff on Shift B, and 11 staff on Shift C. Consistently, the review of a sampling of all three shifts Post Assignments for the past 12 months, it was discovered by the Auditor that there was alignment to the Secure Care Staffing Minimums which was provided by the PREA Coordinator. Additionally, DYRS employs a practice of mandatory overtime if there were an instance in which ratios were in danger of not being maintained. It was also found on the Post Assignments the instances when the practice of mandatory overtime was utilized. All shifts well exceed the PREA mandated ratios for staffing which are 1:8 staff to youth during waking hours and 1:16 staff to resident during sleeping hours. During the interviews with the Assistant Superintendent, PREA Coordinator, and PREA Compliance Manager, they all collaborated that within the last 12 months there were no exigent circumstances, no deviations from staffing plan, and that the organizational chart has been reviewed within the last year. It was further confirmed that all custody staff is included when calculating ratios.
The Auditor researched on the internet as well as interviews with the PREA Coordinator and the PREA Compliance Manager that besides PREA there are no other laws, regulations, or judicial consent decrees that relate to maintaining staffing ratios.

115.313(d)
Additionally, within the last year, SHDC administration completed a Workload Assessment. At the time of development, there was a total of 54 full time employees and 24 casual seasonal employees that were custody staff. The document also provided the specific duties of each position. According to this document, part of the YRC Supervisor's duties is to insure PREA ratios. Enclosed within the document was an organizational chart for the facility. The document provided a breakdown of staffing. In June of 2017, there was a DYRS Team Meeting and included on the agenda as new business was staffing, but on the standing agenda items was PREA, quality assurance and professional standards, and human resource discussion/personnel issues.
After the onsite audit, there were 2 meetings with the local union representatives. On those agendas, there was a discussion relating to staffing as well as the 29 recommended staffing positions as a result of the Workload Assessment. On the other agenda, there was a discussion regarding filling vacancies as well as the 29 recommended staffing positions. Furthermore, in February 2018 SHDC participated in a pre-construction meeting to discuss the upgrade of cameras to improve the detection and prevention of sexual abuse and sexual harassment. The meeting detailed the responsibilities of the agency as well as the contractor that was installing the upgraded equipment.

115.313(e)
During the interview with the Assistant Superintendent and the PREA Compliance Manager, it was found that the intermediate and higher-level staff does conduct unannounced and announced visits frequently per Policy #2.13.IV.B. Additionally, the policy prohibits staff from alerting other staff of unannounced rounds. The Assistant Superintendent gave an account of the way that one could complete an unannounced PREA round. It was gathered from the PREA Compliance Manager that supervisors are always circulating throughout the facility. Random review of sections of the log, documents the occurrences of unannounced and announced PREA rounds. Further, the Auditor requested footage of the recent rounds completed by both the Superintendent and the Assistant Superintendent. Attained footage

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| | shows the Superintendent and Assistant Superintendent on various shifts doing unannounced rounds. |

| 115.315 | Limits to cross-gender viewing and searches |
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| | **Auditor Overall Determination:** Meets Standard |
| | **Auditor Discussion** |
| | Interview with Random Staff, Random Youth, Risk Assessment Targeted Youth-LGBQTI, Assistant Superintendent, PREA Coordinator, PREA Compliance Manager, DSYCF Training Coordinator, Nurse Supervisor, and Psychologist<br>SHDC Policy SHDC-220<br>DYRS Policy #2.20.IV.G<br>DYRS Policy #2.13.IV.5<br>DYRS Policy #2.20.IV.G.2<br>Reviewed Training Logs<br>DYRS Policy #2.13<br><br>SHDC has proven to meet the standard of limits to cross-gender viewing and searches. After reviewing the DYRS Policy #2.13, and SHDC Policy #220, it is apparent that the agency and the facility strive to insure that youth and youth identifying as LGBQTI are searched in a manner that ensures the safety of the facilities as well as the humility of the youth that is served. According to PREA Compliance Manager, random staff, and random youth, there has been no cross-gender pat down searches, no cross-gender strip searches, and no cross-gender visual body cavity searches of any sort in the last 12 months. Also, the interview of the Risk Assessment identified LGBQTI youth, it was found that the youth was searched in a manner that was of humility, and the youth felt that the search was not for identifying the sexual anatomy of the youth. Further, the Auditor found that the configuration of the bathroom allows for residents to groom privately without concern of being viewed, sexually abused, or sexually harassed. Further, staff of the opposite gender must alert and announce themselves prior to entering housing units. Review of the training logs and interview with Training Coordinator prove that all staff has been trained in both clothed and unclothed searches, and specific training has been availed to staff to ensure that youth that identify as LGBQTI are searched in a respectful manner. Policy prohibits staff from searching or physically examining a transgender or intersex youth for the sole purpose of determining a resident's genital status.<br><br>115.315(a)<br>After interviewing the random staff and random residents, it was found that the facility does not conduct cross-gender strip searches, cross-gender visual body cavity searches of residents, or cross-gender pat down searches. According to Nurse Supervisor, the facility has not performed any visual body cavity searches within the last 12 months.<br><br>115.315 (b)<br>Upon reviewing both DYRS Policy #2.13 and Policy SHDC-220, it was also documented that cross-gender strip searches, cross-gender visual body cavity searches, and cross-gender pat down searches are prohibited unless there is an exigent circumstance. According to the Assistant Superintendent, PREA Coordinator, and PREA Compliance Manager, there has been no exigent circumstances within the last 12 months.<br><br>115.315(d)<br>DYRS has implemented policies and procedures that enable youth to shower, perform bodily |

functions, and change clothing without non-medical staff of the opposite gender viewing their breasts, buttocks, or genitalia except in exigent circumstances. In DYRS Policy 2.13.IV.5, when entering a housing unit a staff of the opposite gender must alert the youth by knocking and then the staff member must announce their gender to ensure that youth, requiring privacy, has ample notice/time. This requirement is not needed in the case of an emergency. Each housing unit has individualized bathing stalls which are secured by a door. The individualized bathing stalls are sectioned so that a youth could bath in one section and dress in another without being viewed by staff or other youth. According to residents and staff, the door is unlocked and youth is granted entry. The door is secured on the outside by staff, and when the youth is finished grooming and fully dressed, the youth can exit. After interviewing both random youth and random staff, it was corroborated prior to coming out of individualized bathing stalls that residents undress, shower, and dress.
The housing units are equipped with at least one wet room. The Auditor checked the configuration of the wet room to see if a youth could be easily viewed toileting by staff on unit or by video monitoring. After looking at footage and standing in cell, it was found that residents could not be easily viewed toileting.

115.315(e)
According to the DYRS Policy #2.20, a youth identified as LGBTQI will not be physically searched in a manner that is humiliating or degrading or for the sole purpose of determining the youth's physical anatomy. The youth that was identified by risk assessment as LGBQTI had apprehension identifying as LGBQTI, but the youth stated that when searched that the search was not humiliating or degrading. The youth did not feel that the search was done in an attempt to find out physical anatomy. Additionally, the youth disclosed that there was a conversation during an assessment with the medical and mental health professionals upon intake regarding whether the youth identified as being LGBQTI.

115.315 (f)
According to training records reviewed and interview of Training Coordinator, there were 100% of SHDC staff trained in conducting cross-gender pat-down searches and searches of transgender and intersex youth in a professional and respectful manner. The random staff that was interviewed also stated that they had received training in these types of searches.

| 115.316 | Residents with disabilities and residents who are limited English proficient |
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| | **Auditor Overall Determination:** Meets Standard |
| | **Auditor Discussion** |
| | Interview PREA Coordinator and PREA Compliance Manager<br>Interpretation (Onsite) and Translation (Written) Service Contract<br>DYRS Policy #2.13IV.B.6<br>DSCYF Policy #118.II.A&B Language Access<br>Email of Translation Services<br>Invoice of LTC Language Solutions<br>Translation Documentation<br>DSCYF Policy #118.II.C.<br><br>In the standard of youth with disabilities and youth who are limited English proficient, SHDC meets the standard. Though the facility has not had any youth that were identified as disabled, the PREA related material can be formatted for residents that have low vision, and youth that are deaf can be provided with a sign language interpreter at no cost to the youth. For those students that may have difficulty in reading the PREA material is written at the 4th grade level. To accompany the reading material is a PREA related video. In the past 12 months, there have been no residents that are limited English proficient. In the case of residents that are limited English proficient, the agency is contracted with several vendors to provide translation and interpretation services at no cost. Per policy, absent exigent circumstances, the agency prohibits personnel from using resident interpreters, resident translators, or resident readers for the performance of first responder duties. According to the PREA Compliance Manager, there has been no exigent circumstance, and there has not been any youth that has been identified as disabled or limited English proficient. In collaboration, the invoice from LTC Language Solutions shows no services were provided at SHDC. Further, an email was provided by the Management Analyst and the Translation Contract Administrator which collaborates that there were no translation services provided to SHDC.<br><br>115.316(a)<br>Interview with PREA Coordinator confirmed that the DSCYF makes available to disabled youth access to PREA related information and training. Also, DYRS Policy #2.13.IV.B.6 states that the SHDC must ensure that youth with disabilities of any kind, are given the same information to prevent, detect and respond to sexual abuse and sexual harassment in a format supportive of the disability. According to PREA Coordinator, if youth has low vision, the student handbook and PREA related material would be provided in larger font. In turn if a youth is deaf and needs a sign language interpreter, DSCYF has an established contract for these services through the State of Delaware Executive Department Office of Management and Budget. There are 5 contractors that provide onsite sign language services.<br>The PREA orientation contains reading material as well as a video. Youth that have a learning disability that impacts their ability to read could benefit from a more multi-sensory approach of delivery from watching the PREA video and staff lecture during the PREA orientation. Moreover, the PREA materials at the facility are estimated to be at a readability of a 4th grade reading level. Within the last 12 months, there were no students that needed any translation services or PREA related materials provided in a different font, format, interpretation, or translation. Youth at SHDC with disabilities would benefit from all aspects of PREA training to |

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| | prevent, detect, and respond to sexual abuse and sexual harassment.<br><br>115.316(b)<br>According to PREA Compliance Manager, invoice of LTC Language Solutions, and the email from the department that oversees the service, there were no residents in the last 12 months at SHDC that needed interpretation or translation services. DSYF has an established procedure to provide residents with limited English proficiency 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. DSYF has an established contract for interpretation and translation services through the State of Delaware Executive Department Office of Management and Budget. PREA materials and posters are also available in English and Spanish. DSCYF Policy #118, specifically states that all limited English proficient persons must have equal access to DSCYF services and benefits at no cost.<br><br>115.316(c)<br>Further, language assistance is provided at no cost to participant. Within the policy, it also states that absent exigent circumstances, DSCYF personnel shall not use children, family members, friends, neighbors or clients to provide language assistance services in any context. In the last 12 months, there have been no youth at SHDC that has been limited English proficient. |

| 115.317 | Hiring and promotion decisions |
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| | **Auditor Overall Determination:** Meets Standard |
| | **Auditor Discussion** |
| | DSCYF Policy #109<br>DSYF Policy #313<br>DYRS Policy 2.13.III Definitions<br>DSCYF Policy #109.IV.A<br>PREA Acknowledgment Form<br>Annual PREA Affirmation<br>Human Resource Applicant Statement<br>Interview Criminal Background Check Unit, Human Resource Unit, PREA Coordinator, PREA Compliance Manager, and Representative of the Office of Standards<br>Confirmation of Annual Criminal Background Checks for the employees of SHDC<br>Review of random Staff Records which included newly hired employees<br>DYRS Policy #2.2.IV.B.1.a<br>Operating Guidelines for Contracted Children and Family Programs and Services<br><br>The facility has met the standard in hiring and promotion decisions. The DYRS and SHDC has proven that there hiring practices are diligent in that criminal background checks are completed at the state level as well as the Federal Bureau of Investigations. Prior to hiring, criminal background checks and child abuse/neglect searches must be completed. Since DSCYF is the child state welfare agency, it is responsible for completing the child abuse/neglect searches. The PREA #2.13 definition of staff includes department staff, contractors, and volunteers so all criminal background checks and child abuse/neglect searches apply to all individuals that have contact or potential contact with youth. DYRS completes subsequent criminal background checks annually even though PREA standards only requires every 5 years, and staff is required yearly or upon promotion to complete an affirmation that directly makes inquiries into previous misconduct. Prospective employees are also required to sign an affirmation regarding previous misconduct, and this form serves as a release form for criminal background checks as well as child abuse/neglect searches. DYRS Policy #2.2, supports the PREA standard that if there are any material omissions regarding misconduct or false information it shall be grounds for termination. If former employees provide a release, DSCYF will provide information to a prospective employer of any substantiated allegations of sexual abuse and sexual harassment.<br><br>115.317(a)<br>Prior to being considered for employment, the agency requires all potential employees to complete the Human Resource Applicant Statement which is in alignment with PREA Standard 115.317(a). Potential employees attest that they have not engaged in any sexual abuse or sexual harassment or have not been civilly or criminally adjudicated. This statement was found in random records of employees that were recently employed. The prospective employees signature authorizes the release of any background checks or records information to DSYF. In the Policy #109.I., it specifically states that employees will have their criminal background check prior to employment/placement and/or during a conditional period of employment/placement. It further states, that child/youth care persons be free from any prior criminal activity or involvement in substantiated cases of abuse/neglect that may lead to the |

harm of any child/youth.
DSYF Policy #313, addresses subsequent arrest and/or allegations of child abuse/neglect. In Section II of the policy, the department has the responsibility to ensure that no employee will be retained if he/she poses a potential for risk or harm to children/youth. The policy further states that Criminal History Unit makes checks prior to employment or during conditional period of employment. The Criminal History Unit makes a recommendation to the respective Division Director as to whether or not an employee or prospective employee is suitable, unsuitable, or prohibited from employment.

115.317(b)
Both annually and during promotion, employees of SHDC are required to sign the PREA Acknowledgement Form which is an affirmation that is aligned with PREA standard 1153.17(a). Employees are attesting that they have not engaged in sexual abuse or sexual harassment, and they have not been adjudicated of these behaviors either civilly, administratively, or criminally. During random staff records review, this item was in the files. During the onsite audit, this procedure of collecting information was further confirmed by the Criminal Background Unit Representatives and the Human Resource Unit Representatives.

115.317(c)
When a potential employee is in the hiring process the DSCYF Policy #109.III outlines that a search of substantiated child abuse/neglect must be completed. Since DSCYF is the state's child welfare protection agency the responsibility of the department is to conduct a search of the department records for substantiated cases of child abuse/neglect as well as be responsible for the receipt, evaluation and dissemination of information resulting from the criminal history and department record check. In accordance to the Policy #109.IV.A, the employer shall require that each individual subject to law, complete a Criminal History Record Request form and be fingerprinted during the hiring process. The individual must take the white copy of the form to the Delaware State Police (DSP) and 2 sets of fingerprints are taken. DSP follows established State Bureau of Identification procedures and Federal Bureau of Investigation to obtain criminal background information. Both the Criminal Background Checks Unit Representatives and the Human Resource Unit Representatives stated that during the hiring process prospective employees must sign a release in order for the criminal background check to be performed, as well as deliver a copy of the request form and fingerprint cards to DSP. After interviewing the PREA Coordinator, it was found within the past 12 months that there were 12 new hires for SHDC that went through the process of criminal background checks and the department's child abuse/neglect searches. This information was also collaborated with the Human Resource Unit and the Criminal Background Unit during the interviews with the 2 units.

115.317(d)
According to DYRS Policy #2.13, staff (employee) is defined as any department employee, volunteer, contractor, official visitor, or other agency representative which excludes family, friends and other visitors. This policy and all other policies essentially applies to all persons listed. All required criminal background checks and child abuse/neglect searches are required of contractors and volunteers. It was further confirmed that these criminal background checks were completed by the Criminal Background Unit.

115.317(e)

DYRS practice of completing criminal background checks annually exceeds the PREA standard. Annually, the Office of Professional Standards completes the criminal background checks for the employees of SHDC. The Auditor was provided a copy of the confirmation that the criminal background checks had been completed. According to PREA Coordinator, the criminal background checks are completed yearly instead of every 5 years. Additionally, DSCYF has a continued contract with Christiana Care for medical services. The medical staff is required to have criminal background checks in accordance to the Operating Guidelines for Contracted Children and Family Programs and Services. Proof of this can be found on the Confirmation of Annual Criminal Background Checks for the employees of SHDC.

115.317(f)
Both annually and during promotion, employees of SHDC are required to sign the PREA Acknowledgement Form which is an affirmation that is aligned with PREA standard 1153.17(a). Employees are attesting that they have not engaged in sexual abuse or sexual harassment, and they have not been adjudicated of these behaviors either civilly or administratively. During random staff records review, this item was located. Prior to being considered for employment, the agency requires all potential employees to complete the Human Resource Applicant Statement which is in alignment with PREA Standard 115.317(a). Potential employees attest that they have not engaged in any sexual abuse or sexual harassment or have been civilly or criminally adjudicated. Additionally, the document allows for the release of criminal background information.

115.317(g)
In accordance to PREA substandard 115.317(g), the DYRS Policy #2.2. IV.B.1.a directs that employees have the responsibility of immediately informing supervisor of any criminal investigations, arrests, indictments, or convictions of themselves or any investigation of child/abuse neglect subsequent to initial employment. Failure to immediately notify supervisor of any of the above, including final disposition, could result in discipline up to and including termination. During an interview, this practice was confirmed with the Human Resource Unit Representatives.

115.317(h)
Upon receipt of a release by former employee, DSCYF will provide prospective institutional employer with all substantiated allegations of sexual abuse and sexual harassment. This practice was confirmed with the Human Resource Unit Representative.

| 115.318 | Upgrades to facilities and technologies |
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| | **Auditor Overall Determination:** Meets Standard |
| | **Auditor Discussion** |
| | Interviews with Assistant Superintendent, PREA Coordinator, and PREA Compliance Manager<br>Invoice for Surveillance Equipment Install<br>Pre-Construction Meeting Email 2/7/18<br><br>SHDC meets the standard in upgrades to facilities and technologies. The facility has proven that the PREA standards were considered in the upgrades to the cameras. Prior to the upgrades to the facilities cameras, the administration held meetings to discuss the upgrades to the cameras.<br><br>115.318 (a)<br>SHDC was built in 2003. It is a well-maintained building, and all equipment appeared to be in adequate working order. After interviewing the Assistant Superintendent, PREA Coordinator, and PREA Compliance Manager, it was corroborated that the facility has not undergone any substantial expansion or modifications since the last PREA audit. There are no current plans to do any substantial renovations, expansions or modifications in the near future.<br><br>115.318(b)<br>Recently, there has been some upgrades to the surveillance system at SHDC. Several of the cameras have been upgraded to 360-degree capability cameras. The facility provided the Auditor the schematics of the cameras utilized during meetings as well as the invoice of services provided by the contractor installing the cameras. Though the facility has diligently upgraded cameras, the sally port at the intake entrance and exit has a significant blind spot. Moreover, the area houses the lock box for law enforcement's weapons. The cameras located in intake cannot view inside of the sally port and the camera's that are located outside cannot view anything in the sally port. |

| 115.321 | Evidence protocol and forensic medical examinations |
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| | **Auditor Overall Determination:** Meets Standard |
| | **Auditor Discussion** |
| | DSCYF Policy #208.IV.a-i.<br>DYRS Policy #2.13.VI.D.1.d-g<br>DYRS Policy #2.13.IV.D.2.a-b<br>Interview with Institutional Abuse Investigators, Nurse Supervisor, PREA Coordinator, PREA Compliance Manager, and Contract Manager<br>Affirmation of Compliance with Forensic Investigative Standards for Sexual Assaults with DSP<br>Affirmation of Compliance with Forensic Examinations Standards for Sexual Assaults with Milford Hospital<br>Memorandum of Understanding with DSCYF and Christiana Care Hospital<br>Memorandum of Agreement Between the Division of Youth Rehabilitative Services (DYRS) and Survivors of Abuse in Recovery (SOAR), Inc.<br><br>SHDC meets the standard of evidence protocol and forensic medical examinations. The facility has one internal body for investigations which is the administrative (facility) investigators. There is 2 external investigative bodies which is IA for civil and criminal is either MPD or DSP. All investigations of sexual abuse and sexual harassment begin with a call to the Child Abuse Hotline. The allegation is then forwarded to the Institutional Abuse Investigators who at that time determine whether allegations should be investigated further by the administration, IA, MPD, or DSP. If the allegation does not reach the level of IA which handles civil investigations, it is sent to the administrative (facility) investigators to complete the investigation. The facilities 2 investigators are responsible for conducting administrative investigations within the facility, and any of their decisions would be made in conjunction with the Human Resources Unit. One of the facilities investigators is the Assistant Superintendent. If the investigation meets the level of IA involvement which is civil then IA continues to complete the investigation. If it is determined by IA that the allegation is criminal, IA involves MPD or DSP. During criminal investigations of sexual abuse, IA will assist MPD or DSP in the criminal investigation.<br><br>Additionally, the agency has an Affirmation of Compliance with Forensic Investigative Standards for Sexual Assaults with MPD and an Affirmation of Compliance with Forensic Examinations Standards for Sexual Assaults with Milford Hospital to ensure that investigation protocols and forensic examinations are according to PREA standards. After review of the documents, the Auditor ascertained that both documents meet the standard required by the PREA mandates. In order to provide supportive services to victims of sexual abuse and sexual harassment, the agency has a Memorandum of Agreement Between the Division of Youth Rehabilitative Services (DYRS) and Survivors of Abuse in Recovery (SOAR), Inc. The medical staff at SHDC is contracted by Christiana Care Hospital which in turn operates through a Memorandum of Understanding with DSCYF and Christiana Care Hospital. This MOA further maintains that youth receive all services including SAFE/SANE examinations and victim support services free of charge in accordance to PREA mandates. This information was obtained from the Pre-Audit Questionnaire as well as the Contracts Manager. This information contained on the documentation was further collaborated from the interviews with the Institutional Abuse Investigators for the protocols in place for forensic investigations. For the SANE/SAFE examinations and for the victim support services, the Nurse Supervisor gave a |

detail description of the procedures taken in the instance of sexual abuse and sexual harassment which gave a step by step account of how a youth would be provided services. Lastly, the Contract Manager provided information regarding the contract with Christiana Care Hospital for medical personnel in which the Auditor obtained the Memorandum of Understanding between the agency and Christiana Care Hospital.

115.321(a)
After conferring with the Institutional Abuse Investigators (IA), it was gathered that there are three levels of investigation. There is administrative, civil, and criminal. All matters that involve allegation of any sexual abuse and sexual harassment as defined in DYRS Policy #2.13 will be reported to the Child Abuse Hotline. The allegations are then assigned to IA which determines whether the allegations remain with IA (civil) or to either the administrative (facility) investigators or to the criminal investigative body MPD or DSP. If an allegation does not reach the level of civil or criminal, it is processed through the administrative (facility) investigators. Further this process was established in DYRS Policy #2.13VI.D.1.d-f, the facility is identified as the governing body that is responsible for administrative investigations. For all incidents that occur in Delaware's state operated facilities, the State will pursue personnel actions that honor due process and decision making that is in the best interest of the child. Upon completion of investigation, the facility administrator will make a recommendation for training and/or disciplinary action as necessary, after consulting with the Human Resource Unit.
According to DYRS Policy #2.13, acts that are deemed to be a criminal offense by the IA are to be referred to the (DSP) or the (MPD). According to IA, they would be supporting either DSP or MPD with footage from surveillance and any other documentation to assist with the investigation. Additionally, DSCYF Policy #208 states that the role of the IA shall take a multi-disciplinary approach toward addressing the issues of institutional abuse investigations. Each division is responsible for identifying, and assisting in the resolution of, issues that pertain to the efficient completion of IA investigations. Required by DSCYF Policy #208.III.D, the Institutional Abuse Procedures Manual shall provide detailed procedures for the investigation of institutional abuse allegations.

115.321 (b)
The Institutional Abuse Unit (IA) is a part of the DSCYF which serves youth. The investigative protocols are developmentally appropriate for youth. All procedures listed in the body of DSCYF Policy #208.IV.a-I, are to insure the safety of youth in incidents of sexual abuse. According to the Affirmation of Compliance with Forensic Investigative Standards for Sexual Assaults, the protocols employed by the MPD are in alignment with PREA standards 115.321, 115.334, and 115.371. Additionally, the training curriculum is reviewed at a frequency to ensure compliance with national standards/concerns which is stated within the affirmation.

115.321(c)
According to the Affirmation of Compliance with Forensic Examinations Standards For Sexual Assaults, the protocols employed by Bayhealth-Kent General Hospital and Milford Memorial Hospital are appropriate for youth and adapted using the U.S. Department of Justice's Office on Violence against Women publication "A National Protocol for Sexual Assaults Medical Forensic Examinations Adults/ Adolescents." The interview with the Nurse Supervisor at SHDC detailed the use of the affirmation with Milford Memorial. It was determined that if a youth was sexually abused that they would receive a forensic medical examination at Milford Memorial Hospital by either a Sexual Assault Examiner (SANE) or a Sexual Assault Forensic examiner

(SAFE). DYSCF through the affirmation with Milford Hospital shows diligence in having forensic examinations completed by either a SAFE or SANE. Additionally, the examination would be offered without financial cost to the victim. The interview and the affirmation are in sync with DYRS Policy #2.13.IV.D.2.a-b which states that all physical evidence or medical treatment while investigating prison rape will be done in a hospital setting by medical personnel. The policy refers to Kent and Sussex County and states that all medical interventions for PREA will be referred to Milford Hospital. In the case that a youth is unable to receive services at Milford Hospital, there is an existing Memorandum of Understanding with DSCYF and the Christiana Care Hospital that also provides for the SANE/SAFE Examinations. According to the PREA Coordinator and the PREA Compliance Manager in the past 12 months, there have been no instances in which SHDC was in need of any SANE or SAFE examinations, and this was further confirmed with a telephone by with a hospital representative at Milford Hospital.

115.321 (d)
Indirectly through a contract with the Milford Hospital, SHDC can obtain victim advocacy services for youth from a rape crisis center. According to the affirmation, the hospital does attempt to make available to the victim, a victim advocate from a rape crisis center. As part of our protocol we do access the victim with a victim advocate, qualified agency staff member, or qualified community-based organization staff member. All efforts would be maintained by Milford Hospital.

115.321(e)
Found in the agreement between DYRS and SOAR, there is a clause that states that SOAR will provide mental health professionals who will deliver outreach, advocacy, assessment and psychotherapy services to DYRS youth who have been, or may have been, victims of sexual abuse in accordance with the definitions outlined in the PREA standards. According to PREA Coordinator and PREA Compliance Manager, youth will receive support, advocacy, and mental health services through SOAR.

115.321 (f)
DYRS and MPD have agreed upon and outlined the requirements detailed by the PREA standards in the Affirmation of Compliance with Forensic Investigative Standards for Sexual Assaults. The affirmation states that MPD is responsible for the investigation of alleged crimes that occur at SHDC. All victims of sexual assault have access to forensic medical examinations which occur at Milford Hospital. Additionally, MPD collects and preserves evidence, and they will not terminate an investigation if the source of the allegation recants. Also, criminal investigations shall be documented in a written report.

115.321(g)
There is no Department of Justice component that is responsible for investigating allegations of sexual abuse.

115.321(h)
In order to certify that a qualified community-based staff member would be utilized for services to youth, the Memorandum of Agreement Between DYRS and SOAR has a list of responsibilities of the advocacy organization, which includes the following:

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| | 3.1<br>SOAR shall be responsible for ensuring that background screenings have been completed for mental health professionals assigned to work with DYRS youth.<br>3.2<br>SOAR shall only utilize personnel who are appropriately qualified, licensed or certified as required by state, federal or local law, statute or regulation, with respect to the services provided through this agreement, and shall provide documentation of such. |

| 115.322 | Policies to ensure referrals of allegations for investigations |
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| | **Auditor Overall Determination:** Meets Standard |
| | **Auditor Discussion** |
| | DYRS Policy #2.13.IV.D.1.b<br>DYRS Policy #2.13 IV.C.1<br>DYRS #2.12.III.A.5 and B.1<br>DYRS Policy #2.13 IV.D Investigations<br>DYRS Policy #2.13 Attachment A,B,C,& D Sexual Violence Incident Forms<br>Interview with Institutional Abuse Investigators, PREA Compliance Manager, and Management Analyst<br>PREA Audit - Juvenile Facilities Documentation Review-Investigations<br>https://kids.delaware.gov/yrs/prea.shtml<br>Affirmation of Compliance with Forensic Investigative Standards for Sexual Assaults<br><br>In DSCYF Policy #208 Institutional Abuse, DSCYF meets compliance in the PREA standard of policies to ensure referrals of allegations for investigation to MPD or DSP. DYRS Policy #2.13, complies with PREA standard in requiring allegations of sexual abuse be referred for investigation to an agency that has the legal authority to conduct criminal investigations. Also, the agency has the policy regarding the referral of allegations of sexual abuse and sexual harassment for a criminal investigation posted on the agency's website. All allegations of sexual abuse and sexual harassment are documented on Sexual Violence Incident Forms, and the process of documenting allegations of sexual abuse and sexual harassment are within Policy #2.13 as well as the attachment of the forms. Lastly, the affirmation completed by MPD describes the conduct of criminal investigations in cases of sexual abuse and sexual harassment at SHDC.<br><br>115.322(a)<br>It was confirmed from IA and the PREA Compliance Manager that all allegations of sexual abuse and sexual harassment are reported to the Child Abuse Hotline. Within the DYRS Policy #2.13.IV.D.1.b, all matters that involve the allegation of any sexual contact as defined in this policy will be reported to the Child Abuse Hotline. In the last 12 months, there have been 5 allegations of sexual abuse and sexual harassment at SHDC. In all 5 cases, residents were no longer detained at facility to interview. The Auditor had to rely on documentation and interviews with IA and PREA Compliance Manager. Reports were not handled through a grievance, but a call was placed to the Child Abuse Hotline which resulted in the involvement of IA which determined that all 5 allegations did not reach the level of a civil investigation but rather an administrative investigation. There were no allegations referred for criminal investigation by IA. All five investigations were completed and documented. During the interview with Management Analyst, a review was made of the investigation files. Further, the Auditor utilizing the Juvenile Facilities Documentation Review checked documents. According to the review of the documentation, there were 4 unsubstantiated and 1 unfounded allegations.<br><br>115.322(b)<br>DYRS policy requires that any allegations of sexual abuse or sexual harassment be referred to an investigative agency with legal authority to conduct criminal investigations. DYRS Policy |

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| | #2.13.IV.C.1 states that for matters which could result in criminal action, IA will conduct a joint investigation with the DSP or MPD. This was also confirmed during the interview with IA that their role in a criminal investigation would not impede, but rather be supportive to the criminal investigation with the MPD or DSP. DYRS policy regarding the referral of allegations of sexual abuse or sexual harassment for a criminal investigation is published on the agency website. Refer to https://kids.delaware.gov/yrs/prea.shtml<br><br>115.322(c)<br>DYRS documents all referrals of allegations of sexual abuse and sexual harassment for criminal investigation. The allegations are documented on two forms which are the Critical Event Reporting Form or the Non-Critical Event Reporting Form. A Critical Reporting Form would be used in the case of institutional abuse or child abuse resulting in the arrest of an employee or provider in a Department operated or contracted program for the maltreatment of a child active with the Department. A Non-Critical Reporting Form documents allegation of institutional abuse. According to DYRS #2.12.III.A.5 and B.1, the above procedures are to be taken to completion for allegations of abuse.<br><br>115.322(d)<br>DSCYF does have policies to govern the conduct of investigations for sexual abuse and sexual harassment. According to the Affirmation of Compliance with Forensic Investigative Standards for Sexual Assaults, the protocols employed by the MPD are in alignment with the PREA standards 115.321, 115.334, and 115.371. Additionally, DYRS Policy #2.13 and DSCYF Policy #208 also govern the conduct of investigations.<br><br>115.322(e)<br>There is no Department of Justice component at SHDC that is responsible for conducting administrative or criminal investigations of sexual abuse or sexual harassment. |

| 115.331 | Employee training |
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| | **Auditor Overall Determination:** Meets Standard |
| | **Auditor Discussion** |
| | DYRS Policy #2.2.IV.A.4<br>DYRS Policy #2.20.IV.J.1-2<br>Review of PREA Training PowerPoint<br>Interview with Random Staff, Training Coordinator, PREA Coordinator, and PREA Compliance Manager<br>Training Logs<br>DYRS Policy #2.13.IV.A.1.b.<br>Review of Staff Files<br>Documentation of Comprehension of Training<br><br>Based on the comprehensive PREA Training that staff receives, as well as the refresher every 2 years, SHDC meets the PREA standard on employee training. The PREA Compliance Manager and Training Coordinator both confirm that the staff have received training. Review of the training logs confirms that staff have received PREA training within the last 2 years. From information obtained from the PowerPoint presentation that was utilized for training, it appears that all PREA mandated training requirements were delivered to the staff. Furthermore, all three policies DYRS Policy #2.13, DYRS Policy #2.20, and DYRS Policy #2.1 support the efforts of PREA training. Maintained in staff files is acknowledgement of trainings. Also, the training coordinator maintains electronic evidence of the completion of training.<br><br>115.331(a)<br>The Auditor confirmed through utilizing the PREA Interview Protocols that staff at SHDC received comprehensive training on the PREA standards. The Auditor was assured by the Training Coordinator that during the training staff is instructed utilizing a PowerPoint Presentation on PREA as well as the staff watched a video developed by the Moss Group. After the Auditor reviewed the PowerPoint, it was found that staff was instructed on the agency's zero tolerance policy for sexual abuse and sexual harassment. Within the presentation, there were slides with information pertaining to preventing, deterring, and detecting incidents of juvenile sexual violence. Also, there were slides that educated staff concerning a youth's right to be free from sexual abuse, sexual harassment, and retaliation for reporting incidents. Further, the presentation addressed the dynamics and reactions of sexual abuse and sexual harassment in juvenile settings. Staff is also trained how to detect and respond to signs of threatened and actual sexual abuse. Additionally, staff learned that all sexual acts involving youth within a facility or under supervision are considered non-consensual. Staff was trained on avoiding inappropriate relationships with residents, and this point was reiterated in DYRS Policy #2.2.IV.A.4. The policy states that employees must avoid establishing social relationships with juveniles under DYRS supervision which could compromise the employee's ability to exercise official authority appropriately. Within the PowerPoint presentation, there were several slides that address supervision of youth identified as LGBQTI. The training also provided a means to teach staff how to communicate effectively and professionally with youth that identify as LGBQTI. In DYRS Policy #2.20.IV.J.1-2, it specifically states that staff will receive training pre-service and in-service on communicating effectively and professionally with youth that identify as LGBQTI or gender non-conforming. |

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| | Further, staff was trained on the laws related to mandatory reporting of sexual abuse to the child Abuse Hotline. Located within the training presentation were slides that discussed the age of consent. All staff had received initial training and refresher training on PREA standards. Additionally, all these items outlined in the PowerPoint regarding the PREA mandates for training can be located within DYRS Policy #2.13.<br><br>115.331(b)<br>SHDC is a facility that detains both males and females. During interviews with PREA Coordinator and PREA Compliance Manager, and Training Coordinator it was disclosed that all staff are trained to work with both males and females. The Auditor further asked random staff did they work with a specific gender, and the staff all replied that they work with both genders at SHDC.<br><br>115.331(c)<br>According to the Training Coordinator, all staff have received refresher training. The training is provided online. Random Staff confirmed that they had recently received a refresher on PREA. Additionally, the PREA Compliance Manager confirmed that all staff at SHDC had received the PREA Refresher.<br><br>115.331(d)<br>Review of DYRS Policy #2.13.IV.A.1.b. reveals that staff is to receive a refresher training every 2 years. Interviews with random staff disclosed that they had recently received a PREA training, but they recalled that they do receive the training every 2 years. Staff sign a documentation of comprehension which was found by Auditor in the Random Staff Folders. |

| 115.332 | Volunteer and contractor training |
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| | **Auditor Overall Determination:** Meets Standard |
| | **Auditor Discussion** |
| | PREA Acknowledgement Statement for Employees, Volunteers, Contractors, Mentors, and Interns<br>Interview with Assistant Superintendent, PREA Compliance Manager, Contract Manager, and Volunteer by Telephone<br>Onsite Tour of Medical Suite<br><br>The facility meets the PREA standard for volunteer and contract training. Based on information obtained from the PREA Compliance Manager, Volunteer, and Contract Manager, the group of individuals were identified, and their training documents were provided by the Assistant Superintendent, Training Coordinator, and the PREA Compliance Manager. For the contractors, the Compliance Manager provided the signed PREA Acknowledgement Statement. For the contracted medical staff, the Assistant Superintendent provided the signed roster of specialized training and the Training Coordinator provided the PREA refresher training log for the medical staff. It was confirmed during the interview with both the volunteer and the contracted medical staff that they had received PREA training.<br><br>115.332(a)<br>During the interview with PREA Compliance Manager, the Auditor was given 3 copies of the PREA Acknowledgement Statement completed by volunteers. Presently there is one outside contracted vendor which is the Christiana Care Hospital, which provides direct medical services to the youth at SHDC. This information was provided by the Contract Manager. The volunteers that have direct contact with youth have been trained on their responsibilities under DYRS policy and procedures regarding sexual abuse and sexual harassment prevention, detection, and response. During an interview with a Volunteer, the Auditor found that the Volunteer comprehended the PREA training that was given by SHDC.<br>Documents reviewed confirmed that the volunteers acknowledge that DYRS has a zero-tolerance policy for sexual abuse and sexual harassment. Volunteers are obligated to maintain clear boundaries with DYRS youth and to maintain an ethical supervision relationship with objectivity and professionalism. Additionally, volunteers shall not allow the development of personal, unduly familiar, emotional, or sexual relationship to occur with DYRS youth. They further explained that all forms of sexual contact and sexual harassment between DYRS volunteers are prohibited by DYRS policy and may subject them to further investigation and the possible filing of charges and/or dismissal. Lastly, the acknowledgement details the responsibility of reporting of all instances of sexual abuse and sexual harassment.<br><br>115.332(b)<br>Based on interview with PREA Compliance Manager, all three volunteers are church ministries. The volunteers are always supervised by custody staff during interactions with youth. Based on the items that were covered on the PREA Acknowledgement Statement, the volunteers' training was adequate for the type of interaction and supervision that is provided for church service activities. When youth are seen by medical personnel, they are also always escorted by a custody staff member. This was further confirmed during the onsite tour of the medical suite. |

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| | 115.332(c)<br>The Auditor reviewed the acknowledgement forms. All forms were signed by volunteers. The forms are maintained by the PREA Compliance Manager. In the case of the contracted medical staff, the signed roster for specialized training is maintained with the Assistant Superintendent, and the documentation for PREA Refresher is maintained in the employee file. |

| 115.333 | Resident education |
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| | **Auditor Overall Determination:** Meets Standard |
| | **Auditor Discussion** |
| | DYRS Policy #2.13<br>DSCYF Policy #118<br>DYRS Policy#2.13.IV.B.6<br>Interviews with Random Youth, Random Staff, PREA Coordinator and PREA Compliance Manager<br>SHDC Resident Handbook<br>Brochure “What you need to know about sexual assault, harassment, and abuse”<br>SHDC Brochure “Que es la PREA?”<br>SHDC Resident Handbook in Spanish<br>Random Review of Youth Files – contained signature pages of PREA Training during intake and comprehensive PREA training<br>PREA Video Moss Group<br>Pre-Audit Questionnaire<br>Onsite Tour<br>Demonstration by PREA Compliance Manager of Intake and Comprehensive PREA Trainings<br><br>SHDC demonstrates meeting the standard of resident education. Interviews with random staff and residents, review of random youth files, demonstration by PREA Compliance Manager, and the policy verifies that SHDC provides informational training on PREA during intake. Within 10 days, the facility provides youth with a comprehensive PREA training. Within the last 12 months, all youth have been educated on PREA both at intake and within 10 days of intake. Additionally, if a youth returns to SHDC or is transferred from another facility, they are required to repeat the complete process of informational PREA training at intake and comprehensive PREA training within 10 days. DYRS ensures that all youth have accessibility to PREA education. SHDC utilizes the Resident handbook, the brochure “What You Need to Know About Sexual Assault, Harassment, and Abuse” as well as the PREA video made by the Moss Group. The handbook and brochure are provided in both English and Spanish, and it can be provided in larger font for those youth who may be visually impaired. If a student is limited English proficient or has a disability, they are afforded services by contractors that provide translation, interpretation, or sign language services. After youth complete both informational and comprehensive PREA education sessions, the youth sign 2 documents indicating that they understood both trainings. Copies of these documents were found in the random youth files, and this was further confirmed through the random youth interviews in which the youth interviewed stated that they had received both trainings.<br><br>115.333(a)<br>Found within DYRS Policy #2.13.IV.A.2.a, youth receive PREA information during the intake process. The information explains the zero-tolerance policy regarding sexual abuse and sexual harassment, as well as how to report an incident or suspicions of sexual abuse and sexual harassment. It was disclosed by random staff and random youth interviews that this policy is the practice of SHDC. This practice was further confirmed by the PREA Compliance Manager during the onsite tour in which the Auditor was given a step by step demonstration of both trainings in the intake unit as well as the library where the comprehensive PREA training |

is oriented to youth.
In the last 12 months, it was confirmed by both the PREA Coordinator and the PREA Compliance Manager, there were 331 youth that received PREA training during intake according to the Pre-Audit Questionnaire. Information provided to youth was explained simplistically, and it was age appropriate which was demonstrated by PREA Compliance Manager during tour. During the Auditor's review of the SHDC Resident Handbook and PREA Brochure, the Auditor discovered that materials were written at the 4th grade level.

115.333(b)
According to the PREA Coordinator, all 331 students received comprehensive PREA training within 10 days of intake. The comprehensive training is age-appropriate education on their rights to be free from sexual abuse, sexual harassment, and retaliation. The Auditor further confirmed from random youth interviews and random review of youth files that comprehensive PREA training did occur within 10 days of intake.

115.333(c)
The PREA Compliance Manager reiterated that all 331 youth were given comprehensive PREA training within 10 days of intake. Specifically, the youth receive the training within a few days of intake, because the PREA comprehensive training is part of the orientation process that is given to all youth upon arrival to SHDC. At the time of audit, all students had received PREA information at intake, and they had received comprehensive PREA Training. Both random youth and random staff shared that the comprehensive training occurs in the library at SHDC.
According to the random staff, all new intakes whether they are from another facility or not are given PREA information at intake, and they are required to receive the 10-day comprehensive PREA training. Random youth that was interviewed that had been at the facility on a previous occasion explained that they were required to take the training every time they were detained.

115.333(d)
DSCYF Policy #118, is the agency's language access policy. It states that it ensures that the department and its contractors take reasonable steps to provide children and families in the State of Delaware who have limited English proficiency with meaningful access to all of its benefits and services. In DYRS Policy #2.13 further states that students that are limited English proficient as well as students that have disabilities have full accessibility to PREA education. Material is available in formats that are accessible to all youth at SHDC. DYRS is contracted with several providers that have interpretation, translation, and sign language services. Also, per the PREA Coordinator, fonts can be enlarged if necessary for youth with low vision. Additionally, there were posters, brochures on PREA, and Resident Handbooks written in Spanish. Also, the agency is very diligent in outlining through DSCYF Policy #118 the process and procedures to be utilized when interacting with youth that are limited English proficient, as well as other youth that may need specialized services to benefit from the services that SHDC offers. DYRS Policy #2.13.IV.B.6 specifies that residents with disabilities are to benefit from the same information on the prevention, detection, and response to sexual abuse and sexual harassment.

115.333(e)
After review of youth files, it was found that all files checked contained documentation that youth had signed and understood the PREA information obtained during intake as well as

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| | signed and understood the comprehensive training that occurred within 10 days of intake.<br><br>115.333(f)<br>During the tour of the SHDC, there were PREA related posters throughout the facility which were in both English and Spanish. In the library, there was a table with the resident handbook and PREA brochures in both English and Spanish. |

| 115.334 | Specialized training: Investigations |
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| | **Auditor Overall Determination:** Meets Standard |
| | **Auditor Discussion** |
| | DYRS Policy #2.13.IV.D.1.f-h<br>Policy #208 I & IV.A-H<br>Interview with Institutional Abuse Investigators<br>Specialized Investigators Training Certificates<br>Interview with Training Coordinator<br><br>DYRS meets the standard in specialized training investigations. There are 4 investigators that attended the specialized training. The specialized trainings curriculum meets the mandates required by the PREA standards. All training records are maintained on the agency's database.<br><br>115.334(a)<br>The Assistant Superintendent, YCR Supervisor, and the 2 Institutional Abuse Investigators were trained in conducting sexual abuse investigations in confinement. Gathered from the policy, DYRS administrator's responsibility is to act in the capacity of administrative investigator. Policy #2.13.IV.1.f-h, states that upon completion of an investigation, the facility administrator will make a recommendation for training and/or disciplinary action as necessary, after consulting with the Human Resource Unit. Further in the policy, it states that incidents alleging sexual harassment that are not accepted by IA for investigation, shall receive an internal administrative review in an efficient time frame. It should be noted that all criminal investigations are handled jointly by IA and DSP or MPD. The role of IA in investigations is outlined in DSCYF Policy #208.I & IV.A-H. It was verified during the interview with the IA investigators that the administrative investigators were the Assistant Superintendent of SHDC and a YCR Supervisor.<br><br>115.334(b)<br>Upon review of the investigators' certificates, the following was included in the curriculum:<br>• Special issues related to conducting sexual assault investigations in confinement settings<br>• Basic Trauma Theory<br>• Maladaptive coping skills related to trauma exposure<br>• Report writing<br>• Evidence Collection<br>• Crime scene protection<br>• Use of Miranda and Garrity<br><br>115.334(c)<br>All training is maintained in the Delaware Learning Center Database, and participants were given copies of their specialized training certificates for their files. This was confirmed with the Training Coordinator. The Auditor obtained 4 certificates for completion of the specialized investigators training. |

| 115.335 | Specialized training: Medical and mental health care |
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| | **Auditor Overall Determination:** Meets Standard |
| | **Auditor Discussion** |
| | DYRS Policy #2.13<br>Signed Roster of Medical Personnel attendees to Specialized Medical and Mental Health Training provided by Assistant Superintendent<br>Memorandum of Understanding (MOA) with Milford Hospital<br>PREA Training Log<br><br>The facility meets the standard for specialized training: medical and mental health. The medical and mental health personnel have obtained the necessary PREA training for their level of care. This has been verified by training logs provided to Auditor. The medical staff does not provide forensic medical exams at the SHDC. Forensic exams are done at Milford Hospital. They are done in accordance to the MOA between DYRS and Milford Hospital.<br><br>115.335(a)<br>Medical (contracted) and Mental Health staff fall within the same requirements of DYRS Policy #2.13. They are considered staff as defined in the policy. In total, SHDC has 4 medical/mental health personnel who have received PREA Training who regularly interact with youth.<br><br>115.335(b)<br>In accordance to the existing MOA with Milford Hospital, all forensic medical exams will occur at Milford Hospital by SANE or SAFE personnel. Medical staff at SHDC do not perform forensic medical exams.<br><br>115.335(c-d)<br>Medical and mental health personnel have received the PREA training required by staff in accordance with DYRS Policy #2.13. This has been verified from the PREA Training Log provided by the Training Coordinator, and the specialized training log was provided by the Assistant Superintendent. |

| 115.341 | Obtaining information from residents |
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| | **Auditor Overall Determination:** Meets Standard |
| | **Auditor Discussion** |
| | DYRS Policy #2.13 IV.A.2.a<br>Random Youth File Review<br>Blank Risk Assessment<br>Random Review of Completed Risk Assessment<br>Interview with PREA Compliance Manager, Psychologist, Nurse Supervisor, and Random Youth<br><br>Based on the agency's ability to obtain information from youth, SHDC meets the standard. Within the agency's policy, the facility is required within 72 hours of intake to screen for risk of sexual victimization and risk of sexual abuse towards other youth utilizing an objective screening instrument. The Risk Assessment meets the requirements of the items that should be included on the screening instrument set by the PREA mandates. Youth are involved in conversation with either the Psychologist or medical personnel while they are completing the instrument. Interviews with the Nurse Supervisor and the Psychologist provided information regarding the procedures that were implemented to ensure that sensitive information from the Risk Assessments was not exploited to the youth's detriment by staff or other youth. It was further evident with the PREA Compliance Manager that brief notations were made via email to administrators regarding information obtained from Risk Assessments.<br><br>115.341(a)<br>DYRS Policy #2.13.IV.A.2.a directly addresses the requirement by the PREA standards to screen for risk of sexual abuse victimization or sexual abusiveness toward other youth within 72 hours of intake. This task is done by either the medical personnel or the Psychologist on staff at SHDC. Additionally, it was disclosed by the Nurse Supervisor, the Psychologist, and the PREA Coordinator that medical and mental health personnel work in tandem to ensure that the assessments are done within the 72-hour period which is required by PREA standards. According to the records for the last 12 months, 207 youth received screening for risk of sexual victimization or risk of sexually abusing other youth. During the interview with the Psychologist, it was found that Risk Assessments are completed periodically throughout the youth's detainment. During the on-site audit, the Auditor reviewed a file of a youth that had been at the facility over 6 months. It was found that the youth had been regularly reassessed since the initial intake.<br><br>115.341(b)<br>During the on-site audit, the Auditor was provided a blank copy of the Risk Assessment form which is completed by the medical and mental health personnel within 72 hours of intake in accordance with DYRS Policy #2.13. The document is an impartial form that left responses to be open-ended.<br>Upon review of blank Risk Assessment Form, it was found to contain the following:<br>1. Prior Sexual History- victimization or engaging in inappropriate sexual behavior<br>2. Age<br>3. Current sex related charge<br>4. Non-conforming or Identifying as LGBQTI |

5. How does youth identify their gender?
6. How does the youth identify their sexual orientation?
7. Age inappropriate level of emotional and cognitive development
8. Small physical size and stature
9. Mental illness or mental disabilities
10. Intellectual or developmental disabilities
11. Physical disabilities
12. Resident's own perception of vulnerability
13. History of traumatic experiences
14. Any other specific information that may indicate heightened need for supervision, additional safety precautions, or separation from certain other residents

115.341(c)
In addition to the blank form, the Auditor asked to review 5 random completed Risk Assessments. Upon review, all assessments had notations from medical and mental health personnel indicating risk factors for victimization and/or possibility of victimizing others.

115.341(d)
According to both random youth interviewed and the medical and mental health personnel, the information obtained to complete the Risk Assessment is completed during conversations while medical and mental health screenings are completed. Also, information is obtained from the youth database maintained by DSCYF. According to PREA Coordinator, the relevant information that can be obtained is the youth's history in other facilities within DSCYF. The Psychologist explained that when youth are assessed the youth's behaviors, files, other assessments, and records are considered in determining a youth's risk to be victimized or to victimize others.

115.341(e)
Information obtained from the Risk Assessments are confidential. The information is disseminated solely to the administrators and supervisors by the medical and mental health personnel for the purpose of making appropriate decisions for housing and program placement at SHDC. According to Psychologist, consideration is taken in how information is disclosed. For example, it would be stated that it would be in the best interest of the youth to be placed in a specific unit. The particulars from the Risk Assessment would not be readily disclosed. The Assistant Superintendent substantiated that he received information regarding the recommendation on housing and programing of youth by the medical and mental health personnel by email.

| 115.342 | Placement of residents |
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| | **Auditor Overall Determination:** Meets Standard |
| | **Auditor Discussion** |
| | Memorandum of Understanding between the Division of Prevention and Behavioral Health (PBH) and Division of Youth Rehabilitative Services (DYRS)<br>Interview with Compliance Manager, Psychologist, Assistant Superintendent, Random Youth, and Random Staff<br>DYRS Policy #2.13.IV.B.2-3<br>DYRS Policy #2.20.IV.E.1.c and IV.E.1.d-i<br>DYRS Policy #2.20.IV.C.3<br>Risk Assessment<br>Onsite Audit Tour<br><br>SHDC meets compliance in the PREA standard of placement of residents. The facility utilizes information obtained from a Risk Assessment to make decisions to assign a housing unit, education, and program assignments with the goal of keeping all residents safe and free from sexual abuse and sexual harassment. Within the Memorandum of Agreement between PBH and DYRS, there is an outline of the process and procedures used to obtain and document the risk assessment. The agency has a policy that details the instances of a youth being placed in insolation as a last resort if less restrictive measures are inadequate to keep them and other residents safe, and until other means of keeping all residents safe can be arranged. The facility prohibits youth that identify as LGBQTI from being placed on a particular unit solely on the basis of LGBQTI identification. Additionally, LGBQTI identification is not used as an indication for the likelihood of being sexually abusive. Transgender and intersex residents housing and program assignments are decided on a case by case basis. Generally, youth are at the facility for a short period of time, but if an intersex or transgender youth is there for a year, they will be reassessed twice a year in accordance with policy. Also, aligned with PREA standards is the agency's policy in which a transgender or intersex youth's own safety is given consideration when making housing and program decisions, and the policy further states that a transgender or intersex youth will be given the opportunity to shower and toilet separate from other residents.<br><br>115.342(a)<br>According to the DYRS Policy #2.13.IV.B.2-4, classification or assessment tools will be utilized to determine supervision needs of youth for the protection of victims and those known to be perpetrators. The protective supervision includes housing decisions, movement throughout the facility, all routine and non-routine activities. Additionally, this position is reiterated in the Memorandum of Understanding between PBH and DYRS. Essentially, staff is to obtain sexual risk assessment as well as any other specific information about youth that may indicate heightened need for supervision, additional safety precautions, or separation from certain other youth. It further states to notify administration and supervisory staff about risk factors in writing and identify interventions. This policy is further confirmed with the procedures that was discussed with the Psychologist and the Nurse Supervisor in which both explained the process of disseminating information obtained from the Risk Assessment to the administrators and supervisors by email. Additionally, the Assistant Superintendent confirmed that the emails were received that indicated housing and programming recommendations. |

115.342(b)
It states in DYRS Policy #2.13.IV.B.2 that classification and assessment tools will be utilized to determine supervision needs of youth for the protection of victims and those known to be perpetrators. DYRS Policy #2.20 IV.E.1.c states that a youth that is identified as LGBTQI may be isolated from others only as a last resort when less restrictive measures are inadequate to keep them and other youth safe, and only until an alternative means of keeping youth safe can be arranged. Further in the policy, DYRS shall not deny any youth daily large muscle exercise and any legally required educational programming or special education services. Additionally, the policy requires documentation of the facility's concern for youth's safety, reason for no alternative means of separation can be arranged, and every 30 days a review if there is a continued need for separation. In the last 12 months, there have been no residents placed in isolation. It should be noted that during the onsite audit, there were no youth that disclosed to the Auditor that they identified as LGBQTI, but there was a youth that was identified through the Risk Assessment as being identified LGBQTI. The youth was not separated or isolated from other residents which further confirms that youth identified as LGBQTI at SHDC are not separated from population based on identification as LGBQTI.

115.342(c)
Based on the policy, DYRS does not allow youth that identify as LGBTQI to be placed in isolation or separated solely from other youth due to their LGBQTI status. The PREA Compliance Manager confirmed that this is the practice at SHDC. Stated within DYRS Policy #2.20.IV.E.1.d, the agency shall not consider lesbian, gay, bisexual, transgender, or intersex identification or status as an indicator of likelihood of being sexually abusive. The PREA Compliance Manager confirmed that SHDC does not practice identifying LGBQTI as an indication of the likelihood of being sexually abusive. It should be noted that during the onsite audit, there were no youth that disclosed to the Auditor that they identified as LGBQTI, but the youth was identified during a Risk Assessment.

115.342 (d)
The review of Policy #2.20.IV.E.1.e indicates that the agency's decision whether to assign a transgender or intersex youth to a unit for male or female, and in making other housing and programming assignments, DYRS shall consider on a case by case basis. The facility will consider whether the placement would ensure the youth's health and safety, and whether the placement would present management or security problems. The interview with the Psychologist verified the agency's practice of reviewing on a case-by-case basis when making a determination.

115.342 (e)
Twice a year in accordance with DYRS Policy 2.20.IV.E.1.f placements and programming assignments of transgender and intersex youth are reassessed by the interdisciplinary team to review threats to safety that may have been experienced by youth. A clear majority of youth in the detention facility are detained for short periods of time. The file that was reviewed of a youth that had been in the facility longer than 6 months revealed that the youth had been reassessed.

115.342(f)
Located within the DYRS Policy #2.20.IV.E.1.g the agency is to consider a transgender or

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| | intersex youth's views with respect to his/her own safety. The Assistant Superintendent disclosed that per policy all youth views with respect to his/her own safety is always a consideration. Specifically, within the Risk Assessment, there is a question that relates to a youth's own perception of vulnerability.<br><br>115.342(g)<br>The design of the SHDC's individualized showers and bathrooms gives all youth the opportunity to shower and use the bathroom separately. Specifically, DYRS Policy #2.20.IV.E.1.i requires that transgender and intersex youth shall be given the opportunity to shower and use the bathroom separately from other youth. According to youth, everyone showers and uses the bathrooms privately.<br><br>115.342(h & i)<br>Within the last 12 months, there have been no youth isolated. This was confirmed by interviews of PREA Compliance Manager and random youth. The youth stated in interviews that they had not witness anyone isolated at SHDC. |

| 115.351 | Resident reporting |
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| | **Auditor Overall Determination:** Meets Standard |
| | **Auditor Discussion** |
| | Interview with Random Staff, Random Youth, and PREA Compliance Manager<br>Onsite Audit Tour<br>DYRS Policy #2.13(a).IV.2.c<br>DYRS Policy #2.13.IV.C.1.b-c<br>DYRS Policy #2.13.IV.C.2.d<br>DYRS Policy #2.13(a).IV.C.2<br>Title 10-1007<br><br>SHDC has proven to meet compliance in resident reporting. The facility has established procedures which allow multiple means for youth to privately report sexual abuse, sexual harassment, and retaliation by staff or resident. The residents can utilize the Child Abuse Hotline to report incidents outside of the facility. Residents can also utilize the numbers found on the back of the brochure “What you need to know about Sexual Assault, Harassment, and Abuse.” Additionally, youth can report incidents on an emergency PREA grievance. Based on responses about reporting given by random staff and random youth, it appears that they are both well-educated on the ways and the responsibilities to report.<br><br>115.351(a)<br>The Auditor inquired of both random staff and random youth about the private ways that a youth could report incidents of sexual abuse, sexual harassment, and retaliation by residents or staff. According to both groups, residents could utilize the Child Abuse Hotline, complete an emergency PREA grievance, and verbally tell any staff in the facility as well as report to a third party such as a parent or their attorney. This procedure was further confirmed with DYRS Policy #2.13(a) IV.C.2. a-b which detailed that a youth can report incidents of sexual abuse, sexual harassment, and retaliation by staff or resident to probation officer, staff, family member, and Child Abuse Hotline. Additionally, youth can report incidents through an emergency PREA grievance. During the onsite tour of the facility, the Auditor located the Child Abuse Hotline phones on each unit and the location of the emergency PREA grievances. Located with the emergency PREA grievance sheets were writing utensils.<br><br>115.351(b)<br>Residents can report to another entity through the Child Abuse Hotline. The phones are readily available to residents on the housing units which is outlined in DYRS Policy #2.13(a) IV.2.c. During the random youth interviews, the Auditor inquired about the process a youth would use to report an incident of sexual abuse and sexual harassment. All the youth responded that they would use the Child Abuse Hotline. Residents can also utilize the numbers found on the back of the brochure “What you need to know about Sexual Assault, Harassment, and Abuse.”<br>According to Title 10-1007, youth are not detained at SHDC solely for civil immigrations.<br><br>115.351(c)<br>DYRS Policy #2.13.IV.C.1.b-c, states that all staff are required to report any allegations and instances of non-consensual sexual acts, abusive sexual contact, and sexual harassment to |

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| | the Child Abuse Hotline (800-292-9582). Failure to report any sexually related incident will result in disciplinary action up to and including termination and/or criminal prosecution. Random staff indicated that reports are to be written as soon as possible, and they are to accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously, and from third parties.<br><br>115.351(d)<br>Both random youth and random staff confirmed that allegations of sexual abuse, sexual harassment, and retaliation can be reported utilizing an emergency PREA Grievance. During the tour, the Auditor checked for the location of the emergency PREA grievance forms. Located with forms was a writing utensil. The PREA Compliance Manager demonstrated the process of completing a grievance form, and further discussed that the form could be given to any staff.<br><br>115.351(e)<br>According to random staff, incidents of sexual abuse, sexual harassment, or retaliation by staff or youth can be privately reported by utilizing the Child Abuse Hotline. This procedure is documented in DYRS Policy #2.13 IV.C.2.d. Additionally, the staff can also report online at the DSYF website, and they must send the accompanying form to Child Services within 72 hours of making the report online. |

| 115.352 | Exhaustion of administrative remedies |
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| | **Auditor Overall Determination:** Meets Standard |
| | **Auditor Discussion** |
| | DYRS Policy #2.13.IV.C.2.c<br>PREA Compliance Manager<br><br>115.352(a)<br>SHDC meets compliance in the exhaustion of administrative remedies. The agency is exempt from this standard. There is no administrative procedure at SHDC to address resident emergency grievances regarding sexual abuse. Residents can submit an emergency PREA grievance, but once received the incident is called and reported to the Child Abuse Hotline and further handled by IA. Based on the interview with PREA Compliance Manager, it was confirmed that the emergency PREA grievances are handled in that manner. DYRS Policy #2.13.IV.C.2.c paraphrased that each facility is to show youth how to initiate an emergency PREA grievance and the procedure must ensure that access is unimpeded and all tools necessary to make a written report are provided. |

| 115.353 | Resident access to outside confidential support services and legal representation |
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| | **Auditor Overall Determination:** Meets Standard |
| | **Auditor Discussion** |
| | DYRS Policy #2.13.IV.E.1-2.<br>Memorandum of Agreement between SOARS and DYRS<br>Brochure “What you need to know about Sexual Assault, Harassment, and Abuse”<br>Interview with PREA Compliance Manager and Random Youth<br>SHDC Policy #505.II.A.2 & C.2<br>SHDC Policy #504<br><br>Interviews with random youth, policy review, and the Memorandum of Agreement between SOARS and DYRS, the facility meets the standards of resident access to outside confidential support services and legal representation. Youth stated that they had access to legal representation, family, as well as case workers. Within the Memorandum of Agreement between SOARS and DYRS, youth are afforded the opportunity to have crisis intervention and emotional support services.<br><br>115.353(a)<br>Youth can obtain victim advocates for emotional support services through the existing Memorandum of Agreement between SOARS and DYRS. The purpose of the memorandum is to connect mental health professionals and advocates from community based nonprofit organizations serving sexual trauma victims with youth in the care of DYRS who have been or may have been victims of sexual abuse. Also, DYRS Policy #2.13.IV.E.2. collaborates with the memorandum. Additionally, the brochure “What You Need to Know About Sexual Assault, Harassment, and Abuse” that is given to youth contains the contact information for several community based victim advocacy and rape crisis organizations. The Auditor found that if a resident requested to see an advocate that they would be afforded confidential communication.<br><br>115.353(b)<br>Within the Memorandum of Agreement between SOARS and DYRS, there are specific responsibilities of the advocacy organization to respond to youth that are in the physical custody of a DYRS residential program whom have been the victim of sexual abuse. They are to provide mental health services, including crisis intervention, emotional support and information or referrals. SOARS shall maintain the confidentiality of DYRS youth receiving services; however, the following information must be reported to the DYRS PREA site coordinator/designee if a DYRS youth discloses the following:<br>(a) Plans to do harm<br>(b) Information that creates concern for the safety and security of the DYRS site or its staff<br>(c) Plans to run from custody<br>(d) Behaves inappropriately with a mental health professional<br><br>When residents are in any activity, they are under the direct supervision (line of sight and hearing distance) of a staff person. In the case of phone calls to victim advocacy, the facility |

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| | has implemented SHDC Policy #505. During the business week, the “A” shift will have a procedure for ensuring that youth can make professional phone calls (attorney, probation or other case worker etc.). In the visitation area of SHDC, the youth could meet with advocate in the area that is designated for attorney consultation.<br><br>115.353(c)<br>The Auditor was provided a copy of the Memorandum of Agreement between SOARS and DYRS through the Pre-Audit Questionnaire. SHDC is a part of that agreement. If a youth has been sexually abused, SOARS would provide confidential emotional support services related to the sexual abuse that the youth has experienced.<br><br>115.353(d)<br>All youth interviewed, stated that they have reasonable and confidential access to their attorneys and other legal representation. Found in SHDC Policy #505.I youth will have uncensored, confidential contact by telephone, in writing, or in person with their legal representative, court officials, and case managers. Additionally, it was relayed by the interviewed youth that the facility allowed for reasonable access to parents and legal guardians. Detailed in SHDC Policy #504 in the agency’s attempt to maintain family ties, contact with attorneys, case managers, and other support services, each youth shall have equal and adequate access to a telephone. Calls are made using an automated collect and/or pre-paid collect calling system. |

| 115.354 | Third-party reporting |
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| | **Auditor Overall Determination:** Meets Standard |
| | **Auditor Discussion** |
| | DYRS Policy #2.13.IV.2.D.1.b<br>Onsite Tour<br>Interview with Random Staff<br><br>Based on the use of the Child Abuse Hotline and the agency's website to report online as a means for third-party reporting, DYRS meets the standard of third-party reporting. Additionally, the reports can be made third-party to staff.<br><br>115.354(a)<br>According to DYRS Policy #2.13.IV.2.D.1.b, all matters that involve allegations of any sexual contact as defined in this policy will be reported to the Child Abuse Hotline. The DYRS has published a brochure, "What you need to know about Sexual Assault, Harassment, and Abuse." During the onsite tour of the facility, the Auditor located copies of the brochure in the entrance of the facility which were readily accessible to third-party reporters. Located on the rear of the brochure is the Child Abuse Hotline number. On the agency's website, DYRS provides information on how to report sexual abuse and sexual harassment. Information can be located at https://kids.delaware.gov/yrs/prea.shtml. From this website, a third-party reporter can make a report online. During the random staff interviews, staff was asked how someone could third-party report. It was disclosed to Auditor by the random staff that they could receive reports of sexual abuse and sexual harassment. |

| 115.361 | Staff and agency reporting duties |
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| | **Auditor Overall Determination:** Meets Standard |
| | **Auditor Discussion** |
| | DYRS Policy #2.2.VI.A.21<br>DYRS Policy #2.13.IV.C.1.a<br>DYRS Policy #2.2.A.23<br>Interview with Random Staff, Nurse Supervisor, Psychologist, Assistant Superintendent, and PREA Compliance Manager<br>Coordinated Response Plan<br>First Responder Checklist<br>Interview with IA<br>PREA Training Curriculum<br>DSCYF Website-Mandatory Reporting<br><br>Based on policy and practice of SHDC, the facility meets the standard in staff and agency reporting. Through policy the facility has proven that all staff, including medical and mental health personnel, are required to report immediately allegations of sexual abuse, sexual harassment, and retaliation. Further, all staff is required to comply with all mandatory child abuse reporting laws. Additionally, DYRS policy prohibits staff from revealing any information related to a sexual abuse report. To insure uniformity in the handling of instances of sexual abuse and sexual harassment, DYRS has a coordinated response flowchart to assist in the navigation of procedures. DYRS requires that all allegations of sexual abuse and sexual harassment, including third-party and anonymous reports, are reported to the child Abuse Hotline which prompts IA Investigators. Upon review of the PREA training curriculum provided to staff, the Auditor located instruction that specifically pertains to the reporting of allegations of sexual abuse, sexual harassment, and retaliation. The Auditor questioned staff regarding the reporting of incidences of sexual abuse, sexual harassment, and retaliation and they all responded that they would utilize the Child Abuse Hotline.<br><br>115.361(a)<br>Random staff disclosed that they were responsible to report all incidents of sexual abuse and sexual harassment. The PREA training curriculum also has a section that pertains to the reporting of sexual abuse and sexual harassment. Upon review of DYRS Policy #2.2.VI.A.21, the Auditor found that the policy encompasses the PREA standard of staff needing to report immediately regarding any knowledge, suspicion, or information received relating to an incident of sexual abuse or sexual harassment. It specifically, states that each employee must report, without reservation, any corrupt or unethical behavior which could affect either a juvenile or the integrity of the organization. Additionally, this position is stated in DYRS Policy #2.13.IV.C.1.a. It reads, all staff are required to report any allegations and instances of non-sexual sexual acts, abusive sexual contact, and sexual harassment to the Child Abuse Hotline (800-292-9582). During interviews with staff, all staff were aware of their reporting responsibilities. Scenarios were presented to the staff by the Auditor, and they explained the steps they would follow in the case of an incident.<br><br>115.361(b)<br>As stated previously, the policy requires that all staff must comply with mandatory child abuse |

reporting laws. The requirement of mandatory reporting is in DYRS policy and training curriculum. Also, mandatory reporting can be found on the agency website. During the interview with both the Psychologist and Nurse Supervisor, both immediately stated that they were mandatory reporters.

115.361(c)
The DYRS requires that employees must maintain the integrity of confidential information in accordance with DYRS Policy #2.2.A.23. It further states that they will not reveal case information to anyone not having proper professional use for such. During the interviews with the medical/mental health professionals, there was a discussion regarding confidentiality. Both individuals detailed how information is shared with the administrators and supervisors as a best decision or practice for the youth without disclosing the specifics of the sexual risk assessment. For example, the identification of gender conformity or non-conformity is documented and communicated as one or the other without further detail to administrators and supervisors. Additionally, the random staff also stated that they are not allowed to share the details of incidents of sexual abuse or sexual harassment.

115.361(d)
As aforementioned, all staff which includes medical and mental health personnel are required to report allegations and instances of sexual abuse and sexual harassment. During interviews with both the Nurse Supervisor and Psychologist, it was determined to be common practice by both at the initiation of services to inform youth of their duty to report and to remind youth that there are limitations of confidentiality.

115.361 (e)
In the instance of an allegation of sexual abuse, there is a coordinated response by SHDC. Additionally, the facility maintains a First Responders Checklist which gives step by step details of the task that need to be initiated in the case of an allegation of sexual abuse, sexual harassment, or retaliation. In the coordinated response plan, the staff members are required upon receipt of a report to immediately ensure the safety of the youth by separating from perpetrator as well as maintaining any physical evidence on persons, secure scene so that evidence can be collected, contact Child Abuse Hotline, and youth is taken for medical and mental health evaluations. Staff prepares documentation of incident, and the supervisor notifies Superintendent. At that time, Superintendent is to implement DYRS Policy #2.13 and complete documentation per that policy. The facility head is to begin reportable event procedures per policy, and then the Deputy Director is contacted through the chain of command. The Auditor was also given a description of the steps taken by the first responders by the Assistant Superintendent. This information coincided with the First Responder Checklist as well as the Coordinated Plan.

115.361(f)
Within DYRS Policy #2.13, it states to report all allegations of sexual abuse and sexual harassment to the Child Abuse Hotline which initiates the participation of the facility's designated investigators which is IA. This is collaborated with the interviews with IA. The Auditor attained that reporting to the Child Abuse Hotline was located on the First Responders Checklist, PREA training curriculum, and the Coordinated Response Plan. In conversation with the PREA Compliance Manager, it was found that the First Responder Checklist is readily available for staff in the case of an incident of sexual abuse or sexual harassment.

| 115.362 | Agency protection duties |
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| | **Auditor Overall Determination:** Meets Standard |
| | **Auditor Discussion** |
| | DYRS Policy #2.13 IV.C.2.e<br>Coordinated Response - Secure Care Scenario #3<br>Interview with Random Youth and Targeted Population, PREA Compliance Manager and Assistant Superintendent<br><br>SHDC has been found to meet compliance on the standard of agency protection duties. The policy directly states that youth can be temporarily transferred in the case of imminent sexual abuse. The youth can request a temporary transfer if they fear for safety, as well as the Superintendent or designee can make a temporary transfer if there are concerns of imminent sexual abuse of a youth. Also, DYRS has shown evidence of a reassessment of housing within the Coordinated Response Plan.<br><br>115.362(a)<br>If a youth fears for their safety in their current setting, they can make a request for a temporary transfer to another location. Additionally, a Superintendent or designee can temporarily transfer a youth if they feel the youth's safety is in jeopardy or there is a substantial risk of imminent sexual abuse. In the last 12 months, the PREA Compliance Manager disclosed that there were no determinations of any youth in substantial risk of imminent sexual abuse at SHDC. Scenario #3 located in the Coordinated Response flow chart shows that SHDC would also reassess housing of a youth in the instance of sexual abuse. During the discussion with the Assistant Superintendent, the Auditor questioned the actions that would be taken if a youth was in imminent danger of sexual abuse or if they feared for their safety. It was disclosed that the youth would be given a transfer to another housing unit or to another facility within DYRS state operated facilities. There were no random youth or youth identified as target population by Risk Assessment that was interviewed that felt any imminent danger of being sexually abused or sexually harassed. |

| 115.363 | Reporting to other confinement facilities |
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| | **Auditor Overall Determination:** Meets Standard |
| | **Auditor Discussion** |
| | DYRS Policy #2.13.IV.C.3 & IV.D.1.b<br>Interview Assistant Superintendent and PREA Coordinator<br>Review of Non-Critical Incident Reports<br><br>DYRS has proven through policy and by interview with the Assistant Superintendent and PREA Coordinator, that the facility meets the standard in reporting to other confinement facilities. The policy directs the Superintendent to notify the respective administrator of the facility or office of the agency where the alleged abuse occurred and the investigative agency. The notification is to occur within 72 hours of receiving the allegation of sexual abuse. The DYRS administrator is to prepare documentation of the notification to the other agency administrator, the investigative agency, the YRS Director, and the Division's PREA Coordinator. Lastly, all allegations of sexual abuse are handled in accordance to the PREA standards.<br><br>115.363(a)-(d)<br>DYRS Policy #2.13.IV.C.3 directs that upon receiving an allegation that a youth was sexually abused while detained at another facility, the administrator who received the allegation will notify the administrator of the facility or the appropriate office of the agency where the alleged abuse occurred and notify the appropriate investigative agency. The notifications are required to be provided as soon as possible, but no later than 72 hours after receiving the allegation. The facility administrator is required to document the notification of the other agency administrator, as well as the investigative agency. Additionally, the documentation should also reflect that YRS Director and the PREA Coordinator have been notified. According to the Assistant Superintendent and PREA Coordinator, SHDC has not received allegations of a youth being sexually abused at another facility in the past 12 months. Further review by Auditor of non-critical incidents have proven that there have been no sexual abuse allegations at another confinement facility. As stated before, DYRS maintains that all matters that involve the allegation of any sexual contact as defined in this policy will be reported to the Child Abuse Hotline which further prompts investigation in accordance to PREA standards. |

| 115.364 | Staff first responder duties |
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| | **Auditor Overall Determination:** Meets Standard |
| | **Auditor Discussion** |
| | Coordinated Response Scenarios<br>First Responder Checklist<br>Interview with Random Staff, Non-Custodial Employee, Volunteer, PREA Compliance Manager, and Contracted Medical Personnel<br>Sexual Abuse Incident Review<br>PREA Training Curriculum<br><br>DYRS meets the standard in staff first responder duties. Compliance was met based on interviews with random staff who indicated that they were familiar with the first responder duties. Though the policy does not specifically state first responder duties, the facility utilizes the First Responders Checklist for reference. Upon review of the document by the Auditor, the First Responder Checklist was in alignment with the PREA standards for first responder responsibilities.<br><br>115.364(a)<br>During the random staff interviews, it was noted that all custody staff were versed on the first responder's duties. According to the Sexual Abuse Incident Review, there have been 3 allegations of sexual abuse and 2 of sexual harassment in the prior 12 months. Upon review of records, it was documented that in 2 of the 3 abuse allegations, victim and abuser were separated. According to the Sexual Abuse Incident Reviews, surveillance footage of several of the allegations was collected. Review of the First Responder Checklist confirmed that DYRS was conforming to PREA standards as follows:<br>1. Separate alleged victim and abuser<br>2. Preserve evidence<br>3. Request both victim and abuser to take no action so that physical evidence can be collected<br><br>115.364(b)<br>At all times, custody staff is with youth. There is no time that non-custody staff is left alone with youth. This was confirmed in interviews with Volunteer, Contracted Medical Personnel, Random Staff, Non-Custodial Staff and PREA Compliance Manager. All staff were trained on first responder duties, but custody staff are always responsible for the safety and security of youth. |

| 115.365 | Coordinated response |
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| | **Auditor Overall Determination:** Meets Standard |
| | **Auditor Discussion** |
| | Coordinated Response Scenarios<br>First Responder's Checklist<br>PREA Compliance Manager<br><br>The institutional plan that is utilized by SHDC meets the standard in coordinated response. The plan contains three scenarios of allegations of sexual abuse and sexual harassment. The plan resembles a graphic organizer or flowchart. It illustrates the necessary steps in chronological order. Additionally, to accompany this coordinated plan, there is a First Responder's Checklist which also provides steps as well as a script to follow in order to ascertain pertinent information from youth.<br><br>115.365(a)<br>SHDC follows the Coordinated Response Scenarios that are specifically written for secure care facilities. The actions are taken in response to incidents that involve sexual abuse of youth. The flowchart lists the duty, as well as who is responsible for that duty. The positions listed are as follows: staff first responders, investigators, medical and mental health personnel, facility leadership and agency leadership. The document is a flow chart that clearly maps out the duties that should be taken at SHDC in the instances of sexual abuse. The First Responder's Checklist also takes it a step further by scripting pertinent questions to ask by staff and the notifications that shall be made. The PREA Compliance Manager stated that this information is easily accessible by staff to utilize in the instance of sexual abuse and sexual harassment. |

| 115.366 | Preservation of ability to protect residents from contact with abusers |
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| | **Auditor Overall Determination:** Meets Standard |
| | **Auditor Discussion** |
| | DSCYF Policy #309<br>DYRS Policy #2.13.IV.D.1.e<br>Interview Agency Director and Human Resource Representative<br><br>DYRS meets the standard in the preservation of ability to protect residents from contact with abusers through established policies. There has been no collective bargaining agreement since 2006 to address the ability to protect residents from contact with abusers, but there are two policies specifically that speaks to the removal of staff in the instance of an allegation of sexual abuse which are DSCYF Policy #309 and DYRS Policy #2.13.<br><br>115.366(a)<br>Since the last PREA audit in June of 2015, DYRS has not had a collective bargaining agreement opened since 2006. This was further confirmed with the Agency Director that the SHDC has not been in collective bargaining. During the interview with the Human Resource Representative, it was explained that during the collective bargaining agreement process that the discipline process must be consistent with PREA standard 115.372 and 115.376 in future collective bargaining agreements. DYRS retains the ability through policy to remove alleged staff sexual abusers from contact with residents pending the outcome of an investigation or of a determination of whether, and to what extent, discipline is warranted. DYRS Policy #2.13.IV.D.1.e cites that all incidents that occur in Delaware's state operated facilities, the state will pursue personnel actions that honor due process and decision making that is in the best interest of the child. Also, DSCYF Policy #309 is to minimize the risk to employees and the public by removing employees from the workplace when their continued presence may pose a risk to the safety or security of residents, employees, and the public or public's confidence. Allegations of events that may lead to immediate removal from the workplace will include, but not be limited to, the following which includes physical or sexual abuse against a resident. |

| 115.367 | Agency protection against retaliation |
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| | **Auditor Overall Determination:** Meets Standard |
| | **Auditor Discussion** |
| | DYRS Policy #2.13.IV.C.2.f<br>Interview with Assistant Superintendent<br><br>Based on the review of the policy and the interview with the Assistant Superintendent, SHDC meets compliance in the standard of agency protection against retaliation.<br><br>115.367(a)<br>In the instances of retaliation, DYRS policy states that retaliation from youth and staff will result in disciplinary action and be subject to the full progression of sanctions and/or referral for criminal prosecution. During the interview with the Assistant Superintendent, part of the job duties of that position is monitoring for retaliation after an allegation of sexual abuse and sexual harassment. In the last 12 months, the Auditor ascertained from the interview that there were no instances of retaliation. The last allegation of sexual abuse and sexual harassment was July 2017. There are no victims from those allegations that can attest that there was no retaliation.<br><br>115.367(b)<br>As stated earlier from DYRS Policy #2.13, if a youth fears for safety in their current setting they can request a temporary transfer to another location (unit or facility). The request can be made through the facility procedures governing this type of request. In the case of staff concern of retaliation, any decisions would have to be made with facility administrators. Both actions were confirmed by the Assistant Superintendent in the event of retaliation. |

| 115.368 | Post-allegation protective custody |
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| | **Auditor Overall Determination:** Meets Standard |
| | **Auditor Discussion** |
| | DYRS Policy #2.13.4.B.2<br>DYRS Policy #2.20.IV.E.1.c<br>Interview of Random Youth, Assistant Superintendent, and PREA Compliance Manager<br><br>SHDC has demonstrated that it meets the standard in post-allegation protective custody. The facility has proven through policy that assessments are made prior to housing decisions, and the facility would only place a resident in isolation only as a last resort. If youth are placed in isolation, they would receive large-muscle exercise, legally required educational programming, and special education services. Also, SHDC would document the reason for concern necessitating the placement, as well as the reason no other arrangements were able to be made. In the last 12 months, there have been no placement in isolation at SHDC.<br><br>115.368(a)<br>In the last 12 months, there have been no cases of youth who allege to have suffered sexual abuse being placed in isolation according to the Assistant Superintendent and PREA Compliance Manager. DYRS Policy #2.13.4.B.2 addresses the classification and assessment tools utilized to determine supervision needs of youth for the protection of victims and those known to be perpetrators. Further, DYRS Policy #2.20.IV.E.1.c allows for youth to be isolated from others only as a last resort when less restrictive measures are inadequate to keep them and other youth safe and only until an alternative means of guaranteeing everyone's safety can be arranged. Continued in the policy is the requirement to provide large muscle exercise, legally required educational programming, and special education services. Additionally, the policy requires documentation of the basis for the facility's concern for youth's safety, as well as the reason why no alternative means of separation can be arranged. |

| 115.371 | Criminal and administrative agency investigations |
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| | **Auditor Overall Determination:** Meets Standard |
| | **Auditor Discussion** |
| | DYRS Policy #2.13.IV.D.1<br>Memorandum 8/24/10-Incident Investigation Protocols<br>Interview with IA Investigators, Assistant Superintendent – Administrative Investigator<br>Sexual Abuse Incident Review Documentation<br>Copies of Investigators Certifications<br>DYRS Policy #2.13.IV.F.6-7<br>Interview with Management Analyst<br><br>It is determined that DYRS exceeds the standard in criminal and administrative agency investigations. which are cited in DYRS policy. SHDC conducts only administrative investigations. It is detailed within the policy that allegations of sexual abuse and sexual harassment is done promptly, thoroughly, and efficiently. There is an objective form that is utilized to complete investigations. This practice is in alignment with the PREA standards. Also, DYRS policy states that all sexual abuse investigations are investigated, including third-party and anonymous reports. Additionally, all investigators have received specialized training in sexual abuse investigations, and the training was in accordance to PREA standards. The investigator's duties require the collection and preservation of evidence and interviewing alleged victims, suspected perpetrators, and witnesses. Lastly, all documentation of sexual abuse allegations is maintained by the Management Analyst for 10 years per policy.<br><br>115.371(a)<br>DYRS Policy #2.13.IV.D.1 addresses criminal and administrative investigations. SHDC conducts administrative investigations only. Detailed within DYRS Policy #2.13.IV.D.1 are the roles of three investigative bodies. There are 2 administrative investigators at SHDC. They is an administrator and a supervisor. Their responsibility is to investigate administrative allegations. Also, there are 2 investigators in the Institutional Abuse Unit (IA) that investigate civil investigations at SHDC. In the case of the criminal investigators, they are members of the local police department, Milford Police Department (MPD) and the Delaware State Police (DSP). All matters that involve an allegation of sexual abuse are reported to the Child Abuse Hotline. The Child Abuse Hotline notifies the Institutional Abuse Investigators (IA). In matters which could result in a criminal action, IA notifies either MPD or DSP. IA and DSP or MPD conduct joint investigations.<br>Further during the interviews, the IA investigators confirmed that all allegations are given to IA. If it is deemed by IA that the allegation does not reach the level of IA or the allegations are not of a criminal nature, it is then sent to the administrative investigators. Also, IA held that the Child Abuse Hotline contacts them immediately regarding allegations of sexual abuse and sexual harassment. From the interview, it was also found that all allegations of sexual abuse are handled in the same manner. It does not matter if allegations are third-party or from an anonymous source.<br>After reviewing Sexual Abuse Incident Review, the Auditor found that 4 investigations were done on the same day of incident, and another investigation was completed the next day. The investigative documentation was an objective form. In all 5 allegations, the forms were filled out completely and promptly. |

Additionally, in the Memorandum on 8/24/10-Incident Investigation Protocols, the memorandum requires that investigations are completed promptly, thoroughly, and efficiently. It does not state objectively, but the form that is utilized to obtain information is objective.

115.371(b)
All 4 investigators within DSCYF have obtained the required specialized investigation trainings mandated by PREA. SHDC has 2 administrative investigators that have received training in investigations in accordance with the PREA standards, and the Institutional Abuse Unit has 2 investigators that have received the training as well. The Assistant Superintendent, which is one of the Administrative Investigators, stated that the specialized training received certified the following:
Issues in conducting sexual assault investigations in confinement
Trauma Theory
Maladaptive coping skills related to trauma
Report writing
Evidence Collection
Crime scene protection
Miranda and Garrity

115.371(c)
Within the Memorandum dated 8/24/10 during the administrative review, the facility/head unit administrator will secure and protect all documentary evidence, gathered during the course of the incident review. This includes, but is not limited to, security tapes, videos, photographs, incident reports, interview notes, witness statements and medical reports. According to IA, investigators collect evidence as well as interview victims, suspected perpetrators, and witnesses. If the allegation is of a criminal nature, the investigation would be in conjunction with either DSP or MPD. According to the Assistant Superintendent, whenever possible, the facility maintains footage of allegations of sexual harassment and sexual abuse. In the Sexual Incident Reporting Form, it is documented that alleged victims, suspected perpetrators, and witnesses were interviewed, and their responses were documented on form.

115.371(d)
According to IA, investigations are not terminated, because the source of the allegation recants the allegation. In one of the allegations, a youth recanted story, but the investigation continued. This was documented on the Sexual Incident Reporting Form.

115.371(e)
In order to prevent any obstacles to subsequent criminal prosecution, investigations that have the potential to be criminal are investigated by both IA and DSP or MPD. This practice is confirmed from the interviews with IA. According to the Memorandum 8/24/10, the DYRS must exercise reasonable care not to jeopardize a criminal investigation. A review/investigation shall not be put on hold to allow for completion of law enforcement investigation. DYRS will cooperate with law enforcement investigations by providing access to staff, youth and materials as requested by the law enforcement agency. There have been no sexual abuse allegations that were deemed criminal within the prior 12 months.

115.371(f)

During the Investigators' interviews, it was disclosed that youth are not required to submit to a polygraph examination or other truth telling device. Additionally, it was found that investigators based credibility of victims on an individual basis.

115.371(g & h)
Located on the Sexual Abuse Incident Review are questions that pertain to staffing level at the time of the incident as well as the findings of the Incident Review Team. The review of the documentation of the 5 allegations findings of the Incident Review Team supports that there is a consideration of staff actions or failures to act contributed to incident. The Sexual Abuse Incident Review is a written report that includes the description of physical evidence, testimonial evidence, credibility assessment, investigative facts and findings.

115.371(i)
According to IA, substantiated allegations of sexual abuse or conduct that appears to be criminal are referred to the prosecutor's office by DSP or MPD.

115.371(j)
Stated in DYRS Policy #2.13.IV.F.6-7, all data collected throughout the division on PREA allegations and all associated reports, shall be securely stored by the Management Analyst using a double lock system. Documentation referenced will be retained for no less than 10 years after the date of its initial collection unless Federal, State, or Local law requires otherwise. This protocol was confirmed during the interview with the Management Analyst. This practice was further confirmed during an interview with the Management Analyst.

115.371(k)
According to IA, investigations are not terminated due to the departure of an alleged abuser or victim from the employment or control of the facility or agency.

115.371(m)
Stated in Memorandum dated 8/24/10, DYRS will cooperate with law enforcement investigations by providing access to staff, youth and materials as requested by the law enforcement agency.

| 115.372 | Evidentiary standard for administrative investigations |
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| | **Auditor Overall Determination:** Meets Standard |
| | **Auditor Discussion** |
| | Interviews with IA Investigators and Assistant Superintendent<br>DSCYF Policy #208<br>Title 16 Chapter 9<br><br>In the PREA evidentiary standard for administrative investigations, the agency meets the standard. According to the PREA standard, the evidentiary standard utilized cannot be higher than the preponderance of the evidence. For both administrative and civil investigations, the standard is not higher than preponderance of the evidence.<br><br>115.372(a)<br>It was disclosed by the Interviews with IA that for civil investigations the evidentiary standard is the preponderance of the evidence, but in the case of administrative review the evidentiary standard would be just cause. Neither evidentiary standard is higher than the preponderance of the evidence. Detailed in both DSCYF Policy #208 and Title 16 Chapter 9 is the evidentiary standard that is utilized at DSCYF for administrative and civil investigations. The same was confirmed with the Assistant Superintendent who is the administrative investigator at SHDC. |

| 115.373 | Reporting to residents |
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| | **Auditor Overall Determination:** Meets Standard |
| | **Auditor Discussion** |
| | Investigation File Record Review<br>Interview with Manager Analyst and Assistant Superintendent<br>DYRS Policy #2.13.IV.D.1.i<br>Notification of Investigation Form<br>DYRS Policy #2.13.IV.D.1.i<br>DYRS Policy #2.13.IV.F.6<br>Memorandum 8/24/10-Incident Investigation Protocols<br>Notification Training Agenda<br>Signed Roster of Professional Development Attendance-Superintendent, Assistant Superintendent, and PREA Compliance Manager<br>Six Completed Mock Notifications<br><br>After completing corrective action, SHDC was found to meet compliance for the standard of reporting to youth the outcomes of PREA investigations. Initially, SHDC was found to have lacked documentation on reporting outcomes of investigations to residents, and it was determined by the Auditor that SHDC did not meet compliance in notifying residents of PREA Investigation findings. After review of investigative files, the Auditor only located 1 Notification of Investigation Form. In total, there were 5 sexual abuse and sexual harassment investigations that occurred in the previous 12 months.<br><br>115.373(a)<br><br>DYRS has a policy that requires youth to be notified of the outcome of sexual abuse and sexual harassment allegations. Cited within DYRS Policy #2.13.IV.D.1.i is a clause that states that upon notification from IA or law enforcement, the program administrator will ensure that the youth is notified of the outcome of the case via the Notification of Investigation Form. In order to reinforce the practice of completing and maintaining notification documentation, SHDC was required to complete the following task for corrective action:<br><br>1. DYRS must provide professional development on the notification process based on the requirement set by DYRS Policy #2.13. The policy requires that youth are notified of outcomes of unsubstantiated, substantiated, and unfounded allegations of sexual abuse and sexual harassment investigations. The participants in the professional development should include SHDC administrators and the PREA Compliance Manager. Information that should be included in the professional development are as follows:<br><br>a. Notification process<br>b. Roles of the administrators<br>c. Notification form completion<br>d. Timeframes<br><br>2. Due to the infrequency of allegations of sexual abuse and sexual harassment allegations at SHDC, the facility was required to provide the Auditor with scenario based tasks which |

included utilizing past allegations to complete mock notification forms as well as an additional created mock notification. In total, there were six mock notifications forms completed.

SHDC provided the Auditor with the following documentation for verification of completion of corrective action:

a. Training Agenda from the Professional Development on the Notification Process
b. Handouts
c. Sign in Roster with the following signatures
Superintendent
Assistant Superintendent
PREA Compliance Manager
d. Copies of six completed mock notifications

115.373(b)
Per policy in the case that SHDC or IA does not complete the investigation it is the responsibility of the facility head to obtain all reports from the investigative entity in accordance to Memorandum dated 8/24/10. In the previous 12 months, there were no sexual abuse allegations that were criminal that involved a law enforcement agency. All allegations were investigated by institutional abuse and administrative review.

115.373(c)
As stated prior, there was only 1 Notification of Investigation Form completed. That allegation involved youth on youth and it was unsubstantiated. In the case of an unfounded allegation of staff on resident sexual abuse within the prior 12 months, there was no notification completed.

115.373(d)
After reviewing investigative records, it was found that following a youth's allegation of being sexually abused by another youth in SHDC there was only 1 Notification of Investigation Form completed which was an unsubstantiated allegation of youth on youth sexual abuse.

115.373(e)
All notifications to youth are to be completed on a Notification Investigation Form in accordance to policy. Additionally, DYRS Policy #2.13.IV.F.6 mandates that all documentation pertaining to investigation is maintained with the Manager Analyst.

| 115.376 | Disciplinary sanctions for staff |
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| | **Auditor Overall Determination:** Meets Standard |
| | **Auditor Discussion** |
| | DSCYF Policy #109.VII.A.1-6<br>DSCYF Policy #309.I-II.1-6<br>DYRS Policy #2.13.IV.C.1.b<br>DYRS Policy #2.13.IV.C.1.f<br>DYRS Policy #2.13.IV.D.1.e-f<br>DYRS Policy #208.IV.E-F<br>Interview with PREA Compliance Manager, PREA Coordinator, and Assistant Superintendent<br>Review of Investigative Files<br>Interview with Human Resources Unit<br><br>Based on the agency's adherence to the PREA standard of disciplinary sanctions for staff, it is found that DSCYF and DYRS meets the standard. The policies have language that provides for the discipline and/or termination of a staff at SHDC in the instances of sexual abuse and sexual harassment. Additionally, there is policy that requires information to be disseminated to other regulatory bodies.<br><br>115.376(a)<br>DSCYF and DYRS has several policies that address discipline including termination for staff that engage in sexual abuse or sexual harassment. The following are the policies that address discipline and termination:<br>DSCYF Policy #109<br>DSCYF Policy #309<br>DYRS Policy #2.13<br><br>In DSCYF Policy #109.VII.A.1-6, it specifies the discipline remedies for allegations of sexual abuse and sexual harassment which includes training, retraining, and disciplinary action including dismissal for the infraction.<br>In DSCYF Policy #309.I-11.1-6, there is a description of guidelines for removal of employees from the workplace when it is determined that their continued presence jeopardizes other's safety, security or the public confidence. Further in the policy, it lists the allegations of events that may lead to immediate removal from the workplace, which include if an employee is being investigated for alleged child abuse/neglect and the physical or sexual abuse against a youth.<br>Within Policy #2.13, there are several locations within the policy that states the reasons a staff could receive discipline including termination. In the section of reporting, failure to report any sexually related incident will result in disciplinary action up to and including termination and/or criminal prosecution. Further in that section it states that retaliation from youth or staff will result in disciplinary action subject to the full progression of sanctions and/or referral for criminal prosecution. Lastly, cited in the policy is that all incidents that occur in Delaware's state operated facilities, the state will pursue personnel actions that honor due process and decision making that is in the best interest of the child.<br><br>115.376(b)<br>Gathered from several interviews with the PREA Coordinator, PREA Compliance Manager of |

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| | SHDC, and the Assistant Superintendent, there were no instances in the prior 12 months that a staff has violated agency sexual abuse or sexual harassment policies or been terminated for such behaviors. There was no documentation in the investigative files of substantiated allegations that notated any violation of staff being sexually abusive or sexually harassing residents.<br><br>115.376(c)<br>Based on the interviews with the Human Resource Unit and the Assistant Superintendent, disciplinary sanctions for agency policies relating to sexual abuse and sexual harassment was found to be done in tandem with the facility administrator. Stated in Policy #2.13.IV.D.1.e-f, for all incidents that occur in Delaware's State operated facilities, the State will pursue personnel actions that honor due process and decision making that is in the best interest of the child. Upon completion of an investigation, the facility administrator will make a recommendation for training and/or disciplinary action as necessary, after consulting with the Human Resource Unit. In a review of an unsubstantiated allegation of sexual harassment, there was a staff member that was asked to review policy and procedures surrounding resident supervision and use of force.<br><br>115.376(d)<br>Per policy DSCYF ensures that terminations for violations of sexual abuse and sexual harassment policies or resignations by staff are reported to the appropriate regulatory bodies. Located in Policy #208.IV.E-F the agency formulates findings and develops recommendations to the appropriate regulatory body and submits findings and recommendations to the appropriate regulatory body. There have been no instances in the prior 12 months that initiated the agency to apply these policies to a staff or former staff at SHDC. |

| 115.377 | Corrective action for contractors and volunteers |
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| | **Auditor Overall Determination:** Meets Standard |
| | **Auditor Discussion** |
| | Interview with PREA Compliance Manager and Volunteer by Telephone<br>Volunteer Acknowledgement of Training<br>DSCYF Policy #109-Background<br>DSCYF Policy #309-Purpose<br>DSCYF Policy #305.IV.C<br>DSCYF Policy #305.VII.A.3<br>DSCYF Policy #208<br>DYRS Policy #2.13.III.A<br><br>In the PREA standard of corrective action for contractors and volunteers, it was found that DSCYF and DYRS meets compliance. It was ascertained by the Auditor that contractors and volunteers are considered staff which is defined in several policies. All disciplinary sanctions that apply to employees also apply to contractors and volunteers, including termination of services.<br><br>115.377(a)<br>Under DYRS Policy #2.13, staff is defined as any department employee, volunteer, contractor, official visitor, or other agency representative. Essentially, any discipline or termination of services would be applied as if an employee of SHDC. During the phone interview with a volunteer, it was found that SHDC required PREA training and signature of completion that any sexual abuse and sexual harassment would constitute removal and up to possible criminal prosecution. The same language was found within DSCYF Policy #109.III.G-J. In the background section of that policy, it reiterates that anyone working with children within DSCYF should be free from any prior criminal activity or involvement in substantiated cases of abuse/neglect that may lead to the harm of any child/youth. Gathered from the interview with the Compliance Manager, there has been no allegations of sexual abuse and sexual harassment by contractors or volunteers.<br><br>115.377(b)<br>The purpose of DSCYF Policy #309 is to establish the guidelines for removal of employees from the workplace when it is determined that their continued presence jeopardizes others' safety, security or the public confidence. As stated prior, contractors and volunteers are considered staff per DSCYF policy. In the background section of DYRS Policy #305, details that anyone defined as staff be free from any prior criminal activity or involvement in substantiated cases of abuse/neglect that may lead to the harm of a child/youth. Further in the policy, there is language that gives the criteria by which a volunteer or contractor can be removed from facility. The policy reiterates that disciplinary sanctions can include dismissal. Lastly, DSCYF Policy #208 cited in the purpose section was for DYRS to prevent future occurrences of institutional abuse/neglect by offering recommendations which would aid in the process of correcting existing problems identified in the course of the investigation. Ascertained from the interview with the PREA Compliance Manager was that volunteers and contractors would be processed in accordance with the same policies that apply to staff in the case of sexual abuse and sexual harassment allegations. |

| 115.378 | Interventions and disciplinary sanctions for residents |
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| | **Auditor Overall Determination:** Meets Standard |
| | **Auditor Discussion** |
| | DYRS Policy #2.13.IV.2.f,h,i<br>DYRS Policy #2.13.II<br>Interview PREA Compliance Manager and Psychologist<br>Mock Incident Review Team Minutes<br><br>For the PREA standard of interventions and disciplinary sanctions for residents, DYRS meets compliance. In place, DYRS has CBT as the behavioral therapy model to process sanctions as it relates to sexual abuse and sexual harassment. There is an incident review team and Psychologist onsite that can further process sanctions so that the discipline takes into consideration the youth's mental disabilities and mental illness. Additionally, SHDC has a Psychologist onsite that provides risk assessments, counseling, therapy, and other interventions when deemed necessary. If a youth commits a sexual act against staff, they can be disciplined within the scope of DYRS policy. Finally, residents can be disciplined if a sexual abuse allegation is submitted in bad faith.<br><br>115.378(a)<br>Within the DYRS Policy #2.13.VI.2.h-i it mentions that youth sexual contact and sexual harassment is prohibited in all Division programs and contracts. These contacts shall be addressed in the behavioral management programs. In the case of SHDC, the behavioral management program utilized is Cognitive Behavioral Therapy (CBT). If a matter is in bad faith, the program administrator may discipline. The policy also states that if a program administrator has demonstrated that a youth has filed a PREA grievance in bad faith or made a verbal report about a PREA matter in bad faith, the program administrator may discipline a youth via CBT. According to the PREA Compliance Manager, there were no incidents of youth being disciplined for filing a PREA grievance or making a verbal report in bad faith. Additionally, there have been no administrative or criminal findings of guilt of resident on resident sexual abuse.<br><br>115.378(b)<br>In the prior 12 months, there have been no incidents of residents placed in isolation at SHDC according to the PREA Compliance Manager.<br><br>115.378(c)<br>SHDC has an Incident Review Team that includes personnel from administration, mental health and education department. During the processing of the incident, staff discusses all information pertaining to the child in order to make a recommendation of discipline and other recommendations. Additionally, the team reviews staff ratio and video monitoring equipment.<br><br>115.378(d)<br>The facility has a psychologist that completes PREA required assessments as well as counseling, therapy, and other interventions as necessary. Participation in CBT is offered to all youth. According to PREA Compliance Manager, education programming and other programming is not contingent upon participating in CBT. |

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| | 115.378(e)<br>In the DYRS policy, it commits to full compliance with PREA. Any type of forced or unwanted sexual activity, touching or sexual harassment between youth or any type of sexual activity or sexual harassment between staff and youth (including consensual) is criminal and prohibited. Once it is established that staff did not consent than youth would be disciplined for such behavior.<br><br>115.378(f)<br>DYRS' position is very clear in DYRS Policy #2.13.IV.2.f,h,i that only bad faith allegations regarding sexual abuse and sexual harassment would be disciplined.<br><br>115.378(g)<br>Within DYSR Policy #2.13, in the instances that sexual activity is not coerced between youth, it is not considered sexual abuse. Specifically, omitted is consensual sexual acts. Staff is required to report any allegations and instances of non-consensual sexual acts, abusive sexual contact, and sexual harassment to the Child Abuse Hotline. Cited earlier, any type of forced or unwanted sexual activity, touching or sexual harassment between youth or any type of sexual activity or sexual harassment between staff and youth (including consensual) is criminal and prohibited. Consensual sexual acts between youth are prohibited but are not considered sexual abuse. |

| 115.381 | Medical and mental health screenings; history of sexual abuse |
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| | **Auditor Overall Determination:** Meets Standard |
| | **Auditor Discussion** |
| | Interview with Psychologist, Nursing Supervisors, and Youth Who Disclosed Sexual Victimization at Risk Assessment<br>Review of Sexual Risk Assessments<br>DYRS Policy #2.13<br>Memorandum of Understanding Between Division of Prevention and Behavioral Health Services (PBHS) and the Division of Youth and Rehabilitative Services (DYRS)<br>Interview with Psychologist and Nurse Supervisor<br><br>SHDC meets compliance with the PREA standard for medical and mental health screenings; and history of sexual abuse. The facility ensures through the Memorandum of Agreement with PBHS that residents are screened for victimization or history of being a perpetrator. In addition, youth are offered follow-up services by a mental health professional within 14 days of the intake screenings. These youth would have identified as being victimized or having victimized others. Also, it was found that information is strictly limited by medical and mental health personnel if it relates to sexual victimization or abusiveness. Lastly, medical and mental health staff obtain informed consent from youth prior to reporting information about prior sexual victimization that did not occur in an institution.<br><br>115.381(a)<br>The purpose of the Memorandum of Understanding between PBHS and DYRS is to identify youth at risk of being sexually victimized as well as those at risk for sexually victimizing others in order to limit such risk. The role of the PBHS clinicians:<br>1. Meet with youth admitted to DYRS within 1 business day<br>2. To obtain information about youth from FACTS database<br>3. Review information obtained and interview youth to identify the risk factors contained on Sexual Risk Assessment<br>4. Utilize any other specific information about youth that may indicate heightened need of supervision, additional safety precautions, or separation from certain other youth.<br>Once all the information is gathered, the clinician is to notify administration and the supervisors when there are concerns for safety, identify interventions to provide safety and security, and document notification of concern about risk factors and recommended interventions. In speaking with medical and health personnel, it was found that the Memorandum of Understanding was still in existence. It was confirmed by the Nurse Supervisor that the above steps are still in practice. The Auditor reviewed the Sexual Risk Assessments and found that the form was in alignment with the requirements set forth by the PREA standards. According to the Psychologist, there is an ongoing process of follow-up with youth at SHDC. There was one youth that identified on Risk Assessment as disclosing sexual victimization at intake. Upon review of file, the youth was seen by the Psychologist within 14 days for follow-up. This practice was also confirmed by the youth.<br><br>115.381(b)<br>According to the Psychologist, there is continued follow-up with residents that have been identified as at risk of being victimized as well as perpetrators of sexual abuse and sexual |

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| | harassment. According to Psychologist, any information regarding sexual victimization or abusiveness that has occurred is strictly limited and only for security and management decisions, treatment plans, housing, education, and program assignments.<br><br>115.381(c)<br>According to medical and mental health personnel, their practice is to obtain consent from youth before reporting information about prior sexual victimization that did not occur in confinement unless the youth is under the age of 18. |

| 115.382 | Access to emergency medical and mental health services |
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| | **Auditor Overall Determination:** Meets Standard |
| | **Auditor Discussion** |
| | DYRS Policy #7.3.II<br>DYRS Policy #2.13.IV.D.2.b<br>Affirmation of Compliance with Forensic Examinations Standards for Sexual Assaults<br>Interview with Nurse Supervisor<br>Coordinated Response Plan-Scenario #3<br>First Responder Checklist<br><br>Based on information obtained by interview and the Affirmation between DYRS and Milford Hospital, SHDC meets compliance in the standard of access to emergency medical and mental health services. In the instance of sexual abuse, youth would receive timely and unimpeded access to medical treatment. There are procedures in place that would ensure that services were provided immediately within 4 minutes, and all PREA related instances would be taken to Milford Hospital. Youth would be provided information on emergency contraception and sexually transmitted infections prophylaxis. Additionally, all treatment services would be provided to youth without cost, and youth does not have to name perpetrator or cooperate with an investigation to receive services.<br><br>115.382(a)<br>If a youth were sexually abused at SHDC, the youth would receive timely and unimpeded access to emergency medical treatment and crisis intervention. Staff is trained to respond to youth within a 4 minute response time in accordance to DYRS Policy #7.3.II. Further, the policy details the training that staff receives. It is cited that the physician in charge should be contacted immediately in the event of an emergency. Additionally, staff is trained on transfer procedures to an emergency facility. Lastly, the policy states the sequence of telephone contacts that are required. Per DYRS Policy #2.13.IV.D.2.b, all medical interventions for PREA related incidents for Kent and Sussex counties will be referred to Milford Hospital.<br><br>115.382(b)<br>If an incident of sexual abuse happens after the hours of medical or mental health personnel, the procedure is as stated prior that physician in charge should be contacted immediately per policy. Additionally, staff is to activate the Coordinated Response Plan- Scenario #3 as well as the First Responders Checklist. According to the Coordinated Response Plan, the youth would be taken to Milford Hospital for medical and mental evaluation which includes SANE/SAFE. In speaking with the Nurse Supervisor, it was further confirmed that for sexual abuse that the Coordinated Response Plan-Scenario #3 would be implemented in which youth would receive medical and mental health services at Milford Hospital.<br><br>115.382(c)<br>There exists an Affirmation of Compliance between DSYCF, DYRS, and Milford Hospital that the hospital employs forensic protocols in regard to sexual assaults of children in Delaware. The protocols are in alignment with the PREA standards. According to the Affirmation of Compliance, youth victims of sexual abuse while detained would be offered timely information about timely access to emergency contraception and sexually transmitted infections |

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| | prophylaxis at Milford Hospital. The Nurse Supervisor confirmed the information obtained from the Affirmation.<br><br>115.382(b)<br>The affirmation confirms that treatment would be provided to the youth without cost and it is not contingent upon victim identifying perpetrator or whether victim cooperates with investigation. Based on interview with Nurse Supervisor, youth would be provided treatment without cost, and the victim is not required to name perpetrator or cooperate with investigation. |

| 115.383 | Ongoing medical and mental health care for sexual abuse victims and abusers |
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| | **Auditor Overall Determination:** Meets Standard |
| | **Auditor Discussion** |
| | Interview with Psychologist and Nurse Supervisor<br>DYRS Policy #2.13.IV.E.1-2<br>Affirmation of Compliance with Forensic Examinations Standards for Sexual Assaults between Milford Hospital and DYRS<br><br>Through the Affirmation between Milford Hospital and DYRS, the facility has meet compliance in the PREA standard of ongoing medical and mental health care for sexual abuse victims and abusers. In the event of sexual abuse, youth detained at SHDC would receive both forensic examination as well as follow-up services in accordance to the established Affirmation. Mental Health services are made available from a community-based advocacy agency, SOARS.<br><br>115.383(a)<br>The SHDC offers medical and mental health evaluations and, as appropriate, treatment of youth that have been victimized by sexual abuse in confinement. The Psychologist and Nurse Supervisor have had specialized PREA training for medical and mental health personnel. Further confirmed in DYRS Policy #2.13.IV.E.1, PBHS Psychologist or DYRS medical provider will provide counseling to detained youth that have been involved in non-consensual sex, abusive sexual contact, or sexual harassment.<br><br>115.383(b & c)<br>Residents level of care at SHDC is equivalent if not better than the level of care received in the community. Youth can receive at SHDC follow-up services, treatment plans, and referrals for continued care if they are transferred to another facility or released from custody. Additionally, as mentioned in DYRS Policy #2.13.IV.E.2 that youth would be made aware of community agencies, addresses, and contact information of mental health practitioners that provide emotional support services related to sexual abuse.<br><br>115.383(d & e)<br>In the instance of sexual abuse at SHDC, female youth are offered pregnancy tests. As stated prior in the event of a pregnancy, the affirmation details that youth would be offered timely information about timely access to emergency contraception and sexually transmitted infections prophylaxis at Milford Hospital.<br><br>115.383(f-h)<br>In the instance of sexual abuse, youth will be provided services listed in the Affirmation without a fee or corroborating with investigation. In the past 12 months, there have been no cases of sexual abuse that required any of the services provided in the Affirmation including the 60-day review. |

| 115.386 | Sexual abuse incident reviews |
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| | **Auditor Overall Determination:** Meets Standard |
| | **Auditor Discussion** |
| | Review of Sexual Abuse Incident Review Form<br>Interview with PREA Coordinator and Assistant Superintendent<br>DYRS Policy #2.13.IV.D.4<br>DYRS Policy #2.13.IV.D.3.f<br>DYRS Policy #2.13..IV.D.3.d<br>DYRS Policy #2.13IV.D.3.e<br>Onsite Audit<br><br>Based on the review of the Sexual Abuse Incident Review forms, SHDC meets compliance on the PREA standard of sexual abuse incident reviews. The facility had completed a review for all 5 allegations of sexual abuse and sexual harassment. In all 5 review forms, the review team consisted of upper-level management. The tool that is utilized to complete reviews are aligned with the requirements of the PREA standards which is the Sexual Abuse Incident Review Form. Also, the facility implements recommendations to improve on the forms to promote sexual safety at SHDC.<br><br>115.386(a)<br>According to the completed Sexual Abuse Incident Reports, there were Incident Review Meetings held after the sexual abuse and sexual harassment investigations. Per DYRS Policy #2.13.IV.D.4, Incident Review Meetings will occur within 30 days of Institutional Abuse Investigation or 45 days if investigation is extended. The review is to occur in all cases where allegations are accepted by IA and for administrative review. In instances in which there are no incidents than a mock incident review is to be held annually. There were 5 administrative reviews held based on information obtained from Sexual Abuse Incident Forms. PREA Coordinator confirmed that in the absence of incidents that SHDC is to have an annual mock incident review.<br><br>115.386(b)<br>Review of Sexual Abuse Incident Review Forms from all investigations revealed that the team reviews were done within 30 days. The Assistant Superintendent had completed majority of the reviews and documented the review meetings. During the interview, there was further confirmation that review meetings were held.<br><br>115.386(c)<br>DYRS Policy #2.13.IV.D.3.d stated that the sexual abuse incident review team should consist of upper-level management officials, input from supervisors, investigators, and medical or mental health practitioners. When forms were reviewed, there were upper level management, medical, mental health, and administrative investigator listed as participants in the review meetings. .<br><br>115.386(d)<br>Also, documented in the policy is that the sexual abuse review team will prepare a report of findings and any recommendations for improvement. During the onsite audit, the Auditor was |

provided with forms from the sexual abuse review team which is the Sexual Abuse Incident Review form. The Auditor asked the PREA Compliance Manager during review meetings was there anything that was discussed that revealed any trends or common issues occurring that may cause an increase in allegations? The response was that there was nothing specifically that would cause an increase in allegations.

115.386(e)
Information contained on form complies with the PREA standards. The form requires the following information:
• PREA Type of Incident
• Type of Sexual Violence
• Incident Description
• Substantiated or Unsubstantiated
• Review Team Members
• Chief Reviewer
• Need for Policy Change or Practice change
• Checklist of possible motivation for allegation
• Construction Barriers
• Staffing Level; adequate?
• Monitoring technology adequate?
• Findings of team
• Final recommendation
• Facility Head Comments
• Facility Head Signature and Date

115.386 (e)
On the Sexual Abuse Incident Review form, there is a section in which a final recommendation is required. In all 5 forms reviewed, all the forms had a recommendation listed. Per policy, the facility shall implement the recommendations for improvement or shall document its reasons for not doing so, in the submitted report. All recommendations were followed.

| 115.387 | Data collection |
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| | **Auditor Overall Determination:** Meets Standard |
| | **Auditor Discussion** |
| | Interview Management Analyst<br>DYRS Policy #2.13 Attachments A,B,C & D<br>DYRS Policy #2.13.IV.D.4.F.1-5.a-d<br><br>In the PREA standard of data collection, DYRS meets compliance. The agency collects accurate, uniform data for allegations of sexual abuse and sexual harassment at SHDC. Also, a standardized instrument is utilized to collect information, and the information is aggregated annually according to PREA standards. Data obtained is utilized to complete the Survey of Sexual Violence conducted by the Department of Justice. The same information is collected for the contracted residential facilities. The data for state operated facilities and contracted facilities is available on the agency's website.<br><br>115.387(a)<br>There are several documents that are maintained with the Management Analyst of DSCYF. The agency collects accurate and uniformed information by utilizing the following 4 forms that are attachments to the DYRS Policy #2.13:<br>Attachment A- Sexual Violence Incident Form<br>Attachment B- Sexual Violence Incident Form- Victim<br>Attachment C- Sexual Violence Incident Form- Youth Perpetrator<br>Attachment D- Sexual Violence Incident Form- Adult Perpetrator<br><br>DYRS Policy #2.13.IV.D.4.F.1-5 requires the distribution of these forms within 24 hours of an allegation of sexual abuse or sexual harassment to the following administrators:<br>• Director<br>• Deputy Director<br>• Management Analyst<br>• Quality Assurance Officer<br>• Administrative Specialist<br><br>On a quarterly basis, a report is completed by the Management Analyst who will in turn provide it to Deputy Director to ensure outcome information is accurate and current.<br><br>115.387(b &c)<br>According to Management Analyst, data collected is aggregated for the annual report. This report is posted on the agency's website. The agency does complete the Survey of Sexual Violence which is conducted by the Department of Justice. The agency's policy confirms that there is an annual report that must be completed. The annual report contains the following:<br>1. The findings and corrective actions for allegations identified by facility.<br>2. A comparison of the current year's data and corrective action with those of prior years.<br>3. An assessment of the Division's progress in addressing sexual abuse.<br>4. The division may redact specific material from the reports when a publication would present a clear and specific threat to the safety and security of a facility. |

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| | 115.387(d-f)<br>The DYRS maintains, reviews, and collects data from all available reports, investigation files, and sexual abuse incident reviews from its facilities as well as contracted facilities in accordance with DYRS Policy #2.13.IV.D.4.F.1-5.a-d. This information was further confirmed with the Management Analyst. Also, it was disclosed during the interview that the Management Analyst does provide information from the previous calendar year to the Department of Justice no later than June 30. Also, this information is posted to the agency's website. |

| 115.388 | Data review for corrective action |
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| | **Auditor Overall Determination:** Meets Standard |
| | **Auditor Discussion** |
| | DYRS Policy #2.13.IV.F.1-5<br>Interview with PREA Coordinator<br>Meeting Minutes from June 2017<br>Review of PREA Annual Report<br>Agency's Website<br><br>The agency meets compliance on the PREA standard of data review for corrective action. The facility reviews data collected. Also, the Annual Report is available to the public through the agency's website, and the report is approved by the agency head. When necessary, the agency will redact information from reports based on safety and security, but it will provide the nature of the redaction.<br><br>115.388(a)<br>According to PREA Coordinator, there was a meeting held in June 2017 in which the agency reviewed aggregated data collected on PREA within the DYRS facilities. In attendance were division heads as well as facility leaders. There was a discussion on how to improve the effectiveness of the agency's sexual abuse prevention, detection, and response. Per Policy, the information must be reviewed by the Director prior to being posted on the website.<br><br>115.388 (b & C)<br>The review of the Annual Report found that there was information from the current year. The previous year's annual reports were available on the website. As stated prior, the agency's policy requires that the agency head must review the Annual Report before its posted to website. All reports were signed by the agency head.<br><br>115.388(d)<br>Per DYRS Policy #2.13.IV.F.1-5, the division may redact specific material from the reports when a publication would present a clear and specific threat to the safety and security of a facility, but must indicate the nature of the material redacted. This was confirmed with the PREA Coordinator. |

| 115.389 | Data storage, publication, and destruction |
|---|---|
| | **Auditor Overall Determination:** Exceeds Standard |
| | **Auditor Discussion** |
| | Interview with Management Analyst<br>DYRS Policy #2.13.IV.F.6-7<br>Review of all Annual Reports 2012-2017<br>DYRS Policy #2.13.IV.F.7<br><br>DYRS meets the standard in data storage, publication, and destruction. Information is securely maintained in a double lock system. Also, the agency collects, maintains, and reports to the public the aggregated sexual abuse data from contracted residential facilities. Before making information available publicly, the agency removes all personal identifiers. Lastly, the agency maintains all sexual abuse data for no less than 10 years unless Federal, State, or local law requires otherwise.<br><br>115.389(a)<br>It was disclosed to the Auditor by the Management Analyst that all data collected throughout DYRS on PREA allegations and associated documents are secured using a double lock system. This procedure was cited in DYRS Policy #2.13.IV.F.6-7.<br><br>115.389(b)<br>Contained within the Annual Report is a section that is specifically for the reporting of the residential contracts.<br><br>115.389(c)<br>In review of Annual Reports since 2012 on the agency's website, the agency has removed all personal identifiers.<br><br>115.389(d)<br>All sexual abuse and sexual harassment allegations and associated reports are maintained for no less than 10 years after the date of initial collection unless Federal, State, or Local laws requires otherwise. This is in accordance to DYRS Policy #2.13.IV.F.7, and it was confirmed with the Management Analyst. |

| 115.401 | Frequency and scope of audits |
|---|---|
| | **Auditor Overall Determination:** Meets Standard |
| | **Auditor Discussion** |
| | Interview with PREA Coordinator and Contract Manager<br>DSCYF Website<br><br>The agency meets compliance in the PREA standard of frequency and scope of audits.<br><br>115.401(a-b)<br>During the prior three-year audit periods, DYRS has committed to the PREA standards by having all youth residential facilities both state operated and contracted complete a PREA audit. They have all been audited at least once which was confirmed by the Contract Manager and the PREA Coordinator. The final reports are located on the agency website. Each year at least one-third of the facilities have been audited. |

| 115.403 | Audit contents and findings |
|---|---|
| | **Auditor Overall Determination:** Meets Standard |
| | **Auditor Discussion** |
| | Auditor<br>https://kids.delaware.gov/yrs/prea-reports.shtml<br><br>SHDC meets compliance in the standard of audit contents and findings.<br><br>115.403(f)<br>The Auditor located the previous PREA Audit on DSCYF's website. The PREA audit was completed in 2015 for SHDC. Please refer to https://kids.delaware.gov/yrs/prea-reports.shtml to review the previous audit. |

## Appendix: Provision Findings

| 115.311 (a) | Zero tolerance of sexual abuse and sexual harassment; PREA coordinator | |
|---|---|---|
| | Does the agency have a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment? | yes |
| | Does the written policy outline the agency's approach to preventing, detecting, and responding to sexual abuse and sexual harassment? | yes |

| 115.311 (b) | Zero tolerance of sexual abuse and sexual harassment; PREA coordinator | |
|---|---|---|
| | Has the agency employed or designated an agency-wide PREA Coordinator? | yes |
| | Is the PREA Coordinator position in the upper-level of the agency hierarchy? | yes |
| | 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 |

| 115.311 (c) | Zero tolerance of sexual abuse and sexual harassment; PREA coordinator | |
|---|---|---|
| | 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 |
| | 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 |

| 115.312 (a) | Contracting with other entities for the confinement of residents | |
|---|---|---|
| | 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 adopt and 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 |

| 115.312 (b) | Contracting with other entities for the confinement of residents | |
|---|---|---|
| | 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 OR the response to 115.312(a)-1 is "NO".) | yes |

| 115.313 (a) | Supervision and monitoring | |
|---|---|---|
| | Does the agency ensure that each facility has developed a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse? | yes |
| | Does the agency ensure that each facility has implemented a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse? | yes |
| | Does the agency ensure that each facility has documented a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse? | yes |
| | Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: The prevalence of substantiated and unsubstantiated incidents of sexual abuse? | yes |
| | Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Generally accepted juvenile detention and correctional/secure residential practices? | yes |
| | Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any judicial findings of inadequacy? | yes |
| | Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any findings of inadequacy from Federal investigative agencies? | yes |
| | Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any findings of inadequacy from internal or external oversight bodies? | yes |
| | | |

| | | |
|---|---|---|
| | Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: All components of the facility's physical plant (including "blind-spots" or areas where staff or residents may be isolated)? | yes |
| | Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: The composition of the resident population? | yes |
| | Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: The number and placement of supervisory staff? | yes |
| | Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Institution programs occurring on a particular shift? | yes |
| | Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any applicable State or local laws, regulations, or standards? | yes |
| | Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any other relevant factors? | yes |

| **115.313 (b)** | **Supervision and monitoring** | |
|---|---|---|
| | Does the agency comply with the staffing plan except during limited and discrete exigent circumstances? | yes |
| | In circumstances where the staffing plan is not complied with, does the facility fully document all deviations from the plan? (N/A if no deviations from staffing plan.) | na |

| 115.313 (c) | Supervision and monitoring | |
|---|---|---|
| | Does the facility maintain staff ratios of a minimum of 1:8 during resident waking hours, except during limited and discrete exigent circumstances? (N/A only until October 1, 2017.) | yes |
| | Does the facility maintain staff ratios of a minimum of 1:16 during resident sleeping hours, except during limited and discrete exigent circumstances? (N/A only until October 1, 2017.) | yes |
| | Does the facility fully document any limited and discrete exigent circumstances during which the facility did not maintain staff ratios? (N/A only until October 1, 2017.) | na |
| | Does the facility ensure only security staff are included when calculating these ratios? (N/A only until October 1, 2017.) | yes |
| | Is the facility obligated by law, regulation, or judicial consent decree to maintain the staffing ratios set forth in this paragraph? | yes |

| 115.313 (d) | Supervision and monitoring | |
|---|---|---|
| | 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 |
| | In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: Prevailing staffing patterns? | yes |
| | 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? | 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 |

| 115.313 (e) | Supervision and monitoring | |
|---|---|---|
| | Has the facility 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? (N/A for non-secure facilities ) | no |
| | Is this policy and practice implemented for night shifts as well as day shifts? (N/A for non-secure facilities ) | yes |
| | Does the facility 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? (N/A for non-secure facilities ) | yes |

| 115.315 (a) | Limits to cross-gender viewing and searches | |
|---|---|---|
| | 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 |

| 115.315 (b) | Limits to cross-gender viewing and searches | |
|---|---|---|
| | Does the facility always refrain from conducting cross-gender pat-down searches in non-exigent circumstances? | yes |

| 115.315 (c) | Limits to cross-gender viewing and searches | |
|---|---|---|
| | Does the facility document and justify all cross-gender strip searches and cross-gender visual body cavity searches? | yes |
| | Does the facility document all cross-gender pat-down searches? | yes |

| 115.315 (d) | Limits to cross-gender viewing and searches | |
|---|---|---|
| | Does the facility implement policies and procedures that enable 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 |
| | Does the facility require staff of the opposite gender to announce their presence when entering a resident housing unit? | yes |
| | In facilities (such as group homes) that do not contain discrete housing units, does the facility require staff of the opposite gender to announce their presence when entering an area where residents are likely to be showering, performing bodily functions, or changing clothing? (N/A for facilities with discrete housing units) | na |

| 115.315 (e) | Limits to cross-gender viewing and searches | |
|---|---|---|
| | 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 |
| | If a 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 |

| 115.315 (f) | Limits to cross-gender viewing and searches | |
|---|---|---|
| | 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 |
| | 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 |

| 115.316 (a) | Residents with disabilities and residents who are limited English proficient | |
|---|---|---|
| | Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all | yes |

| | | |
|---|---|---|
| | 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? | |
| | 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 |
| | 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 |
| | 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 |
| | 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 |
| | 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 |
| | Do such steps include, when necessary, ensuring effective communication with residents who are deaf or hard of hearing? | yes |
| | 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 |
| | 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 |
| | 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 |
| | Does the agency ensure that written materials are provided in formats or | yes |

| | | |
|---|---|---|
| | through methods that ensure effective communication with residents with disabilities including residents who: Who are blind or have low vision? | |

| 115.316 (b) | Residents with disabilities and residents who are limited English proficient | |
|---|---|---|
| | 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 |
| | Do these steps include providing interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary? | yes |

| 115.316 (c) | Residents with disabilities and residents who are limited English proficient | |
|---|---|---|
| | Does the agency always refrain from relying 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 the resident's safety, the performance of first-response duties under §115.364, or the investigation of the resident's allegations? | yes |

| 115.317 (a) | Hiring and promotion decisions | |
|---|---|---|
| | 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 |
| | 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 |
| | 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 bullet immediately above? | yes |
| | 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 |
| | 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 |
| | 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 two bullets immediately above? | yes |

| 115.317 (b) | Hiring and promotion decisions | |
|---|---|---|
| | Does the agency consider any incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any contractor, who may have contact with residents? | yes |

| 115.317 (c) | Hiring and promotion decisions | |
|---|---|---|
| | Before hiring new employees who may have contact with residents, does the agency: Perform a criminal background records check? | yes |
| | Before hiring new employees who may have contact with residents, does the agency: Consult any child abuse registry maintained by the State or locality in which the employee would work? | yes |
| | 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 |

| 115.317 (d) | Hiring and promotion decisions | |
|---|---|---|
| | Does the agency perform a criminal background records check before enlisting the services of any contractor who may have contact with residents? | yes |
| | Does the agency consult applicable child abuse registries before enlisting the services of any contractor who may have contact with residents? | yes |

| 115.317 (e) | Hiring and promotion decisions | |
|---|---|---|
| | 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 |

| 115.317 (f) | Hiring and promotion decisions | |
|---|---|---|
| | 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 |
| | 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 |
| | Does the agency impose upon employees a continuing affirmative duty to disclose any such misconduct? | yes |

| 115.317 (g) | Hiring and promotion decisions | |
|---|---|---|
| | Does the agency consider material omissions regarding such misconduct, or the provision of materially false information, grounds for termination? | yes |

| 115.317 (h) | Hiring and promotion decisions | |
|---|---|---|
| | Unless prohibited by law, 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 |

| 115.318 (a) | Upgrades to facilities and technologies | |
|---|---|---|
| | 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.) | no |

| 115.318 (b) | Upgrades to facilities and technologies | |
|---|---|---|
| | 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 |

| 115.321 (a) | Evidence protocol and forensic medical examinations | |
|---|---|---|
| | 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 |

| 115.321 (b) | Evidence protocol and forensic medical examinations | |
|---|---|---|
| | Is this protocol developmentally appropriate for youth? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.) | yes |
| | 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 |

| 115.321 (c) | Evidence protocol and forensic medical examinations | |
|---|---|---|
| | Does the agency offer all residents who experience sexual abuse access to forensic medical examinations, whether on-site or at an outside facility, without financial cost, where evidentiarily or medically appropriate? | yes |
| | Are such examinations performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) where possible? | yes |
| | 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 |
| | Has the agency documented its efforts to provide SAFEs or SANEs? | yes |

| 115.321 (d) | Evidence protocol and forensic medical examinations | |
|---|---|---|
| | Does the agency attempt to make available to the victim a victim advocate from a rape crisis center? | yes |
| | 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? | yes |
| | Has the agency documented its efforts to secure services from rape crisis centers? | yes |

| 115.321 (e) | Evidence protocol and forensic medical examinations | |
|---|---|---|
| | 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 |
| | As requested by the victim, does this person provide emotional support, crisis intervention, information, and referrals? | yes |

| 115.321 (f) | Evidence protocol and forensic medical examinations | |
|---|---|---|
| | If the agency itself is not responsible for investigating allegations of sexual abuse, has the agency requested that the investigating entity follow the requirements of paragraphs (a) through (e) of this section? (N/A if the agency is not responsible for investigating allegations of sexual abuse.) | yes |

| 115.321 (h) | Evidence protocol and forensic medical examinations | |
|---|---|---|
| | 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? (Check N/A if agency attempts to make a victim advocate from a rape crisis center available to victims per 115.321(d) above.) | yes |

| 115.322 (a) | Policies to ensure referrals of allegations for investigations | |
|---|---|---|
| | Does the agency ensure an administrative or criminal investigation is completed for all allegations of sexual abuse? | yes |
| | Does the agency ensure an administrative or criminal investigation is completed for all allegations of sexual harassment? | yes |

| 115.322 (b) | Policies to ensure referrals of allegations for investigations | |
|---|---|---|
| | Does the agency have a policy 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 |
| | Has the agency published such policy on its website or, if it does not have one, made the policy available through other means? | yes |
| | Does the agency document all such referrals? | yes |

| 115.322 (c) | Policies to ensure referrals of allegations for investigations | |
|---|---|---|
| | If a separate entity is responsible for conducting criminal investigations, does such publication describe the responsibilities of both the agency and the investigating entity? (N/A if the agency/facility is responsible for criminal investigations. See 115.321(a)) | yes |

| 115.331 (a) | Employee training | |
|---|---|---|
| | Does the agency train all employees who may have contact with residents on: Its zero-tolerance policy for sexual abuse and sexual harassment? | yes |
| | 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 |
| | 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 |
| | 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 |
| | Does the agency train all employees who may have contact with residents on: The dynamics of sexual abuse and sexual harassment in juvenile facilities? | yes |
| | Does the agency train all employees who may have contact with residents on: The common reactions of juvenile victims of sexual abuse and sexual harassment? | yes |
| | 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 |
| | Does the agency train all employees who may have contact with residents on: How to avoid inappropriate relationships with residents? | yes |
| | 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 |
| | 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 |
| | Does the agency train all employees who may have contact with residents on: Relevant laws regarding the applicable age of consent? | yes |

| 115.331 (b) | Employee training | |
|---|---|---|
| | Is such training tailored to the unique needs and attributes of residents of juvenile facilities? | yes |
| | Is such training tailored to the gender of the residents at the employee's facility? | 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? | no |

| 115.331 (c) | Employee training | |
|---|---|---|
| | Have all current employees who may have contact with residents received such training? | yes |
| | 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 |
| | 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 |

| 115.331 (d) | Employee training | |
|---|---|---|
| | Does the agency document, through employee signature or electronic verification, that employees understand the training they have received? | yes |

| 115.332 (a) | Volunteer and contractor training | |
|---|---|---|
| | 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 |

| 115.332 (b) | Volunteer and contractor training | |
|---|---|---|
| | 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 |

| 115.332 (c) | Volunteer and contractor training | |
|---|---|---|
| | Does the agency maintain documentation confirming that volunteers and contractors understand the training they have received? | yes |

| 115.333 (a) | Resident education | |
|---|---|---|
| | During intake, do residents receive information explaining the agency's zero-tolerance policy regarding sexual abuse and sexual harassment? | yes |
| | During intake, do residents receive information explaining how to report incidents or suspicions of sexual abuse or sexual harassment? | yes |
| | Is this information presented in an age-appropriate fashion? | yes |

| 115.333 (b) | Resident education | |
|---|---|---|
| | Within 10 days of intake, does the agency provide age-appropriate comprehensive education to residents either in person or through video regarding: Their rights to be free from sexual abuse and sexual harassment? | yes |
| | Within 10 days of intake, does the agency provide age-appropriate comprehensive education to residents either in person or through video regarding: Their rights to be free from retaliation for reporting such incidents? | yes |
| | Within 10 days of intake, does the agency provide age-appropriate comprehensive education to residents either in person or through video regarding: Agency policies and procedures for responding to such incidents? | yes |

| 115.333 (c) | Resident education | |
|---|---|---|
| | Have all residents received such education? | yes |
| | 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 |

| 115.333 (d) | Resident education | |
|---|---|---|
| | Does the agency provide resident education in formats accessible to all residents including those who: Are limited English proficient? | yes |
| | Does the agency provide resident education in formats accessible to all residents including those who: Are deaf? | yes |
| | Does the agency provide resident education in formats accessible to all residents including those who: Are visually impaired? | yes |
| | Does the agency provide resident education in formats accessible to all residents including those who: Are otherwise disabled? | yes |
| | Does the agency provide resident education in formats accessible to all residents including those who: Have limited reading skills? | yes |

| 115.333 (e) | Resident education | |
|---|---|---|
| | Does the agency maintain documentation of resident participation in these education sessions? | yes |

| 115.333 (f) | Resident education | |
|---|---|---|
| | 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 |

| 115.334 (a) | Specialized training: Investigations | |
|---|---|---|
| | In addition to the general training provided to all employees pursuant to §115.331, does the agency ensure that, to the extent the agency itself conducts sexual abuse investigations, its investigators have received 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 |

| 115.334 (b) | Specialized training: Investigations | |
|---|---|---|
| | Does this specialized training include: Techniques for interviewing juvenile 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 |
| | 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 |
| | 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 |
| | 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 |

| 115.334 (c) | Specialized training: Investigations | |
|---|---|---|
| | 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 |

| 115.335 (a) | Specialized training: Medical and mental health care | |
|---|---|---|
| | 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? | yes |
| | 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? | yes |
| | 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 juvenile victims of sexual abuse and sexual harassment? | yes |
| | 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? | yes |

| 115.335 (b) | Specialized training: Medical and mental health care | |
|---|---|---|
| | 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.) | no |

| 115.335 (c) | Specialized training: Medical and mental health care | |
|---|---|---|
| | 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? | yes |

| 115.335 (d) | Specialized training: Medical and mental health care | |
|---|---|---|
| | Do medical and mental health care practitioners employed by the agency also receive training mandated for employees by §115.331? | yes |
| | Do medical and mental health care practitioners contracted by and volunteering for the agency also receive training mandated for contractors and volunteers by §115.332? | yes |

| 115.341 (a) | Obtaining information from residents | |
|---|---|---|
| | Within 72 hours of the resident's arrival at the facility, does the agency obtain and use information about each resident's personal history and behavior to reduce risk of sexual abuse by or upon a resident? | yes |
| | Does the agency also obtain this information periodically throughout a resident's confinement? | yes |

| 115.341 (b) | Obtaining information from residents | |
|---|---|---|
| | Are all PREA screening assessments conducted using an objective screening instrument? | yes |

| 115.341 (c) | Obtaining information from residents | |
|---|---|---|
| | During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Prior sexual victimization or abusiveness? | yes |
| | During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Any gender nonconforming appearance or manner or identification as lesbian, gay, bisexual, transgender, or intersex, and whether the resident may therefore be vulnerable to sexual abuse? | yes |
| | During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Current charges and offense history? | yes |
| | During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Age? | yes |
| | During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Level of emotional and cognitive development? | yes |
| | During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Physical size and stature? | yes |
| | During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Mental illness or mental disabilities? | yes |
| | During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Intellectual or developmental disabilities? | yes |
| | During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Physical disabilities? | yes |
| | During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: The resident’s own perception of vulnerability? | yes |
| | During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Any other specific information about individual residents that may indicate heightened needs for supervision, additional safety precautions, or separation from certain other residents? | yes |

| 115.341 (d) | Obtaining information from residents | |
|---|---|---|
| | Is this information ascertained: Through conversations with the resident during the intake process and medical mental health screenings? | yes |
| | Is this information ascertained: During classification assessments? | yes |
| | Is this information ascertained: By reviewing court records, case files, facility behavioral records, and other relevant documentation from the resident's files? | yes |

| 115.341 (e) | Obtaining information from residents | |
|---|---|---|
| | 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 |

| 115.342 (a) | Placement of residents | |
|---|---|---|
| | Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Housing Assignments? | yes |
| | Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Bed assignments? | yes |
| | Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Work Assignments? | yes |
| | Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Education Assignments? | yes |
| | Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Program Assignments? | yes |

| 115.342 (b) | Placement of residents | |
|---|---|---|
| | Are residents 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 keeping all residents safe can be arranged? | yes |
| | During any period of isolation, does the agency always refrain from denying residents daily large-muscle exercise? | yes |
| | During any period of isolation, does the agency always refrain from denying residents any legally required educational programming or special education services? | yes |
| | Do residents in isolation receive daily visits from a medical or mental health care clinician? | yes |
| | Do residents also have access to other programs and work opportunities to the extent possible? | yes |

| 115.342 (c) | Placement of residents | |
|---|---|---|
| | Does the agency always refrain from placing: Lesbian, gay, and bisexual residents in particular housing, bed, or other assignments solely on the basis of such identification or status? | yes |
| | Does the agency always refrain from placing: Transgender residents in particular housing, bed, or other assignments solely on the basis of such identification or status? | yes |
| | Does the agency always refrain from placing: Intersex residents in particular housing, bed, or other assignments solely on the basis of such identification or status? | yes |
| | Does the agency always refrain from considering lesbian, gay, bisexual, transgender, or intersex identification or status as an indicator or likelihood of being sexually abusive? | yes |

| 115.342 (d) | Placement of residents | |
|---|---|---|
| | 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 |
| | 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 |

| 115.342 (e) | Placement of residents | |
|---|---|---|
| | 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 |

| 115.342 (f) | Placement of residents | |
|---|---|---|
| | 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 |

| 115.342 (g) | Placement of residents | |
|---|---|---|
| | Are transgender and intersex residents given the opportunity to shower separately from other residents? | yes |

| 115.342 (h) | Placement of residents | |
|---|---|---|
| | If a resident is isolated pursuant to paragraph (b) of this section, does the facility clearly document: The basis for the facility's concern for the resident's safety? (N/A for h and i if facility doesn't use isolation?) | na |
| | If a resident is isolated pursuant to paragraph (b) of this section, does the facility clearly document: The reason why no alternative means of separation can be arranged? (N/A for h and i if facility doesn't use isolation?) | na |

| 115.342 (i) | Placement of residents | |
|---|---|---|
| | In the case of each resident who is isolated as a last resort when less restrictive measures are inadequate to keep them and other residents safe, does the facility afford a review to determine whether there is a continuing need for separation from the general population EVERY 30 DAYS? | yes |

| 115.351 (a) | Resident reporting | |
|---|---|---|
| | Does the agency provide multiple internal ways for residents to privately report: Sexual abuse and sexual harassment? | yes |
| | Does the agency provide multiple internal ways for residents to privately report: 2. Retaliation by other residents or staff for reporting sexual abuse and sexual harassment? | yes |
| | 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 |

| 115.351 (b) | Resident reporting | |
|---|---|---|
| | 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 |
| | Is that private entity or office able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials? | yes |
| | Does that private entity or office allow the resident to remain anonymous upon request? | yes |
| | 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 to report sexual abuse or harassment? | no |

| 115.351 (c) | Resident reporting | |
|---|---|---|
| | Do staff members accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously, and from third parties? | yes |
| | Do staff members promptly document any verbal reports of sexual abuse and sexual harassment? | yes |

| 115.351 (d) | Resident reporting | |
|---|---|---|
| | Does the facility provide residents with access to tools necessary to make a written report? | yes |

| 115.351 (e) | Resident reporting | |
|---|---|---|
| | Does the agency provide a method for staff to privately report sexual abuse and sexual harassment of residents? | yes |

| 115.352 (a) | Exhaustion of administrative remedies | |
|---|---|---|
| | 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 a 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 |

| 115.352 (b) | Exhaustion of administrative remedies | |
|---|---|---|
| | 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 |
| | Does the agency always refrain from requiring an 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 |

| 115.352 (c) | Exhaustion of administrative remedies | |
|---|---|---|
| | 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 |
| | 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 |

| 115.352 (d) | Exhaustion of administrative remedies | |
|---|---|---|
| | 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.) | na |
| | If the agency determines that the 90 day timeframe is insufficient to make an appropriate decision and claims an extension of time (the maximum allowable extension of time to respond is 70 days per 115.352(d)(3)) , 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.) | 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 a resident consider the absence of a response to be a denial at that level? (N/A if agency is exempt from this standard.) | na |

| 115.352 (e) | Exhaustion of administrative remedies | |
|---|---|---|
| | 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 |
| | Are those third parties also permitted to file such requests on behalf of residents? (If a third party, other than a parent or legal guardian, files such a request on behalf of a 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 |
| | 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 |
| | Is a parent or legal guardian of a juvenile allowed to file a grievance regarding allegations of sexual abuse, including appeals, on behalf of such juvenile? (N/A if agency is exempt from this standard.) | yes |
| | If a parent or legal guardian of a juvenile files a grievance (or an appeal) on behalf of a juvenile regarding allegations of sexual abuse, is it the case that those grievances are not conditioned upon the juvenile agreeing to have the request filed on his or her behalf? (N/A if agency is exempt from this standard.) | na |

| 115.352 (f) | Exhaustion of administrative remedies | |
|---|---|---|
| | Has the agency established procedures for the filing of an emergency grievance alleging that a resident is subject to a substantial risk of imminent sexual abuse? (N/A if agency is exempt from this standard.) | na |
| | After receiving an emergency grievance alleging a 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.) | 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.) | 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.) | 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.) | 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.) | 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.) | na |

| 115.352 (g) | Exhaustion of administrative remedies | |
|---|---|---|
| | 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.) | na |

| 115.353 (a) | Resident access to outside confidential support services and legal representation | |
|---|---|---|
| | Does the facility provide residents with access to outside victim advocates for emotional support services related to sexual abuse by providing, posting, or otherwise making accessible mailing addresses and telephone numbers, including toll-free hotline numbers where available, of local, State, or national victim advocacy or rape crisis organizations? | yes |
| | 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? | no |
| | Does the facility enable reasonable communication between residents and these organizations and agencies, in as confidential a manner as possible? | yes |

| 115.353 (b) | Resident access to outside confidential support services and legal representation | |
|---|---|---|
| | 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 |

| 115.353 (c) | Resident access to outside confidential support services and legal representation | |
|---|---|---|
| | 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 |
| | Does the agency maintain copies of agreements or documentation showing attempts to enter into such agreements? | yes |

| 115.353 (d) | Resident access to outside confidential support services and legal representation | |
|---|---|---|
| | Does the facility provide residents with reasonable and confidential access to their attorneys or other legal representation? | yes |
| | Does the facility provide residents with reasonable access to parents or legal guardians? | yes |

| 115.354 (a) | Third-party reporting | |
|---|---|---|
| | Has the agency established a method to receive third-party reports of sexual abuse and sexual harassment? | yes |
| | Has the agency distributed publicly information on how to report sexual abuse and sexual harassment on behalf of a resident? | yes |

| 115.361 (a) | Staff and agency reporting duties | |
|---|---|---|
| | Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information they receive regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency? | yes |
| | Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information they receive regarding retaliation against residents or staff who reported an incident of sexual abuse or sexual harassment? | yes |
| | Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information they receive regarding any staff neglect or violation of responsibilities that may have contributed to an incident of sexual abuse or sexual harassment or retaliation? | yes |

| 115.361 (b) | Staff and agency reporting duties | |
|---|---|---|
| | Does the agency require all staff to comply with any applicable mandatory child abuse reporting laws? | yes |

| 115.361 (c) | Staff and agency reporting duties | |
|---|---|---|
| | Apart from reporting to designated supervisors or officials and designated State or local services agencies, are staff prohibited 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 |

| 115.361 (d) | Staff and agency reporting duties | |
|---|---|---|
| | 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 |
| | Are medical and mental health practitioners required to inform residents of their duty to report, and the limitations of confidentiality, at the initiation of services? | yes |

| 115.361 (e) | Staff and agency reporting duties | |
|---|---|---|
| | Upon receiving any allegation of sexual abuse, does the facility head or his or her designee promptly report the allegation to the appropriate office? | yes |
| | Upon receiving any allegation of sexual abuse, does the facility head or his or her designee promptly report the allegation 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 |
| | If the alleged victim is under the guardianship of the child welfare system, does the facility head or his or her designee promptly report the allegation to the alleged victim's caseworker instead of the parents or legal guardians? (N/A if the alleged victim is not under the guardianship of the child welfare system.) | yes |
| | If a juvenile court retains jurisdiction over the alleged victim, does the facility head or designee also report the allegation to the juvenile's attorney or other legal representative of record within 14 days of receiving the allegation? | yes |

| 115.361 (f) | Staff and agency reporting duties | |
|---|---|---|
| | 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 |

| 115.362 (a) | Agency protection duties | |
|---|---|---|
| | 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 |

| 115.363 (a) | Reporting to other confinement facilities | |
|---|---|---|
| | 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 |
| | Does the head of the facility that received the allegation also notify the appropriate investigative agency? | yes |

| 115.363 (b) | Reporting to other confinement facilities | |
|---|---|---|
| | Is such notification provided as soon as possible, but no later than 72 hours after receiving the allegation? | yes |

| 115.363 (c) | Reporting to other confinement facilities | |
|---|---|---|
| | Does the agency document that it has provided such notification? | yes |

| 115.363 (d) | Reporting to other confinement facilities | |
|---|---|---|
| | Does the facility head or agency office that receives such notification ensure that the allegation is investigated in accordance with these standards? | yes |

| 115.364 (a) | Staff first responder duties | |
|---|---|---|
| | 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 |
| | 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 |
| | 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 |
| | 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 |

| 115.364 (b) | Staff first responder duties | |
|---|---|---|
| | 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 |

| 115.365 (a) | Coordinated response | |
|---|---|---|
| | 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 |

| 115.366 (a) | Preservation of ability to protect residents from contact with abusers | |
|---|---|---|
| | 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? | no |

| 115.367 (a) | Agency protection against retaliation | |
|---|---|---|
| | 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 |
| | Has the agency designated which staff members or departments are charged with monitoring retaliation? | yes |

| 115.367 (b) | Agency protection against retaliation | |
|---|---|---|
| | Does the agency employ multiple protection measures for residents or staff who fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations, 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? | yes |

| 115.367 (c) | Agency protection against retaliation | |
|---|---|---|
| | 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 |
| | 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 |
| | 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 |
| | 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 |
| | 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 |
| | 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 |
| | 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 |
| | 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 |
| | Does the agency continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need? | no |

| 115.367 (d) | Agency protection against retaliation | |
|---|---|---|
| | In the case of residents, does such monitoring also include periodic status checks? | yes |

| 115.367 (e) | Agency protection against retaliation | |
|---|---|---|
| | 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 |

| 115.368 (a) | Post-allegation protective custody | |
|---|---|---|
| | 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 § 115.342? | yes |

| 115.371 (a) | Criminal and administrative agency investigations | |
|---|---|---|
| | 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 does not conduct any form of administrative or criminal investigations of sexual abuse or harassment. See 115.321(a).) | yes |
| | Does the agency conduct such investigations for all allegations, including third party and anonymous reports? (N/A if the agency does not conduct any form of administrative or criminal investigations of sexual abuse or harassment. See 115.321(a).) | yes |

| 115.371 (b) | Criminal and administrative agency investigations | |
|---|---|---|
| | Where sexual abuse is alleged, does the agency use investigators who have received specialized training in sexual abuse investigations involving juvenile victims as required by 115.334? | yes |

| 115.371 (c) | Criminal and administrative agency investigations | |
|---|---|---|
| | Do investigators gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data? | yes |
| | Do investigators interview alleged victims, suspected perpetrators, and witnesses? | yes |
| | Do investigators review prior reports and complaints of sexual abuse involving the suspected perpetrator? | yes |

| 115.371 (d) | Criminal and administrative agency investigations | |
|---|---|---|
| | Does the agency always refrain from terminating an investigation solely because the source of the allegation recants the allegation? | yes |

| 115.371 (e) | Criminal and administrative agency investigations | |
|---|---|---|
| | 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? | no |

| 115.371 (f) | Criminal and administrative agency investigations | |
|---|---|---|
| | 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 |
| | 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 |

| 115.371 (g) | Criminal and administrative agency investigations | |
|---|---|---|
| | Do administrative investigations include an effort to determine whether staff actions or failures to act contributed to the abuse? | yes |
| | 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 |

| 115.371 (h) | Criminal and administrative agency investigations | |
|---|---|---|
| | 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 |

| 115.371 (i) | Criminal and administrative agency investigations | |
|---|---|---|
| | Are all substantiated allegations of conduct that appears to be criminal referred for prosecution? | yes |

| 115.371 (j) | Criminal and administrative agency investigations | |
|---|---|---|
| | Does the agency retain all written reports referenced in 115.371(g) and (h) for as long as the alleged abuser is incarcerated or employed by the agency, plus five years unless the abuse was committed by a juvenile resident and applicable law requires a shorter period of retention? | no |

| 115.371 (k) | Criminal and administrative agency investigations | |
|---|---|---|
| | Does the agency ensure that the departure of an alleged abuser or victim from the employment or control of the facility or agency does not provide a basis for terminating an investigation? | yes |

| 115.371 (m) | Criminal and administrative agency investigations | |
|---|---|---|
| | 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 115.321(a).) | yes |

| 115.372 (a) | Evidentiary standard for administrative investigations | |
|---|---|---|
| | 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 |

| 115.373 (a) | Reporting to residents | |
|---|---|---|
| | Following an investigation into a resident's allegation of sexual abuse suffered in the facility, does the agency inform the resident as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded? | no |

| 115.373 (b) | Reporting to residents | |
|---|---|---|
| | 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 |

| 115.373 (c) | Reporting to residents | |
|---|---|---|
| | 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? | 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? | 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? | 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? | no |

| 115.373 (d) | Reporting to residents | |
|---|---|---|
| | 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? | 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? | no |

| 115.373 (e) | Reporting to residents | |
|---|---|---|
| | Does the agency document all such notifications or attempted notifications? | no |

| 115.376 (a) | Disciplinary sanctions for staff | |
|---|---|---|
| | Are staff subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies? | yes |

| 115.376 (b) | Disciplinary sanctions for staff | |
|---|---|---|
| | Is termination the presumptive disciplinary sanction for staff who have engaged in sexual abuse? | yes |

| 115.376 (c) | Disciplinary sanctions for staff | |
|---|---|---|
| | 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 |

| 115.376 (d) | Disciplinary sanctions for staff | |
|---|---|---|
| | 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 |
| | 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 |

| 115.377 (a) | Corrective action for contractors and volunteers | |
|---|---|---|
| | Is any contractor or volunteer who engages in sexual abuse prohibited from contact with residents? | yes |
| | Is any contractor or volunteer who engages in sexual abuse reported to: Law enforcement agencies (unless the activity was clearly not criminal)? | yes |
| | Is any contractor or volunteer who engages in sexual abuse reported to: Relevant licensing bodies? | yes |

| 115.377 (b) | Corrective action for contractors and volunteers | |
|---|---|---|
| | 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 |

| 115.378 (a) | Interventions and disciplinary sanctions for residents | |
|---|---|---|
| | 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, may residents be subject to disciplinary sanctions only pursuant to a formal disciplinary process? | yes |

| 115.378 (b) | Interventions and disciplinary sanctions for residents | |
|---|---|---|
| | 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 |
| | In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident is not denied daily large-muscle exercise? | yes |
| | In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident is not denied access to any legally required educational programming or special education services? | yes |
| | In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident receives daily visits from a medical or mental health care clinician? | yes |
| | In the event a disciplinary sanction results in the isolation of a resident, does the resident also have access to other programs and work opportunities to the extent possible? | yes |

| 115.378 (c) | Interventions and disciplinary sanctions for residents | |
|---|---|---|
| | When determining what types of sanction, if any, should be imposed, does the disciplinary process consider whether a resident's mental disabilities or mental illness contributed to his or her behavior? | yes |

| 115.378 (d) | Interventions and disciplinary sanctions for residents | |
|---|---|---|
| | 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 offer the offending resident participation in such interventions? | yes |
| | If the agency requires participation in such interventions as a condition of access to any rewards-based behavior management system or other behavior-based incentives, does it always refrain from requiring such participation as a condition to accessing general programming or education? | yes |

| 115.378 (e) | Interventions and disciplinary sanctions for residents | |
|---|---|---|
| | 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 |

| 115.378 (f) | Interventions and disciplinary sanctions for residents | |
|---|---|---|
| | 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 |

| 115.378 (g) | Interventions and disciplinary sanctions for 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 |

| 115.381 (a) | Medical and mental health screenings; history of sexual abuse | |
|---|---|---|
| | If the screening pursuant to § 115.341 indicates that a 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? | no |

| 115.381 (b) | Medical and mental health screenings; history of sexual abuse | |
|---|---|---|
| | If the screening pursuant to § 115.341 indicates that a 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? | yes |

| 115.381 (c) | Medical and mental health screenings; history of sexual abuse | |
|---|---|---|
| | 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 |

| 115.381 (d) | Medical and mental health screenings; history of sexual abuse | |
|---|---|---|
| | Do medical and mental health practitioners obtain informed consent from residents before reporting information about prior sexual victimization that did not occur in an institutional setting, unless the resident is under the age of 18? | yes |

| 115.382 (a) | Access to emergency medical and mental health services | |
|---|---|---|
| | 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 |

| 115.382 (b) | Access to emergency medical and mental health services | |
|---|---|---|
| | If no qualified medical or mental health practitioners are on duty at the time a report of recent sexual abuse is made, do staff first responders take preliminary steps to protect the victim pursuant to § 115.362? | yes |
| | Do staff first responders immediately notify the appropriate medical and mental health practitioners? | yes |

| 115.382 (c) | Access to emergency medical and mental health services | |
|---|---|---|
| | 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 |

| 115.382 (d) | Access to emergency medical and mental health services | |
|---|---|---|
| | 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 |

| 115.383 (a) | Ongoing medical and mental health care for sexual abuse victims and abusers | |
|---|---|---|
| | 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 |

| 115.383 (b) | Ongoing medical and mental health care for sexual abuse victims and abusers | |
|---|---|---|
| | 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 |

| 115.383 (c) | Ongoing medical and mental health care for sexual abuse victims and abusers | |
|---|---|---|
| | Does the facility provide such victims with medical and mental health services consistent with the community level of care? | yes |

| 115.383 (d) | Ongoing medical and mental health care for sexual abuse victims and abusers | |
|---|---|---|
| | Are resident victims of sexually abusive vaginal penetration while incarcerated offered pregnancy tests? (N/A if all-male facility.) | yes |

| 115.383 (e) | Ongoing medical and mental health care for sexual abuse victims and abusers | |
|---|---|---|
| | 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.) | yes |

| 115.383 (f) | Ongoing medical and mental health care for sexual abuse victims and abusers | |
|---|---|---|
| | Are resident victims of sexual abuse while incarcerated offered tests for sexually transmitted infections as medically appropriate? | yes |

| 115.383 (g) | Ongoing medical and mental health care for sexual abuse victims and abusers | |
|---|---|---|
| | 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 |

| 115.383 (h) | Ongoing medical and mental health care for sexual abuse victims and abusers | |
|---|---|---|
| | Does the facility 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? | yes |

| 115.386 (a) | Sexual abuse incident reviews | |
|---|---|---|
| | 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 |

| 115.386 (b) | Sexual abuse incident reviews | |
|---|---|---|
| | Does such review ordinarily occur within 30 days of the conclusion of the investigation? | yes |

| 115.386 (c) | Sexual abuse incident reviews | |
|---|---|---|
| | Does the review team include upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners? | yes |

| 115.386 (d) | Sexual abuse incident reviews | |
|---|---|---|
| | 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 |
| | 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 |
| | 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 |
| | Does the review team: Assess the adequacy of staffing levels in that area during different shifts? | yes |
| | Does the review team: Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff? | yes |
| | 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 |

| 115.386 (e) | Sexual abuse incident reviews | |
|---|---|---|
| | Does the facility implement the recommendations for improvement, or document its reasons for not doing so? | yes |

| 115.387 (a) | Data collection | |
|---|---|---|
| | 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 |

| 115.387 (b) | Data collection | |
|---|---|---|
| | Does the agency aggregate the incident-based sexual abuse data at least annually? | yes |

| 115.387 (c) | Data collection | |
|---|---|---|
| | 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 |

| 115.387 (d) | Data collection | |
|---|---|---|
| | 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 |

| 115.387 (e) | Data collection | |
|---|---|---|
| | 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 |

| 115.387 (f) | Data collection | |
|---|---|---|
| | 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 |

| 115.388 (a) | Data review for corrective action | |
|---|---|---|
| | 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 |
| | 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 |
| | 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 |

| 115.388 (b) | Data review for corrective action | |
|---|---|---|
| | 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 |

| 115.388 (c) | Data review for corrective action | |
|---|---|---|
| | 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 |

| 115.388 (d) | Data review for corrective action | |
|---|---|---|
| | 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 |

| 115.389 (a) | Data storage, publication, and destruction | |
|---|---|---|
| | Does the agency ensure that data collected pursuant to § 115.387 are securely retained? | yes |

| 115.389 (b) | Data storage, publication, and destruction | |
|---|---|---|
| | 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 |

| 115.389 (c) | Data storage, publication, and destruction | |
|---|---|---|
| | Does the agency remove all personal identifiers before making aggregated sexual abuse data publicly available? | yes |

| 115.389 (d) | Data storage, publication, and destruction | |
|---|---|---|
| | 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 |

| 115.401 (a) | Frequency and scope of audits | |
|---|---|---|
| | 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 |

| 115.401 (b) | Frequency and scope of audits | |
|---|---|---|
| | During each one-year period starting on August 20, 2013, the agency shall ensure that at least one-third of each facility type operated by the agency, or by a private organization on behalf of the agency, is audited. | yes |

| 115.401 (h) | Frequency and scope of audits | |
|---|---|---|
| | Did the auditor have access to, and the ability to observe, all areas of the audited facility? | yes |

| 115.401 (i) | Frequency and scope of audits | |
|---|---|---|
| | Was the auditor permitted to request and receive copies of any relevant documents (including electronically stored information)? | yes |

| 115.401 (m) | Frequency and scope of audits | |
|---|---|---|
| | Was the auditor permitted to conduct private interviews with inmates, residents, and detainees? | yes |

| 115.401 (n) | Frequency and scope of audits | |
|---|---|---|
| | Were inmates, residents, and detainees permitted to send confidential information or correspondence to the auditor in the same manner as if they were communicating with legal counsel? | yes |

| 115.403 (f) | Audit contents and findings | |
|---|---|---|
| | The agency has published on its agency website, if it has one, or has otherwise made publicly available, all Final Audit Reports within 90 days of issuance by auditor. The review period is for prior audits completed during the past three years PRECEDING THIS AGENCY AUDIT. In the case of single facility agencies, the auditor shall ensure that the facility's last audit report was published. The pendency of any agency appeal pursuant to 28 C.F.R. § 115.405 does not excuse noncompliance with this provision. (N/A only 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 |