PREA Facility Audit Report: Final

Name of Facility: New Castle County Detention Center
Facility Type: Juvenile
Date Interim Report Submitted: 06/21/2022
Date Final Report Submitted: 08/14/2022

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:** 08/14/2022

AUDITOR INFORMATION	
Auditor name:	Hardy-Kesler, Tammy
Email:	tammy.hardy@camdendoc.com
Start Date of On-Site Audit:	04/18/2022
End Date of On-Site Audit:	04/21/2022

FACILITY INFORMATION	
Facility name:	New Castle County Detention Center
Facility physical address:	963 Centre Road, Building 14, Wilmington, Delaware - 19805
Facility mailing address:	

Primary Contact	
Name:	Elizabeth M Cole
Email Address:	elizabeth.cole@delaware.gov
Telephone Number:	3026333151

Superintendent/Director/Administrator	
Name:	Raheem Perkins
Email Address:	raheem.perkins@delaware.gov
Telephone Number:	3026333152

Facility PREA Compliance Manager	
Name:	Elizabeth Cole
Email Address:	elizabeth.cole@delaware.gov
Telephone Number:	O: (302) 633-3151
Name:	Espie Hart
Email Address:	Espie.Hart@delaware.gov
Telephone Number:	

Facility Health Service Administrator On-Site	
Name:	Sarah Ciano
Email Address:	sarah.ciano@delaware.gov
Telephone Number:	3026333121

Facility Characteristics	
Designed facility capacity:	64
Current population of facility:	33
Average daily population for the past 12 months:	43
Has the facility been over capacity at any point in the past 12 months?	No
Which population(s) does the facility hold?	Both females and males
Age range of population:	12-18
Facility security levels/resident custody levels:	5
Number of staff currently employed at the facility who may have contact with residents:	97
Number of individual contractors who have contact with residents, currently authorized to enter the facility:	9
Number of volunteers who have contact with residents, currently authorized to enter the facility:	2

AGENCY INFORMATION	
Name of agency:	Delaware 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:	3026332620

Agency Chief Executive Officer Information:	
Name:	Renee Ciconte
Email Address:	renee.ciconte@delaware.gov
Telephone Number:	302-633-2620

Agency-Wide PREA Coordinator Information			
Name:	Danielle Stevenson	**Email Address:**	danielle.stevenson@delaware.gov

SUMMARY OF AUDIT FINDINGS

The OAS automatically populates the number and list of Standards exceeded, the number of Standards met, and the number and list of Standards not met.

Auditor Note: In general, no standards should be found to be "Not Applicable" or "NA." A compliance determination must be made for each standard. In rare instances where an auditor determines that a standard is not applicable, the auditor should select "Meets Standard" and include a comprehensive discussion as to why the standard is not applicable to the facility being audited.

Number of standards exceeded:	
0	
Number of standards met:	
43	
Number of standards not met:	
0	

POST-AUDIT REPORTING INFORMATION

GENERAL AUDIT INFORMATION

On-site Audit Dates

1. Start date of the onsite portion of the audit:	2022-04-18
2. End date of the onsite portion of the audit:	2022-04-21

Outreach

10. Did you attempt to communicate with community-based organization(s) or victim advocates who provide services to this facility and/or who may have insight into relevant conditions in the facility?	(•) Yes ( ) No
a. Identify the community-based organization(s) or victim advocates with whom you communicated:	Interviewed via teleconference the Christiania Care SANE/SAFE Coordinator Interviewed via Zoom SOAR Survivors of Abuse in Recovery, Inc. the victim advocacy agency During onsite audit, the auditors visited the Children's Advocacy Center of Delaware.

AUDITED FACILITY INFORMATION

14. Designated facility capacity:	64
15. Average daily population for the past 12 months:	43
16. Number of inmate/resident/detainee housing units:	6
17. Does the facility ever hold youthful inmates or youthful/juvenile detainees?	( ) Yes ( ) No (•) Not Applicable for the facility type audited (i.e., Community Confinement Facility or Juvenile Facility)

Audited Facility Population Characteristics on Day One of the Onsite Portion of the Audit

Inmates/Residents/Detainees Population Characteristics on Day One of the Onsite Portion of the Audit

36. Enter the total number of inmates/residents/detainees in the facility as of the first day of onsite portion of the audit:	40
38. Enter the total number of inmates/residents/detainees with a physical disability in the facility as of the first day of the onsite portion of the audit:	0
39. Enter the total number of inmates/residents/detainees with a cognitive or functional disability (including intellectual disability, psychiatric disability, or speech disability) in the facility as of the first day of the onsite portion of the audit:	9

40. Enter the total number of inmates/residents/detainees who are Blind or have low vision (visually impaired) in the facility as of the first day of the onsite portion of the audit:	0
41. Enter the total number of inmates/residents/detainees who are Deaf or hard-of-hearing in the facility as of the first day of the onsite portion of the audit:	0
42. Enter the total number of inmates/residents/detainees who are Limited English Proficient (LEP) in the facility as of the first day of the onsite portion of the audit:	0
43. Enter the total number of inmates/residents/detainees who identify as lesbian, gay, or bisexual in the facility as of the first day of the onsite portion of the audit:	1
44. Enter the total number of inmates/residents/detainees who identify as transgender or intersex in the facility as of the first day of the onsite portion of the audit:	0
45. Enter the total number of inmates/residents/detainees who reported sexual abuse in the facility as of the first day of the onsite portion of the audit:	0
46. Enter the total number of inmates/residents/detainees who disclosed prior sexual victimization during risk screening in the facility as of the first day of the onsite portion of the audit:	1
47. Enter the total number of inmates/residents/detainees who were ever placed in segregated housing/isolation for risk of sexual victimization in the facility as of the first day of the onsite portion of the audit:	0
48. Provide any additional comments regarding the population characteristics of inmates/residents/detainees in the facility as of the first day of the onsite portion of the audit (e.g., groups not tracked, issues with identifying certain populations):	No text provided.
Staff, Volunteers, and Contractors Population Characteristics on Day One of the Onsite Portion of the Audit	
49. Enter the total number of STAFF, including both full- and part-time staff, employed by the facility as of the first day of the onsite portion of the audit:	96
50. Enter the total number of VOLUNTEERS assigned to the facility as of the first day of the onsite portion of the audit who have contact with inmates/residents/detainees:	1
51. Enter the total number of CONTRACTORS assigned to the facility as of the first day of the onsite portion of the audit who have contact with inmates/residents/detainees:	9
52. Provide any additional comments regarding the population characteristics of staff, volunteers, and contractors who were in the facility as of the first day of the onsite portion of the audit:	No text provided.

INTERVIEWS

Inmate/Resident/Detainee Interviews

Random Inmate/Resident/Detainee Interviews	
53. Enter the total number of RANDOM INMATES/RESIDENTS/DETAINEES who were interviewed:	10
54. Select which characteristics you considered when you selected RANDOM INMATE/RESIDENT/DETAINEE interviewees: (select all that apply)	☑ Age ☑ Race ☑ Ethnicity (e.g., Hispanic, Non-Hispanic) ☑ Length of time in the facility ☑ Housing assignment ☑ Gender ☐ Other ☐ None
55. How did you ensure your sample of RANDOM INMATE/RESIDENT/DETAINEE interviewees was geographically diverse?	Reviewed population sheet which included demographics and housing placement.
56. Were you able to conduct the minimum number of random inmate/resident/detainee interviews?	◉ Yes ○ No
57. Provide any additional comments regarding selecting or interviewing random inmates/residents/detainees (e.g., any populations you oversampled, barriers to completing interviews, barriers to ensuring representation):	There were no barriers to completing interviews or ensuring representation.
Targeted Inmate/Resident/Detainee Interviews	
58. Enter the total number of TARGETED INMATES/RESIDENTS/DETAINEES who were interviewed:	4
As stated in the PREA Auditor Handbook, the breakdown of targeted interviews is intended to guide auditors in interviewing the appropriate cross-section of inmates/residents/detainees who are the most vulnerable to sexual abuse and sexual harassment. When completing questions regarding targeted inmate/resident/detainee interviews below, remember that an interview with one inmate/resident/detainee may satisfy multiple targeted interview requirements. These questions are asking about the number of interviews conducted using the targeted inmate/resident/detainee protocols. For example, if an auditor interviews an inmate who has a physical disability, is being held in segregated housing due to risk of sexual victimization, and disclosed prior sexual victimization, that interview would be included in the totals for each of those questions. Therefore, in most cases, the sum of all the following responses to the targeted inmate/resident/detainee interview categories will exceed the total number of targeted inmates/residents/detainees who were interviewed. If a particular targeted population is not applicable in the audited facility, enter "0".	
60. Enter the total number of interviews conducted with inmates/residents/detainees with a physical disability using the "Disabled and Limited English Proficient Inmates" protocol:	0

a. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/detainees in this category:	☑ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.
b. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	The facility stated there were no residents at the facility that had a physical disability. During the onsite review of the facility, the auditor did not observe any residents that appeared to have any visible physical disability.
61. Enter the total number of interviews conducted with inmates/residents/detainees with a cognitive or functional disability (including intellectual disability, psychiatric disability, or speech disability) using the "Disabled and Limited English Proficient Inmates" protocol:	2
62. Enter the total number of interviews conducted with inmates/residents/detainees who are Blind or have low vision (i.e., visually impaired) using the "Disabled and Limited English Proficient Inmates" protocol:	0
a. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/detainees in this category:	☑ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.
b. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	The facility did not identify any residents with low or limited vision. During the onsite review, there were no residents located that appeared to have limited or low visibility.
63. Enter the total number of interviews conducted with inmates/residents/detainees who are Deaf or hard-of-hearing using the "Disabled and Limited English Proficient Inmates" protocol:	0
a. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/detainees in this category:	☑ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.
b. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	Residential staff and medical personnel did not identify any residents that were deaf or hard of hearing.

64. Enter the total number of interviews conducted with inmates/residents/detainees who are Limited English Proficient (LEP) using the "Disabled and Limited English Proficient Inmates" protocol:	0
a. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/detainees in this category:	☑ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.
b. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	During interviews with random residents and random staff, there were no residents identified as limited English proficient.
65. Enter the total number of interviews conducted with inmates/residents/detainees who identify as lesbian, gay, or bisexual using the "Transgender and Intersex Inmates; Gay, Lesbian, and Bisexual Inmates" protocol:	1
66. Enter the total number of interviews conducted with inmates/residents/detainees who identify as transgender or intersex using the "Transgender and Intersex Inmates; Gay, Lesbian, and Bisexual Inmates" protocol:	0
a. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/detainees in this category:	☑ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.
b. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	Facility provided information, but there were no residents at the facility at the time of the onsite audit that identified as transgender or intersex.
67. Enter the total number of interviews conducted with inmates/residents/detainees who reported sexual abuse in this facility using the "Inmates who Reported a Sexual Abuse" protocol:	0
a. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/detainees in this category:	☑ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.

b. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	During random resident and targeted resident interviews, there were no reports of sexual abuse.
68. Enter the total number of interviews conducted with inmates/residents/detainees who disclosed prior sexual victimization during risk screening using the "Inmates who Disclosed Sexual Victimization during Risk Screening" protocol:	1
69. Enter the total number of interviews conducted with inmates/residents/detainees who are or were ever placed in segregated housing/isolation for risk of sexual victimization using the "Inmates Placed in Segregated Housing (for Risk of Sexual Victimization/Who Allege to have Suffered Sexual Abuse)" protocol:	0
a. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/detainees in this category:	☑ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.
b. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	The auditor utilized a combination of strategies to determine if there were any residents that were in segregated housing/isolation for the risk or sexual victimization. The strategies included interviews with random residents, random staff, specialized staff, medical and mental health personnel. During the onsite review, the auditor informally asked questions of staff and residents. Also, the auditor did not observe any residents that were in cells, isolated or segregated in a housing unit. All residents were in their corresponding activity areas.
70. Provide any additional comments regarding selecting or interviewing targeted inmates/residents/detainees (e.g., any populations you oversampled, barriers to completing interviews):	There were no barriers in identifying or interviewing targeted residents.

Staff, Volunteer, and Contractor Interviews

Random Staff Interviews

71. Enter the total number of RANDOM STAFF who were interviewed:	12
72. Select which characteristics you considered when you selected RANDOM STAFF interviewees: (select all that apply)	☑ Length of tenure in the facility ☑ Shift assignment ☑ Work assignment ☑ Rank (or equivalent) ☐ Other (e.g., gender, race, ethnicity, languages spoken) ☐ None

73. Were you able to conduct the minimum number of RANDOM STAFF interviews?	◉ Yes ○ No
74. Provide any additional comments regarding selecting or interviewing random staff (e.g., any populations you oversampled, barriers to completing interviews, barriers to ensuring representation):	There were no barriers in completing interviews.
Specialized Staff, Volunteers, and Contractor Interviews	
Staff in some facilities may be responsible for more than one of the specialized staff duties. Therefore, more than one interview protocol may apply to an interview with a single staff member and that information would satisfy multiple specialized staff interview requirements.	
75. Enter the total number of staff in a SPECIALIZED STAFF role who were interviewed (excluding volunteers and contractors):	54
76. Were you able to interview the Agency Head?	◉ Yes ○ No
77. Were you able to interview the Warden/Facility Director/Superintendent or their designee?	◉ Yes ○ No
78. Were you able to interview the PREA Coordinator?	◉ Yes ○ No
79. Were you able to interview the PREA Compliance Manager?	◉ Yes ○ No ○ NA (NA if the agency is a single facility agency or is otherwise not required to have a PREA Compliance Manager per the Standards)

80. Select which SPECIALIZED STAFF roles were interviewed as part of this audit from the list below: (select all that apply)	☑ Agency contract administrator ☑ Intermediate or higher-level facility staff responsible for conducting and documenting unannounced rounds to identify and deter staff sexual abuse and sexual harassment ☑ Line staff who supervise youthful inmates (if applicable) ☑ Education and program staff who work with youthful inmates (if applicable) ☑ Medical staff ☑ Mental health staff ☑ Non-medical staff involved in cross-gender strip or visual searches ☑ Administrative (human resources) staff ☑ Sexual Assault Forensic Examiner (SAFE) or Sexual Assault Nurse Examiner (SANE) staff ☑ Investigative staff responsible for conducting administrative investigations ☑ Investigative staff responsible for conducting criminal investigations ☑ Staff who perform screening for risk of victimization and abusiveness ☑ Staff who supervise inmates in segregated housing/residents in isolation ☑ Staff on the sexual abuse incident review team ☑ Designated staff member charged with monitoring retaliation ☑ First responders, both security and non-security staff ☑ Intake staff ☑ Other
If "Other," provide additional specialized staff roles interviewed:	Maintenance Food Service Worker Training Director Database Management Volunteer Contract Coordinator Grievance Staff Coordinator Volunteer/Contract Coordinator
81. Did you interview VOLUNTEERS who may have contact with inmates/residents/detainees in this facility?	◉ Yes ○ No
a. Enter the total number of VOLUNTEERS who were interviewed:	2

b. Select which specialized VOLUNTEER role(s) were interviewed as part of this audit from the list below: (select all that apply)	☑ Education/programming ☐ Medical/dental ☐ Mental health/counseling ☑ Religious ☐ Other
82. Did you interview CONTRACTORS who may have contact with inmates/residents/detainees in this facility?	◉ Yes ○ No
a. Enter the total number of CONTRACTORS who were interviewed:	4
b. Select which specialized CONTRACTOR role(s) were interviewed as part of this audit from the list below: (select all that apply)	☐ Security/detention ☑ Education/programming ☑ Medical/dental ☐ Food service ☐ Maintenance/construction ☑ Other
83. Provide any additional comments regarding selecting or interviewing specialized staff.	There were no barriers to interviewing specialized staff. Interviews were conducted in person, telephone, and virtually.

SITE REVIEW AND DOCUMENTATION SAMPLING

Site Review

PREA Standard 115.401 (h) states, "The auditor shall have access to, and shall observe, all areas of the audited facilities." In order to meet the requirements in this Standard, the site review portion of the onsite audit must include a thorough examination of the entire facility. The site review is not a casual tour of the facility. It is an active, inquiring process that includes talking with staff and inmates to determine whether, and the extent to which, the audited facility's practices demonstrate compliance with the Standards. Note: As you are conducting the site review, you must document your tests of critical functions, important information gathered through observations, and any issues identified with facility practices. The information you collect through the site review is a crucial part of the evidence you will analyze as part of your compliance determinations and will be needed to complete your audit report, including the Post-Audit Reporting Information.

84. Did you have access to all areas of the facility?	◉ Yes ○ No
Was the site review an active, inquiring process that included the following:	
85. Observations of all facility practices in accordance with the site review component of the audit instrument (e.g., signage, supervision practices, cross-gender viewing and searches)?	◉ Yes ○ No

86. Tests of all critical functions in the facility in accordance with the site review component of the audit instrument (e.g., risk screening process, access to outside emotional support services, interpretation services)?	◉ Yes ○ No
87. Informal conversations with inmates/residents/detainees during the site review (encouraged, not required)?	◉ Yes ○ No
88. Informal conversations with staff during the site review (encouraged, not required)?	◉ Yes ○ No
89. Provide any additional comments regarding the site review (e.g., access to areas in the facility, observations, tests of critical functions, or informal conversations).	During the site review, the auditors noticed that all supervisor's office windows were covered by blinds. Inquiry was made if residents were taken to those offices. It was confirmed that residents were counseled in the offices. Auditor requested that blinds be removed since there were no cameras in the offices. The auditor asked that pictures be provided in the supplemental files that showed blinds were removed. The pictures showed only one side of the windows. The auditor returned to the facility on 7/29/2022 to ensure that the blinds were taken down from the offices. Also, the double-lock system for sexual abuse and sexual harassment allegation files was reviewed. The auditor found that the files were secured by a double-lock system.

Documentation Sampling

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

90. In addition to the proof documentation selected by the agency or facility and provided to you, did you also conduct an auditor-selected sampling of documentation?	◉ Yes ○ No
91. Provide any additional comments regarding selecting additional documentation (e.g., any documentation you oversampled, barriers to selecting additional documentation, etc.).	Files were reviewed of random and targeted residents which coincided with interviews. The files were checked for PREA training records and intake processing records. Additionally, all PREA Risk Assessments were reviewed of all residents including medical records. The volunteer and contractor records were reviewed for background checks and PREA education. Interviewed random staff records were reviewed for background checks and PREA education. Logs were requested for all housing units and were reviewed for supervisory rounds on all shifts. The auditor requested investigative files for all sexual abuse and sexual harassment allegations. Additionally, the auditor requested documentation from an incident that was reported on 3/31/2022. Information was provided to auditor in its entirety via the supplemental files of the OAS.

SEXUAL ABUSE AND SEXUAL HARASSMENT ALLEGATIONS AND INVESTIGATIONS IN THIS FACILITY

Sexual Abuse and Sexual Harassment Allegations and Investigations Overview

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

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

	# of sexual abuse allegations	# of criminal investigations	# of administrative investigations	# of allegations that had both criminal and administrative investigations
Inmate-on-inmate sexual abuse	0	0	0	0
Staff-on-inmate sexual abuse	2	0	2	0
Total	2	0	2	0

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

	# of sexual harassment allegations	# of criminal investigations	# of administrative investigations	# of allegations that had both criminal and administrative investigations
Inmate-on-inmate sexual harassment	0	0	0	0
Staff-on-inmate sexual harassment	1	0	1	0
Total	1	0	0	0

Sexual Abuse and Sexual Harassment Investigation Outcomes

Sexual Abuse Investigation Outcomes

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

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

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

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

	Ongoing	Unfounded	Unsubstantiated	Substantiated
Inmate-on-inmate sexual abuse	0	0	0	0
Staff-on-inmate sexual abuse	2	1	1	0
Total	2	1	1	0

Sexual Harassment Investigation Outcomes

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

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

	Ongoing	Referred for Prosecution	Indicted/Court Case Filed	Convicted/Adjudicated	Acquitted
Inmate-on-inmate sexual harassment	0	0	0	0	0
Staff-on-inmate sexual harassment	0	0	0	0	0
Total	0	0	0	0	0

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

	Ongoing	Unfounded	Unsubstantiated	Substantiated
Inmate-on-inmate sexual harassment	0	0	0	0
Staff-on-inmate sexual harassment	1	0	1	0
Total	0	0	0	0

Sexual Abuse and Sexual Harassment Investigation Files Selected for Review

Sexual Abuse Investigation Files Selected for Review

98. Enter the total number of SEXUAL ABUSE investigation files reviewed/sampled:	2
99. Did your selection of SEXUAL ABUSE investigation files include a cross-section of criminal and/or administrative investigations by findings/outcomes?	(•) Yes ( ) No ( ) NA (NA if you were unable to review any sexual abuse investigation files)

Inmate-on-inmate sexual abuse investigation files

100. Enter the total number of INMATE-ON-INMATE SEXUAL ABUSE investigation files reviewed/sampled:	0

101. Did your sample of INMATE-ON-INMATE SEXUAL ABUSE investigation files include criminal investigations?	○ Yes ◉ No ○ NA (NA if you were unable to review any inmate-on-inmate sexual abuse investigation files)
102. Did your sample of INMATE-ON-INMATE SEXUAL ABUSE investigation files include administrative investigations?	○ Yes ◉ No ○ NA (NA if you were unable to review any inmate-on-inmate sexual abuse investigation files)
Staff-on-inmate sexual abuse investigation files	
103. Enter the total number of STAFF-ON-INMATE SEXUAL ABUSE investigation files reviewed/sampled:	2
104. Did your sample of STAFF-ON-INMATE SEXUAL ABUSE investigation files include criminal investigations?	◉ Yes ○ No ○ NA (NA if you were unable to review any staff-on-inmate sexual abuse investigation files)
105. Did your sample of STAFF-ON-INMATE SEXUAL ABUSE investigation files include administrative investigations?	◉ Yes ○ No ○ NA (NA if you were unable to review any staff-on-inmate sexual abuse investigation files)
Sexual Harassment Investigation Files Selected for Review	
106. Enter the total number of SEXUAL HARASSMENT investigation files reviewed/sampled:	1
107. Did your selection of SEXUAL HARASSMENT investigation files include a cross-section of criminal and/or administrative investigations by findings/outcomes?	◉ Yes ○ No ○ NA (NA if you were unable to review any sexual harassment investigation files)
Inmate-on-inmate sexual harassment investigation files	
108. Enter the total number of INMATE-ON-INMATE SEXUAL HARASSMENT investigation files reviewed/sampled:	0

109. Did your sample of INMATE-ON-INMATE SEXUAL HARASSMENT files include criminal investigations?	○ Yes ◉ No ○ NA (NA if you were unable to review any inmate-on-inmate sexual harassment investigation files)
110. Did your sample of INMATE-ON-INMATE SEXUAL HARASSMENT investigation files include administrative investigations?	○ Yes ◉ No ○ NA (NA if you were unable to review any inmate-on-inmate sexual harassment investigation files)
Staff-on-inmate sexual harassment investigation files	
111. Enter the total number of STAFF-ON-INMATE SEXUAL HARASSMENT investigation files reviewed/sampled:	1
112. Did your sample of STAFF-ON-INMATE SEXUAL HARASSMENT investigation files include criminal investigations?	◉ Yes ○ No ○ NA (NA if you were unable to review any staff-on-inmate sexual harassment investigation files)
113. Did your sample of STAFF-ON-INMATE SEXUAL HARASSMENT investigation files include administrative investigations?	◉ Yes ○ No ○ NA (NA if you were unable to review any staff-on-inmate sexual harassment investigation files)
114. Provide any additional comments regarding selecting and reviewing sexual abuse and sexual harassment investigation files.	During the post onsite audit, there were two additional sexual abuse allegations of staff on inmate. Both allegations were being criminally investigated by the Delaware State Police. During the finalization of this audit report, the two investigations of staff on inmate allegations of sexual abuse were ongoing.

SUPPORT STAFF INFORMATION

DOJ-certified PREA Auditors Support Staff

115. Did you receive assistance from any DOJ-CERTIFIED PREA AUDITORS at any point during this audit? REMEMBER: the audit includes all activities from the pre-onsite through the post-onsite phases to the submission of the final report. Make sure you respond accordingly.	◉ Yes ○ No
a. Enter the TOTAL NUMBER OF DOJ-CERTIFIED PREA AUDITORS who provided assistance at any point during this audit:	1

Non-certified Support Staff

116. Did you receive assistance from any NON-CERTIFIED SUPPORT STAFF at any point during this audit? REMEMBER: the audit includes all activities from the pre-onsite through the post-onsite phases to the submission of the final report. Make sure you respond accordingly.	◉ Yes ○ No
a. Enter the TOTAL NUMBER OF NON-CERTIFIED SUPPORT who provided assistance at any point during this audit:	1

AUDITING ARRANGEMENTS AND COMPENSATION

121. Who paid you to conduct this audit?	◉ The audited facility or its parent agency ○ My state/territory or county government employer (if you audit as part of a consortium or circular auditing arrangement, select this option) ○ A third-party auditing entity (e.g., accreditation body, consulting firm) ○ Other

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: Meets Standard
	Auditor Discussion
	Documents: 1. Policy 2.13 Division of Youth Rehabilitative Services (DYRS) Prisoner Rape Elimination Act (PREA) (Revised 5/13/21). 2. Youth Rehabilitative Services Director's Office Organizational Chart (Effective 02/10/22). 3. State of Delaware Department of Services for Children Youth and Their Families Division of Youth Rehabilitative Services PREA Compliance 4.Managers Organizational Chart (2022). 5. State of Delaware Employee Performance Plan PREA Coordinator Section I, B (pp. 2), (2/9/21). 6. State of Delaware Employee Performance Plan PREA Compliance Manager Section III, A (pp. 5), (4/15/21). 7. New Castle County Detention Center Organizational Chart (9/17/21) 8. Pre-Audit Questionnaire (PAQ) Interviews: 1. Coordinator 2. PREA Compliance Manager Site Review Observations: 1. Observation of the PREA Coordinator and PREA compliance manager performing duties onsite. Findings (by Provision): 115.311 (a) 1-5: The agency has a written policy mandating zero-tolerance against all forms of sexual abuse and sexual harassment. Policy 2.13 Division of Youth Rehabilitative Services (DYRS) Prison Rape Elimination Act, section II titled Policy, (pp.1) establishes zero-tolerance for any incidence of sexual activity with youth, sexual abuse and sexual harassment. 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. Any incidents of sexual abuse and sexual harassment will be reported to the child abuse hotline. This policy applies to all staff which includes department employee, volunteer, contractor, official visitor or other agency representatives. Agency Policy 2.13 (DYRS) Prisoner Rape Elimination Act, Section IV tilted procedures, (pp.3-4) outlines the agency's approach to preventing, detecting, and responding to sexual abuse and sexual harassment. The agency's policy outlines prevention of sexual abuse and sexual harassment through the staffing plan, video monitoring and maintaining minimum staff ratio of 1:8 during the day and a minimum staff ratio of 1:16 at night. The policy outlines detection though staff announcement of the opposite gender in the housing unit, documented unannounced rounds of superintendents, assistant superintendent, supervisors, program and managers on all three shifts to deter sexual abuse and sexual harassment. The facility conducts National Criminal Information Center (NCIC checks on all facility staff every five years. Staff complete intake screening for residents, risk assessments, and PREA training for staff. The agency's policy addressed responding to sexual abuse and sexual harassment through resident and staff reporting, first responder duties, staff training, resident orientation and comprehensive training, child abuse hotline, emergency PREA grievance, investigations, disciplinary action, terminations and or criminal prosecution, medical and mental health treatment, incident review team, victim services, community emotional support services, and data collection. This policy provides and outlines the agency's approach to preventing, detecting and responding to sexual abuse and sexual harassment. Policy 2.13 III, Section II, B Definitions (pp.1-3), defines sexual abuse of a resident by another resident and Sexual abuse of a resident by a staff member, contractor or volunteer as outlined in PREA standards definition 115.6. Agency policy 2.13 PREA Section IV B, H, includes sanctions for staff and residents found to have participated in prohibited behavior of sexual abuse and sexual harassment that includes disciplinary sanctions up to and including termination for staff and disciplinary sanctions for residents upon an administrative or criminal finding. Agency policy 2.13 PREA Section VI, the policy outlines the agencies response for preventing detecting and responded to sexual abuse and sexual harassment. The evidence shows that the agency has a zero tolerance PREA policy that outlines the agencies efforts in preventing detecting and responding to sexual abuse and sexual harassment. Based upon this analysis, the facility is substantially compliant with this provision and no corrective action is required. 115.311 (b) 1-3:

Agency policy 2.13 (DYRS) (PREA) Section III, G., (pp.2 outlines the position of the PREA Coordinator (PC). The policy provides that the PC acts as the agency representative on PREA related issues, coordinates PREA audits, ensures timely submission for the PRE-Audit questionnaire, completes policy related corrective actions, support and monitor changes in corrective actions, and provides assistance to the PREA compliance managers (PCM). The PC will develop, implement and oversee the agency's efforts to comply with the PREA standards in all facilities. In review of Pre-Audit Questionnaire (PAQ) and the DYRS Director's Office organizational chart, the agency employs an upper-level agency-wide PREA coordinator that holds the position of Professional Standards Manager. The PC performance plan outlines that the Professional Standards Manager/PREA coordinator reports directly to the agency DYRS Director and provides assistance to four PREA compliance managers. The PREA coordinator was just appointed to this position on 2/1/21. During an interview, the PREA coordinator reported that she has sufficient time to manage PREA related responsibilities. The PC indicated that although it is tough, she makes time for her PREA related duties. The PC indicated she works together with the PREA compliance managers to get things done. In the PAQ, the PC provided agency documentation for the auditor's review and met directly with the auditors while onsite. The PC demonstrated knowledge about her duties, agency policy, practices and efforts for compliance with the PREA standards.

The evidence shows that the agency has designated an upper-level agency-wide PREA coordinator which was verified through the agency policy, organizational chart, performance plan and interview with PC. The PC has worked in her position since 2/1/21 and has led the agency's efforts towards compliance with the PREA standards. In the Pre-Audit Questionnaire (PAQ), the PREA coordinator provided audit documentation, 53 supplemental file documentation, scheduled required interviews with facility staff that demonstrated the PC has sufficient time and authority to oversee the agency's efforts in complying with PREA.

Based upon this analysis, the facility is substantially compliant with this provision and no corrective action is required.

115.311 (c): 1-4:

Agency policy 2.13 (DYRS) (PREA) Section III, F., Page 2 outlines the position of the PREA compliance manager (PCM). The policy provides that the PCM will ensure PREA compliance operationally and its readiness for all related PREA standards. In review of the DYRS New Castle County Detention Center Organizational chart, the facility has designated a PREA Compliance Manager that holds the position of Assistant Superintendent in the organizational structure and reports directly to the Superintendent. A review of the State of Delaware Employee Performance Plan the Assistant Superintendent is designated as the PREA Compliance Manager for the facility. Department of Services for Children Youth and Their Families Division of Youth Rehabilitative Services PREA compliance managers Organizational Chart, the agency operates four facilities and has designated a PCM at each facility. During an interview, the PCM reported that she does have enough time as the PREA compliance manager. The PCM provided agency documentation onsite as well as 52 supplemental files for the auditor's review. During the site review, the PCM provided additional documentation to the auditors. The auditors observed the PCM interactions with the facility staff and residents which demonstrated knowledge about her efforts for compliance with the PREA standards.

The evidence shows that the agency has designated a PREA compliance manager which was verified through the agency policy, organizational chart, and interview with the PCM. The PCM works closely with the PREA Coordinator and is leading the facilities efforts to comply with the PREA standards.

Based upon this analysis, the facility is substantially compliant with this standard and no corrective action is required.

115.312	Contracting with other entities for the confinement of residents

Auditor Overall Determination: Meets Standard

Auditor Discussion

Documents:

1. Division of Youth Rehabilitative Services DYRS Contracts (updated 1/2022).
2. Division of Youth Rehabilitative Services DYRS Operating Guidelines for Contracted Children and Family Programs and Services Section V, D pp 11, (revised 3/01/21). http://www.kids.delaware.gov/mss/mss_contracts.shtml
3. Pre-Audit Questionnaire (PAQ)
4. Community Specialist Corporation (New Outlook Academy) Final Report 1/12/21
5. Natchez Trace Youth Academy Residential Treatment Program Interim Report 12/19/21
6. Abraxas Youth and Family Services Final Report 7/28/20
7. Detroit Behavioral Institute, DBA Capstone Academy PREA Final Report 12/21/21
8. Diversified Treatment Alternatives PREA Final Report 7/2/19
9. George Junior Republic PREA Final Report 8/24/20
10. Summit School Inc. (Summit Academy) PREA Final Report 10/21/21
11. Vision Quest RAD PREA Final Report 4/10/19
12. Silver Oak Academy Final Report 10/2/20
13. White Deer Run (Cove Prep) PREA Final Report 2/28/20
14. Woodland Academy PREA Final Report 6/18/19
15. Keystone Continuum LLC DBA Natchez Trace Youth Academy Contract
16. Vision Quest RAD Contract
17. Cornell Abraxas Group LLC, Pittsburgh, PA Contract
18. KidsPeace National Center Inc. Contract 8/5/21
19. Whitney Academy Contract 6/24/21
20. Devereux, Inc. Contract 9/23/20

Interviews:

1. Agency contract administrator

Findings (by Provision):

115.312 (a) 1-4:

The agency reported in the Pre-Audit Questionnaire (PAQ) that they have entered into or renewed 21 contracts for confinement of residents. The Division of Youth Rehabilitative Services DYRS Operating Guidelines for Contracted Children and Family Programs and Services Section V, D page 11, establishes that providers shall comply with all applicable PREA standards and any DSCYF policies or standards related to PREA for preventing, detecting, monitoring, investigating and eradicating any form of sexual abuse within DSCYF contracted or subcontracted facilities. In addition to "self-monitoring requirements" and submission to PREA state or federal audits, providers will allow DSCYF announced or unannounced, compliance monitoring to include "on-site" monitoring. 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.

In review of the DYRS residential contracts dated (1/2022), the agency reported they had 17 contracts with facilities for confinement of residents and all contracts required contractors to adopt and comply with the PREA standards. The DYRS residential contracts list the facilities, contact information, website, PREA compliance manager, and status of compliance under the standard. The auditor reviewed six of the 17 contracts for confinement of the agency's residents. The contracts reviewed has a section on reporting requirements that specifically require contractors to maintain compliance with the DSCYF operating guidelines. The DSCYF operating guidelines is located on the agency's website at http://www.kids.delaware.gov/mss/ mss_contracts.shtml and does require the contractor to comply with the PREA standards. The agency reported that six out of the 17 facilities had less than 51% Juvenile Justice. Since the last PREA audit, the agency had 17 facilities that were under contract. The auditor was able to review 11 PREA audit reports provided by the agency.

The evidence shows that the agency has entered into contracts for confinement of residents and that those contracts require the providers to adopt and comply with the PREA standards as verified through the review of the PAQ, contracts, provider website and agency guidelines.

115.312 (b) 1-2:

The Division of Youth Rehabilitative Services DYRS Operating Guidelines for Contracted Children and Family Programs and

	Services Section V, D page 11, establishes self-monitoring requirements and submission to PREA state or federal audits. Providers will allow DSCYF announced or unannounced compliance monitoring to include on-site monitoring. In the PAQ, the agency reported that nine facilities are less than 51% juvenile justice and do not require the agency to monitor the contractor for compliance with PREA standards. In review of the DYRS residential contracts dated (1/2022), agency has a list of all contracts that includes the contract information for the provider, PREA compliance manager information, website and status of PREA final audit report. Six providers were listed as having less than 51% juvenile justice youth. During an interview with the agency contract administrator, only contracts with PREA eligible providers is monitored for compliance. Once a provider enters into contract, they are to comply with the PREA standards. YRS would not enter or award a contract with a provider until they are compliant with PREA. Providers that are less than 51% juvenile justice do not require the agency to monitor the contract for compliance with PREA standards. The auditor reviewed three contracts that are less than 51% juvenile justice that confirms the agency's compliance with this provision. The evidence shows that the agency does require monitoring of a contractors' compliance with the PREA standards with the providers unless the provider is less than 51% juvenile justice. This was verified through review of the PAQ, agency guidelines, provider website and interview with agency contract administrator. Based upon this analysis, the facility is substantially compliant with this standard and no corrective action is required.

115.313	Supervision and monitoring
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents 1. Division of Youth Rehabilitative Services Prisoner Rape Elimination Act (PREA) 2.13 (Revised 5/13/21). 2. New Castle County Detention Center Staffing Plan (01/01/2022). 3. New Castle County Detention Center Organizational Chart (09/17/2021). 4. New Castle County Detention Center Yearly Staff Schedule January, February and March (02/22/2022). 5. New Castle County Detention Center (NCCDC) Shift Reports 2/1/22, 2/15/22, 2/28/22, 3/1/22, 3/15/22, 3/30/22, 4/1/22, 4/15/22, 4/20/22). 6. Director's Team Meeting Minutes (2/4/2022). 7. Director's Team Meeting Minutes (2/5/2021 and 4/9/2021). 8. Unannounced PREA Rounds A unit (02/02/2022). 9. Unannounced PREA Rounds B unit (12/29/2021). 10. Unannounced PREA Rounds C unit (02/26/2022). 11. Unannounced PREA Rounds D unit (02/04/2022). 12. Unannounced PREA Rounds E unit (02/092022). 13. Unannounced PREA Rounds F unit (12/24/2021). Site Review Observations: 1. Facility video camera system and observation of camera placement during onsite audit. Interviews: 1. Superintendent 2. PREA compliance manager 3. PREA coordinator 4. Intermediate or higher-level facility staff Findings (by Provision): 115.313 (a-c): In the PAQ, the agency reported that they require each facility it operates to develop, document, and make its best efforts to comply on a regular basis with a staffing plan that provides for adequate levels of staffing and video monitoring, to protect residents against abuse. The facility reported that the average daily number of residents at the facility was 43 and the staffing plan was predicated on that number. At the time of the onsite audit, there were 40 residents at the facility. The facility reported in the last 12 months they have not deviated from the staffing plan as staff are frozen on shift as needed to ensure they remain in compliance with staffing ratios. The facility relies on PREA Policy 2.13 Section IV Titled Procedures, A, 1a and1b, (pp. 4) that provides that the administration and supervisors have a responsibility to maintain staff to student ratio. The shifts are A shift (7:00am -3:00pm), B shift (3:00pm-11:00pm), and C shift (11:00pm-7:00am). The facility has three shift supervisors on 7:00am-3:00pm shift, two on 3:00pm-11:00pm and two on 11:00pm-7:00am. The facility reported they currently employ 97 staff, 9 contractors and 2 volunteers that may have contact with residents. In review of the New Castle County Detention Center organizational chart, the facility reported that they have the staffing capacity of 121 employees. The facility reported they currently have 106 with 15 vacancies. The current administrative and security staff consist of one superintendent, one assistant superintendent, one management analyst, one administrative specialist, one program manager, nine youth care specialist supervisors, three youth care specialist III, one volunteer coordinator, 33 youth rehabilitative counselor I, 23 youth rehabilitative counselors II, two rehabilitative counselor III, one food service supervisor, six food service staff, six transportation staff, two recreation staff, seven case management staff that work on either A shift 0700-1500, B shift, 1500-2300 or C shift 2300-0700. A review of the facility shifts reports for A, B and C shift, the facility has a log report that outlines the movement of residents, intakes, releases, restrictions and observations. The report outlines the number of staff and residents in each housing unit. The staffing plan calls for a minimum of one staff per eight residents during A, B and C shift. The staffing plan requires that staff be aware of the location of the group and individual residents at all times by conducting random head counts. Residents are never left unsupervised in any area. Staff must conduct periodic headcounts to ensure the earliest possible detection of a missing resident and movement must be noted in the unit logbook. Staff are must employ direct and active supervision techniques to be in close proximity of the

residents so they are able to physically intervene if necessary. The C shift have the same minimum one staff to 8 residents with 15-minute checks during sleeping hours. The staffing plan also outlines that that NCCDC mandates that the ratio is one staff per eight residents during waking hours and one staff per 12 residents during sleeping hours.

The auditor was able to observe that the residents were never alone. Residents traveled in a group escorted by staff when they left the unit, in the main hallway, in healthcare and intake. Staff utilized radios for communication between other staff. On the first day of the onsite audit, 40 residents resided at the New Castle County Detention Center. The auditor was able to review the camera system in central control and observe all areas of the facility and camera placement.

In the PAQ, the facility reported they have a video monitoring system and had not added any new technology in the past 12 months. During the onsite review, on April 18, 2022, the total number of residents was 40, on April 19, 2022 the total number of residents was 38, on April 20, 2022 the total number of residents was 40, and on April 21, 2022 the total number of residents was 39. New Castle County Detention Center has a facility capacity count of 64. There are 151 video monitoring cameras installed throughout the facility in the housing units, yard, classrooms, visitation, dining area, library, education, gym, intake area, maintenance, administration building, medical/mental health. All the cameras can be monitored by staff. The auditor did not observe any cameras in the bathroom. All cameras are date and time stamped and has a retention of 30 days.

During interviews, the superintendent stated that the facility has a documented staffing plan that considers staffing levels and video monitoring. The superintendent reported that the staffing plan considers accepted detention and correctional practices, any findings of inadequacy, resident population, staff positions, blind spots, programming schedule, any applicable laws, and sexual abuse unsubstantiated and substantiated findings at the facility. The superintendent stated he checks for compliance of the staffing plan by looking at the coverage each day including reaching out to other facilities to ensure they have extra staff coverage. The superintendent indicated that the facility had installed two new cameras. During an interview the PREA Compliance Manager stated that an additional camera was being installed on 4/22/22.

The evidence shows that the facility provides adequate staffing levels and video monitoring to protect residents against abuse. This was verified through policy, interviews, video monitoring, staff and supervisor shift assignments.

Based upon this analysis, the facility is substantially compliant with this provision and no corrective action is required.

115.313 (d):

In the PAQ, the facility reported that annually with the agency's PREA coordinator they review the staffing plan to see if adjustments are needed to the staffing plan, prevailing staffing patterns, monitoring technology, allocation of agency or facility resources to ensure compliance with the staffing plan.

The agency provided the Directors team meeting that outline the agency’s discussion for staffing plans, update staffing ratios, video monitoring system concerns, include program managers and office locations on the staffing plan.

During interviews, the PREA coordinator stated that assessments or adjustments to the staffing plan is discussed through directors’ team meeting. The Director’s team meeting was February 4, 2022. The PREA coordinator had provided previous director’s team meetings.

The evidence shows that the facility does meet with the PREA coordinator to discuss the staffing plan to ensure compliance which was verified by interviews and director’s meeting minutes.

Based upon this analysis, the facility is substantially compliant with this standard and no corrective action is required.

115.313 (e):

In the PAQ, the facility reported they require that intermediate level or higher-level staff conduct unannounced rounds to identify and deter staff sexual abuse and sexual harassment. The facility reported that unannounced rounds are documented and cover all shifts and staff are prohibited from alerting other staff conducting rounds.

The agency relies on PREA Policy 2.13 Section IV, A, 2 and 2a that outlines supervisors, program managers, assistant superintendents and superintendents must conduct and document unannounced rounds to identify and deter staff sexual abuse and sexual harassment on all shifts. Staff are prohibited from alerting other staff of these unannounced rounds.

A review of the logbook for all housing units over the course of four months shows that PREA unannounced rounds are documented in the unit logbook. A review of the video system shows that rounds are being completed. The intermediate higher-level staff do conduct PREA unannounced rounds on all shift and log such rounds in the unit logbook in red ink. PREA unannounced rounds are documented as PREA check with a time and notation if any issues were found.

During Interview, higher-level staff stated that they do conduct unannounced rounds and document these rounds in the green logbook in red. Staff indicated they would write in when they start and finish the unannounced PREA Round. When asked how do you prevent staff from alerting other staff, higher level staff indicated they would carry a radio during the round. Other

	higher-level staff indicated they would not tell staff, check all the rooms, log in the logbook in red, switch up the way they conduct rounds and listen to the radio. The evidence shows that the higher-level staff conduct unannounced rounds and they are documented in the log book which was verified through review of the log books, policy, video monitoring and interviews. Based upon this analysis, the facility is substantially compliant with this standard and corrective action is not required.

115.315	Limits to cross-gender viewing and searches
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. Division of Youth Rehabilitative Services Prisoner Rape Elimination Act (PREA) 2.13 (Revised 5/13/21). 2. Division of Youth Rehabilitative Services State Managed Facilities Searches of Youth, Visitors and Facilities 5.14 (Revised 2/28/19). 3. Division of Youth Rehabilitative Services Professional Practices Lesbian, Gay, Bi-sexual, Transgender, Questioning, and Intersex (LGBTQI) Policy 2.20 (Revised 3/5/19). 4. New Castle County Detention Center: Clothed and Unclothed Searches; Frisking NCCDC-215 (Effective 3/29/21) 5. Policy 5.7 Division of Youth Rehabilitative Services State Managed Facilities Youth Supervision and Movement (Effective 6/1/15). 6. Male Staff Announce Sign and Female Announce Sign 7. New Castle County Detention Center Un-Clothed Search Logs September 6, 2020 to April 6, 2022. 8. PREA Refresher Training Records 24 staff. Site Review Observations: 1. Intake, housing units. Interviews: 1. Random staff 2. Resident Findings (by Provision): 115.315 (a): In the PAQ, the agency reported that they do not conduct cross gender strip or cross gender visual body cavity searches of residents. In the past 12 months the facility reported they did not conduct cross gender strip or cross gender visual body cavity searches of residents. The facility relies on Search of Youth, visitors and facilities policy 5.14 Section III A, unclothed searches are conducted by a minimum of two-line staff of the same gender without touching the youth. Policy LGBTQI 2.20 Section IV titled search procedure. G 3-4, outlines that LGBTQI shall be asked about their preference of being searched. If the youth does not express a preference the same gender staff shall conduct the search. Search of Youth, visitors and facilities policy 5.14 Section IV F, outlines that youth shall never be subjected to a body cavity search unless authorized by the medical authority, when directed this shall occur in the hospital setting and completed by hospital staff. During the onsite audit, the auditor was able to observe an intake of a resident where a unclothed search was conducted. The auditor observed staff of the same gender conducting the search. Staff indicated that if a staff of the same gender was not present, they would observe the staff conducting the search absent any view of the resident being searched. Staff conducting the search would log in the Un-clothed search log the date, resident, location, start and end time, staff conducting the search staff gender and reason for the unclothed search. The evidence shows that the facility does not conduct cross gender strip searches or body cavity searches of residents which was verified by policy, and onsite observation. Based upon this analysis, the facility is substantially compliant with this provision and no corrective action is required. 115.315 (b-c): In the PAQ, the facility reported that they do not conduct cross gender pat searches of residents, absent exigent circumstances. The facility reported in the past 12 months they had no cross-gender pat searches and none that involve an exigent circumstance. Policy 2.20 LGBTQI outlines that cross-gender searches should not occur except in exigent circumstances. In an exigent circumstance, a written report must be completed, reviewed, and approved by the program manager immediately following and submitted to the deputy director, PREA coordinator and PREA compliance manager. The auditor was able to observe the intake areas and speak with staff regarding the intake process. Staff stated that each

resident is searched when they come into the facility by the same gender staff. The auditors observed the intake area that had one shower area. Two staff of the same gender would be present during a search of the resident that is not visible by any other staff or residents. If there was a staff of the opposite gender, that staff would not be in the view of the resident while the search was being conducted.

During the onsite audit, the auditor was able to observe that two staff of the same gender conducted intake with a resident of the same gender. The intake was not visible to any other staff or residents.

The evidence shows that the facility does not conduct cross gender pat searches of residents which was verified by policy, unclothed search log and onsite observation.

Based upon this analysis, the facility is substantially compliant with this provision and no corrective action is required.

115.315 (d):

In the PAQ, the facility has implemented policies and procedures that enable residents 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 or when such viewing is incidental to routine cell checks (including video monitoring.

The facility relies on policy 5.7 Youth Supervision and Movement Section IV E, 1, that outlines staff shall not observe youth of the opposite sex when they are dressing and or undressing, bathing, or using toilet facilities. Agency policy PREA 2.13 Section IV, A, 3 requires staff of the opposite gender to alert the youth via knocking on the door and then announce their gender to ensure requiring privacy has ample notice and time.

During interviews with 12 random staff, when asked do you or other staff announce your presence when entering a housing unit that houses residents of the opposite gender, 11 out of 12 staff stated yes. Eleven out of 12 staff stated they would announce female in unit, male in unit. When staff was asked if residents are able to dress, shower and use the toilet without being viewed by staff of the opposite gender, eleven out of twelve staff stated yes. Staff indicated the residents have a door on the shower and bathroom. Residents go into the shower area dressed and must come out fully dressed.

During interviews with 12 residents, when asked do male or female staff announce their presence when they enter your housing area or any area where you shower, change clothes, or perform bodily functions, 11 out of 12 residents stated yes, staff say female on the unit and when asked are you or other residents ever naked in full view of a female or male staff when using the toilet, showering or changing clothes, 11 out of 12 residents stated no.

During the onsite review, the auditor observed the unit bathrooms, shower area and toilet facility. The auditor asked staff about the use of the shower, toilet and how residents change clothes, staff stated only one resident can shower at a time and use the restroom at one time. There is a door to the shower and toilet areas and residents must change in the shower area and get dressed before they come out. The intake area has a bathroom and shower area.

The evidence shows residents are able to shower, change clothes and perform bodily functions without being viewed by non-medical staff of the opposite gender and that staff announce their presence when entering a residents housing unit which was verified by policy, interviews and observation.

Based upon this analysis, the facility is substantially compliant with this provision and no corrective action is required.

115.315 (e):

In the PAQ, the facility reported they have a policy prohibiting staff from searching or physically examining a transgender or intersex resident for the sole purpose of determining the resident's genital status. In the last 12 months, the facility reported that no such search occurred.

Agency policy 2.20 LGBTQI section IV G, 2, outlines that LGBTQI youth 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. If a youth’s gender is unknown, it will be determined during conversations with the youth, by reviewing medical records, or as a part of a broader medical examination conducted in private by a medical practitioner.

During interviews with 12 random staff, when asked are you aware of the policy prohibiting staff from searching or physically examining a transgender or intersex resident for the purpose of determining the resident’s genital status, 10 out of 12 staff stated they were aware of the policy.

During the onsite review, the auditor reviewed 12 resident files and interviewed 12 residents and determined there were no transgender or intersex residents at the facility during the onsite audit.

The evidence shows that the facility prohibits staff from examining residents for sole purpose of determining a resident’s genital status which was verified by PAQ, policy, interviews, file review and onsite observation.

Based upon this analysis, the facility is substantially compliant with this provision and no corrective action is required.

115.315 (f):

In the PAQ, the facility reported that 100 percent of security staff have received training on conducting cross-gender pat down searches and searches of transgender and intersex residents in a professional and respectful manner, consistent with security needs.

Agency policy 2.20 LGBTQI section IV J, (1-2), outlines that all staff shall receive training on how to communicate effectively and professionally with youth including LGBTQI or gender nonconforming youth. The facility uses the PREA Resource Center Guidance in Cross Gender and Transgender Pat Searches to train staff on pat down searches of transgender and intersex residents.

During interview with 12 random staff, when asked did you receive training on how to conduct a cross gender pat down search and searches of transgender or intersex residents in a professional and respectful manner, consistent with security needs, all 12 staff stated they have been trained and received update training and watched a video. The auditor reviewed training records for 24 staff that confirms staff have received training on searches of residents through PREA refresher training.

The evidence shows that facility staff have received training on how to conduct cross gender pat down searches which was verified through interviews, training documentation, training records, policy, and onsite observation.

Based upon this analysis, the facility is substantially compliant with this standard and no corrective action is required.

Best Practice Recommendation:

1. Include the gender of the resident on the intake unclothed search log.

115.316	Residents with disabilities and residents who are limited English proficient
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. PREA Policy 2.13.IV.A.4 2. DSCYF Policy 118.II 3. DSCYF Policy 118.IV.B.i 4. State of Delaware Executive Department Office of Management and Budget Contract NO. GSS19602-LINGUIST Interpretation & Translation Services- Foreign Languages effective 4/1/2021-3/31/2023 p.9 5. Quick Glance Interpretation & Translation Services 6. Student Handbook in both English and Spanish Interviews: 1. Director 2. PREA Compliance Manager 3. Random Youth- Youth Receiving Special Education Services Identified During Interviews 4. Random Staff Site Review: 1. Intake Findings (by Provision): 115.316 (a)-1: The DSCYF has taken steps to ensure that youth with disabilities have an 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. Within PREA Policy 2.13.IV.A.4 states each facility must take reasonable steps to effectively communicate with youth who have a disability or are limited English proficiency. In the PAQ, the facility provided the contract for interpretation and translation services from the State of Delaware Executive Department Office of Management and Budget Contract NO. GSS19602-LINGUIST Interpretation & Translation Services-Foreign Languages. The contract is a mandatory use contract that requires every state department and agency within the Executive Branch and Judicial Branch of the state government shall procure all material, equipment, and nonprofessional services through the statewide contract administered by Government Support Services. To locate services needed, the document includes the Quick Glance Interpretation & Translation Services. Through the issue log the auditor requested a roster of students that received special education services and youth that were limited English proficient. The list did not include students that were presently at NCCDC. The special education classifications were not indicative of youth that would necessitate assistance or support in understanding the existing PREA delivery of information. During the interviews with all the youth there was no apparent indication of a need for specialized vocabulary on the part of the auditor. There were no youth that had any speech impairment, blindness, or hard of hearing. There was a youth that was identified and exhibited significant cognitive delays. During the random youth interviews, the auditor asked specific questions to determine if the student had an Individualized Education Program (IEP or 504 Plan). Several students knew that they were receiving special education services, and they were aware of their classification. Youth were asked if they received information about sexual abuse and sexual harassment that they were able to understand? All disabled students identified stated that they did receive information that they understood pertaining to sexual abuse and sexual harassment. Additionally, the youth were asked the way they received the information. They stated that they learned in their PREA training. There was no elaboration if the information was learned from a video or the NCCDC Student Handbook. Youth shared that if they needed any assistance that staff were accessible to assist. Also, the youth stated that they were aware of their rights concerning sexual abuse and sexual harassment as well as how to report such incidents. Interview with the director shared that there are procedures implemented to ensure that youth with disabilities and limited English proficiency was receiving information related to PREA. Mentioned was the access to the interpretation and translation services that included sign language, and youth with visual impairments could be provided PREA information in larger print. Though these services were available, the intake staff were not aware of how to access services through the

language and translation services. There was no literature in the intake area to assist staff if they were confronted with a youth that needed translation or interpretation services. Additionally, the auditor was given conflicting accounts by staff whether youth were given an opportunity to see the PREA video. The PREA video would be beneficial for youth that have comprehension difficulties, cognitive delays, or limited vision. An age-appropriate video would afford the opportunity for PREA information to be viewed and/or heard.

The facility does not meet compliance in this provision.

115.316 (b)-1:

In DSCYF Policy 118.II, it is the policy of the Department that all LEP persons must have equal access to Department services, whether they are delivered by the Department or its contractors and shall be entitled to language assistance at no cost to themselves. There were no youth listed or identified as limited English proficient. It should be noted that Spanish is the second largest spoken language in the state of Delaware.

Auditors were provided the NCCDC Student Handbook in both English and Spanish.

Meaningful access to all aspects of DSCYF's efforts to prevent, detect, and respond to sexual abuse and sexual harassment to youth who are limited English proficient are met through the availability of the contract for interpretation and translation services. In the PAQ, the facility provided the contract for interpretation and translation services from the State of Delaware Executive Department Office of Management and Budget Contract NO. GSS19602-LINGUIST Interpretation & Translation Services- Foreign Languages. The contract is a mandatory use contract that requires every state department and agency within the Executive Branch and Judicial Branch of the state government shall procure all material, equipment, and nonprofessional services through the statewide contract administered by Government Support Services. To locate services needed, the document includes the Quick Glance Interpretation & Translation Services.

Review of the contract, it was found that all vendors must provide certified/qualified and experienced language professionals with relevant knowledge in the required field of expertise. Based on contract requirements, the interpreters and translators are screened to ensure individuals providing services were effective, accurate, and impartial both receptively and expressively.

In practice, NCCDC staff were unable to prove to the auditors their ability to access the interpretation and translation services. During the onsite review, there were no posting or instruction available to access the interpretation and translation services in the intake area.

The agency does not meet compliance in this provision.

115.316 (c)-1-3:L

Review of DSCYF Policy 118.IV.B.i does prohibit the use of youth interpreters, youth readers, or other types of youth assistants except in limited circumstances. The policy does state that Department staff should utilize language assistance services in any situations where they are not able to communicate at a satisfactory level with an LEP person. Utilizing the interview protocols for random staff, it was found that nine out of twelve random staff was aware that youth could not be utilized as translators or interpreters.

There were no limited English proficient youth listed or identified to interview nor documentation in PAQ to determine if youth interpreters, youth readers, or other types of youth assistants were utilized except in limited circumstances. According to random staff, there has not been any limited English proficient youth.

According to the information taken from the PAQ, there were no instances in the past 12 months that indicated where youth interpreters, readers, or other types of youth assistants had been used. There were no instances documented or located by the auditor that there was an extended delay in obtaining an interpreter that could have compromised the youth's safety, first-responder duties, or the investigation of the youth's allegations.

The agency is substantially compliant with this provision.

The evidence demonstrates that DSCYF has procedures to ensure that youth with disabilities and limited English proficiency 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. In practice, NCCDC has not demonstrated the ability to access translation and interpretive services. During the onsite review, the auditors were given conflicting answers regarding the use of a PREA video to assist with delivery of PREA information to disabled youth. Additionally, there was no utilization of youth interpreters, youth readers, or other types of youth assistants.

Based upon this analysis, the facility is not compliant with this standard and corrective action is required.

Corrective Action:

1. Train supervisors and intake staff on how to access the interpretation and translation services.
2. Add PREA video to curriculum for the youth PREA training.

Recommendation:

1. Post information in the intake area on accessing the language and translation services.
2. Utilize an age-appropriate PREA video for youth training.

Verification of Corrective Action since the audit:

The facility sent the auditor documentation on 7/29/2022 and 8/8/22 in response to the corrective actions.

Copies of the following

- Email sent regarding Interpretation and Translation Services training (1 page)
- Curriculum of Interpretation and Translation Services (16 pages)
- Intake staff acknowledgement of receiving training on Interpretation and Translation Services (7 pages)

Letter of Affirmation of the utilization of YouTube video titled PREA Training Juvenile located at https://www.YouTube.com/watch?v+TRqJd_tZh1A

The following actions were taken: DYRS provided training on Interpretation and Translation Services to 7 intake staff at NCCDC. Intake staff were informed on the process to access and purchase contracted translation services and how to access immediate translation services. Additionally, intake staff was provided the contact information for all services translation and interpretation services contracted.

The following action was taken: DYRS provided youth access to PREA video that was age appropriate. The video outlined information pertaining PREA specifically sexual abuse and sexual harassment in confinement.

Corrective Action #1 and #2

The intent of this corrective action was to ensure that youth have access to interpretation and translation services to inform them of the zero-tolerance policy, the right to be free from sexual harassment, sexual abuse, and retaliation, and how to report sexual harassment, sexual abuse, and retaliation.

The facility provided a 16-page training curriculum on interpretation and translation services. There were 7 intake staff training acknowledgements.

The intent of this corrective action was to ensure that all youth were provided the opportunity to view and understand information pertaining to sexual abuse and sexual harassment in confinement. According to the affirmation, the facility implemented the use of the PREA video to all new admits to NCCDC. This satisfies the auditor's corrective action requirements.

Based on review of the information received, the auditor finds the facility substantially compliant with this standard.

115.317	Hiring and promotion decisions
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. DYRS Policy 2.13.III 2. DYRS Policy 2.13 Attachment F-DYRS Hiring and Promotion Decisions 3. DSCYF Policy 313.III cites Title31, Chapter 3, Section 309 4. DSCYF Policy 318.IV.E 5. Letter of Affirmation of NCIC 5-year Checks of Employees of NCCDC 6. Volunteer and Contractor Roster 7. Delaware Criminal Justice Information System (DELJIS) 8. Employee Files Interviews: 1. Human Resources 2. Criminal Background Unit Site Review: 1. Employment Files Findings (by Provision): 115.317 (a)-1: DSCYF has implemented policies and a form to address and obtain information related to PREA Standard 115.317 prohibiting the hiring, promoting, or contracting of anyone who may have contact with residents who has engaged, attempted to engage, convicted of sexual abuse in prison, jail, lockup, community confinement facility, juvenile facility, other institutions, the community, which was facilitated by force or coercion, consent, or unable to consent or has been civilly or administratively adjudicated of the above actions. DYRS Policy 318.IV.E states that PRE A requires pre-employment reference checks for covered employees to determine whether the candidate; 1. Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility or other institution; 2. Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or cohesion, or if the victim did not consent or was unable to consent or refuse; and/or 3. Has been adjudicated in civil court or administratively adjudicated substantiated in employment related hearings. DYRS Policy 2.13 Attachment F-PREA Acknowledgement Form is an affirmation completed during hiring, promotion and annually with evaluation. This form specifically addresses sexual abuse and sexual harassment. During the hiring process, annually, and prior to promotion, employees must complete the PREA Acknowledgement Form which affirms that in the past 12 months, the employee has not engaged in behaviors outlined in PREA Standard 115.317. The auditor did locate this form in facility employee folders, but they were outdated. In the supplemental files, the auditor was provided 26 employee affirmations out of a possible 117 employees. The agency substantially meets compliance in this provision. 115.317(b)-1: Attachment F of DYRS Policy 2.13 the PREA Acknowledgement form captures the affirmation that in the last 12 months employees and or contractors have or have not been investigated or engaged in sexual assault or sexual harassment in confinement, community and civilly or administratively adjudicated. There is a designation for both sexual abuse and sexual harassment. During the onboarding process, there is a service letter that is sent to previous employers. The service letter does not specifically speak to sexual harassment, but the questions that are asked should be sufficient to capture the occurrence of sexual harassment and/or sexual abuse in the workplace. The agency substantially meets compliance in this provision. 115.317(c)-1-2 DSCYF Policy 313.III cites Title31, Chapter 3, Section 309 of the Delaware Code requires of SBI and FBI records a review of

the Department's Child Protection Registry be conducted on employees of the Department hired after September 1, 1989 who have regular direct access or unsupervised direct access to children and/or adolescents under the age of 18.

During the interview with the Criminal History Unit it was confirmed that criminal background checks are completed on all newly hired employees, volunteers, and contractors who may have contact with residents.

In DSCYF Policy 3.18.IV.E specifically address the mandates required by PREA. The policy states that PREA requires pre-employment reference checks for covered employees to determine whether the candidate (1) Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility or other institution; (2) Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; and/or (3) Has been adjudicated in civil court or administratively adjudicated (substantiated) in employment related hearings. Within the past 12 months, there were 14 new candidates at the NCCDC that had criminal background checks and child registry completed.

Inquiry of the Human Resources and Criminal Background Unit confirmed that during onboarding of new employees, volunteers, and contractors consisted of the child abuse registry consulted.

Further in the policy is the General Guidance for Pre-Employment Checks. According to the policy the pre-employment checks must be considered in hiring decision making. Additionally, all information provided on the employment application, resume, reference, and pre-employment check materials may be verified, including but not limited to, contacting current and former employers.

The agency substantially meets compliance in this provision.

115.317(d)-1-2
According to the DYRS Policy 2.13.III.a Definition the contractors at NCCDC are considered staff. The DYRS Policy 3.18.IV.E requires that criminal background checks are to be completed and child abuse registries consulted prior to enlisting the services of any contractor who may have contact with residents.

Inquiry was made by the auditor regarding the criminal background checks for contractors that were provided on the volunteer and contractor roster for NCCDC. During the review of the contractors' files, criminal background checks were documented in the contractors' files by the volunteer and contractor coordinator.

The agency is substantially compliant with this provision.

115.317(e)-1
Provided through the supplemental files of the AOS the PREA coordinator provided a Letter of Affirmation for the five-year employee background checks of NCCDC. Additionally, the auditor contacted the criminal history department. DYRS employs the use of the Delaware Criminal Justice Information System (DELJIS). This system flags the department if any employee, contractor, or volunteer receives a criminal charge while employed with the agency. Only criminal charges that occur in Delaware are subject to be flagged.

The agency is substantially compliant with this provision.

115.317(f)-1
The auditor reviewed DYRS Policy 2.13 – Attachment F-PREA Acknowledgement Form which is used as a continuing affirmative duty to disclose the engagement of sexual abuse in a place of confinement, convicted of engaging; attempting to engage in sexual activity in the community; or civilly or administratively adjudicated of said behavior and investigated in sexual harassment.

It was confirmed by human resources that the Human Resource Applicant Statement is completed by the new hire candidates and contractors. It was also confirmed that DYRS Policy 2.13 – Attachment F-PREA Acknowledgement Form is completed by employees annually and upon promotion. The employee file review yielded out of date PREA Acknowledgement Forms. The facility uploaded 26 signed employee PREA Acknowledgement Forms which is significantly lower than the 117 employees listed on NCCDC's rosters.

The agency is not compliant in this provision.

115.317(g)-1

Found in DYRS Policy 2.2 maintains that employees have the responsibility to immediately disclose to their supervisor any criminal investigations, arrests, indictments, or convictions of themselves or any investigation of child abuse or entry onto the Child Abuse Protection Registry subsequent to initial employment. Failure to immediately notify a supervisor of any of the above, including final disposition, could result in discipline up to and including termination.

The agency is substantially compliant in this provision.

115.317(h)-1

According to human resources, DYRS would provide information on substantiated allegations of sexual abuse or sexual harassment involving a former employee to an institutional employer with a service letter and a signed consent by a former employee.

The agency is substantially compliant in this provision.

The evidence has shown that the agency has established policies and procedures that prohibit the hiring or promotion of employees, volunteers or contractors who may have contact with residents who have engaged in sexual abuse in confinement, institutional settings, community or civilly or administratively adjudicated for said behaviors. The facility through practice has established forms and service letters to obtain information if an individual has any incidents of sexual harassment. The agency completes criminal background checks and child abuse registry consult prior to hiring. The agency does complete background checks every five years or less for current employees. New hire candidates are required to disclose prior misconduct. Imposed on employees is a continuing affirmative duty to disclose any misconduct including PREA Standard 115.316(a). There are inconsistencies in the annual and promotional completion of the PREA Acknowledgement forms. The agency has policy that any omissions or false statements are grounds for termination. With a written consent from a former employee, the agency would provide information of a substantiated allegation of sexual harassment and sexual abuse.

Based on this analysis, the facility does not meet compliance, and corrective action is needed at this time.

Corrective Action:

1. In the instances of hiring, promotion, and annually, all staff is to complete the PREA acknowledgement form which affirms that in the past 12 months an employee has or has not incurred any of the following: Engaged in sexual abuse in a prison, jail, lock up, community confinement facility, juvenile facility, or other institutions; 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; been civilly or administratively adjudicated to have engaged in the activity described in this acknowledgment form and/or been investigated for or engaged in sexual assault or sexual harassment
2. Review, correct, and resubmit PREA acknowledgement forms submitted in the supplemental files.

Verification of Corrective Action since the audit:

The facility sent the auditor documentation on 5/13//2022 and 8/5/22 in response to the corrective actions.

77 PREA Acknowledgement Forms Submitted

The following actions were taken: NCCDC provided 77 PREA Acknowledgement Forms in the instances of hiring, promotion, and annually. The form affirms that in the past 12 months an employee has or has not incurred any of the following: Engaged in sexual abuse in a prison, jail, lock up, community confinement facility, juvenile facility, or other institutions; 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; been civilly or administratively adjudicated to have engaged in the activity described in this acknowledgment form and/or been investigated for or engaged in sexual assault or sexual harassment.

The following action was taken: NCCDC reviewed, corrected, and resubmitted PREA acknowledgement forms that were submitted incomplete at the time of the onsite audit.

Corrective Action #1 and #2

The intent of this corrective action was to ensure that staff at NCCDC had affirmed that in the past 12 months they have or have not incurred any of the following: Engaged in sexual abuse in a prison, jail, lock up, community confinement facility, juvenile facility, or other institutions; 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; been civilly or administratively adjudicated to have engaged in the activity described in this acknowledgment form and/or been investigated for or engaged in sexual assault or sexual harassment.

The intent of this corrective action was to ensure that all PREA Acknowledgement Forms were completed correctly.

115.318	Upgrades to facilities and technologies
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Interviews: 1. Director 2. Former Superintendent 3. Superintendent Site Review: 1. Central Control 2. Review of Physical Plant Findings (by Provision): 115.318 (a)-1: This provision is not applicable. During the interview with the director, it was stated that sexual safety and physical safety are considered when designing, acquiring, and planning modifications to facilities. Additionally, it was stated that there were no new facilities or substantial modifications to NCCDC. Both the superintendent and the former superintendent confirmed there were no substantial expansion or modifications to the facility. During the site review, the auditor did not observe any substantial expansion or modification from the prior PREA audit in 2018. The facility is substantially compliant with this provision. 115.318 (b)-1: Since the last PREA audit in 2018, there were two additional cameras installed. The facility has 151 cameras. According to the former superintendent, there was consideration when adding additional cameras to increase the ability to protect youth from sexual abuse. The facility is substantially compliant with this provision. Based on information provided by interview and the site review, DYRS has not acquired a new facility or made substantial expansion or modification to NCCDC since the last PREA audit in 2018. The NCCDC has installed two new cameras, and there was consideration for the ability to improve the ability to protect youth from sexual abuse. Based on this analysis, the facility is substantially compliant with this standard and there is no corrective action required. Best Practice Recommendations: 1. Add cameras to supervisor’s office if youth are to be counseled in that area with blinds. 2. Clean and repair all cameras of debris and insects. Check and realign cameras. 3. Add cameras to outside recreation area to improve view of basketball court and benches.

115.321	Evidence protocol and forensic medical examinations
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. DYRS Policy 2.13.IV.B.2-3 2. DYRS 2.13.IV.D.2.a-b 3. DYRS Policy 2.13.IV.E.4.a-b 4. State of Delaware Memorandum of Understanding for the Multidisciplinary Response to Child Abuse and Neglect pp 79-101 5. US Department of Justice's Office on Violence Against Women publication, "National Protocol for Sexual Assault Medical Forensic Examination, Adult/Adolescents" 6. Affirmation of Compliance with Forensic Examinations Standards for Sexual Assaults-Christiana Care Hospital 7. Affirmation of Compliance with Investigative Standards for Sexual Assaults with Delaware State Police Interviews: 1. Institutional Abuse (IA) 2. Survivors of Abuse Recovery, Inc. (SOAR) 3. Delaware State Police Department (DSP) 4. PREA Coordinator Findings (by Provision): 115.321(a)-1-4 DYRS Policy 2.13.IV.B.2 states that all allegations of sexual abuse or sexual harassment will receive an administrative and criminal investigation. The DYRS does not conduct criminal investigations. DYRS Policy 2.13.IV.B.3 states that all allegations of sexual abuse and sexual harassment that involve potentially criminal behavior will be referred to DSP by institutional abuse for joint investigation. When conducting sexual abuse investigations, there is an existing memorandum of understanding which was contained in the PAQ. It is titled the State of Delaware Memorandum of Understanding for the Multidisciplinary Response to Child Abuse and Neglect. Within the document there is the Child Sexual Abuse Protocol. Found in the protocol there is a description and mention of PREA mandates. All police departments within the state of Delaware have signed this document. According to the IA PREA investigator, there were no sexual abuse allegations at NCCDC referred by the Child Abuse Hotline within the last 12 months. The auditor located an investigative file alleging sexual abuse that was determined by the Child Abuse Hotline to be administrative. Further research found the sexual abuse allegations were found to be unsubstantiated. Based on this analysis, the agency substantially meets compliance for this provision 115.321(b) State of Delaware Memorandum of Understanding for the Multidisciplinary Response to Child Abuse and Neglect was developed for youth and children. During the auditor's review, the protocols appear to be developmentally appropriate for youth. The document does not specifically cite as the framework the US Department of Justice's Office on Violence Against Women publication, "National Protocol for Sexual Assault Medical Forensic Examination, Adult/Adolescents." Upon further investigation with the PREA coordinator, it was found that the framework from the US Department of Justice's Office was not utilized. Rather the protocol was developed based on best practice. The auditor continues to make a comparison of both documents, it was found that there were commonalities between the protocols. Items covered in the US Department of Justice's Office on Violence Against Women publication, "National Protocol for Sexual Assault Medical Forensic Examination, Adult/Adolescents: • Coordinated Team Approach • Informed Consent • Confidentiality • Reporting to Law Enforcement • Payment for the Examination Under VAWA • Sexual Assault Forensic Examiners • Facilities • Equipment and Supplies • Sexual Assault Evidence Collection • Timing Considerations for Collecting Evidence

- Evidence Integrity
- Initial Contact
- Triage and Intake
- Documentation by Health Care Personnel
- Medical Forensic History
- Photography
- Exam and Evidence Collection Procedures
- Alcohol and Drug-Facilitated Sexual Assault
- STI Evaluation and Care
- Pregnancy Risk Evaluation and Care
- Discharge and Follow-up
- Examiner Court Appearances

Majority of these key points were utilized in the creation of the State of Delaware Memorandum of Understanding for the Multidisciplinary Response to Child Abuse and Neglect.

In the Affirmation of Compliance with Forensic Examinations Standards for Sexual Assaults between the Christiana Care Hospital, SANE coordinator, the prior director of DYRS and the prior PREA coordinator, there is language in the document stating that the protocols employed at Christiana Care Hospital are appropriate for youth and adapted by the US Department of Justice's Office on Violence Against Women publication, "National Protocol for Sexual Assault Medical Forensic Examination, Adult/Adolescents" or similarly comprehensive and authoritative protocols.

Based on this analysis, the agency substantially meets compliance for this provision.

115.321(c)-1-10
In DYRS 2.13.IV.D.2.a-b, it is referenced that all medical personnel gathering physical evidence or engaged in legitimate medical treatment while investigating prison rape will do so in a hospital setting. Existing is the Affirmation of Compliance with Forensic Examinations Standards for Sexual Assaults between the Christiana Care Hospital SANE coordinator, the former director of DYRS, and the former PREA coordinator. The affirmation states that forensic examinations are made available without consideration of cost to the youth where evidentiary or medically appropriate. The affirmation assured those forensic medical examinations would be completed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) or other qualified medical practitioners. According to PREA coordinator, IA, and documentation provided in the PAQ, there were no forensic medical examinations sent to Christiana Care Hospital within the last 12 months. During the post audit stage, the Christiana Care Hospital's SANE/SAFE were interviewed. Additionally, the auditor decided to interview the other hospital listed in the Memorandum of Understanding for the Multidisciplinary Response to Child Abuse for forensic examinations of sexual abuse. During the onsite audit of NCCDC, the auditors visited and interviewed the representative of the Child Advocacy Center of Delaware an affiliation of AI Dupont/Nemours. According to the representative, there were no forensic examinations of sexual abuse victims from NCCDC within the last 12 months.

Based on this analysis, the agency substantially meets compliance for this provision.

115.321(d)-1-3
Through a memorandum of agreement, Survivors of Abuse Recovery, Inc. (SOAR) and YRS have an agreement for SOAR to provide victim support services to individuals who have been a victim of sexual abuse. The services include support during forensic medical examination and emotional support during the investigative process, and counseling while in custody.

DYRS Policy 2.13.IV.E.4.a-b, referenced that youth shall be made aware of community agencies, addresses and contact numbers of victim advocates that provide emotional support services related to sexual abuse. The division shall maintain a memorandum of agreement with one or more such agencies to ensure statewide service agreement. According to information provided in the PAQ, if victim advocate services are not available the facility would provide qualified DYRS licensed behavioral health clinicians to provide advocacy services. The auditor was unable to determine the use of victim advocacy services because there were no youth who reported sexual abuse during the random interviews. During the interview with SOAR, it was found that there was no request for victim advocacy services from NCCDC over the last 12 months. The PREA compliance coordinator stated that there is an existing MOU for victim advocacy services, and the document requires that qualified staff members would provide advocacy services.

Based on this analysis, the agency substantially meets compliance for this provision.

115.321(e)-1
Through a memorandum of agreement, Survivors of Abuse Recovery, Inc. (SOAR) and YRS have an agreement for SOAR to provide victim support services to individuals who have been a victim of sexual abuse. The services include support during forensic medical examination and emotional support during the investigative process, and counseling while in custody. In the affirmation between DYRS and Christiana Care Hospital there is reference that the hospital would make available to the victim, a victim advocate, qualified agency staff member, or a qualified community-based organization

member with support through the forensic medical examination process, investigatory interviews, and assist in providing emotional support, crisis intervention, information, and referrals. The auditors interviewed SOAR, and it was confirmed by the staff of SOAR that the agency had an affirmation with DYRS. During an interview with SOAR, it was confirmed that the services listed in the affirmation were still available to victims at NCCDC.

Based on this analysis, the agency substantially meets compliance for this provision.

115.321(f)-1
Criminal investigations at the NCCDC are conducted by the DSP. DYRS and the DSP has implemented the Affirmation of Compliance with Investigative Standards for Sexual Assaults. Additionally, there is the State of Delaware Memorandum of Understanding for the Multidisciplinary Response to Child Abuse and Neglect. Both documents include the requirements mandated by PREA Standard 115.321(a)-(e).

Based on this analysis, the agency substantially meets compliance for this provision.

The evidence shows that DYRS is responsible for conducting administrative sexual abuse investigations in cases that Child Abuse Hotline screens out the allegations. When it is determined that the allegations meet the criminal threshold by IA, criminal sexual abuse allegations are conducted by the DSP in conjunction with IA. The State of Delaware Memorandum of Understanding for the Multidisciplinary Response to Child Abuse and Neglect, the Affirmation of Compliance with Forensic Examinations Standards for Sexual Assaults, and the Affirmation of Compliance with Investigative Standards for Sexual Assaults are developmentally appropriate protocols for youth. The three protocols are an adaption of the US Department of Justice's Office on Violence Against Women publication, "National Protocol for Sexual Assault Medical Forensic Examination, Adult/Adolescents." DYRS provides forensic medical examinations utilizing the SANE/SAFE from Christiana Care Hospital. Residents are provided victim advocacy services from SOAR, a community-based victim advocacy agency.

Based on this analysis, the agency substantially meets compliance for this standard and no corrective action is needed at this time.

115.322	Policies to ensure referrals of allegations for investigations
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. Policy 2.13 Division of Youth Rehabilitative Services Prisoner Rape Elimination Act (PREA) 2.13 Section IV, B, pp 2-3, G, 1-3, page 8, (Revised 5/13/21). 2. Policy 2.13 Division of Youth Rehabilitative Services Prisoner Rape Elimination Act (PREA) Sexual Incident Form Attachment A. 3. Policy 2.13 Division of Youth Rehabilitative Services Prisoner Rape Elimination Act (PREA) Investigative Summary Template Attachment B. 4. Policy 2.13 Division of Youth Rehabilitative Services Prisoner Rape Elimination Act (PREA) Substantiated Sexual Abuse or Sexual Harassment Form Attachment C. 5. Policy 2.13 Division of Youth Rehabilitative Services Prisoner Rape Elimination Act (PREA) Notification of Investigation Attachment D. 6. Policy 2.13 Division of Youth Rehabilitative Services Prisoner Rape Elimination Act (PREA) Sexual Abuse Incident Review of Substantiated or Unsubstantiated Investigations Attachment E 7. Policy 2.12 Division of Youth Rehabilitative Services Professional Practices Reportable Events Section III A-5, B-1 page 1, (Revised 6/27/14). 8. Policy 208 Institutional Abuse Section V A-E, page 2, (revised 6/8/16). 9. Child Sexual Abuse Protocol Memorandum of Understanding (2/6/17), (pp. 5) Interviews: 1. Agency head 2. Investigative staff Findings (by Provision): 115.322 (a) 1-5: In the PAQ, the agency reported they ensure that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment. Although a policy is not required for this provision, the agency relies on Policy 2.13 Division of Youth Rehabilitative Services Prisoner Rape Elimination Act (PREA) Section IV, B, page 2-3, that states all allegations of sexual abuse or sexual harassment will receive an administrative and criminal investigation. The policy outlines that all allegations of sexual abuse and sexual harassment that involve potentially criminal behavior will be referred to the Delaware State Police or Milford Police by institutional abuse for joint investigation. A review of Policy 208 Institutional Abuse Section V, page 2, outlines that the Institutional Abuse Investigation Unit will screen reports of alleged sexual abuse by a DSCYF employee, investigate utilizing DFS Institutional Abuse Investigation Protocol policy and procedures, formulate findings and cite concerns obtained during the investigation and distribute findings and cite concerns to be distributed to the appropriate division or external entity. The facility reported in the PAQ there was one sexual abuse and sexual harassment allegations reported in the past 12 months that resulted in an administrative investigation and no allegations referred for criminal investigation in the past 12 months. In the PAQ, the facility reported all allegations received during the last 12 months for an administrative investigation was completed. The auditor was able to review three allegations of sexual abuse or sexual harassment reported during the 12 months preceding the onsite audit. In review of the three allegations, two of the three allegations resulted in an administrative investigation and one was undetermined as no investigative report was provided. During an interview, the agency head stated that they do ensure that administrative and criminal investigations are completed. Institutional Abuse investigates administrative allegations and criminal allegations which might be in conjunction with Delaware State Police. During an interview, Delaware State Police (DSP) reported that there were no criminal cases of sexual abuse or sexual harassment reported to the department for New Castle County Detention Center (NCCDC). During an interview, Internal affairs investigator stated that the agency has a policy that requires that allegations of sexual abuse and sexual harassment be referred for investigation. Referrals for investigation is completed immediately. The evidence shows that during the past 12 months there was one allegation that that was not completed. This information was verified through the PAQ, interviews, policy, and documentation review. Based upon this analysis, the auditor finds the facility is not substantially compliant with this provision and corrective action is required.

115.322 (b) 1-3:

In the PAQ, the agency reported that they have a policy that requires allegations of sexual abuse or sexual harassment be referred for investigation to an agency with the legal authority to conduct criminal investigations, including the agency if it conducts its own investigations, unless the allegation does not involve potentially criminal behavior.

Policy 2.13 Division of Youth Rehabilitative Services Prisoner Rape Elimination Act (PREA) Section IV, G, 1-3, page 8, outlines that all allegations of any sexual abuse or sexual harassment are reported to the child abuse hotline and screened for institutional abuse investigation. Institutional abuse may complete a joint investigation with the Delaware State Police or Milford Police for allegations that involve potentially criminal behavior. Institutional abuse will investigate all matters involving staff actions that may not be potentially criminal behavior but still violates PREA. Any allegation that Institutional abuse does not investigate will be administratively investigated by facility PREA investigators.

In the PAQ, the facility outlined in the Child Sexual Abuse protocol (MOU), page 5, a civil offense of sexual abuse as any sexual contact, sexual intercourse, or sexual penetration as defined in the Delaware Criminal Code between any individual and a child. This protocol outlines that DFS must make an immediate report to the appropriate law enforcement jurisdiction for all civil offenses identified in the sexual abuse protocol and document its contact with the appropriate law enforcement agency.

In the PAQ, the agency reported the policy regarding referral of allegations of sexual abuse or sexual harassment for criminal investigation is published on the agency's website or made publicly available via other means. The agency provides that Policy 2.13 Division of Youth Rehabilitative Services Prisoner Rape Elimination Act PREA (https://kidsfiles.delaware.gov/policies/yrs/2.13_PREA_PrisonRapeElimi nationAct.pdf) is publicly available. The auditor reviewed the agency's website and determined that Policy 2.13 Division of Youth Rehabilitative Services Prisoner Rape Elimination Act (PREA) is available on the website.

The agency relies on Policy 2.12 Reportable events as evidence that all referrals of allegations of sexual abuse or sexual harassment for criminal investigation is documented. As written, the policy does not outline sexual abuse and sexual harassment as a reportable event.

The auditor was able to determine that there was no criminal cases of sexual abuse or sexual harassment received during the audit period for the New Castle County Detention Center.

During an interview, facility investigator stated that all allegations of sexual abuse and sexual harassment are referred to the Delaware State Police. The auditor was able to interview a Detective with the Delaware State Police who was responsible for conducting criminal investigations for allegations of sexual abuse and sexual harassment. Delaware State Police reported they have not had any sexual abuse or sexual harassment cases in the last 12 months that occurred at the facility.

The evidence shows that the agency has a policy that outlines the investigation process but does not specifically outline sexual abuse and sexual harassment as a reportable event. The agency Child Sexual Abuse protocol (MOU), does establish a reporting requirement to the appropriate law enforcement for all criminal offenses identified in the sexual abuse protocol and documenting that contact. Based upon this analysis, the auditor finds the facility is substantially compliant with this provision and corrective action is not required.

115.322 (c):

Policy 2.13 Division of Youth Rehabilitative Services Prisoner Rape Elimination Act (PREA) Section IV, G-1, describes the responsibility for conducting criminal investigations for Institutional Abuse and Delaware State Police. The agency's policy is published on the agency's website that identifies the agency and Delaware State Police for conducting joint criminal investigations.

During an interview, facility investigator stated that all allegations of sexual abuse and sexual harassment are referred to the Delaware State Police. The auditor was able to interview a Detective with the Delaware State Police who was responsible for conducting criminal investigations for allegations of sexual abuse and sexual harassment. Delaware State Police reported they have not had any sexual abuse or sexual harassment cases in the last 12 months that occurred at the facility. Delaware State Police (DSP) was able to described to the auditor how they would process an allegation of sexual abuse. Once DSP receives the phone call, a detective is called out to the scene, they would get the victim to the hospital, have an evidence technician on the scene to gather evidence bring a video van, interview with victim and witnesses. We can have 10 detectives to assist as this is handled as a criminal investigation.

Based upon this analysis, the auditor finds the facility is substantially compliant with this provision and corrective action is not required.

Based upon this analysis, the auditor finds the facility is not substantially compliant with this standard and corrective action is required.

Corrective Action:

1. Ensure that all allegations of sexual abuse and sexual harassment is completed.
2. Train investigative staff of this requirement.
3. Document that staff have received training

Best Practice Recommendations:

1. Revise Policy 2.12 Reportable events to include Sexual Abuse and Sexual Harassment is documented as a reportable event.
2. Train staff and document that staff have received training.

Verification of Corrective Action since the audit:

The facility sent the auditor documentation on 7/27/22 and 7/28/22 in response to the corrective action recommendations.

1. Provided non-critical reportable event form and Sexual Incident form (8 pages)

2. Provided PREA Resource Center (PRC) Specialized Training Investigating Sexual Abuse in Correctional Setting Training Curriculum. (75 pages).

3. Provided Staff training acknowledgements (1 page).

The following action were taken: DYRS provided PREA investigations training agenda that included PRC module 7 interviewing Juvenile Sexual Abuse Victims, Module 8 report writing, agency PREA policy 2.13, PREA incident forms and sexual abuse incident review team. The agency trained one facility investigator on the PREA investigation training and documented that the staff received the training.

Corrective Action #1

The intent of this corrective action was to ensure that administrative or criminal investigations were referred and completed for all allegations of sexual abuse and sexual harassment. The facility reported they had two allegations of sexual abuse and no sexual harassment after onsite audit. Currently, the two sexual abuse allegations are pending investigation with the Delaware State Police. Once the facility receives notification that the investigations have concluded, the facility will conduct an administrative investigation. This satisfies the auditor's corrective action requirement.

Corrective Action #2 and #3

The intent of this corrective action was to ensure that facility investigative staff received investigative training and that the training was documented. The agency provided a PREA Resource Center (PRC) Specialized Training Investigating Sexual Abuse in Correctional Setting Training Curriculum (75 pages). The facility provided one page training roster that included one staff signature acknowledging that they were trained on Specialized Training Investigating Sexual Abuse in Correctional Setting on 7/25/22. This satisfies the auditor's corrective action requirement.

Based on review of the information received, the auditor finds the facility substantially compliant with this standard.

115.331	Employee training
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. DYRS Policy 2.13.IV.C.1.a-d 2. DSCYF Academy Staff Training PowerPoint-Updated 2021 3. PREA Refresher Training Roster 4. Staff Roster 5. PAQ Interviews: 1. Random Staff 2. PREA Coordinator 3. Training Administrator Findings (by Provision): 115.331 (a)-1-11: All new hires are provided PREA training during their orientation at the Center for Professional Development. All employees are to complete refresher training every 2 years. Though not required, DYRS has implemented Policy 2.13.IV.C.1.a-d to address PREA training for all department staff working directly with or monitoring programs/services of youth in secure care must receive PREA training. In the policy, employees include agency employees, contractors, and volunteers. Further, the policy details that the Center for Professional Development will provide the training to all new DYRS employees during orientation. In the case of contractors and volunteers, PREA training is completed by the volunteer and contractor coordinator. Lastly, the training will include, but not be limited to, complaint recipient responsibility, how to report an incident, coordinated responses duties, investigations, and how to access victim services. The auditors were provided the training material in the PAQ. The initial PREA training is provided in person, and instructions are led utilizing a PowerPoint presentation which is based on the revised DYRS policy 2.13. Located in the Academy Staff Training on slide 6, there is specific language that addresses the agency's Zero-Tolerance Policy. The slide was titled PREA Policy Basics. The slide read DYRS commits to full compliance with the Prison Rape Elimination Act (PREA). There are two statements that are bulleted. The first bullet states DYRS has a zero-tolerance for any incidence of sexual abuse of youth in our care, and the last bullet details 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 is criminal and prohibited.

DSCYF Academy Staff Training PowerPoint Presentation	
>Subject Matter	>Slide Number
Agency's Zero-Tolerance Policy for sexual abuse and sexual harassment	>Slides 6-8
Responsibilities of prevention, detection, reporting, and response policies and procedures	>Slides 44-64
Right of residents to be free from sexual abuse and sexual harassment	>Slides 9-12
Right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment	>Slide 54
Dynamics of sexual abuse and sexual harassment	>Slides 34-43
Common Reactions of juvenile victims of sexual abuse and sexual harassment	>Slides 41-43
How to detect and respond to signs of threatened and actual sexual use and how to distinguish between consensual sexual contact and sexual abuse between residents	> Slides 11-25 Slides 42-43
How to avoid inappropriate relationships with residents	>Slides 72-92
How to communicate effectively and professionally with residents including lesbian, gay, bisexual, transgender, intersex, or gender non-conforming residents	>Slides 65-78
How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities	Slides 50-52
Relevant laws regarding the applicable age of consent	Slides 15-25

Utilizing the PREA protocols for random staff, the auditors found that all twelve random staff interviewed stated that they had received PREA training and PREA refresher training.

The facility substantially meets compliance in this provision.

115.331(b)-1-2

During interviews with the PREA coordinator and the training administrator, it was found there was no separate training for female and male facilities. Staff is provided comprehensive training to work with both males and females. Review of training materials gave no indication of gender specific based training.

The facility substantially meets compliance in this provision.

115.331(c)1-2

In accordance with DYRS Policy 2.13.IV.C.1.b-c, employees are required to participate in PREA refresher trainings. During the interview with the training administrator, it was found that the refresher training is provided online. Based on information obtained from the randomly interviewed staff, they received PREA refresher trainings. Based on the PAQ, the PREA refresher training is completed annually.

During the onsite audit comparison of staff rosters and the PREA training refresher roster, the auditor was able to determine that 49 of 106 staff members had received the PREA refresher training within the last 12 months. It should be mentioned that 13 individuals were hired within 12 months and received PREA training through the Center of Professional Development. Comparison of the rosters netted nine new hirers were still employed at NCCDC. Out of the nine, there were three duplicated on the staff roster and the PREA refresher roster.

Though the PREA refresher is provided annually, there was no record of PREA refresher from the preceding year. In years in which there was not a refresher training, there was no evidence in staff files of refresher information distributed on current

sexual abuse and sexual harassment policies.

The facility did not meet compliance in this provision.

115.331(d)-1

The auditor received a roster of completion of the PREA refresher training, but this information may not have been an electronic verification that the employees understood the PREA training, but rather a verification that the individual participated in the training. According to the training director employees are provided a prompt that confirms that there is understanding of training.

The facility substantially meets compliance in this provision.

The evidence has proven that all staff receive a comprehensive PREA training during orientation. The training meets all PREA standard requirements of 115.331(a). NCCDC has provided PREA Refresher training to 46% of the staff. The facility does not substantially or consistently provide the necessary PREA Refreshers. According to the training director, acknowledgements of understanding are maintained in the training database.

Based upon this analysis, the facility does not meet compliance with this standard and corrective action is required.

Corrective Action:

1. All staff need to complete PREA Refresher training every 2 years. In years that there is no refresher training, there needs to be evidence of the agency providing refresher information on current sexual abuse and sexual harassment policies.

Best Practice Recommendations:

1. Maintain a copy of individualized transcripts from Learning Management System in employee file.
2. Provide documentation in employee file by either employee signature or electronic verification that employees understand the PREA training received in accordance with 115.311(d).

Verification of Corrective Action since the audit:

The facility sent the auditor documentation on 8/4/2022 and 8/5/2022 in response to the corrective action recommendation.

1. Provided PREA Refresher Training Progress Summary
2. Provided List of Active Staff indicating staff on leave
3. Provided List of Termination and Promotion of staff since 4/21/2022 (last day of onsite PREA audit)

The following action was taken: DYRS provided PREA Refresher Training

Corrective Action #1

The intent of this corrective action was to ensure staff that encounter and interact with youth at NCCDC were provided PREA Refresher Training. The facility provides online refresher training annually.

The facility provided the PREA Refresher Training Progress Summary, the List of Active Staff indicating staff on leave, and the List of Terminated and Promoted Staff since the onsite PREA Audit. When tallied the facility trained nearly 80% of active staff. This satisfies the auditor’s corrective action requirement.

Based on review of the information received, the auditor finds the facility substantially compliant with this standard.

115.332	Volunteer and contractor training
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. DYRS 2.13.III 2. DYRS 2.13.IV.C.1 3. NCCDC PREA Presentation Refresher 4. NCCDC Orientation Checklist 5. NCCDC Contractor-Volunteer Chart Revised 3-4-2022 6. Volunteer Files 7. Contractor Files 8. Volunteer Application 9. Contractor Onboarding Guide Interviews: 1. Volunteers 2. Contractors 3. Volunteer and Contractor Coordinator Findings (by Provision): 115.332 (a):-1-2 According to DYRS 2.13.III, staff is defined as any Department employee, volunteer, contractor, official visitor, or other agency representative. Further in DYRS 2.13.IV.C.1, all department staff working directly with or monitoring programs/services of youth in secure care must receive PREA training. In accordance with sections of the DYRS Policy 2.13, volunteers and contractors are to be trained on the agency's zero-tolerance policy for sexual abuse and sexual harassment. The volunteer and contractor coordinator provided detailed procedures and files pertaining to both volunteers and contractors. The information was provided via the PAQ, supplemental files, and interview. The auditor was provided the NCCDC Contractor-Volunteer Chart. The document listed the names, status, program, business/organization, email, phone number, and criminal background check. There were nine contractors and two volunteers. Within the supplemental files were copies of the volunteer and contractor files which contained NCCDC Policy and Information Checklist that is utilized during orientation. Within the packet was a signature page that stated that the participant read and agreed to abide by the DYRS PREA Policy 2.13. Also, located was the NCCDC PREA Presentation utilized for training volunteers and contractors. During the interview with the volunteer and contractor coordinator, the auditor was provided the Volunteer Application and the Contractor Onboarding Guide. It was also confirmed that the coordinator provides the PREA related training to the volunteers and coordinators. In the PAQ, it was indicated that there were 11 volunteers and contractors. During the onsite audit, the auditors were provided a roster for both volunteers and contractors. There were nine contractors and there were two volunteers. There was a total of 11 volunteer and contractors folders available for the auditors to review. All 11 folders contained evidence of the completion of the checklist that acknowledges they received orientation. Based on the information provided in the packets, the volunteers receive training specific to PREA. From the list provided by the volunteer and contract coordinator, the auditor interviewed two volunteers and two contractors by telephone. All the volunteers and contractors recalled some form of training pertaining to PREA during the orientation at NCCDC. The volunteers and the contractors stated there was training pertaining to PREA and the agency's zero-tolerance for sexual abuse and sexual harassment. It should be mentioned that the volunteer and contract coordinator is responsible for contracts that provide activities for residents not the medical contract. The agency does meet compliance in this provision. 115.332(b)-1-2 The auditor determined that volunteers and contractors are provided orientation to the facility. The volunteer and contract coordinator provided the NCCDC Orientation Checklist. Upon completion, the checklist is initialed by the participants. Found

	within the volunteer and contractor's files were copies of a signature page which established the participant read and will abide by the guidelines of the DYRS PREA Policy 2.13. During interviews with the coordinator, volunteers and contractors it was disclosed the facility utilizes the NCCDC PREA Presentation during the orientation process. Review of all nine files, the auditor determined that volunteers and contractors are trained in the agency's zero-tolerance policy regarding sexual abuse and sexual harassment or the agency's policies and procedures regarding sexual abuse and sexual harassment prevention, detection, and response. There was evidence of this information provided in the files. The agency does meet compliance in this provision. 115.332 (c)-1 Based on the review of the nine volunteer and contractor files, the auditor concluded that the volunteer and contractor coordinator does maintain all the folders of volunteers and contractor's orientation documentation. Additionally, there was evidence provided in the PAQ of maintenance of this information. The agency does meet compliance in this provision. NCCDC was able to provide evidence that all volunteers and contractors are trained on their responsibilities under the agency's policies and procedures regarding sexual abuse and sexual harassment. The facility's orientation is in depth and provided by the volunteer and contractor coordinator. The training includes the agency's zero-tolerance policy regarding sexual abuse and sexual harassment. Files are maintained by the volunteer and contract coordinator. Based on this analysis, the facility does substantially meet compliance with this standard and corrective action is not required.

115.333	Resident education
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. DYRS 2.13.IV.C.2 2. DYRS Policy 2.13.IV.C.2.c 3. DSCYF Policy 118 4. NCCDC Handbook- English and Spanish p. 4-5 5. Intake Process Form 6. Youth PREA Pamphlet “What You Need to Know About Sexual Assault, Harassment, and Abuse”” 7. NCCDC PREA Orientation and Resident Safety Guide Acknowledgement Form 8. NCCDC PREA Comprehensive Training Acknowledgement Form. 9. NCCDC Parent/Guardian Safety Guide Interviews: 1. Intake Staff 2. Random Youth Site Review: 1. Intake Process Findings (by Provision): 115.333 (a): 1-3 According to DYRS Policy 2.13.IV.C.2, all youth in secure care shall receive PREA orientation and comprehensive training. Further, the policy states that during the intake process, youth shall receive information explaining the zero-tolerance rule regarding sexual abuse and sexual harassment and how to report incidents or suspicions of sexual abuse or sexual harassment. The intake staff detailed that youth receive information about the agency’s zero-tolerance policy during the intake process. Also, youth are provided information through a pamphlet on how to report incidents or suspicions of sexual abuse and sexual harassment. At the end of the intake process, youth sign a roster confirming receiving information. Additionally, the intake staff member shared that those from other facilities obtain information about the agency’s zero-tolerance policy on sexual abuse and sexual harassment from the PREA intake orientation. There was ambiguity regarding whether a PREA video was shown during the intake process and/or the comprehensive PREA training. Located in the supplemental files of OAS, the auditor was provided the PREA Acknowledgment Roster which is signed after the PREA orientation during intake. Review of the roster, the auditor determined that there were only 25 out of 431 youth provided PREA orientation at intake since April 2021.During the intake process, the auditor observed that the PREA information was not readily available. During the site observation of the intake process, the PREA information was not in the intake area, but it was handed to the intake worker by another employee. Youth were asked if they had received the facility’s rules against sexual abuse and sexual harassment during the intake process. Of the 12 youth, there were 11 that confirmed they did receive the rules against sexual abuse and sexual harassment during intake. During the review of PREA Acknowledgement Roster, there were minimal youth that had signed that they had received PREA orientation. The auditor was unable to locate any of the names of youth selected for file review on the PREA Acknowledgement Roster. Located in the supplemental files were copies of two different types of forms that the auditor determined to be utilized for either PREA orientation or PREA comprehensive training. There were 79 NCCDC PREA Orientation and Resident Safety Guide Acknowledgement Forms and 12 NCCDC PREA Comprehensive Training Acknowledgement Forms. Neither form equated to the number of youth that should have received either the PREA orientation or the PREA comprehensive training within the last 12 months at NCCDC. The facility does not meet compliance in this provision. 115.333(b)-1

According to DYRS 2.13.IV.C.2, all youth in secure care shall receive PREA orientation and comprehensive training. The policy requires within 10 days of intake the secure care program is responsible for implementing a comprehensive PREA education. Within the supplemental files of the OAS, the auditor was provided the following documents:

1. “What You Need to Know About Sexual Assault, Harassment, and Abuse””
2. PREA Orientation Information – Orientation Group (Day 2)- p.4
3. NCCDC Youth Safety Guide
4. NCCDC Handbook both English and Spanish

It was unclear when the above documents were introduced into either the PREA orientation or the PREA comprehensive trainings. During the onsite audit, the auditor did inquire about the use of a student handbook at the facility. During pre-onsite review, the auditor was provided a copy of the facility’s handbook which is provided to youth during the comprehensive PREA training. On pages 4-5 of The NCCDC Handbook, the auditor discovered there is information pertaining to PREA. There is information provided about zero-tolerance of sexual abuse and sexual harassment. Review of the handbook, the auditor determined there are several ways listed to report sexual abuse.

The auditor inquired of the youth if they were informed about their right not to be sexually abused or sexually harassed. Of the twelve random youth interviewed, there were twelve youth who affirmed that they were aware. The auditor questioned the youth if they were aware of how to report sexual abuse and sexual harassment, and the random twelve youth said that they were aware. Additionally, they were aware that they had a right not to be punished for reporting sexual abuse or sexual harassment. Youth were asked when they received the information. The youth stated that they learned it during PREA training. The youth did not differentiate whether it was PREA orientation or the comprehensive PREA training. The auditor determined through review of the twelve random youth files that there were 11 youths that received the PREA comprehensive training either on 4/10/2022 or 4/11/2022. Many of those youth did not receive the PREA comprehensive training within the 10 days, and they had not received the PREA comprehensive training until the pre onsite phase of the PREA audit.

Located in the supplemental files were copies of two different types of forms that the auditor determined to be utilized for either PREA orientation or PREA comprehensive training. There were 79 NCCDC PREA Orientation and Resident Safety Guide Acknowledgement Forms and 12 NCCDC PREA Comprehensive Training Acknowledgement Forms. Neither form equated to the number of youth that should have received either the PREA orientation or the PREA comprehensive training within the last 12 months at NCCDC.

The facility does not meet compliance in this provision.

115.333(c)-1-4

During the review of the twelve youth files, there were only eleven files that contained evidence that youth received comprehensive PREA training. None of the 12 youth files contained evidence that youth received PREA orientation. There was an Acknowledgement Roster provided in the supplemental files, but there were none of the twelve-youth names present on the roster.

Based on the review of the 12 youth files, youth were not necessarily provided PREA orientation within the 10 days of intake. NCCDC did subsequently provide PREA orientation to youth during the pre-onsite phase of the audit.

Stated in DYRS Policy 2.13.IV.C.2.c states any resident who transfers to a different facility must immediately be taught about any difference in the policies and procedures at the new facility. The intake staff confirmed that all intakes are given the same PREA orientation no matter if they are from the community or a transfer from another facility.

DYRS substantially meets compliance in this provision.

115.333(d)-1-5

Youth PREA education is available for limited English proficient youth. Spanish is the second language spoken in Delaware. NCCDC Safety Guide-Spanish was uploaded in the PAQ.

Upon auditor’s request, the Spanish version of the handbook was provided in the supplemental files of the OAS. Based on the English version of the handbook, there is information provided pertaining to sexual abuse and sexual harassment. There is an existing contract to provide interpretative and translation services for limited English proficient youth. For youth that are deaf, there are vendors on the state contract that can provide sign language services at no cost to the youth. NCCDC has the capability to enlarge PREA training materials for youth that are visually impaired. Youth are not provided a PREA video for the students that may have disabilities.

DSCYF Policy 118 ensures that youth with disabilities are given the same information to prevent, detect, and respond to sexual abuse and sexual harassment in a format supportive of the disability. Additionally, DYRS Policy 2.13.IV.C.2.d cites

each facility must ensure that youth with language barriers or 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 language barrier or disability.

The agency does not meet this provision.

115.333(e)-1

The auditor determined that the facility inconsistently maintains documentation of youth participation in PREA related training. During review of the student files, there was limited documentation maintained in youth files of PREA education. Inconsistently, the auditors located the documentation for PREA orientation being completed at intake and documentation of the completion of comprehensive PREA training. Located in the supplemental files were copies of two different types of forms that the auditor determined to be utilized for either PREA orientation or PREA comprehensive training. There were 79 NCCDC PREA Orientation and Resident Safety Guide Acknowledgement Forms and 12 NCCDC PREA Comprehensive Training Acknowledgement Forms. Neither form equated to the number of youth that should have received either the PREA orientation or the PREA comprehensive training within the last 12 months at NCCDC.

The facility does not meet compliance in this provision.

115.333(f)-1

NCCDC consistently ensure that the agency's PREA policy is continuously and readily available. During the site review, the auditor observed that there were in English and Spanish PREA related posters around the facility and there were victim advocacy posters. During the site review, there were several locations that contained PREA related pamphlets. Also, the facility had a PREA poster contest.

The auditor did locate brochures on sexual safety and victim advocacy at the entrance and throughout the building. All information pertaining to contacting the Child Abuse Hotline was correct.

The evidence shows that the NCCDC inconsistently provides information at the time of intake about the agency's zero-tolerance and how to report incidents or suspicions of sexual abuse and sexual harassment. The facility does not consistently provide comprehensive PREA training within 10 days of intake. The DYRS Policy 2.13 does state that youth that are transferred are to receive PREA training. The agency does not provide PREA education in formats such as a video that would be accessible to all youth including students that are limited English proficient or disabled.

Based on the analysis, the facility does not meet compliance, and corrective action is required.

Corrective Action:

1. Provide PREA orientation at intake.
2. Provide comprehensive PREA Orientation within 10 days of intake in accordance with PREA Standard 115.333(b).
3. Document and maintain both PREA orientation and PREA comprehensive training in the youth files.
4. Include in PREA training an age-appropriate video for students that may have disabilities.

Verification of Corrective Action since the audit:

The facility sent the auditor documentation on 5/3/2022, 5/9/2022, 5/13/2022, 6/3/2022, 6/10/2022, 6/27/2022, 7/1/2022, and 8/1/2022 in response to the corrective actions.

1. Provided Rosters and PREA Orientation and Resident Safety Guide Acknowledgement Forms
2. Provided Rosters and New Castle County Detention Center PREA Comprehensive Training Acknowledgement Forms
3. Provided Letter of Affirmation of the utilization of YouTube video titled PREA Training Juvenile located at https://www.YouTube.com/watch?v+TRq Jd_tZh1A

The following action was taken: NCCDC provided PREA Orientation to all admitted youth. Rosters were maintained and acknowledgement signed by youth.

The following action was taken: Within 10 days of admittance, NCCDC provided PREA Comprehensive Training to all youth. Rosters were maintained and acknowledgements signed by youth.

The following action was taken: NCCDC implemented the use of an age- appropriate PREA video to supplement PREA instruction.

	Corrective Action #1 and #2 The intent of this corrective action was to ensure that youth are provided PREA orientation at intake and comprehensive PREA training within 10 days of admittance to NCCDC. Corrective Action #3 The intent of this corrective action was to ensure that the facility maintains documentation of both the PREA orientation at intake and PRE comprehensive training within 10 days of admittance. Corrective Action #4 The intent of this corrective action was to ensure that facility provided an age appropriate PREA video to supplement instruction for all youth at NCCDC. The facility regularly provided PREA orientation and comprehensive documentation via the supplemental upload. Based on review of the information received, the auditor finds the facility substantially compliant with this standard.

115.334	Specialized training: Investigations
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. DYRS Policy 2.13.IV.4.C.3.a 2. DSCYF Policy 208.I 3. DSCYF Policy 208.V.a-f 4. PAQ 5. Certificates for PREA: Investigating Sexual Abuse in a Confinement Setting 6. Certificate for PREA: Investigating Sexual Abuse in a Confinement Setting: Advanced I 7. NIC Website- https://nicic.gov/specialized-training-investigating-sexual-abuse-confinement-settings 8. Certificate: PREA Investigations Training hosted by the Delaware Department of Corrections Interviews: 1. Institutional abuse investigator (IA) 2. Facility PREA investigator Findings (by Provision): 115.334 (a)-1 DYRS Policy 2.13.IV.4.C.3.a specifically states PREA investigators are required to complete specialized training in conducting investigations in confinement settings. This training will include training about techniques for interviewing juvenile sexual abuse victims, proper use of Miranda and Gary warnings, how to collect evidence after sexual abuse incidents and what criteria and evidence are needed to substantiate a case. During interviews with IA PREA investigator and the NCCDC PREA investigator, it was determined both investigators had received training in NCIC PREA: Investigating Sexual Abuse in a Confinement Setting. They recalled several topics that were included in the training. Review of three allegations of sexual abuse and sexual harassment, the auditor determined there was one administrative allegation of sexual harassment that was investigated by a NCCDC PREA investigator. The remaining allegation of sexual abuse and an undetermined allegation were investigated by individuals who later became certified to investigate PREA allegations. Review of training documents provided through the PAQ, indicated there were four certifications for two IA PREA investigators. There were two certificates for PREA: Investigating Sexual Abuse in a Confinement Setting and there were two certificates for PREA: Investigating Sexual Abuse in a Confinement Setting: Advanced Investigations. Both trainings were three-hour online trainings. The trainings were provided by the National Institute of Corrections Training (NIC). Also included in the PAQ were six certifications for three NCCDC PREA investigators. There were three certificates for PREA: Investigating Sexual Abuse in a Confinement Setting and there were three certificates for PREA: Investigating Sexual Abuse in a Confinement Setting: Advanced Investigations. Both trainings were three-hour online trainings. The trainings were provided by the National Institute of Corrections Training (NIC). The agency does not meet this provision. 115.334 (b)-1 During the interviews with PREA investigative staff, it was disclosed receiving the specialized training in conducting sexual abuse investigations in confinement settings. There was recollection that the training received included securing the crime scene, criteria for substantiating a case, collecting circumstantial evidence, and interviewing of witnesses and alleged perpetrators. According to the website, the following topics are covered in the three-hour online training: 1. PREA Update and Standards Overview 2. Legal Issues and Liability 3. Culture 4. Trauma and Victim Response 5. Medical and Mental Health Care 6. First Response and Evidence Collection 7. Juvenile/Adult Interviewing Techniques

8. Report Writing
9. Prosecutorial Collaboration

The agency substantially meets this provision.

115.334(c)-1-2
NCCDC maintains copies of the certificates for PREA investigators. Uploaded on the PAQ, there were 10 certificates of the trainings completed by the IA PREA investigators and NCCDC PREA investigators.

The agency substantially meets this provision.

115.334(d)-1
Auditors are not required to audit this provision.

DYRS provides required specialized investigation training to both IA PREA investigators and NCCDC PREA investigators. The agency maintains copies of the PREA investigator's certificates. The training provided includes required topics mandated by PREA standard 115.334(b).

The agency does not meet this standard and corrective action is needed at this time.

Corrective Action:

1. Prior to investigating sexual abuse and sexual harassment, investigators must be trained in NCIC PREA: Investigating Sexual Abuse in a Confinement Setting.
2. Retrain NCCDC PREA investigators in

- Response and Evidence Collection
- Juvenile/Adult Interviewing Techniques
- Report Writing

Verification of Corrective Action since the audit:

1. The facility sent the auditor documentation on 7/27/22 and 7/28/22 in response to the corrective actions.
2. Certificate of an additional NCCDC PREA Investigator
3. Retraining materials Provided PREA Resource Center- Specialized Training Investigating Sexual Abuse in Correctional Setting Training Curriculum
4. Provided Staff training acknowledgements
5. NCCDC PREA Investigators summary of NCIC- retraining

The following actions were taken: An additional PREA Investigator was trained utilizing the NCIC PREA Investigation Training in Confinement Settings.

The following action was taken: DYRS provided PREA investigations training agenda that included interviewing Juvenile Sexual Abuse Victims, report writing, and the agency PREA policy 2.13 which included attachments PREA incident forms. The agency retrained one facility investigator on the PREA investigation training and documented that the staff received the training. Additionally, staff that needed retraining summarized the initial training from the NCIC training.

Corrective Action #1

The intent of this corrective action was to ensure that facility investigative staff received investigative training and that the training was documented. The agency provided a PREA Resource Center (PRC) Specialized Training Investigating Sexual Abuse in Correctional Setting Training Curriculum (75 pages). The facility provided one page training roster that included one staff signature acknowledging that they were trained on Specialized Training Investigating Sexual Abuse in Correctional Setting on 7/25/22. This satisfies the auditor's corrective action requirement.

Corrective Action #2

The intent of this corrective action was to ensure that administrative or criminal investigations were referred and completed for all allegations of sexual abuse and sexual harassment. The facility reported they had two allegations of sexual abuse and no sexual harassment after onsite audit. Currently, the two sexual abuse allegations are pending investigation with the Delaware State Police. Once the facility receives notification that the investigations have concluded, the facility will conduct an administrative investigation. This satisfies the auditor's corrective action requirement.

Based on review of the information received, the auditor finds the facility substantially compliant with this standard.

115.335	Specialized training: Medical and mental health care
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. DYRS Policy 2.13.IV.C.3.b 2. DYRS Policy 2.13.III.3.A 3. DYRS Policy 2.13.IV.C.1.a-d 4. Affirmation of Compliance with Forensic Examinations Standards for Sexual Assault 1/4/2021- Christiana Care Interviews: 1. Medical Staff 2. Mental Health Staff Findings (by Provision): 115.335 (a)-1 DYRS Policy 2.13.IV.C.3.b requires medical and mental health staff are required to complete specialized training that includes how to detect and assess signs of sexual abuse and sexual harassment, how to preserve physical evidence of sexual abuse, how to respond effectively and professionally to juvenile victims of sexual abuse and sexual harassment and how and whom to report allegations or suspicions of sexual abuse and sexual harassment. This is in addition to the general PREA training given to all employees. Documented on the PAQ, there were nine medical and mental health staff that worked regularly at the NCCDC. There were nine medical and mental health practitioners that received the PREA specialized medical and mental health training. Copies of certificates were located within the PAQ. The auditors interviewed a mental health practitioner and a medical practitioner. In both cases, the staff members recalled receiving specialized training. Both medical and mental health staff were able to recall some topics from the training. The agency does meet this provision. 115.335 (b)-1 The medical staff at the NCCDC do not perform forensic medical examinations. For NCCDC, forensic examinations are performed at the Christiana Care Hospital. In existence, there is an Affirmation of Compliance with Forensic Examinations Standards for Sexual Assault between DYRS and Christiana Care Hospital. During the interview, medical staff stated that they do not perform forensic medical examinations at the NCCDC, and it was added that the resident would be taken to the above-named hospital. The agency does meet this provision. 115.335 (c)-1 The agency maintains copies of the specialized training for medical and mental health staff certificates. All nine certificates were made available through the PAQ and the supplemental files. The agency does meet this provision. 115.333 (d)-1 DYRS Policy 2.13.III.A includes the medical and mental health personnel as staff. The policy states that staff for the purpose of this policy, is defined as any Department employee, volunteer, contractor, official visitor, or other agency representative (exclude family, friends, and other visitors). Further, within the DYRS Policy 2.13.IV.C.1.a-d it is quoted that all staff working directly with or monitoring programs/services of youth in secure care must receive PREA training. The Center for Professional Development will provide PREA training to all new DYRS during orientation. DYRS staff must have a PREA refreshener training every two years. In the years that an employee does not receive PREA refresher training, refresher information must be provided on current sexual abuse and sexual harassment policies. Training will include all training topics listed in PREA Standard 115.331. All nine medical and mental health staff received the training mandated for employees by PREA Standard 115.331.

	The agency does meet this provision. The evidence provided that the DYRS Policy references specialized PREA training for medical and mental health practitioners. All medical and mental health practitioners are trained in the PREA training referred in PREA Standard 115.331. The agency maintains copies of all certifications of the PREA training required by 115.331 and the PREA specialized training for medical and mental health practitioners. Based upon this analysis, the facility substantially meets this standard and corrective action is not required at this time.

115.341	Obtaining information from residents
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. Division of Youth Rehabilitative Services Prisoner Rape Elimination Act (PREA) 2.13 Section IV, D-1, (Revised 5/13/21). 2. PREA Risk Assessment and PREA Recommendation Decision Tree 3. Resident Files 4. PAQ Site Review Observation: 1. Intake Interviews: 1. Staff responsible for risk screening 2. Resident 3. PREA coordinator 4. PREA compliance manager Findings (by Provision): 115.341 (a): In the PAQ, the agency reported that they have a policy that requires screening upon admission to a facility or transfer to another facility for risk of sexual abuse victimization or sexual abusiveness toward other residents within 72 hours and reassessed periodically throughout their confinement. Agency relies on PREA Policy 2.13 Prevention Section IV D, 1, that outlines that it requires a formal PREA risk assessment is completed by facility clinical staff within 72 hours of a new admission or transfer from another facility and residents are reassessed every 6 months thereafter. The facility reported in the PAQ, 182 residents that entered the facility in the past 12 months whose length of stay was 72 hours or more was screened for risk of sexual victimization and risk of sexually abusing others was completed within 72 hours of admission. At the time of the onsite audit there were 40 residents admitted to the facility. The auditors reviewed 12 resident PREA screening and 12 resident files. In review,11 out of 12 residents that were screened at intake was completed within 72 hours of admission to the facility. The PREA risk assessment form used provides that the resident is being screened for victimization and abusiveness. During interviews with residents, all 12 residents recall being asked questions related to sexual abuse by the doctor or nurse at intake on the first day. During interviews with staff that are responsible for risk screening, mental health and medical staff complete risk screening of residents upon admission to the facility. Staff indicated that screening is provided Monday through Friday to ensure screening is completed within 72 hours. Staff indicated the medical staff cover on the weekend. Staff indicated they use files and the FOCUS database to conduct initial risk screening and on March 8, 2022 they implemented the new decision tree and risk assessment in all the facilities. When asked how often are resident's risk levels assessed, staff stated risk levels are reassessed every six months. In the PAQ the facility reported the average length of stay was 48 days. At the time of the onsite audit, three of the 12 residents had been at the facility for more than six months. All three residents were reassessed within six months that confirms that residents are reassessed periodically throughout their confinement. The evidence shows that the agency requires for screening upon admission or transfer and periodic reassessments which was verified through PAQ, policy, resident files, resident interviews, staff interviews. Based upon this analysis, the facility is substantially compliant with this provision and corrective is not action is required. 115.341 (b): In the PAQ, the facility reported that a risk assessment is conducted using an objective screening instrument. On March 8, 2022, the agency reported they implemented the new decision tree and risk assessment in all the facilities. Some of it was based on the auditor's recommendation and the agency own discussion across empirical review of literature-based research and the increased risk of being victims and victimizing others. The facility provided a PREA risk assessment and decision

tree for review.

The auditor reviewed the PREA risk assessment and decision tree and was able to determine that the screening instrument was objective. The risk assessment screening instrument assist staff in ascertaining information that provide a resident's overall risk of sexual victimization or risk of abusiveness towards others. During interviews with staff that conduct risk screening, the staff stated that they go through the risk screening form on FOCUS.

In review of the risk assessments, 2 out of12 residents had PREA related factors identified and a recommendation. The PREA risk assessment is comprised of a series of questions and information about the resident and the PREA recommendation decision tree yield an outcome that could be used to inform staff of supervision needs for housing, bed, education and program placement.

The evidence shows that the agency's risk assessment is conducted using an objective screening instrument which was verified through PAQ, risk assessment, PREA recommendation decision tree, staff interviews.

Based upon this analysis, the facility is substantially compliant with this provision and corrective action is not required.

115.341 (c):

The auditor was able to review the PREA risk assessment provided by the agency. Upon review, the risk assessment contains all eleven key components of the initial PREA risk assessment.

During an interview with staff responsible for conducting risk screening, when asked what does the initial risk screening consider, staff indicated they go through the risk screening form on FOCUS.

The evidence shows that all of the criteria for the PREA risk screening is included in the risk assessment instrument which was verified by the PAQ, risk assessment and staff interviews.

Based upon this analysis, the facility is substantially compliant with this provision and corrective action is not required.

115.341 (d):

PREA Policy 2.13 Section IV D, outlines that upon intake staff will ask the youth their gender identify for immediate safety and housing decisions. The PREA risk assessment is completed by facility clinical staff within 72 hours of a new admission or a transfer from another facility.

During an interview with staff that conduct risk screening, when asked how is information ascertained, staff stated the information is in the files, focus and during intake with the resident. It is noted that the mental health staff conduct risk assessment screening at intake. All the information is located in the FOCUS database.

The evidence shows that information is ascertained from talking with the resident, file and focus database which is verified through the risk assessment, onsite observation of intake and staff interviews.

Based upon this analysis, the facility is substantially compliant with this provision and corrective action is not required.

115.341 (e):

In the PAQ, the provision requires that an agency implement appropriate controls on the dissemination within the facility of the responses to questions in order to ensure that sensitive information is not exploited to the resident's detriment by staff or other residents.

During an interview with the PREA coordinator, when asked has the agency outlined who should have access to a resident's risk assessments within the facility in order to protect the resident's information from exploitation, staff indicated the psychologist and the PREA Coordinator is the only one that has risk assessment access through FOCUS. During an interview with staff that conduct risk screening, staff stated the recommendations would go to the superintendent and assistant superintendent. During an interview with the PREA compliance manager, she confirmed that mental health has access. During the onsite review, the auditor was able to determine that access to information in FOCUS was granted based on the staff person's position and information is disseminated regarding recommendations to the superintendent and assistant superintendent.

The evidence shows that the agency has controlled the level of access that each staff has in the FOCUS database to control and protect sensitive information which was verified by the interviews, risk assessments, onsite observation.

Based upon this analysis, the facility is substantially compliant with this provision and corrective action is not required.

Based upon this analysis, the facility is substantially compliant with this standard and corrective action is not required.

115.342	Placement of residents
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. Division of Youth Rehabilitative Services Prisoner Rape Elimination Act (PREA) 2.13 Section IV D, (Revised 5/13/21). 2. Division of Youth Rehabilitative Services Professional Practices Lesbian, Gay, Bisexual, Transgender, Questioning, and Intersex (LGBTQI) Policy 2.20 Sections IV (Revised 3/5/19). 3. New Castle County Detention Center Security/Control Room Confinement for Control NCCDC-216. 4. Resident Files 5. Housing Unit Logbooks Interviews: 1. PREA compliance manager 2. Staff responsible for risk screening 3. Superintendent 4. Medical and mental health staff Site Review Observation: 1. Observation during onsite review of physical plant Findings (by Provision): 115.342 (a): In the PAQ, the facility reported that they use information from the risk screening to form housing, bed, work, education, and program assignments with the goal of keeping all residents safe and free from sexual abuse. The agency relies on PREA Policy 2.13 Section IV D, the PREA risk assessment is used to determine risk of sexual abuse victimization or sexual abusiveness toward other residents and will inform housing, bed, work, education, and program, assignments for all residents. LGBTQI Policy 2.20 Sections IV Titled special considerations E, 1, outlines that DYRS shall use information obtained in intake and referral documentation and the mental health assessment to make housing, bed, program, education and work assignments for youth with the goal of keeping all youth safe and free from sexual abuse and sexual assault. During interviews with the PREA compliance manager, when asked how does the facility use information from the risk screening during intake to keep residents safe and free from sexual abuse, staff stated Mental Health provide the recommendation and send the information for placement. During interviews with staff responsible for risk screening, when asked how does the facility use information from the risk screening during intake to keep residents safe and free from sexual abuse and sexual harassment, staff stated they have meeting about where kids would be placed and room assignment. When asked about residents on Administrative Intervention, staff stated they may be placed in their own room. The auditor was able to determine that residents identified as having a PREA risk related factor are provided any specific recommendations as it relates to housing, bed, work, education, and program assignments with the goal of keeping all residents safe and free from sexual abuse. The evidence shows that the facility has demonstrated how the information obtained from the risk assessment is used to inform them of housing, bed, education and program assignments that would keep residents safe and free from sexual abuse which was verified by risk assessment, policy and staff interviews. Based upon this analysis, the facility is substantially compliant with this provision and corrective action is not required. 115.342 (b): In the PAQ, the facility reported they have a policy for residents at risk of sexual victimization may only be placed in isolation as a last resort if less restrictive measures are inadequate to keep them and other residents safe, and only until an alternative means of keeping all resident's safe can be arranged. The policy also requires that residents at risk of sexual victimization who are placed in isolation have access to legally required educational programming, special education services, and daily large-muscle exercise. LGBTQI Policy 2.20 Sections IV Titled special considerations E, 1, c, outlines that LGBTQI residents may be isolated from others only as a last result and only until less restrictive means of keeping resident safe can be arranged. During any period of isolation resident shall not be denied daily large-muscle exercise, legally required programming or special education

services.

In the PAQ, the facility reported that in the past 12 months there was no residents at risk of sexual victimization placed in isolation that would have been denied access to daily large-muscle exercise, legally required educational programming or special education services.

Policy NCCDC-216 New Castle County Detention Center Security and Control (Room Confinement for Control). Specifically, this policy addresses that confinement is necessary to prevent imminent physical harm to other persons and to maintain security control of the facility or for disciplinary reasons following required due process proceedings. The policy outlines that protective custody may be used to protect a youth from sexual or physical assault or other forms of abuse. While in confinement, the youth shall have the same access to hygiene, bedding, reading material, clothing, supplies and recreation. As written, the policy does not state residents who are placed in isolation because they allege to have suffered sexual abuse have access to legally required educational programming, special education services, and daily large muscle exercise. The policy outlines that protective custody may be used no longer than 24 hours without written approval of the division director.

During interviews with mental health and medical staff, when asked do residents in isolation receive visits from medical and mental health care, staff stated all residents receive visit by the mental health clinicians every day except Saturday. Staff explained they are trying to hire a staff for Saturday. During interviews with the superintendent, when asked are residents only isolated from others as a last resort when less restrictive measures are inadequate to keep them and other residents safe, and only until an alternative means of keeping all residents safe can be arranged, Always, we do not like to isolate. We have the ability to transfer to Stevenson house Residents in isolation would receive education packets and large muscle exercise. Large muscle exercise would be one hour a day for 24 hours and we log it in the logbook.

During the onsite review, the auditor was able to observe the housing unit rooms that is utilized for Isolation. The housing units had secure entrances, cells and exits. All areas require a key or remote access to enter. At the time of the onsite review, there were no residents in isolation that were at risk of sexual victimization or alleged to have suffered sexual abuse. The auditor reviewed six housing unit logbooks that confirm that no resident was in isolation during the onsite review. The housing unit logbooks provide a detailed tracking of the resident, date, time, activity observed, and staff assigned to the unit.

The evidence shows the facility does isolate residents at the facility, residents in isolation receive daily visits from medical or mental health care clinician and a review twice a month as provided in the agency policy. Residents are provided educational packets large-muscle exercise which is documented on the housing unit logbook. There were no residents at risk for sexual victimization placed in isolation in the 12 months preceding the onsite audit which was verified through interview, observation, policy and documentation review.

Based upon this analysis, the facility is substantially compliant with this provision and corrective action is not required.

115.342 (c):

In the PAQ, facility reported they prohibit placing lesbian, gay, bisexual, transgender, or intersex residents in particular housing, bed, or other assignments solely on the basis of such identification or status. Also, the facility prohibits considering lesbian, gay, bisexual, transgender, or intersex identification or status as an indicator of likelihood of being sexually abusive.

The agency relies on LGBTQI Policy 2.20 Section IV E, 1, d, that outlines LGBTQI youth shall not be placed in particular housing, bed, or other assignments solely on the basis of such identification or status, nor shall DYRS consider lesbian, gay, bisexual, transgender or intersex identification or status as an indicator of likelihood of being sexually abusive.

During an interview with the PREA coordinator, when asked does the facility have special housing units for lesbian, gay, bisexual, transgender or intersex residents, staff stated no. During interview with the PREA compliance manager, when asked does the facility have special housing units for lesbian, gay, bisexual, transgender or intersex residents, staff stated no.

At the time of the onsite audit, the auditor reviewed resident files and housing unit placements for all residents. There were no residents placed in a housing assignment solely based off of their identification status. There were no special housing units solely for LGBTQI residents.

Based on the evidence the facility does not have a special housing for LGBTQI residents or consider identification status as a likelihood of being sexually abusive this was verified by policy, interviews, resident files and onsite observation.

Based upon this analysis, the facility is substantially compliant with this provision and no corrective action is required.

115.342 (d):

In the PAQ, the facility reported they make housing and program assignments for transgender or intersex residents in a facility on a case-by-case basis.

Agency LGBTQI Policy 2.20 Section IV E, 1, d, outlines that DYRS shall consider on a case-by-case basis whether to assign a transgender or intersex youth to a facility and whether placement would ensure the youth's health, safety or present a management or security problem.

During an interview with the PREA compliance manager, when asked how does the facility determine housing and program assignments for transgender or intersex residents, staff indicated they assign based on gender.

Prior to the onsite review, the auditor reviewed the facility website and obtained information that the facility housed female and male residents. During the onsite review, the auditor observed female and male residents at the facility.

The evidence shows that the facility makes housing and program assignments for transgender and intersex residents on a case-by-case basis which is verified by PAQ, policy, interview, website and onsite review.

Based upon this analysis, the facility is substantially compliant with this provision and no corrective action is required.

115.342 (e):

In the PAQ, the facility reported placement and programming assignments for each transgender or intersex resident shall be assessed at least twice each year to review any threats to safety experienced by the resident.

The agency relies on PREA Policy 2.13 Section IV D, 2, placement and programming assignments for each transgender youth, intersex youth, youth assessed as high risk for being victimized or offending or in need of protective housing is reviewed by the facilities assessment team at least twice a month to review any threats to safety experienced by the resident.

Agency LGBTQI Policy 2.20 Section IV E, 1, f, outlines that placement and programming assignments for each transgender or intersex youth shall be reassessed by the interdisciplinary team at least twice each year to review any threats to safety experienced by the youth.

As written agency policy outlines two timelines for when transgender and intersex residents are reassessed. Although both time frames are with in the requirements of the standards, it is recommended the facility determine what procedure is best for the agency.

During an interview with the PREA compliance manager, when asked how often are placement and programming assignments for each transgender or intersex resident reassessed to review any threats to safety experienced by the resident, the staff indicated absolutely that they would reassess but did not indicate how often. During interview with staff that are responsible for risk screening, when asked often are placement and programming assignments for each transgender or intersex resident reassessed to review any threats to safety experienced by the resident, staff stated every six months unless there is an incident that requires reassessment.

During the onsite audit, the auditor reviewed 12 resident files and was able to determine there were no residents that identified as transgender or intersex.

The evidence shows that each transgender or intersex resident shall be assessed at least twice monthly and also twice each year and which is verified through PAQ, policy, interviews and documentation review.

Based upon this analysis, the facility is substantially compliant with this provision and no corrective action is required.

115.342 (f):

In the PAQ, A transgender or intersex resident's own views with respect to his or her own safety shall be given serious consideration.

Agency LGBTQI Policy 2.20 Section IV E, 1, g, outlines that a transgender or intersex youth's views with respect to his or her own safety shall be given serious consideration.

During an interview with the PREA compliance manager, when asked are transgender or intersex residents own views with respect to his or her own safety given serious consideration when making placement and programming assignments, staff stated yes. During an interview with staff responsible for risk screening, when asked are transgender or intersex residents own views with respect to his or her own safety given serious consideration in placement and programming assignments, staff stated yes.

During the onsite audit, the auditor reviewed 12 resident files and was able to determine there were no residents that identified as transgender or intersex.

The evidence shows that each transgender or intersex resident views are considered which is verified by PAQ, policy, and interviews.

Based upon this analysis, the facility is substantially compliant with this provision and no corrective action is required.

115.342 (g):

In the PAQ, transgender and intersex residents shall be given the opportunity to shower separately from other residents.

Agency LGBTQI Policy 2.20 Section IV F, outlines that transgender and intersex youth shall be given the opportunity to shower and use the bathroom separately from other youth.

During an interview with the PREA compliance manager, when asked are transgender or intersex residents given an opportunity to shower separately from other residents, staff stated yes, all residents are able to shower separately. During an interview with staff responsible for risk screening, when asked are transgender or intersex residents given the opportunity to shower separately from other residents, staff stated yes everyone showers separately.

During the onsite review, the auditor observed the showers are separate and all residents shower separately. Only one resident may shower at any given time.

During the onsite audit, the auditor reviewed 12 resident files and was able to determine there were no residents that identified as transgender or intersex

The evidence shows that each transgender or intersex resident are given an opportunity to shower separate from other residents which is verified by PAQ, policy, interviews and onsite observation.

Based upon this analysis, the facility is substantially compliant with this provision and no corrective action is required.

115.342 (h):

In the PAQ, the facility reported there were no residents isolated pursuant to paragraph b of this section in the past 12 months that required the facility to document a concern of a resident's safety.

During an interview, the superintendent stated do not like to isolate residents and have the option of moving the resident to Stevenson House.

During the onsite review, the auditor did observe any housing unit rooms that could be utilized for isolation. A review of 12 resident files and six housing unit logbooks did not reveal that residents were placed in isolation as outlined in this provision for risk of sexual victimization.

The evidence shows the facility does isolate residents at the facility which was verified through interview, observation, and documentation review.

Based upon this analysis, the facility is substantially compliant with this provision and no corrective action is required.

115.342 (i):

In the PAQ, every 30 days, the facility shall afford each resident described in paragraph h of this section a review to determine whether there is a continuing need for separation from the general population.

Agency LGBTQI Policy 2.20 Section IV E, I, outlines that every 30 days the facility shall afford each youth in isolation a review to determine whether there is a continuing need for separation from general population.

During an interview, staff the supervise residents in isolation stated they do not keep residents in isolation for more than 30 days.

During the onsite review, the auditor did observe any housing unit rooms utilized that could be utilized for isolation. A review of 12 resident files did not reveal that residents were placed in isolation as outlined in this provision housing unit logbooks did not reveal that residents were placed in isolation as outlined in this provision.

The evidence shows the facility does isolate residents at the facility which was verified through interview, observation, and documentation review, the facility did not have an incident where a resident was isolated at the facility as outlined in this provision that would prompt a 30-day review which was verified through interviews, observation, and documentation review.

Based upon this analysis, the facility is substantially compliant with this provision and no corrective action is required.

Based upon this analysis, the facility is substantially compliant with this standard and corrective action is not required.

Best Practice Recommendations:

1. As written agency PREA Policy 2.13 Section IV D, 2 and LGBTQI Policy 2.20 Section IV E, 1, f, outlines two timelines for when transgender and intersex residents are reviewed/reassessed. Although both time frames are within the requirements of

	the standards, it is recommended the facility determine what procedure is best for the agency.

115.351	Resident reporting
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. Division of Youth Rehabilitative Services Prisoner Rape Elimination Act (PREA) 2.13 Section E-1-3, pp.6, (Revised 5/13/21). 2. New Castle County Detention Center (NCCDC) Student Handbook English 2018 3. New Castle County Detention Center (NCCDC) Student Handbook Spanish 2022 4. New Castle County Detention Center (NCCDC) Parent/Guardian Safety Guide English. 5. New Castle County Detention Center (NCCDC) Parent/Guardian Safety Guide Spanish. 6. Title 10 Courts and Judicial Procedure 7. Division of Youth Rehabilitative Services Prisoner Professional Practices Reportable Events 2.12 III.B.1-3 (Revised 6/27/14). 8. Agency Website www.kids.delaware.gov/yrs/prea 9. PREA Academy Training Manual pp. 51-52 (2021) 10. Policy 208 Institutional Abuse Section V, D, page 2, (revised 6/8/16). Interviews: 1. Random staff 2. Resident 3. PREA compliance manager 4. Just Detention International (JDI) Operations Director 5. Child Advocacy Center Inc. Site Review Observations: 1. Observation during onsite review of physical plant posting. Findings (by Provision): 115.351 (a): In the PAQ, the agency reported that they provide multiple internal ways for residents to privately report sexual abuse and sexual harassment; retaliation by other residents or staff for reporting sexual abuse and sexual harassment and staff neglect or violation of responsibilities that may have contributed to such incidents. The agency provided Policy 2.13 Division of Youth Rehabilitative Services (DYRS) Prisoner Rape Elimination Act, Section E-1-3, pp.6 which states that residents can privately report sexual abuse and sexual harassment, retaliation by other residents or staff for reporting sexual abuse and sexual harassment and cases where sexual abuse, harassment or retaliation might have happened because staff were neglectful or failed their responsibilities verbally to staff, by filing an emergency PREA grievance or by calling the child abuse hotline. The policy states that staff shall accept any report of sexual abuse and sexual harassment made verbally, in writing, anonymously and from third parties. The New Castle County Detention Center Resident Handbook outlines residents can report sexual abuse to staff, nurse, supervisor, psychologist, case manager, PO, parent/guardian or calling PREA hotline 1-800-292-9582 or on the GTL phone system at *7735# then press 4. During the site review the auditor observed telephones in each housing unit that was designated for the residents to call the hotline and family. The phone is located in a common area on the base and outside the housing unit in a common area that is accessible to all residents and staff. This area provides very little privacy. The New Castle County Detention Center Parent/Guardian Safety Guide provides that residents can report sexual abuse and sexual harassment to a nurse, supervisor, treatment specialist, program manager, psychologist, teachers, security staff, other staff members at the facility, filing an emergency grievance and calling the institutional abuse hotline1-800-292-9582. During the onsite review, the auditor did observe posting with the outside victim advocate number and the PREA hotline number and information on how to report that included calling the hotline 1-800-292-9582 or 7735. During Interviews with random staff, all 12 staff interviewed stated that residents have multiple ways to report sexual abuse, sexual harassment, retaliation and neglect. Residents stated they could call the hotline, write a grievance, call someone they trust, and report it to staff. Staff stated residents can report it in writing, anonymously and through third parties.

During Interviews the auditor asked all of the residents about the multiple ways they can make a report, 7 out of 12 stated they could call the PREA hotline, 5 out of 12 stated they could write a grievance, 2 out of 12 stated they could tell a family member and 8 out of 12 stated they could tell a staff member.

The evidence shows that the facility has provided multiple ways for a resident to report sexual abuse, sexual harassment, retaliation, and staff neglect or which was verified through handbook, policy, resident interviews, staff interviews, PREA phone and posting in the housing units.

Based upon this analysis, the facility is not substantially compliant with this provision and corrective action is required.

115.351 (b):

In the PAQ, the agency reported that they provide at least one way for residents to report abuse or harassment to a public or private entity or office that is not part of the agency. The agency reported they do not provide information for immigrant services because the Delaware code prohibits detention of persons for civil immigration purposes.

The agency relies on PREA Policy 2.13, which states that a resident can make a complaint about sexual abuse and sexual harassment verbally to staff, filing a emergency PREA grievance, or calling the child abuse hotline. The child abuse hotline is a designated 24-hour, seven days a week resource for residents to report abuse. In a memorandum of agreement, Survivors of Abuse in Recovery (SOARS) has partnered with the Department of Services for Children, Youth and Their Families to provide survivors of sexual abuse with emotional support services. The facility did provide information posted and in written format that would establish residents knew of the way in which they could contact SOARS a third-party victim advocate. Agency relies on Institutional Abuse Policy 208, which states that sexual abuse allegations will include a forensic interview with Child Advocacy Center and a medical examination. The agency relies on Title 10 courts and judicial procedure 1007 that outlines that the facility does not detain residents for immigration purposes.

During Interviews, the PREA compliance manager stated residents have access to call the hotline or tell a staff member.

During interviews, the Child Advocacy Center reported that they would provide advocacy services to the facility. The agency had not received any contact from the facility requesting services. Post audit, auditors were able to speak with SOARS Executive Director, regarding their contact and services with the facility. Staff at SOARS confirmed that they have a memorandum of agreement with the facility to provide victim advocate for emotional support but have not had any contact with any residents at the facility. When asked how does a resident contact your agency, the SOARS staff stated they would call (302)-655-3953 and after the prompts select extension 1 for the intake department. When asked if the agency would receive a report of sexual abuse and sexual harassment from a resident at the facility, SOARS staff indicated they were not the appropriate party to report and it is not a part of their formal agreement. The agency stated that they are mandated reporters and if a resident provides a report, they would report it but their line is for someone seeking services. The auditor was able to speak with Just Detention International (JDI) Operations Director regarding any reports received from the facility. Just Detention International (JDI) Operations Director reported that they have not received any reports from the facility.

During Interviews the auditor asked all of the residents about one way they can make a report to a public or private office, 7 out of 12 stated they could call the PREA hotline, 5 out of 12 stated they could write a grievance, 2 out of 12 stated they could tell a family member and 8 out of 12 stated they could tell a staff member. None of the residents knew about contacting SOARS at an outside agency.

During the onsite review, the auditor did observe posting with the SOARS outside victim advocate number and the PREA hotline number and information on how to report that included calling the hotline 1-800-292-9582 or 7735 #4. The auditor tested the hotline number on every housing unit and was able to contact the PREA hotline. The auditor did not observe any posting for the Child Advocacy Center.

The evidence shows that the facility has provided at least one way for a resident to report sexual abuse and sexual harassment which was verified through interviews, memorandum, policy, posting in the housing units. The agency does not provide information for consulate officials or relevant officials with Homeland Security because the court places a child in secure detention pending adjudication but not for civil immigration purposes.

Based upon this analysis, the facility is substantially compliant with this provision and no corrective action is required.

115.351 (c):

In the PAQ, the agency reported that they have a policy mandating that staff accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously and from third parties. Staff are required to document verbal reports within 24 hours.

The agency relies on PREA Policy 2.13 that outlines staff accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously and from third parties and Reportable events Policy 2.12 requires staff to report in 24 hours.

During Interviews with random staff, all 12 staff stated if a resident alleges sexual abuse and sexual harassment they can do so verbally, in writing anonymously and through third parties.

During Interviews with 12 Residents, 11 out of 12 residents said they knew they could make a report of sexual abuse or sexual harassment in person or in writing.

The evidence shows that the facility has a policy that mandate that staff accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously and from third parties. Interviews with staff are consistent with the requirements of the provision and interviews with residents verifies they knew they could make a report in person or in writing.

Based upon this analysis, the facility is substantially compliant with this provision and corrective action is required.

115.351 (d):

In the PAQ, the agency reported that they provide residents with access to tools to make written reports of sexual abuse or sexual harassment, retaliation by other residents or staff for reporting sexual abuse and sexual harassment, and staff neglect or violation of responsibilities that may have contributed to such incidents.

During an interview, the PREA compliance manager stated that residents can use the telephone to call the hotline, report it to staff verbally and in writing. During an interview, the resident reported they knew how to make a verbal report to a third party.

During the onsite review, the auditor did observe posting with the outside victim advocate number, grievance forms, the PREA hotline number and information on how to report by calling the hotline 1-800-292-9582 or 7735 #4.

The evidence shows that the facility provides residents access to make written reports through staff, PREA hotline and grievance form which was verified through interviews, posting in the housing unit, and grievance forms.

Based upon this analysis, the facility is substantially compliant with this provision and no corrective action is required.

115.351 (e):

In the PAQ, the agency reported that they established procedures for staff to privately report sexual abuse and sexual harassment of residents and staff are informed of these procedures through staff training.

The agency relies on PREA Policy 2.13 that states how staff can privately report sexual abuse and sexual harassment of residents through their chain of command, facility administrator, PREA Coordinator, child abuse hotline and submitting an anonymous administrative report.

Agency PREA Academy Training outlines that staff can privately report sexual abuse and sexual harassment through their chain of command, facility administrator, PREA coordinator, submitting an anonymous administrative report and calling the Child Abuse hotline 800-292-9582. A review of the agency website, provides information for the public to the Child Abuse hotline number 800-292-9582 or contact local law enforcement to report any sexual abuse or sexual harassment allegations regarding any DYRS youth.

During Interviews with 12 random staff, all 12 staff reported that they can privately report through the PREA hotline and to their supervisor.

The evidence shows that the agency has an established procedure for staff to privately report sexual abuse and sexual harassment of residents through calling PREA hotline, making an anonymous administrative report, talking with a supervisor, administrator or PREA coordinator which was verified through interviews, training documentation, postings, and agency website.

Based upon this analysis, the facility is substantially compliant with this provision and corrective action is not required.

Best Practice Recommendations:

Educate residents on how to contact third-party Survivors of Abuse in Recovery SOARS and Child Advocacy Center Inc.
Document that residents have been educated on SOARS and Child Advocacy Center Inc.
Collaborate with SOARS in a workshop with residents.

115.352	Exhaustion of administrative remedies
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. Division of Youth Rehabilitative Services Prisoner Rape Elimination Act (PREA) 2.13 (Revised 5/13/2021). 2. New Castle County Detention Center (NCCDC) Resident Handbook pp. 7, (revised 5/2018). 3. New Castle County Detention Center (NCCDC) Grievance Complaint Form 4. New Castle County Detention Center (NCCDC) Emergency PREA Grievance Form 5. New Castle County Detention Center (NCCDC) Parent/Guardian Safety Guide English and Spanish. Interviews: 1. Grievance coordinator Findings (by Provision): 115.352 (a-g): In the PAQ, the agency stated that they are exempt from this standard as they do not have an administrative procedure that address resident grievances regarding sexual abuse. All allegations of sexual abuse are called in to the hotline. All staff are mandatory reporters of sexual abuse to the hotline. The New Castle County Detention (NCCDC)Resident Handbook outline a process of reporting sexual abuse and harassment by completing an emergency grievance form (red). The auditor was able to review 10 resident grievance complaints. There were no NCCDC emergency grievance complaints with PREA. There was no information presented on the grievance forms that indicated that the form was used for an allegation of sexual abuse. The facility has a parent/guardian safety guide in English and Spanish that provides information on filing out an emergency PREA grievance to report sexual abuse and sexual harassment. During an interview, the Grievance staff stated they have a process for residents to file a grievance and an emergency grievance. The Grievance staff explained if a resident writes on an emergency grievance that has a PREA complaint, staff would hand deliver it to the assistant superintendent. If the grievance is in the box, it would be addressed immediately. Only administrative staff have access to the grievance box. Any staff can help a resident make a complaint by calling the Child Abuse hotline. Residents can also have their family call from home or report on the hotline. During the site review, the auditor observed grievance boxes, grievance forms and emergency grievance forms in all the housing units, outside the housing units and in the school area. The evidence shows that the agency does not have an administrative procedure for processing grievances regarding sexual abuse. If a grievance form contains PREA it is addressed immediately by reporting to a supervisor or program manager. This was verified by policy, interviews, and resident handbook. Based upon this analysis, the facility is substantially compliant with this standard and no corrective action is required.

115.353	Resident access to outside confidential support services and legal representation
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. Division of Youth Rehabilitative Services Prisoner Rape Elimination Act (PREA) 2.13 Section IV E-4-5 pp. 6-7, (Revised 5/13/21). 2. New Castle County Detention Center (NCCDC) Parent/Guardian Safety Guide English. 3. New Castle County Detention Center (NCCDC) Parent/Guardian Safety Guide Spanish. 4. Title 10 Courts and Judicial Procedure 5. Division of Youth Rehabilitative Services State Managed Facilities Mail, Telephone and Visitation Policy 5.24 IV B-4 & IV C-1, pp. 3-4, (Effective 6/1/15). 6. New Castle County Detention Center (NCCDC) Resident Rights Visitation Procedures (5/6/09). 7. New Castle County Detention Center (NCCDC) Resident Rights Access to Telephone, Mail and Visitation (5/6/09). 8. New Castle County Detention Center (NCCDC) Admission and Release Resident Orientation. 9. Memorandum of Agreement Between the Division of Youth Rehabilitative Services and Survivors of Abuse in Recovery, Inc. (3/11/19). 10. New Castle County Detention Center (NCCDC) Student Handbook English 2018 11. New Castle County Detention Center (NCCDC) Student Handbook Spanish 2022 12. Children's Advocacy Center of Delaware, Inc. Interviews: 1. Resident 2. Superintendent 3. PREA compliance manager 4. Survivors of Abuse in Recovery (SOARS) Director 5. Children's Advocacy Center of Delaware, Inc. Site Review Observation: 1. Observation during on-site review of Intake Findings (by Provision): 115.353 (a): In the PAQ, the agency reported that they provide residents with access to outside victim advocates for emotional support services related to sexual abuse including making available addresses, telephone numbers including toll free hotline numbers for state, local, or national victim advocacy or rape crisis organizations. The facility provides residents access for reasonable communication to these organizations in as confidential manner as possible. The agency reported they do not provide information for immigrant services because they prohibit detention of persons for civil immigration purposes. The agency relies on Division of Youth Rehabilitative Services Prisoner Rape Elimination Act (PREA) 2.13 Section IV E-4-5 pp. 6-7, outlines that all youth shall be made aware of community agencies, address and contact numbers of mental health practitioners that provide emotional support services related to sexual abuse. The policy states that the agency shall maintain a memorandum of agreement with one or more such agencies to ensure statewide service agreement and communication between resident and these agencies will be in as confidential manner as possible. The agency relies on Title 10 courts and judicial procedure1007 that outlines that the facility does not detain residents for immigration purposes. The New Castle County Detention Center Parent/Guardian Safety Guide provides that residents can call Survivors of Abuse in Recovery 302-655-3953 with a website address http://soarinc.com/, Brandywine Counseling and Community Services 302-656-2348 http://www.brandywinecounselin.org/, Delaware Guidance Services http://delawarguidance.org/, Delaware Renaissance http:/www.delren.org/, AIDS Delaware 302-652-6776 http://aidsdelaware.org/ for victim support. During the site review, the auditors did observe SOARS victim advocate postings and the parent/guardian safety guide for victim advocacy or rape crisis organizations in the housing units, hallways, and lobby. The auditor did not observe any posting for the Children's Advocacy Center of Delaware, Inc. During interviews, 12 residents could not provide the name of the agency, knew about or how to receive the mailing

addresses or phone numbers for contacting SOARS, a victim advocate or rape crisis organizations and was unaware of a toll-free number for the outside victim advocacy agency SOARS, or knew about communicating to this organization confidentially.

Prior to the onsite audit, the auditor tested the SOARS telephone number at (302)-655-3953 and was taken through a series of prompts to leave a message. During the post audit the auditors were able to speak with SOARS Executive Director regarding their contact and services with the facility. Staff at SOARS confirmed that they have a memorandum of agreement with the facility to provide victim advocate for emotional support but have not had any contact with any residents at the facility. When asked how does a resident contact your agency, the SOARS staff stated they would call (302)-655-3953 and after the prompts select extension 1 for the intake department. During the onsite audit, the auditor was able to interview Children's Advocacy Center of Delaware that provides free counseling and advocacy services for sexual assault victims which is available to residents at NCCDC. The auditor was able to observe that residents are provided the New Castle County Detention Center (NCCDC) Parent/Guardian Safety Guide English.

The evidence shows that the agency has a policy that establishes that residents will be provided access to outside victim advocates for emotional support services related to sexual abuse and make available agency contact information. As written the policy does provide any information about the confidentiality between residents and outside victim advocates. The auditor did observe information that would provide residents with the victim advocate for emotional support. Residents interviewed could not provide the auditor any information about SOARS including their telephone number, mailing address or the level of confidentiality of communication between the agency and resident. The New Castle County Detention Center resident's handbook did not provide any information to the residents about SOARS or any other outside victim advocate for emotional support related to sexual abuse. The New Castle County Detention Center Safety Guide did provide information to residents about SOARS and other outside victim advocates. The agency does not provide information for immigrant services because the court places a child in secure detention pending adjudication but not for civil immigration purposes.

Based upon this analysis, the facility is substantially compliant with this provision and corrective action is not required.

115.353 (b):

In the PAQ, the facility reported that they inform residents, prior to giving them access to outside support services, the extent to which such communications will be monitored. The facility reported prior to giving them access to outside support services, the facility would inform residents of the mandatory reporting rules governing privacy, confidentiality, and/or privilege that apply to disclosures of sexual abuse made to outside victim advocates, including any limits to confidentiality under relevant Federal, State, or local law

During interviews, 12 residents reported that they were not informed that conversations with outside support services would be monitored, the mandatory reporting rules regarding privacy and confidentiality, disclosures of sexual abuse made to outside victim advocates including any limits to confidentiality.

The evidence shows that not all residents interviewed were informed of the communication monitoring with SOARS or mandatory reporting limits to confidentiality with outside support services.

Based upon this analysis, the facility is not substantially compliant with this provision and corrective action is required.

115.353 (c):

In the PAQ, the facility reported that they maintain memorandum of understanding or other agreements with community service providers that are able to provide residents with emotional support services related to sexual abuse.

The agency provided a copy of the Memorandum of agreement between the Division of Youth Rehabilitative Services and Survivors of Abuse in Recovery, Inc (SOARS). The Memorandum of agreement outlines that SOARS will provide victims of sexual abuse direct mental health services including crisis intervention, emotional support, information or referrals.

The evidence shows that the agency and SOARS has entered into a memorandum of agreement on 3/11/19 that outlines SOARS will provide victims of sexual abuse direct mental health services including crisis intervention, emotional support, information or referrals.

Based upon this analysis, the facility is substantially compliant with this provision and no corrective action is required.

115.353 (d):

In the PAQ, the facility reported they provide residents with reasonable and confidential access to their attorneys or other legal representation and reasonable access to parents or legal guardians.

The facility relies on Policy 5.24 Mail Telephone and Visitation, outlines that residents can contact their attorney at any reasonable time excluding weekends and holidays as often as the resident wishes if their attorney agrees to accept charges for these calls. No time limits shall be placed on calls from the attorney. The policy provides that residents may make local

and collect calls to their parents, legal guardians, foster parents, or custodians during times established by each facility.

Policy outlines that attorney's, clergy, government officials, legislators, media representatives and family may be approved by the superintendent on a case-by-case basis and will not count against the youth's normal visiting schedule. An area is to be set aside for attorney/client interviews.

Policy outlines that the amount of mail a resident may send or receive is unlimited. All residents can send sealed correspondences to courts, counsel, officials of the confining authority and administrator of grievance systems or representatives. Legal correspondence is never opened by staff. Letters incoming and outgoing are not read by staff except if there is clear evidence to justify such action. If the mail is read the resident is present when the letter is opened. Outgoing mail will be submitted unsealed to staff, inspected for contraband before it is processed to be mailed.

During interviews, the Superintendent stated the facility provides residents access to their Attorney visiting onsite and calls.

During interview, the PREA Compliance Manager stated that the attorney was not coming in during covid. The attorney would make contact and get the day and time for the call and the facility would schedule calls with the attorney in advance. The residents get calls with family based on phases. We do hardship calls once per week. We would schedule facetime calls through google duo. We are now back to in person visits on Tuesday, Wednesday, Thursday. They can either have face to face or google duo but they cannot have both.

During interviews with Residents, 12 residents knew that they could make a private call to their attorney, all 12 residents knew that they could contact their families through facetime.

During the onsite review, the auditor observed the telephone in every housing unit and the visitation area.

The evidence shows that agency policy provides that residents can make confidential calls and visits with their attorney and have contact with a parent through phone calls and visits. Facility staff stated that residents are allowed access to their attorney though phone calls and parents through phone calls, facetime visits and in person visits. The residents knew that they were allowed access to contact their attorney privately and visit with their parents through a facetime calls and visits

Based upon this analysis, the facility is substantially compliant with this provision and no corrective action is required.

Based upon this analysis, the facility is not substantially compliant with this standard and corrective action is required.

Corrective Action:

1. Educate all residents on the services provided by Survivors of Abuse in Recovery (SOAR) victim advocate for emotional support related to sexual abuse, contact information for the agency telephone, mailing address and inform residents of the mandatory reporting and limits to confidentiality.
2. Document that all residents have received the education on SOAR and Child Advocacy Center, Inc.
Verification of Corrective Action since the audit:

The facility sent the auditor documentation on 7/27/22 in response to the corrective action recommendations.

1. Provided SOAR Training Curriculum. (8 pages).
2. Provided Youth training acknowledgements (29 pages).

The following action were taken: DYRS provided training on SOAR to 29 residents that inform residents on the services provided by Survivors of Abuse in Recovery (SOAR) victim advocate for emotional support related to sexual abuse, agency contact information that included telephone and mailing address. Training informed residents of the mandatory reporting and limits to confidentiality.

Corrective Action #1 and #2

The intent of this corrective action was to ensure that residents have reasonable access to outside victim advocate organizations and communication between residents to these organizations is in a confidential manner as possible and be informed the extent their communications will be monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws.

The facility provided 8-page training curriculum on SOAR and training acknowledgements from 29 resident with signatures acknowledging they were trained about the SOAR outside victim advocate on 7/20/22. This satisfies the auditor's corrective action requirement.

Based on review of the information received, the auditor finds the facility substantially compliant with this standard.

115.354	Third-party reporting
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. Division of Youth Rehabilitative Services Prisoner Rape Elimination Act (PREA) 2.13 Section IV, E-1 & 6 and IV F-1 pp 6-7 (Revised 5/13/21). 2. Child Abuse Reporting Line (800-292-9582) 3. Department of Services for Children, Youth and Their Families (DSCYF) Public Website https://kids.delaware.gov/yrs/prea.shtml 4. New Castle County Detention Center (NCCDC) Parent/Guardian Safety Guide English. 5. New Castle County Detention Center (NCCDC) Parent/Guardian Safety Guide Spanish. New Castle County Detention Center (NCCDC) Resident Handbook pp. 7, (revised 5/2018). https://kidsfiles.delaware.gov/pdfs/yrs-resident-handbook-nccdc.pdfi> 6. PREA Contacts: https://kids.delaware.gov/youth-rehabilitative-services/prea-contacts/ Findings (by Provision): 115.354 (a): In the PAQ, the facility indicated that they provide a method to receive third-party reports of sexual abuse or sexual harassment. Division of Youth Rehabilitative Services Prisoner Rape Elimination Act (PREA) 2.13 Section IV, E-1 & IV F.1 pp. 6-7 establishes that the Child Abuse hotline (800-292-9582) may be used by staff to report sexual abuse and sexual harassment. The agency policy Division of Youth Rehabilitative Services Prisoner Rape Elimination Act (PREA) 2.13 Section IV E-6 pp.7 establishes a method for third-party reporting of sexual abuse and sexual harassment by calling the child abuse hotline and publicly through the agency's website http://kids.delaware.gov/yrs/prea). The website provides a quick link for PREA that provides a method of receiving third-party reports of sexual abuse or sexual harassment by calling the Delaware Child Abuse hotline (800-292-9582) or contacting a local law enforcement agency. The website also provides information on applicable PREA statutes and policies, contact information for the agency PREA coordinator, facility PREA compliance manager, Survivors of Abuse and Recovery, Inc. (SOARS) a victim advocate agency, and facility PREA audit reports. The agency provides a resident handbook on the website that outlines how to report sexual abuse and sexual harassment by calling the child abuse hotline, completing an emergency grievance form, and telling any adult the resident feels comfortable telling. The facility has a parent/guardian safety guide in English and Spanish that provides information on how to report sexual abuse and sexual harassment to the Institutional abuse hotline. The evidence shows the agency and facility provide a method of receiving third-party reports of resident sexual abuse or sexual harassment. This information was verified through review of the agency policy, parent/guardian safety guide and website information. Based on the review of the policy, parent/guardian safety guide and agency website, staff and the public can make a third-party report of sexual abuse or sexual harassment by calling the child abuse hotline, reporting to a local law enforcement agency, contacting the agency PREA coordinator or facility PREA compliance manager. Based upon this analysis, the facility is substantially compliant with this standard and no corrective action is required.

115.361	Staff and agency reporting duties
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. Division of Youth Rehabilitative Services Prisoner Rape Elimination Act (PREA) 2.13 Section IV, F-1, (Revised 5/13/21). 2. Division of Youth Rehabilitative Services Code of Ethics Policy 2.2 Section IV A-21, A25, (Revised 5/13/21). 3. Pre-Audit Questionnaire (PAQ) 4. Investigation Records Interviews: 1. Superintendent 2. PREA compliance manager 3. Medical and mental health staff 4. 12 Random staff 5. Delaware State Police Findings (by Provision): 115.361 (a): In the PAQ, the agency reported they 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. The agency relies on Policy 2.13 Division of Youth Rehabilitative Services (DYRS) Prisoner Rape Elimination Act, Section IV F.1, that outlines all staff must comply with child abuse reporting laws and will report any incidents of sexual abuse and sexual harassment to the child abuse hotline. In the PAQ, the agency reported they require all staff to report immediately any retaliation against residents or staff who reported such an incident. The agency relies on Policy 2.2 Division of Youth Rehabilitative Services Code of Ethics Section IV A.21 and Policy 2.13 Division of Youth Rehabilitative Services (DYRS) Prisoner Rape Elimination Act, Section IV F.2, that outlines staff will immediately report to facility administration any retaliation against a resident or staff who reported sexual abuse or sexual harassment. In the PAQ, the agency reported they require all staff to report immediately and according to agency policy any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. The agency relies on Policy 2.2 Division of Youth Rehabilitative Services Code of Ethics Section IV A.22, and Policy 2.13 Division of Youth Rehabilitative Services (DYRS) Prisoner Rape Elimination Act, Section IV F.3 which outlines that staff will immediately report any staff neglect or violation of responsibilities that may have contributed to an incident of retaliation. DSCYF Academy Training outlines that staff must report all knowledge, suspicion, or information regarding sexual abuse or sexual harassment, retaliation against residents or staff who report such incidents and staff neglect or violation of responsibilities that may have contributed to abuse or retaliation. The training does not provide that staff immediately report. During interviews, 12 Random staff reported that the knew about the agencies requirement to report regarding any incident of sexual abuse or sexual harassment that occurred in the facility including retaliation against residents or staff who reported sexual abuse or sexual harassment. During interviews, 12 random staff knew the agency's policy or procedure for reporting any information related to a resident sexual abuse. The facility provided staff first responders cards as a quick reference guide for processing incidents of sexual abuse. Evidence shows that all staff are required to report an incident of sexual abuse or sexual harassment, any retaliation against residents or staff and any staff neglect or violation of responsibilities that may have contributed to an incident of retaliation which was verified through policy, staff interviews and academy training. Based upon this analysis, the facility is substantially compliant with this provision and corrective action is not required. 115.361 (b): In the PAQ, the agency reported that they require all staff to comply with any applicable mandatory child abuse reporting

laws.

The agency relies upon Policy 2.13 Division of Youth Rehabilitative Services (DYRS) Prisoner Rape Elimination Act, Section IV F.1, outlines staff must comply with child abuse reporting laws and will report any incidents of sexual abuse and sexual harassment to the Child Abuse Hotline.

DSCYF Academy Training outlines that all YRS staff are mandatory reporters and required to report any allegations and instances of sexual abuse and sexual harassment to the Child Abuse Hotline (800)-292-9582.

During interviews, 12 Random staff interviewed knew they were required to comply with mandatory reporting of sexual abuse and noted they would call the hotline.

Evidence shows that the agency requires all staff to comply with any applicable mandatory child abuse reporting laws which was verified through policy, staff interviews and academy training.

Based upon this analysis, the facility is substantially compliant with this provision and corrective action is not required.

115.361 (c):

In the PAQ, the agency reported that policy prohibits staff from revealing any information related to a sexual abuse report to anyone other than to the extent necessary to make treatment, investigation, and other security and management decisions.

Agency relies on Policy 2.2 Division of Youth Rehabilitative Services Code of Ethics Section IV.A,25 that staff will not reveal any information related to sexual abuse report to anyone other than to the extent necessary to make treatment, investigation and other security and management decisions.

During interviews all 12 staff knew the agency's policy for revealing information related to a resident sexual abuse incident.

Evidence shows that the agency prohibits staff from revealing any information related to sexual abuse report to anyone other than to the extent necessary to make treatment, investigation and other security and management decisions which was verified through policy and staff interviews.

Based upon this analysis, the facility is substantially compliant with this provision and corrective action is not required.

115.361 (d):

Medical and mental health staff when asked about a requirement to report sexual abuse to officials as well as state and local agencies medical and mental health staff stated they are mandated reporters and would call the hotline, report to their supervisors and facility administrators. When medical and mental health staff were asked at the initiation of services to a resident, do you disclose the limitations of confidentiality and your duty to report, all 3 medical/mental health providers stated that they do disclose the limitations and their duty to report as they are mandated reporters.

The auditor reviewed 12 resident files and 12 intake assessment reports and was able to confirm that residents were informed of medical and mental health limits on confidentiality or duty to report.

Evidence shows that medical and mental health staff are required to report sexual abuse to designated supervisors as well as state or local services agency required by mandatory reporting laws which was verified through staff interviews, resident files and intake assessments.

Based upon this analysis, the facility is substantially compliant with this provision and corrective action is not required.

115.361 (e):

During an interview, the PREA Compliance Manager stated she would report it to the hotline. DFS is the guardian. During interview, the Superintendent stated he would contact the DFS worker immediately. If on the weekend, it would be the next business day. When asked would you report to the juvenile court if they retain jurisdiction or the juvenile's attorney on record, the superintendent stated we would contact that DFS worker when under child welfare.

The facility reported there were no allegations of sexual abuse or sexual harassment during the last 12 months. During an interview, Delaware State Police reported that there were no criminal cases of sexual abuse or sexual harassment reported to the department.

The auditor was able to review three investigations. In review, two of the three investigations did not reveal an allegation of sexual abuse. One allegation of sexual abuse confirmed the agencies practice of reporting to the appropriate agency.

Evidence shows that allegations of sexual abuse are reported to the appropriate agency which was verified through staff interviews and investigative reports.

Based upon this analysis, the facility is substantially compliant with this provision and a corrective action is not required.

115.361 (f):

During an interview, when asked are all allegations of sexual abuse and sexual harassment including those from third-party and anonymous reported directly to designated facility investigators, the superintendent stated we report to the investigators.

The facility reported there were no allegations of sexual abuse or sexual harassment during the last 12 months. During an interview, Delaware State Police reported that there were no criminal cases of sexual abuse or sexual harassment reported to the department.

The auditor was able to review three investigations involving sexual abuse or sexual harassment. In review, all three allegations were reported to facility investigators.

Evidence shows that allegations of sexual abuse are reported to the facility investigators which was verified staff interviews and investigative reports.

Based upon this analysis, the facility is substantially compliant with this provision and a corrective action is not required.

Based upon this analysis, the facility is substantially compliant with this standard and a corrective action is not required.

Best Practice recommendations:

1. Revise DSCYF Academy training to include that staff report immediately.
2. Document staff have received training.

115.362	Agency protection duties
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. Division of Youth Rehabilitative Services Prisoner Rape Elimination Act (PREA) 2.13 Section IV F, 5 pp.7, (Revised 5/13/21). 2. Pre-Audit Questionnaire (PAQ) 3. Investigation Records Interviews: 1. Agency head 2. Superintendent 3. Random staff Findings (by Provision): 115.362 (a) 1-4: In the PAQ, the facility reported that when they learn that a resident is subject to a substantial risk of imminent sexual abuse, they take immediate action to protect the resident assess and implement appropriate protective measures without unreasonable delay. The agency relies on Policy 2.13 Division of Youth Rehabilitative Services (DYRS) Prisoner Rape Elimination Act, Section IV F, 5, (page 7), that outlines upon receiving information that a resident is subject to a substantial risk of imminent sexual abuse, immediate action will be taken to protect the resident. During Interviews, the agency head stated they had no situation but they would take immediate action if they learn that a resident was at substantial risk. During an interview, the superintendent stated immediate action to protect a resident and place them on the opposite side. During interviews, all 12 staff stated they would remove a resident immediately if the resident was at risk of imminent sexual abuse. All staff interviewed reported they would separate, isolate, or remove the victim and notify a supervisor if the resident was at risk of imminent sexual abuse. In the PAQ, the facility reported that for the past 12 months there was no residents determined to be at substantial risk of imminent sexual abuse. The facility reported that the average amount of time and longest time that passed before taking action was not applicable as there were no residents determined to be at substantial risk of imminent sexual abuse. The auditor reviewed three investigation records. Two of the three records revealed an allegation of sexual abuse that confirmed the agency's response to taking immediate action when they learned that a resident is subject to a substantial risk of imminent sexual abuse. The evidence shows that the agency when they learn that a resident is subject to a substantial risk of imminent sexual abuse, they take immediate action. This was verified through the policy, interviews and investigations documents. Based upon this analysis, the facility is substantially compliant with this standard and no corrective action is required.

115.363	Reporting to other confinement facilities
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. Division of Youth Rehabilitative Services Prisoner Rape Elimination Act (PREA) 2.13 Section IV, F 6, and 6a-6b, G 1, (Revised 5/13/21). 2. Pre-Audit Questionnaire (PAQ) Interviews: 1. Agency head 2. Superintendent Findings (by Provision): 115.363 (a): In the PAQ, the facility reported they have a policy requiring that, upon receiving an allegation that a resident was sexually abused while confined at another facility, the head of the facility must notify the head of the facility or appropriate office of the agency or facility where sexual abuse is alleged to have occurred. The agency relies on Division of Youth Rehabilitative Services Prisoner Rape Elimination Act (PREA) 2.13 Section IV, F,6, that states upon receiving an allegation that a youth was sexually abused while confined to another facility, the administrator of the facility that received the allegation shall notify the administrator of the facility or appropriate office of the agency where the alleged abuse occurred and shall notify the appropriate investigative agency. In the PAQ, the agency reported in the last 12 months there has been no allegations received by the facility that a resident was abused while confined at another facility that would prompt a facility response. The evidence shows that the agency has a policy that outlines the actions to be taken by the facility administrator upon receiving an allegation that a resident was sexually abused while confined at another facility including notifying the head of the facility and investigative agency. A review of the PAQ reveals that the facility received no allegations that a resident was abused at another facility and no further information was provided. Based upon this analysis, the facility is substantially compliant with this provision and no corrective action is required. 115.363 (b): In the PAQ, the facility reported that their policy requires that the facility head provides such notification as soon as possible, but no later than 72 hours after receiving the allegation. The agency relies on Division of Youth Rehabilitative Services Prisoner Rape Elimination Act (PREA) 2.13 Section IV, F 6, a, that states such notification shall be provided as soon as possible but no later than 72 hours from receiving the allegation. During an interview, the Agency head stated that the PREA Coordinator, the hotline and the facility where the resident came from would be notified. During an interview, the Superintendent stated he would immediately reach out to the program and DFS worker. The evidence shows that the agency policy outlines that notification would occur within 72 hours after receiving an allegation. Based upon this analysis, the facility is substantially compliant with this provision and no corrective action is required. 115.363 (c): In the PAQ, the facility reported that the facility documents that it has provided such notification within 72 hours of receiving the allegation. The agency relies on Division of Youth Rehabilitative Services Prisoner Rape Elimination Act (PREA) 2.13 Section IV, F 6 b, that states the facility administrator shall document that notification to both the other agency administrator and the investigative agency has been made. Documentation must also show that YRS director and the Division's PREA coordinator have been notified. During an interview, the Superintendent reported that they have not received any allegations of sexual abuse during the last

12 months that would require the facility to document.

The evidence shows that the facility has not received any allegations to provide notification that would prompt the facility to document that notification within 72 hours. The policy outlines that documentation of the notification would occur within 72 hours of receiving the allegation consistent with this provision.

Based upon this analysis, the facility is substantially compliant with this provision and no corrective action is required.

115.363 (d):

In the PAQ, the facility reported that agency policy requires that allegations received from other agencies or facilities are investigated in accordance with the PREA standards. The facility reported in the last 12 months, they did not have any allegations of sexual abuse from other facilities.

The agency relies on Division of Youth Rehabilitative Services Prisoner Rape Elimination Act (PREA) 2.13 Section IV, G 1, that states all allegations sexual abuse or sexual harassment are reported to the Child Abuse Hotline and screened for Institutional Abuse investigation.

During an interview, the Agency head stated that the PREA Coordinator, the hotline and the facility where the resident came from would be notified. During interviews, the superintendent stated that there have been no reports from another agency.

The evidence shows that the agency policy does require that all allegations of sexual abuse are reported to the child abuse hotline for investigation. Information from the PAQ reveals the facility has not received any allegations of sexual abuse from another facility for investigation. Interviews with staff revealed that the PREA Coordinator would be contacted for allegations received from other agencies and the facility would report the allegation to the child abuse hotline.

Based upon this analysis, the facility is substantially compliant with this standard and no corrective action is required.

115.364	Staff first responder duties
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: Division of Youth Rehabilitative Services Prisoner Rape Elimination Act (PREA) 2.13 Section IV, F 7, (Revised 5/13/21). First Responder Cards DSCYF Academy Staff Training 2021 Investigation Records Interviews: Random Staff Security Staff and Non-Security Staff Findings (by Provision): 115.364 (a): In the PAQ, the agency reports that they have a first responder policy for allegations of sexual abuse, The agency relies upon Division of Youth Rehabilitative Services Prisoner Rape Elimination Act (PREA) 2.13 Section IV, F 7 outlines that upon learning of an allegation that a resident was sexually abused, the first staff member to respond to the report must separate the alleged victim and abuser, preserve and protect any crime scene until appropriate steps are taken to until appropriate steps can be taken to collect evidence and if the abuse occurred within a time period that still allows for the collection of physical evidence, they will ensure that the alleged victim and or alleged abuser does not take any actions that could destroy physical evidence. The First Responder Cards outlines four steps to be taken by line staff upon learning of an allegation that a juvenile was sexually abused (don't wash, brush, urinate), take youth to medical, contact supervisor, start administrative reports. The First responder cards outline five steps for a supervisor to secure crime scene, call hotline 1-800-292-9582, contact chain of command, complete reportable event form and PREA documentation attachments A and C. The DSCYF Academy staff training for prevention, detection and response to sexual abuse in detention outlines that first responders are to separate the victim and perpetrator as quickly as possible, ask the victim are you injured, do you need medical attention, do you believe that you or someone else is in immediate danger, alert your administrator, ensure victim is escorted to medical, ensure perpetrator is in a secure room. preserve evidence by not changing clothes, washing face, body, hair, brushing teeth, urinating or defecating, eating, drinking or smoking. In the PAQ, the agency reported there was no sexual abuse allegation of a resident in the last 12 months. During an interview, Delaware State Police reported that there were no criminal cases of sexual abuse or sexual harassment reported to the department. A review of facility investigation records revealed that there was one allegation of sexual abuse that the security first responder separated the alleged victim from abuser. There was no allegation that allowed for collection of physical evidence, protect a crime scene, request the victim or abuser not to destroy evidence. During interviews, all 12 staff stated they would separate the victim from abuse, 6 out of 12 secure the scene, 4 out of 12 stated they would contact their supervisor, 4 out of 12 stated they would request that the victim does not eat, drink, shower, or change clothes. 11 out of 12 Staff interviewed knew the requirement of separating the victim from the abuser and securing the crime scene. All Staff was able to describe the actions in requesting that the alleged victim not take that could destroy evidence or ensuring that the alleged abuser not take that would destroy evidence. Evidence shows that the agency does have a first responder policy. The facility relies on the policy, first Responder Cards and DSCYF academy training for prevention, detection and response to sexual abuse in detention as evidence to support first responder action for an allegation of sexual abuse. The policy, first responder cards, DSCYF academy training provide all the actions of a first responder. Based upon this analysis, the facility is substantially compliant with this provision and corrective action is not required. 115.364 (b): In the PAQ, the agency reports their policy requires that if the first staff responder is not a security staff member, that responder shall be required to request that the alleged victim not take any actions that could destroy physical evidence. The agency relies upon Division of Youth Rehabilitative Services Prisoner Rape Elimination Act (PREA) 2.13 Section IV, F 7

outlines that upon learning of an allegation that a resident was sexually abused, the first staff member to respond to the report must separate the alleged victim and abuser, preserve and protect any crime scene until appropriate steps are taken to until appropriate steps can be taken to collect evidence and if the abuse occurred within a time period that still allows for the collection of physical evidence, they will ensure that the alleged victim and or alleged abuser does not take any actions that could destroy physical evidence. The policy requires that each facility will follow the coordinated facility response plan and utilize the first responder cards and the coordinated response flowcharts.

The DSCYF Academy staff training for prevention, detection and response to sexual abuse in detention outlines that first responders are to separate the victim and perpetrator as quickly as possible, ask the victim are you injured, do you need medical attention, do you believe that you or someone else is in immediate danger, alert your administrator, ensure victim is escorted to medical, ensure perpetrator is in a secure room. preserve evidence by not changing clothes, washing face, body, hair, brushing teeth, urinating or defecating, eating, drinking or smoking. In the PAQ, the facility reported that any staff can be a first responder.

The First Responder Cards outlines four steps to be taken by line staff upon learning of an allegation that a juvenile was sexually abused (don't wash, brush, urinate), take youth to medical, contact supervisor, start administrative reports. In the PAQ, the agency reported that there was no sexual abuse allegation in the past 12 months made to a non-security first responder.

A review of facility investigation records in the past 12 months revealed that there were no sexual abuse allegations where a non-security first responder had to take actions that could destroy physical evidence or notify security staff.

During interviews, all 12 staff stated they would separate the victim from abuse, 6 out of 12 secure the scene, 4 out of 12 stated they would contact their supervisor, 4 out of 12 stated they would request that the victim does not eat, drink, shower, or change clothes. 11 out of 12 Staff interviewed knew the requirement of separating the victim from the abuser and securing the crime scene. All Staff was able to describe the actions in requesting that the alleged victim not take that could destroy evidence or ensuring that the alleged abuser not take that would destroy evidence.

Evidence shows that the agency does have a first responder policy and relies on the DSCYF academy staff training for prevention, detection and response to sexual abuse in detention and the agency's first responder cards as evidence to support non-security first responder action for an allegation of sexual abuse consistent with this provision. Based on the interviews with staff, all staff could describe actions that the alleged victim not take that could destroy physical evidence

Based upon this analysis, the facility is substantially compliant with this standard and corrective action is not required.

115.365	Coordinated response
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. DYRS Secure Care Facilities Coordinated Response Flowchart 2. First Responder Cards Interviews: 1. Superintendent Findings (by Provision): 115.365 (a): In the PAQ, the facility reported they developed a written institutional plan to coordinate actions taken in response to an incident of sexual abuse among staff first responders, medical and mental health practitioners, investigators, and facility leadership. The facility has a DYRS Coordinated Response Flowchart and a First Responder Card as their written institutional plan to coordinate actions taken in response to an incident of sexual abuse among staff first responders, medical and mental health unit, investigators, and facility leadership. There are four flowcharts that outline immediate responses by staff. PREA Allegation Against Staff, PREA allegation against youth, Investigation by IA and Police, Administrative Investigation. The PREA Allegation Against Staff immediate response states a supervisor removes the staff member from unit #1 priority, request that the alleged victim and alleged abuser not to take any actions to destroy physical evidence: washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking or eating, directs location to be secured, contacts supervisor and hotline, supervisor makes chain of command contacts, reportable event procedure is initiated and PREA documentation completed per policy. PREA allegation against youth immediate response states staff will separate both youth (separate units) on one on one supervision, request that the alleged victim and abuser not take any actions to destroy physical evidence washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking or eating, The plan further outlines that the staff will take victim to medical notify a supervisor and supervisor will direct location to be secured, contact hotline, notify AOD on duty, reportable event procedure is initiated and PREA documentation completed per policy reassess housing and safety concerns when victim returns to facility. Investigation by IA and Police outlines that after IA screens allegation if they accept, IA or IA and Police will coordinate investigation. If IA does not accept the IA case is closed and the allegation is referred for administrative investigation. If IA accepts IA or IA and police coordinate investigation, documents reviewed, interviews with witnesses, victim, and alleged abuser, police collect physical evidence and AG office consulted throughout the process. Administrative Investigation outlines that the PREA compliance manager and PREA Investigator conduct internal investigation. Review documentation, interviews with witnesses, victim, alleged abuser, receives victim statement, and review documentation gathered by police/IA. The First Responder Cards outlines four steps to be taken by line staff upon learning of an allegation that a juvenile was sexually abused (don't wash, brush, urinate), take youth to medical, contact supervisor, start administrative reports. The First responder cards outline five steps for a supervisor to secure crime scene, call hotline 1-800-292-9582, contact chain of command, complete reportable event form and PREA documentation attachments A and C. During an interview, the superintendent stated they would separate the victim, get medical attention, secure the scene, notification through the chain of command, critical reporting, can go to IA for investigation or to our internal investigation. The evidence shows that the agency has a written institutional plan to coordinate a response to incidents of sexual abuse among staff first responders, medical and mental health, investigators and facility leadership which was verified through the DYRS immediate response flowchart, first responder cards, and interview with superintendent. Based upon this analysis, the facility is substantially compliant with this standard and no corrective action is required.

115.366	Preservation of ability to protect residents from contact with abusers
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. State of Delaware Department of Services for Children Youth and Their Families Division of Youth Rehabilitative Services Policy 309 Removal of Employees from the Workplace Section II 5 Page 1 (revised 11/1/12). 2. Agency Website https://kidsfiles.delaware.gov/policies/dscyf/dsc309-Removal-of-Employees-from-Workplace.pdf (11/1/2012). 3. AFSCME Local 3384 and DSCYF MOA (7/1/21) 4. AFSCME Local 2004 and DSCYF MOA (7/1/21) Interviews: 1. Agency head 2. Union Representatives Findings (by Provision): 115.366 (a): In the PAQ, the agency reported they have entered into or renewed any collective bargaining agreement or other agreement since August 20, 2012, or since the last PREA audit, whichever is later. State of Delaware Department of Services for Children Youth and Their Families Division of Youth Rehabilitative Services Policy 309 Section II 5 Page 1, establishes the right to remove employees from the workplace when they pose a risk to the safety of residents for allegations of sexual abuse. An administrative investigation would be completed within seven days of a removal from the workplace and if findings indicate termination is warranted the employee may be suspended without pay pending termination. The staff will not be allowed to resign in lieu of termination. A review of Union and DSCYF memorandum of agreement (MOA) does not prohibit the agency from removing alleged staff sexual abusers from contact with any resident pending the outcome of an investigation or to an extent discipline is warranted. During an interview, when asked has the agency entered into or renewed any collective bargaining agreements or other agreements since August 20, 2012, the agency head reported they have a memorandum of understanding and are reviewing the final negotiations. Department policy 309 still permits them to let a staff go. During an interview with union representative, staff stated there is nothing that in collective bargaining prevents removal of an employee for allegations of sexual abuse or sexual harassment. The evidence shows that the agency has not entered into a collective bargaining agreement that limits the agency's ability to remove an employee from duty which is verified through the agency policy, memorandum (MOA) and interviews with staff. Based upon this analysis, the facility is substantially compliant with this standard and no corrective action is required.

115.367	Agency protection against retaliation
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. Division of Youth Rehabilitative Services Prisoner Rape Elimination Act (PREA) 2.13 Section IV, F-9 Page 8 (Revised 5/13/21). 2. New Castle County Detention Center Organizational Chart (2022). Interviews: 1. Agency head 2. Superintendent 3. Designated Staff Member Charged with Monitoring Retaliation Findings (by Provision): 115.367 (a) 1-2: In the PAQ, the agency reported they have 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. Policy 2.13 Division of Youth Rehabilitative Services (DYRS) Prisoner Rape Elimination Act, Section IV F-9 Page 8, establishes that all resident and staff who report sexual abuse or sexual harassment or cooperate with the investigations of sexual abuse or sexual harassment are protected from retaliation by other residents or staff. In the PAQ, the agency reported that they have designated the program manager as the staff member that monitors for possible retaliation. A review of the New Castle County Detention Center organizational chart confirms that the program manager is designated as the retaliation monitor. The evidence shows that the agency has outlined a policy to protect residents and staff from retaliation and has designated staff member to monitor for possible retaliation which was verified through the agency policy and organizational chart. Based upon this analysis, the facility is substantially compliant with this provision and no corrective action is required. 115.367 (b): Policy 2.13 Division of Youth Rehabilitative Services (DYRS) Prisoner Rape Elimination Act, Section IV E-1, F9 a-b, (page 8), residents can privately report sexual abuse and sexual harassment and retaliation by other residents or staff for reporting sexual abuse or sexual harassment. Retaliation from youth or staff will result in disciplinary action and subject to the full progression of sanction and or referral for criminal prosecution. Retaliation will be monitored for 90 or longer if needed. During an interview, the agency head stated she would remove the youth to keep them safe and the staff from building to building. We have put staff off work for protective measures. During an interview, the superintendent stated the we have the monitoring where we check in with the resident to make sure they are not being mistreated. During an interview, the retaliation monitor stated he would meet with the victim and meet with the perpetrator for 90 days or longer if needed. Every week or two weeks. The monitor stated they would ask them a series of questions. Staff would be out of work no kid contact until investigation is complete or put them in a secluded area. If unsubstantiated unfounded meet with them separately and meet with the youth as well. We also consider moving resident or staff to another facility. During an interview, a resident that reported sexual abuse stated they did feel protected enough against possible revenge from staff of other youth. The evidence shows that the agency has outlined that they employ multiple measures residents and staff that fear retaliation for reporting sexual abuse or sexual harassment. Based upon this analysis, the facility is substantially compliant with this provision and no corrective action is required. 115.367 (c) 1-5: In the PAQ, the facility reported that they monitor the conduct or treatment of residents or staff who reported sexual abuse and of residents who were reported to have suffered sexual abuse to see if there are any changes that may suggest possible retaliation by residents or staff for 90 days or longer if needed. The facility reported there has been no incidents of retaliation

in the past 12 months.

Policy 2.13 Division of Youth Rehabilitative Services (DYRS) Prisoner Rape Elimination Act, Section IV E-1, F9 a-b, (page 8), residents can privately report sexual abuse and sexual harassment and retaliation by other residents or staff for reporting sexual abuse or sexual harassment. Retaliation from youth or staff will result in disciplinary action and subject to the full progression of sanction and or referral for criminal prosecution. Retaliation will be monitored for 90 or longer if needed.

During an interview, the superintendent stated If they feel they have been retaliated against we use progressive discipline. During an interview, the retaliation monitor stated he would monitor for 90 days or up to 120 days. We also consider moving resident or staff to another facility.

The evidence shows that the agency has a policy to protect residents and staff from retaliation and has designated a supervisor to monitor retaliation of residents and staff which was verified through the agency policy, organizational chart, interview with the agency head, Superintendent and Program Manager in charge of retaliation monitoring.

Based upon this analysis, the facility is substantially compliant with this provision and no corrective action is required.

115.367 (d):

The agency reported in the PAQ that there has not been an incident of retaliation in the past 12 months that would prompt monitoring a resident as required by this provision.

During interviews, the retaliation monitor stated he would meet with the residents over a 90-day period or longer if needed. He would meet with the victim and meet with the perpetrator for 90 days or longer if needed. Every week or two weeks. The monitor stated they would ask them a series of questions. The evidence shows that the facility has a process to monitor retaliation for residents through the Program Manager who is responsible for retaliation monitoring.

Based upon this analysis, the facility is substantially compliant with this provision and no corrective action is required.

115.367 (e):

Policy 2.13 Division of Youth Rehabilitative Services (DYRS) Prisoner Rape Elimination Act, Section IV F-9a, Page 8, establishes that retaliation from youth or staff will result in disciplinary action and subject to full progression of sanctions and or referral for criminal prosecution. The agency reported in the PAQ that there has not been an incident of retaliation in the past 12 months.

During interviews, the agency head stated she would remove the youth to keep them safe and the staff from building to building. We have put staff off work for protective measures. During interviews, the superintendent stated we have the monitoring where we check in with the resident to make sure they are not being mistreated. If they feel they have been retaliated against we use progressive discipline.

The evidence shows that the facility has a process to take appropriate measures to protect an individual that fears retaliation which was verified through the PAQ, organizational chart and staff interviews.

Based upon this analysis, the facility is substantially compliant with this standard and no corrective action is required.

115.368	Post-allegation protective custody
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1, Division of Youth Rehabilitative Services Prisoner Rape Elimination Act (PREA) 2.13 Section IV D-2, (Revised 5/13/21). 2. Division of Youth Rehabilitative Services Professional Practices Lesbian, Gay, Bisexual, Transgender, Questioning, and Intersex (LGBTQI) 2.20 (Revised 3/5/19). 3. New Castle County Detention Center Security and Control (Room Confinement for Control) NCCDC-216, (3/20/21) 4. 12 Resident Files 5. 6 Housing unit record logs. Interviews: 1. Superintendent 2. Medical and mental health staff 3. Staff that Supervise Residents in Isolation Site Review Observations: 1. Site review of facility housing units. Findings (by Provision): 115.368 (a) 1-7: In the PAQ, the agency reported residents who allege to have suffered sexual abuse may only be placed in isolation as a last resort if less restrictive measures are inadequate to keep them and other residents safe, and only until an alternative means of keeping all resident's safe can be arranged. Policy 2.13 Division of Youth Rehabilitative Services (DYRS) Prisoner Rape Elimination Act, Section IV D-2, pp.6, establishes that placement and programming assignments for each transgender youth, intersex youth, youth assessed as high risk for being victimized or offending or in need of protective housing is reviewed by the facility's assessment team at least twice a month to review any threats to safety experienced by the resident. In the PAQ, the agency reported that they have a policy that requires that residents who are placed in isolation because they allege to have suffered sexual abuse have access to legally required educational programming, special education services, and daily large muscle exercise. In the PAQ, the facility reported there were no residents to have suffered sexual abuse placed in Isolation, who have been denied daily access to large muscle exercises and/or legally required education or special education, held in isolation to protect them from sexual victimization in the last 12 months. The facility reported there were no residents at risk of sexual victimization held in isolation in the past 12 months. Policy Division of Youth Rehabilitative Services Professional Practices Lesbian, Gay, Bisexual, Transgender, Questioning, and Intersex (LGBTQI) 2.20 Section IV, Titled Special Considerations E, C, establishes that LGBTQI youth may be isolated from others only as a last resort when less restrictive measures are inadequate to keep them and other youth safe, and then only until alternative means of keeping all youth safe can be arranged. During any period of isolation, DYRS staff shall not deny youth daily large-muscle exercise and any legally required educational programming or special education services. Youth in isolation shall receive daily visits from medical staff or behavioral health services clinician or provider. Youth shall also have access to other programs and work opportunities to the extent possible. Policy NCCDC-216 New Castle County Detention Center Security and Control (Room Confinement for Control) Specifically, this policy addresses that confinement is necessary to prevent imminent physical harm to other persons and to maintain security control of the facility or for disciplinary reasons following required due process proceedings. The policy outlines that protective custody may be used to protect a youth from sexual or physical assault or other forms of abuse. While in confinement, the youth shall have the same access to hygiene, bedding, reading material, clothing, supplies and recreation. As written, the policy does not state residents who are placed in isolation because they allege to have suffered sexual abuse have access to legally required educational programming, special education services, and daily large muscle exercise. The policy outlines that protective custody may be used no longer than 24 hours without written approval of the division director. During an interview, the Superintendent stated that there were no residents alleged to have suffered sexual abuse placed in isolation during the last 12 months. Isolation is always used as a last resort. We have the flexibility to transfer to Stevenson House Detention Center. Education and large muscle exercise is happening in isolation. They residents would be given

	education packets in isolation. Large muscle exercise one hour a day for 24 hours and they would log it in the logbook. We have staff constantly checking on them. During an interview, mental health staff indicated that everyday mental health staff would check on a resident in isolation. They have an hour of large muscle and are brought school work. During an interview, medical staff indicated they would visit a resident twice daily sometimes more. During an interview, Staff that supervise residents in isolation stated residents would receive programs, privileges, and education/special education. Residents are only placed in isolation for one hour, medical and mental health visits residents daily, and residents do not stay in isolation 30 days. During a review of 12 residential files, the auditor was able to confirm that there were no residents isolated at the facility that alleged to have suffered from sexual abuse in the last 12 months preceding the onsite audit. A review of the observation log reveals that residents are seen by medical and mental health providers, provided education packets are provided large muscle exercise daily as outlined in the agency policy. During the onsite review, the auditor was able to observe the housing units that can be utilized for room confinement/Isolation. The New Castle County Detention Center had secure housing unit entrances, cells and exits. All areas require a key or remote access to enter. The auditor reviewed six housing unit logs that confirm the agencies practice. The logs provide a detailed tracking of the resident, staff, date, time, and activity observed. The evidence shows the facility does isolate residents at the facility which was verified through interview, observation, policy and documentation review. Residents in isolation receive daily visits from medical or mental health care clinician and a review within 30 days as provided in the standard and the agency policy. The evidence shows that residents are provided educational packets, and daily large muscle exercise. The evidence shows that there were no residents in the 12 months preceding the onsite audit that were isolated at the facility that alleged to have suffered from sexual abuse. Based upon this analysis, the facility is substantially compliant with this standard and no corrective action is required.

115.371	Criminal and administrative agency investigations
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. DYRS 2.13.IV.G,1-4.b 2. Affirmation of Compliance with Investigative Standards for Sexual Assaults:Delaware State Police and the Department of Services for Children, Youth, and Their Families 3. State of Delaware Memorandum of Understanding for the Multidisciplinary Response to Child Abuse and Neglect 4. NCCDC Investigative Files for Sexual Abuse and Sexual Harassment 5. Institutional Abuse Investigator Certificates for NIC PREA: Investigating Sexual Abuse in Confinement Settings and PREA: Investigating Sexual Abuse in Confinement Settings-Advanced 6. Facility PREA investigators Certificates for NIC PREA: Investigating Sexual Abuse in Confinement Settings and PREA: Investigating Sexual Abuse in Confinement Settings-Advanced 7. PREA Policy 2.13 Attachments-Sexual Abuse Review of Substantiated and Unsubstantiated Outcomes Form and the Non-Critical Reportable Event Form 8. PREA Investigative Tracking Form 9. Pictures of Double Lock System Interviews: 1. Delaware State Police Troop #2 (DSP) 2. Institutional Abuse (IA) PREA investigator 3. Facility PREA investigator 4. PREA coordinator 5. PREA compliance manager 6. Former Superintendent of NCCDC 7. Random youth Findings (by Provision): 115.371 (a):-1 Within DYRS Policy 2.13.IV.G.1-4.b, there is a section that addresses investigations in secure care. The policy details that all matters that involve the allegation of any sexual abuse and sexual harassment as in this policy will be reported to the Child Abuse Hotline and screened for Institutional Abuse (IA) investigation. Further, the policy mentions that for matters which could result in a criminal action, Institutional Abuse will conduct a joint investigation with the Delaware State Police (DSP). During interviews with IA, and the onsite PREA investigators, it was confirmed that the first steps in initiating an investigation would be to contact the Child Abuse Hotline. The hotline would determine if the investigation would be handled by IA or screened back to the facility to conduct an administrative investigation to be handled by the onsite PREA investigators. If the allegation is determined to be screened to IA, the investigation would be completed by IA. If the allegation is determined to be criminal, DSP would be contacted, and IA would assist with the investigation. It was further determined through interview and policy that all allegations including third-party and anonymous reports would be handled in the same manner. Review of investigative documents provided to the auditor, it was determined that investigations are reported to the Child Abuse Hotline in a timely manner, but the documentation is not completed in a timely manner. There was an allegation that the auditor could not determine the status due to lack of submission of documentation of the incident. The incident occurred almost 20 days prior, and documentation was not provided or completed until requested by auditor. Based on review of investigative files, the auditor determined that PREA investigations of sexual abuse and sexual harassment are not conducted in a manner which is thorough. In two of the three investigative files reviewed, there was a lack of documentation. Below are the items that were not available in the investigative file. 1. Sexual Abuse Incident Review of Substantiated and Unsubstantiated Outcomes 2. Footage of Incident 3. Facility PREA Investigators Report 4. Victim Written Statement 5. Notification of Investigation Due to the lack of information obtained in the investigative files, the auditor was unable to determine if investigations were

completed objectively.

The auditor further researched to determine if there were any PREA investigations completed by the DSP or IA. During an interview with DSP, it was disclosed that there were no criminal sexual abuse or sexual harassment allegations reported from IA, Child Abuse Hotline, or NCCDC. According to the Institutional Abuse investigator, there were no criminal nor administrative sexual abuse or sexual harassment allegations investigated by IA PREA investigators for NCCDC.

Based on the analysis, the agency does not substantially meet compliance in this provision of providing timely, thorough, and objective investigations.

115.371(b)-1

Information obtained from the PAQ confirmed a total of 5 staff had obtained certification to be a PREA investigator. Those 5 were comprised of 2 IA officers and 3 staff members that were employed onsite at NCCDC. All 5 individuals were certified in NIC PREA: Investigating Sexual Abuse in a Confinement Setting and NIC PREA: Investigating Sexual Abuse in a Confinement Setting: Advanced. Of the 5 certified PREA auditors, 2 IA investigators had prior experience in conducting investigations.

During the interviews with 3 of the certified PREA investigators, it was determined they received training in conducting sexual abuse and sexual harassment investigations in confinement settings. They identified that they had been trained in techniques to interview juvenile sexual abuse victims, use of Miranda and Garrity warnings, sexual abuse evidence collection in confinement settings, and the criteria and evidence to substantiate a case for administrative or prosecution referral. Additionally, the interviewees explained that allegations of sexual abuse or sexual harassment that was of a criminal nature would be conducted by DSP with the assistance of the PREA certified IA officers.

There were three allegations reviewed that were screened out to be completed administratively. During the onsite document review, the auditor determined the investigation files of sexual abuse and sexual harassment revealed there was only one investigation that utilized a certified PREA investigator at the time of investigation. The authors of the investigative reports in question were later to be certified to be PREA investigators. All investigative files of sexual abuse and sexual harassment were uploaded to the supplemental files in OAS between 4/18/2022-5/3/2022.

Based on the analysis, the agency does not substantially meet compliance in this provision of providing specialized training for investigators.

115.371(c)-1

During an interview with one of the facility's PREA investigators, it was disclosed that there was one allegation of sexual abuse that was assigned. There was one sexual abuse that was provided via the supplemental files on 4/12/2022. Further investigation of non-critical incident reports and staff interviews, it was determined by the auditor that there were allegations of an additional sexual abuse and an incident that occurred that the auditor was unable to determine due to lack of information provided. For the undetermined incident, a non-critical incident report was provided upon request to the auditor on 4/20/2022 which was 20 days after the incident.

Review of the PREA investigations tracking form obtained in the PAQ, there was one sexual harassment allegation investigated and recorded. The allegations of sexual abuse and the undetermined allegation were not identified on the PREA investigations tracking form. According to the PREA coordinator and the management analyst, there were no additional investigative files of sexual abuse or sexual harassment forwarded from NCCDC to be included on the PREA investigation tracking form.

For one of the two sexual abuse investigative files, the auditor determined that there was no gathering or preserving of evidence. There was neither direct or circumstantial evidence including physical, electronic monitoring, interview of victims, suspected perpetrator, or witnesses. Additionally, based on the documentation contained in the file, there was no evidence of a consult to FOCUS or any other location for prior reports and complaints of sexual abuse involving the suspected perpetrator.

Based on this analysis, the agency does not meet compliance in this provision of gathering and preserving evidence of sexual abuse or sexual harassment.

115.371(d)-1

In the Affirmation of Compliance with Investigative Standards for Sexual Assault, it explicitly expresses that DSP will not terminate a criminal PREA investigation solely because the source of the allegation recants the allegation.

In the sexual abuse and the undetermined PREA investigative allegations that were conducted administratively, the auditor could not determine if the allegations were recanted due to the investigative files lacking pertinent information.

According to both the IA investigator, Facility PREA investigator, and DSP investigations do not terminate if the source of the allegation recants.

Based on the analysis, the agency does substantially meet compliance with this provision.

115.371(e)-1

According to the DSP, IA, and the PREA investigators interviewed, there have been no sexual abuse investigations that rose to criminal threshold. Investigations that meet the criminal threshold are jointly investigated by DSP and IA. In the case of compelled interviews, DSP would be responsible for consulting with prosecutors prior to conducting a compelled interview. Interview with DSP and the IA PREA investigator confirmed the procedure for conducting a compelled interview.

Based on the analysis, the agency does substantially meet compliance in this provision.

115.371(f)-1

When assessing the credibility of an alleged victim, witness, or suspect, the IA PREA investigator stated that the credibility is based on an individual basis. It is not based on the individual's status as a resident or staff member. Further, it was confirmed from the IA PREA investigator the agency does not require a youth that alleges sexual abuse to submit to a polygraph examination or other truth telling device as a condition to proceed with an investigation. Confirmed during interview with random youth, there were no residents who had reported sexual abuse at NCCDC.

Based on the analysis, the agency does substantially meet compliance in this provision.

115.371(g)-1

Due to the lack of documentation in the investigative files, the auditor determined there was no statements of concern by the investigator regarding the practice of staff actions or failures to act contributed to the sexual abuse or sexual harassment. Additionally, there was no rationale determining credibility assessments nor investigative facts.

Based on the analysis, the agency does not meet compliance in this provision.

115.371(h)-1

DYRS has not reported or provided documentation of any criminal investigations during the onsite or via the PAQ. Further, the auditor interviewed DSP, and the auditor was informed that there were no criminal investigations of sexual abuse or sexual harassment reported to DSP from NCCDC. It was further explained by DSP that criminal investigations would be documented in a report. The report would be distributed to the IA PREA investigator. The IA PREA investigators would be responsible for providing that information to the facility superintendent and PREA compliance manager.

Based on the analysis, the agency does substantially meet compliance in this provision.

115.371(i)-1

Cited in DYRS Policy 2.13.IV.G.1.a, acts deemed to be a criminal offense, as recognized by the Child Abuse Hotline, will be referred to the DSP. In both the interview with DSP and the IA PREA investigator, the auditor determined that substantiated allegations of conduct that appear to be criminal are referred for prosecution. According to DSP, there were no substantiated allegations of conduct that appeared to be criminal that was referred for prosecution from the NCCDC within the last 12 months.

Based on the analysis, the agency does substantially meet compliance in this provision.

115.371(j)-1

The auditor was provided pictures of the double lock system to secure sexual abuse and sexual harassment investigative files. The file cabinet contained past years of written reports of sexual harassment and sexual abuse investigative files. Additionally, the PREA Coordinator explained that they are in the process of converting all hardcopy files to electronic files. This process will have a double lock system procedure in place. Within the DYRS Policy 2.13.IV.J.9-10 is the agency's procedure for maintaining a double lock system for investigative files of sexual abuse and sexual harassment. Thereafter is stated the retention policy for PREA data to be retained no less than 10 years after the date of its initial collection unless, Federal, State, or local law requires otherwise. The agency does substantially meet compliance in this provision.

115.371(k)-1

According to interviews with both IA PREA investigator and the facility PREA investigator, the departure of an alleged abuser or victim from employment or control of the facility or agency does not provide a basis for terminating an investigation. The agency does substantially meet compliance in this provision.

115.371(l)-1

The Affirmation of Compliance with Investigative Standards for Sexual Assaults between DYRS and the DSP ensures that DSP conducts investigations in accordance with 115.371(a)-(k). The agency does substantially meet compliance in this provision.

115.371(m)

DSP stated during the interview that IA PREA investigator jointly with DSP will conduct investigations, and DSP will provide reports and inform IA PREA investigator of the process of investigations. The auditor confirmed through interviews with the former superintendent and the PREA compliance manager that DSP would provide information pertaining to a sexual abuse investigation at the NCCDC to IA PREA investigator. The agency does substantially meet compliance in this provision.

The information provided from the PAQ shows that the agency has a policy related to criminal and administrative agency investigations. Review of the sexual abuse investigative files within the last 12 months did not demonstrate that PREA investigations were handled promptly, thoroughly, and objectively. Interviews of DSP, IA PREA investigators, and facility PREA investigators have confirmed that investigations are not terminated due to the source of the allegation recants and credibility is assessed on an individual basis. Additionally, investigations are not terminated due to the departure of an alleged abuser or victim from employment or release from the facility. Based on the sexual abuse investigative files within the last 12 months, the facility does not report if staff actions or failures contributed to the sexual abuse, and the PREA investigations lack the description of physical evidence, testimonial evidence, credibility assessment, and investigative facts. The pictures provided in supplemental file confirmed the practice of maintaining written reports in accordance with 115.371(j).

Based on this analysis, the NCCDC does not meet the standard. Corrective action is required.

Corrective Action:

1. Train facility PREA investigators on completing PREA investigations that are thorough, prompt, and objective.
2. All PREA investigations are conducted by certified PREA investigators.
3. Train PREA investigators to include in PREA investigative files direct and/or circumstantial evidence including physical, electronic monitoring, interview of victims, suspected perpetrator, or witnesses and documentation of a consult to youth file or employee file any other location for prior reports and complaints of sexual abuse involving the suspected perpetrator.
4. Train PREA investigators to include in PREA investigative files statements of whether staff actions or failures to act contributed to the sexual abuse or sexual harassment.
5. Train PREA investigators to include in PREA investigative files the reasoning behind credibility assessments and investigative facts.

Best Practice Recommendations:

1. Collaborate with the PREA coordinator, PREA compliance manager, management analyst, facility administration, and the facility PREA investigators to develop a coordinated plan for uniformity in obtaining, retaining, and distributing documentation of PREA investigations.

Verification of Corrective Action since the audit:

The facility sent the auditor documentation on 5/20/2022, 7/27/22, and 7/28/22 in response to the corrective actions.

1. Copies of pending sexual abuse allegations
2. Copy of completed investigation of sexual abuse
3. Certificate of an additional NCCDC PREA Investigator
4. Retraining materials Provided PREA Resource Center- Specialized Training Investigating Sexual Abuse in Correctional Setting Training Curriculum
5. Provided Staff training acknowledgements
6. NCCDC PREA Investigators summary of NCIC- retraining

The following actions were taken: An additional PREA Investigator was trained utilizing the NCIC PREA Investigation Training in Confinement Settings.

The following action was taken: DYRS provided PREA investigations training agenda that included interviewing Juvenile Sexual Abuse Victims, report writing, and the agency PREA policy 2.13 which included attachments PREA incident forms. The agency retrained one facility investigator on the PREA investigation training and documented that the staff received the training. Additionally, staff in need of retraining summarized the initial training from the NCIC training.

	Corrective Action #1 The intent of this corrective action was to ensure that administrative or criminal investigations were referred and completed for all allegations of sexual abuse and sexual harassment. The facility reported they had two allegations of sexual abuse and no sexual harassment after onsite audit. Currently, the two sexual abuse allegations are pending investigation with the Delaware State Police. Once the facility receives notification that the investigations have concluded, the facility will conduct an administrative investigation. This satisfies the auditor's corrective action requirement. Corrective Action #2, #3, #4, and #5 The intent of this corrective action was to ensure that facility investigative staff received investigative training and that the training was documented. The agency provided a PREA Resource Center (PRC) Specialized Training Investigating Sexual Abuse in Correctional Setting Training Curriculum (75 pages). The facility provided one page training roster that included one staff signature acknowledging that they were trained on Specialized Training Investigating Sexual Abuse in Correctional Setting on 7/25/22. This satisfies the auditor's corrective action requirement. Based on review of the information received, the auditor finds the facility substantially compliant with this standard.

115.372	Evidentiary standard for administrative investigations
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. DYRS PREA Policy 2.13.IV.G.2 2. DSCYF Policy 208 3. State of Delaware Memorandum of Understanding for the Multidisciplinary Response to Child Abuse and Neglect: Child Abuse Protocol p.98 Interviews: 1. IA PREA investigator 2. NCCDC Facility PREA investigator Findings (by Provision): 115.372 (a)-1: Three documents were provided in the PAQ to address PREA Standard 115.372(a). DYRS PREA Policy 2.13.IV.G.2 states that for administrative investigations into sexual abuse and sexual harassment, the allegations will be substantiated if most of the evidence supports them. In DSCYF Policy 208, the policy makes references to investigating utilizing DFS Institutional Abuse Investigation Protocol policy and procedures. The policy does not have language specific to determining the standard evidence utilized in sexual harassment and sexual abuse investigations. PREA mandates require imposing a standard of a preponderance of the evidence or a lower standard of proof for determining whether allegations of sexual abuse or sexual harassment are substantiated. The language specific to determining the standard of evidence is written in the State of Delaware Memorandum of Understanding for the Multidisciplinary Response to Child Abuse and Neglect: Child Abuse Protocol. It states DFS (IA) will make a finding once it has established that a preponderance of the evidence exists. In a sexual abuse investigation and a sexual harassment investigation, there were terms written that alluded to the use of preponderance of the evidence, but the term was not specifically written. During the interviews with IA PREA investigator and the NCCDC facility PREA investigators 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. The agency does substantially meet compliance in this provision. Based on the analysis of the DYRS PREA Policy 2.13.IV.G.2 and the State of Delaware Memorandum of Understanding for the Multidisciplinary Response to Child Abuse and Neglect: Child Abuse Protocol, the interviews with the IA PREA investigator and NCCDC PREA investigators, the auditor has determined that DYRS does not impose a standard higher than a preponderance of the evidence when determining if allegations of sexual abuse or sexual harassment are substantiated. The agency is substantially compliant with this standard and no corrective action is needed at this time. Recommendation: 1. Use the terminology of preponderance of the evidence or a clearer term when identifying standard used for substantiating sexual abuse or sexual harassment in PREA investigative files.

115.373	Reporting to residents
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. DYRS Policy 2.13.IV.G.4 2. DYRS Policy 2.13 Attachment D Notification of Investigation 3. Sexual Harassment Investigation 1/20/2022 4. Sexual Abuse Investigation 5/14/2021 Interviews: 1. NCCDC PREA investigator 2. Former Superintendent 3. PREA compliance manager 4. Delaware State Police (DSP) 5. Random youth Findings (by Provision): 115.373 (a)-1-3: DYRS Policy 2.13.IV.G.4 pertains to informing residents who make allegations that they have suffered sexual abuse in an agency facility are informed verbally, or in writing of the allegations that have been determined to be substantiated, unsubstantiated, or unfounded. The policy specifically states that upon completion of an investigation, the resident will be informed whether the allegation was substantiated, unsubstantiated or unfounded. This notification is made using the Notification of Investigation form that is attached to this policy. The auditor reviewed a sexual abuse investigative file from 5/14/2021 to check for compliance. The investigative file did not include a completed Notification of Investigation form. In a sexual harassment investigative file dated 1/20/2022, there was a Notification of Investigation form completed. The auditor was unable to determine the outcome of the incident that occurred on 3/31/2022 due to the limited information available to the auditor. Based on interviews with the former superintendent and the NCCDC PREA investigators, youth are to be notified of outcomes of both sexual abuse and sexual harassment allegations. Based on the analysis, the agency does not meet compliance in this provision. 115.373 (b)-1: In the last 12 months, there were no sexual abuse cases that were referred for criminal investigation documented in the PAQ. Further collaborated with interviews with DSP, the PREA compliance manager, and former superintendent, there were no sexual abuse cases referred for criminal investigation. 115.373 (c)-1-3: Within the last 12 months, there was a sexual abuse allegation dated 5/14/2021. The allegation was unsubstantiated allegedly committed by a staff member against a youth at NCCDC. Upon review of the PREA investigative file, there was no notification documentation located in the file. During the random interviews of youth, there were no residents that reported sexual abuse during the onsite review in order to determine if NCCDC practiced notifying youth of outcomes of sexual abuse allegations. 115.373 (d)-1: Within the last 12 months, there were no sexual abuse cases that were alleged by a resident by another resident documented in the PAQ. Further confirmed by interviews with random residents there were no sexual abuse cases that were alleged to have been committed by a resident. The auditor was unable to determine the practice of notification of youth-on-youth allegations of sexual abuse. 115.373 (e)-1-3: DYRS Policy 2.13.IV.G.4 requires that upon completion of an investigation, the youth will be informed whether the allegation was substantiated, unsubstantiated or unfounded utilizing the Notification of Investigation form which is an attachment to

DYRS Policy 2.13. Within the last 12 months, the sexual abuse allegation dated 5/14/2021 was not documented. In accordance with DYRS Policy 2.13.IV.J.3, the director, management analyst, PREA coordinator are to be provided with the Notification of Investigation form. The facility did not adhere to the agency policy in providing this documentation nor distributing.

Based on the analysis, the agency does not meet compliance in this provision.

It is evident that the agency has a policy that notifies residents who have alleged sexual abuse in an agency facility with written notification utilizing the Notification of Investigation form. The practice of using this form was not evident in the sexual abuse investigative file of 5/14/2021.

Based on the analysis, the facility is not compliant with this standard and corrective action is required.

Corrective Action:

1. NCCDC PREA investigators will be trained in the use of the Notification of Investigation form.
2. NCCDC PREA investigators and PREA compliance manager will be trained in the documentation and dissemination of the Notification of Investigation form to the director, deputy director, management analyst, and PREA coordinator.

Verification of Corrective Action since the audit:

The facility sent the auditor documentation on 7/25/2022 in response to the corrective actions.

1. DYRS PREA Investigations Training Agenda
2. Provided PREA Resource Center- Specialized Training Investigating Sexual Abuse in Correctional Setting Training Curriculum
3. Provided Staff training acknowledgement

The following action was taken: DYRS provided PREA investigations training agenda that included PREA Policy 2.13 which includes attachments of the Notification of Investigation Form. Found in the training was the PREA Incident File Instructions Form listing required documentation and due dates. The agency retrained one facility investigator on the PREA investigation training and documented that the staff received the training.

Corrective Action #1and #2

The intent of this corrective action was to ensure that NCCDC PREA investigators are trained to report and document outcomes of sexual abuse and sexual harassment to youth, and the outcomes are disseminated and documented to all required staff in a timely manner.

Based on review of the information received, the auditor finds the facility substantially compliant with this standard.

115.376	Disciplinary sanctions for staff
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. Division of Youth Rehabilitative Services Prisoner Rape Elimination Act (PREA) 2.13 Section IV, H.1, (Revised 5/13/21). 2. Delaware Children's Department Policy 313 Initial Background Checks and Subsequent Arrest and/or Allegations of Child Abuse/Neglect (Revised 12/15/16). 3. Removal of Employees from the Workplace Policy 309 (Revised 11/1/12) 4. Delaware Department of Human Resources Policy on Respectful Workplace (Revised October 2005). 5. Delaware Children's Department Policy 208 Institutional Abuse (Revised 6/8/16). 6. Investigation Records Interviews: 1. Investigative staff Findings (by Provision): 115.376 (a): In the PAQ, the facility states staff is subject to disciplinary sanctions up to and including termination for violating the agency sexual abuse and sexual harassment policies. The facility relies on Policy 2.13 Division of Youth Rehabilitative Services Prisoner Rape Elimination Act (PREA) Section IV H.1, that outline all staff is subject to disciplinary sanctions up to and including termination for violating the agency sexual abuse and sexual harassment policies. The facility relies on Policy 313 Initial Background Checks and Subsequent Arrest and/or Allegations of Child Abuse/Neglect, that outlines if as a result of a prohibited offense, ineligible determination or a substantiation of child abuse or neglect a recommendation for termination is warranted. As written, the policy does not mention sexual abuse or sexual harassment and does not state that staff is subject to disciplinary sanctions up to and including termination for violating the agency sexual abuse and sexual harassment policies. The facility relies on Policy 309 Removal of Employees from the Workplace, that outlines that allegations of events that may lead to immediate removal from the workplace include but not be limited to physical or sexual abuse against a resident. The policy refers to allegations of sexual abuse and does not specifically outline that staff is subject to disciplinary sanctions up to and including termination for violating the agency sexual abuse and sexual harassment policies. The facility relies on DHR policy on sexual harassment prevention, that outlines that employees are strictly prohibited from engaging in any form of sexual harassment from an employee from any state facility to another employee. As written, this policy refers to employee on employee sexual harassment and not residents. The policy does not specifically state staff is subject to disciplinary sanctions up to and including termination for violating the agency sexual abuse and sexual harassment policies. The facility reported there were no allegations of sexual abuse or sexual harassment during the last 12 months. During an interview, Delaware State Police reported that there were no criminal cases of sexual abuse or sexual harassment reported to the department. The auditor reviewed three investigation records for allegations of sexual abuse and sexual harassment. No staff was subject to disciplinary sanctions for violating the agency sexual abuse or sexual harassment policy. The evidence shows that agency Policy 2.13 Division of Youth Rehabilitative Services Prisoner Rape Elimination Act (PREA) provides that staff is subject to disciplinary sanctions up to and including termination for violating the agency sexual abuse and sexual harassment policies which was verified though policy, staff interviews and investigation records. Based upon this analysis, the facility is substantially compliant with this provision and corrective action is not required. 115.376 (b): In the PAQ, the facility reported in the last 12 months there was no staff at the facility that violated, resigned or have been terminated for violating the agency sexual abuse or sexual harassment policies. The facility relies on Policy 313 Initial Background Checks and Subsequent Arrest and/or Allegations of Child Abuse/Neglect,

that outlines if as a result of a prohibited offense, ineligible determination or a substantiation of child abuse or neglect a recommendation for termination is warranted.

Facility staff reported there were no allegations of sexual abuse or sexual harassment during the last 12 months. During an interview, Delaware State Police reported that there were no criminal cases of sexual abuse or sexual harassment reported to the department.

The auditor reviewed three investigation records for allegations of sexual abuse and sexual harassment. No staff that violated, resigned or was terminated for violating the agency sexual abuse or sexual harassment policy.

The evidence shows that no staff violated, resigned or was terminated for violating the agency sexual abuse or sexual harassment policy which was verified through policy, staff interviews and investigation records.

Based upon this analysis, the facility is substantially compliant with this provision and no corrective action is required.

115.376 (c):

In the PAQ, the facility reported that sanctions for violations of agency policies relating to sexual abuse or sexual harassment are 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. The facility reported the last 12 months there had been no staff disciplined for violating the agency's sexual abuse or sexual harassment policy.

The facility relies on PREA Policy 2.13 Section IV, H.1, that outlines that staff shall be subject to disciplinary sanctions up to including termination for violating agency sexual abuse and sexual harassment policies. Human resources will be consulted as applicable.

Facility staff reported there were no allegations of sexual abuse or sexual harassment during the last 12 months. During an interview, Delaware State Police reported that there were no criminal cases of sexual abuse or sexual harassment reported to the department.

The auditor reviewed three investigation records for allegations of sexual abuse and sexual harassment. No staff was found to have violated the agency's sexual abuse or sexual harassment policy.

The evidence shows that no staff violated the agency sexual abuse or sexual harassment policy which was verified through policy, staff interviews and investigation records.

Based upon this analysis, the facility is substantially compliant with this provision and no corrective action is required.

115.376 (d):

In the PAQ, the facility reported 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, are reported to law enforcement agencies, unless the activity was clearly not criminal, and to any relevant licensing bodies. The facility reported the last 12 months there had been no staff terminations or resignations for violating the agency's sexual abuse or sexual harassment policy.

The facility relies on Institutional Abuse Policy 208 Section D, which outlines the agency is required by law to notify law enforcement and the Department of Justice (DOJ) of potential criminal violations involving children, alleged physical/sexual abuse or serious neglect of a client by a DSCYF employee, contractor or volunteer requires a multidisciplinary response. As written the policy does not include terminations for violations of sexual harassment policies.

Facility staff reported there were no allegations of sexual abuse or sexual harassment during the last 12 months. During an interview, Delaware State Police reported that there were no criminal cases of sexual abuse or sexual harassment reported to the department.

The auditor reviewed three investigation records for allegations of sexual abuse and sexual harassment. No staff was found to have violated the agency's sexual abuse or sexual harassment policy that would have warranted notification to law enforcement agencies.

The evidence shows that no staff violated the agency sexual abuse or sexual harassment policy that would have warranted notification to law enforcement agencies which was verified through policy, staff interviews and investigation records.

Based upon this analysis, the facility is substantially compliant with this provision and no corrective action is required. Based upon this analysis, the facility is substantially compliant with this standard and no corrective action is required.

Best Practice Recommendations:

1. Sexual harassment violations are not included. Revise Institutional Abuse 208 policy to include terminations for violations of sexual harassment policies or resignations by staff who would have been terminated if not for their resignation, are

	reported to law enforcement agencies, unless the activity was clearly not criminal, and to any relevant licensing bodies.

115.377	Corrective action for contractors and volunteers
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. Division of Youth Rehabilitative Services Prisoner Rape Elimination Act (PREA) 2.13 Section III, A, Section IV F.1, (Revised 5/13/21). 2. Child Sexual Abuse Protocol Memorandum of Understanding C.1, (Final 2017). 3. Delaware Children's Department Policy 313 Initial Background Checks and Subsequent Arrest and/or Allegations of Child Abuse/Neglect (Revised 12/15/16). 4. Department of Services for Children, Youth and Their Families Policy 305 Standards of Conduct Employees, Volunteers and Interns (Revised 4/9/2018). 5. Removal of Employees from the Workplace Policy 309 (Revised 11/1/12) 6. Delaware Children's Department Policy 208 Institutional Abuse (Revised 6/8/16). 7. Investigation Records Interviews: 1. Superintendent 2. Delaware State Police Findings (by Provision): 115.377 (a): In the PAQ, the agency reported that agency policy requires that any contractor or volunteer who engages in sexual abuse be reported to law enforcement agencies, unless the activity was not criminal to relevant licensing bodies and be prohibited from contact with residents. In the past 12 months the facility reported that there had been no volunteers or contractors reported to law enforcement or licensing bodies for engaging in sexual abuse of residents. The agency relies on PREA Policy 2.13 Section III A and Section IV, F 1, outlines volunteers and contractor are defined as departmental employees. Staff must comply with child abuse reporting laws and will report any incidents of sexual and sexual harassment to Child Abuse Hotline. The facility provided the Child Abuse Protocol Memorandum that outlines DFS must make an immediate report to the appropriate law enforcement jurisdiction and the Department of Justice for all civil offenses identified in the Sexual Abuse Protocol, DFS is required to report all persons, agencies, organizations and entities to DOJ for investigation if they fail to make mandatory reports of child abuse or neglect. Agency Institutional Abuse Policy 208 Section D, outlines the agency is required by law to notify law enforcement and the Department of Justice (DOJ) of potential criminal violations involving children, alleged physical/sexual abuse or serious neglect of a client by a DSCYF employee, contractor or volunteer requires a multidisciplinary response. Facility staff reported there were no allegations of sexual abuse or sexual harassment during the last 12 months. During an interview, Delaware State Police reported that there were no criminal cases of sexual abuse or sexual harassment reported to the department. The evidence shows that contractor and volunteers are subject to reporting to law enforcement for engaging in sexual abuse, prohibited from contact with residents which was verified by policy, interviews, and file documentation. Based upon this analysis, the facility is substantially compliant with this provision and no corrective action is required. 115.377 (b): In the PAQ, the agency reported that facility takes appropriate remedial measures and considers whether to prohibit further contact with residents in the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer. The facility relies on Policy 309 Removal of Employee from Workplace Section II, which outlines that the allegations of sexual abuse against a resident may lead to immediate removal of the employee from the workplace. As written, the policy does not include the immediate removal for allegations of sexual harassment by a contractor or volunteer. Agency Institutional Abuse Policy 208 Section D, outlines the agency is required by law to notify law enforcement and the Department of Justice (DOJ) of potential criminal violations involving children, alleged physical/sexual abuse or serious

	neglect of a client by a DSCYF employee, contractor or volunteer requires a multidisciplinary response. Institutional Abuse Investigation Unit (IAIU) will take immediate action to ensure the safety of children accessed to be in an unsafe environment. Facility staff reported there were no allegations of sexual abuse or sexual harassment during the last 12 months. During an interview, Delaware State Police reported that there were no criminal cases of sexual abuse or sexual harassment reported to the department. During an interview with the superintendent, when asked in the case of any violation of agency sexual abuse and sexual harassment policy by a contractor or volunteer does your facility take remedial measures and prohibit further contact with residents, staff stated that the facility does take measures and would stop the person from coming into the facility. The auditor reviewed three investigation records for allegations of sexual abuse and sexual harassment. No volunteer or contractor was found to have violated the agency's sexual abuse or sexual harassment policy that would have warranted remedial action to prohibit contact with residents. The evidence shows that the facility would take remedial measure to prohibit further contact of volunteers and contractors from contact with residents for violation of agency sexual abuse or sexual harassment policies which was verified by policy, interviews, and file documentation. Based upon this analysis, the facility is substantially compliant with this provision and no corrective action is required. Based upon this analysis, the facility is substantially compliant with this standard and no corrective action is required. Best Practice Recommendation: 1. Revise Policy 309 Removal of Employees from the workplace to include sexual harassment as an allegation as a remedial measure to prohibit any further contact with residents for violation of the agency's sexual abuse and sexual harassment policy.

115.378	Interventions and disciplinary sanctions for residents
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. Division of Youth Rehabilitative Services Prisoner Rape Elimination Act (PREA) 2.13 Section IV, H.2, (Revised 5/13/21). 2. New Castle County Detention Center (NCCDC) Rules and Discipline Behavior Review NCCDC-603 (7/11/07). 3. Division of Youth Rehabilitative Services Professional Practices Lesbian, Gay, Bi-sexual, Transgender, Questioning, and Intersex (LGBTQI) Policy 2.20 Section IV, E.2c, (Revised 3/5/19). 4. New Castle County Detention Center (NCCDC) Student Handbook English 2018 5. New Castle County Detention Center (NCCDC) Student Handbook Spanish 2022 6. Housing Unit Logs 7. Investigation Records 8. DYRS PREA Academy Training Interviews: 1. Superintendent 2. Medical and mental health staff 3. Discipline staff 4. Delaware State Police Onsite Review Observations: 1. Observations during onsite review of housing units Findings (by Provision): 115.378 (a): In the PAQ, the agency reported that residents are subject to disciplinary sanctions only pursuant to a formal disciplinary process following an administrative finding or criminal finding of guilt that the resident engaged in resident-on-resident sexual abuse. The facility reported in the past 12 months there was no administrative finding or criminal finding of guilt for resident-on-resident sexual abuse that occurred at the facility. The facility relies on PREA Policy 2.13 Section IV, H-2, which outlines residents are subject to disciplinary sanctions if after an investigation there is an administrative finding or criminal findings that he or she sexual abused another resident or if a resident had sexual contact with a staff member and there the finding indicates the staff did not consent. During an interview, the Superintendent reported if it does not warrant a charge we utilize CBT. If there is a charge, it's handled in the courts. During an interview, Delaware State Police reported that there were no criminal cases of sexual abuse or sexual harassment reported to the department. The auditor reviewed three investigation records that confirms no administrative or criminal findings of guilt for resident-on-resident sexual abuse. The evidence shows that there were no administrative or criminal findings of guilt for resident-on-resident sexual abuse which was verified through PAQ, investigation records, interviews, and policy. Based upon this analysis, the facility is substantially compliant with this provision and no corrective action is required. 115.378 (b): In the PAQ, the facility reported if a disciplinary sanction for resident-on-resident sexual abuse results in isolation of a resident, policy requires that residents in isolation have daily access to large-muscle exercise, legally required educational programming, and special education services, shall receive daily visits from medical or mental health care clinician, and have access to other programs and work opportunities. In the PAQ, the facility reported there were no residents placed in isolation as a disciplinary sanction for resident-on-resident sexual abuse that were denied access to large-muscle exercise, legally required programs, special education services, other programs, or work opportunities. Agency Policy LGBTQI 2.20 Section IV, E, 1, c, outlines that during a period of isolation DYRS staff shall not deny youth daily large-muscle exercise, legally required programming, or special education services. Youth in isolation shall receive daily visits from medical staff or behavioral health services clinician provider. The facility reported there are no work programs at the facility.

During an interview with the superintendent, when asked what disciplinary sanctions are residents subject to following an administrative or criminal finding that a resident engaged in resident-on-resident sexual abuse, staff stated residents would receive discipline through Administrative Intervention cognitive behavioral training (CBT). If it was criminal, it would be handled through the courts. Residents would receive education packets and large muscle exercise in isolation. During an interview, disciplinary staff stated they follow policy and procedure and a CBT chart and this is our behavior management model. Residents receive this information in the handbook and staff are trained during new employee training. During interviews, Mental health and medical staff stated they visit residents twice daily if not more.

During the onsite review, the auditor went into all areas of the facility which included the housing units. Each resident was assigned to their own room. If on isolation, residents would be in their own room. The auditor reviewed housing unit logs. The housing log for provides a detailed tracking of the resident, date, time, activity observed, and staff assigned to the housing unit. A review of the log did not reveal provide that a resident was placed in isolation for resident-on-resident sexual abuse. A review of 21 resident files did not reveal that residents were placed in isolation for resident-on-resident sexual abuse.

The evidence shows the facility does isolate residents at the facility. Residents in isolation would receive daily visits from medical or mental health care clinician, residents are provided educational packets and daily access to large-muscle exercise which was verified through interview, observation, policy and documentation review.

Based upon this analysis, the facility is substantially compliant with this provision and no corrective action is required.

115.378 (c):

In the PAQ, the facility reports that the disciplinary process considers whether a resident's mental disabilities or mental health contributed to his or her behavior when determining what sanction, if any, should be imposed.

During an interview with the superintendent, when asked is a mental disability or mental illness considered when determining sanctions, staff indicated that yes it would be considered.

A review of investigative records reveals there were no allegations, administrative finding or criminal finding of guilt of resident-on-resident sexual abuse.

The evidence shows that a resident's disability and mental health is considered when determining sanctions which was verified through interviews, and investigation information.

Based upon this analysis, the facility is substantially compliant with this provision and no corrective action is required.

115.378 (d):

In the PAQ, the facility reported that they offer therapy, counseling, or other interventions designed to address and correct the underlying reasons or motivations for abuse, they do not require the offending resident to participate in such interventions as a condition of access to any rewards-based behavior management system or other behavior-based incentives, access to general programs and education is not conditional on participation.

During interviews with medical and mental health staff, when asked if the facility offers therapy, counseling or other interventions designed to address and correct underlying reasons or motivations for sexual abuse, does the facility offer to offending resident, staff stated they would offer services Within the 14 days of their initial assessment, we offer them additional services and SOAR. When asked do you provide these services as a condition of access, staff stated they do not.

Facility staff reported there were no allegations of sexual abuse or sexual harassment during the last 12 months. During an interview, Delaware State Police reported that there were no criminal cases of sexual abuse or sexual harassment reported to the department. A review of investigative information confirms there was no resident sexual abuse allegations at the facility during the 12 months preceding the onsite audit.

The evidence shows that the facility offers therapy without conditions of access which was verified through PAQ, investigation records and staff interviews.

Based upon this analysis, the facility is substantially compliant with this provision and no corrective action is required.

115.378 (e):

In the PAQ, the facility reports that agency disciplines residents for sexual conduct with staff only upon finding that the staff member did not consent to such contact.

The facility relies on PREA Policy 2.13 Section IV, H-2, which outlines residents are subject to disciplinary sanctions if after an investigation there is an administrative finding or criminal findings a resident had sexual contact with a staff member and there the finding indicates the staff did not consent.

As outlined in the New Castle County Detention Center Resident Handbook, NCCDC has zero tolerance for any incidence of sexual activity with youth in our care. The Prison Rape Elimination Act (PREA) does not allow any sexual contact between youth or staff and youth and it is against the law. the facility uses Cognitive Behavioral Training, or CBT, is the behavior program used at NCCDC. The goal of the program is to change behavior by helping you examine the beliefs and thinking patterns that happen before you behave in an inappropriate way.

Facility staff reported there were no allegations of sexual abuse or sexual harassment during the last 12 months. During an interview, Delaware State Police reported that there were no criminal cases of sexual abuse or sexual harassment reported to the department. A review of investigative information confirms there was no administrative finding or criminal findings a resident had sexual contact with a staff member and the finding indicates the staff did not consent at the facility during the 12 months preceding the onsite audit.

The evidence shows that the agency disciplines residents for sexual conduct with staff upon finding that the staff did not consent, which was verified by PAQ, policy, resident handbook, and interviews.

Based upon this analysis, the facility is substantially compliant with this provision and no corrective action is required.

115.378 (f):

In the PAQ, the facility reported they prohibit disciplinary action for a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred, even if an investigation does not establish evidence sufficient to substantiate the allegation.

Agency relies on PREA Policy 2.13 Section IV H.2, that provides residents are subject to disciplinary sanctions if after an investigation there is an administrative finding or criminal findings that he or she sexual abused another resident or if a resident had sexual contact with a staff member and there the finding indicates the staff did not consent. All residents and staff who report sexual abuse or sexual harassment or cooperate with the investigations are protected from retaliation by other residents or staff. Although a policy is not required as written, the policy does not specifically outline that they prohibit disciplinary action for a report of sexual abuse made in “good faith” based upon a reasonable belief that the alleged conduct occurred, even if an investigation does not establish evidence sufficient to substantiate the allegation.

DYRS PREA Academy Training establishes that the facility treats all reports of sexual abuse or sexual harassment as credible. All reports will be thoroughly investigated and residents will be protected from retaliation.

As outlined in the New Castle County Detention Center Resident Handbook, NCCDC has zero tolerance for any incidence of sexual activity with youth in our care. The Prison Rape Elimination Act (PREA) does not allow any sexual contact between youth or staff and youth and it is against the law. the facility uses Cognitive Behavioral Training, or CBT, is the behavior program used at NCCDC. The goal of the program is to change behavior by helping you examine the beliefs and thinking patterns that happen before you behave in an inappropriate way.

Facility staff reported there were no allegations of sexual abuse or sexual harassment during the last 12 months. During an interview, Delaware State Police reported that there were no criminal cases of sexual abuse or sexual harassment reported to the department. A review of investigative information confirms there was no disciplinary action for a report of sexual abuse made in good faith.

The evidence shows that the agency prohibits disciplinary action for a report of sexual abuse made in good faith, which was verified by PAQ, interviews, DYRS academy training, policy and investigation records.

Based upon this analysis, the facility is substantially compliant with this provision and no corrective action is required.

115.378 (g):

In the PAQ, the agency prohibits all sexual activity between residents and disciplines residents for such activity, the agency deems such activity to constitute sexual abuse only if it determines that the activity is coerced.

As outlined in the New Castle County Detention Center Resident Handbook, NCCDC does not allow any sexual contact between youth or staff and youth. Any form of sexual contact within the facility is not considered consensual and it is against the law NCCDC has zero tolerance for any incidence of sexual activity with youth in our care. The Prison Rape Elimination Act (PREA) does not allow any sexual contact between youth or staff and youth and it is against the law. the facility uses Cognitive Behavioral Training, or CBT, is the behavior program used at NCCDC. The goal of the program is to change behavior by helping you examine the beliefs and thinking patterns that happen before you behave in an inappropriate way.

Facility staff reported there were no allegations of sexual abuse or sexual harassment during the last 12 months. During an interview, Delaware State Police reported that there were no criminal cases of sexual abuse or sexual harassment reported to the department. A review of investigative information confirms there was no reported sexual activity between residents at

	the facility during the 12 months preceding the onsite audit. The evidence shows that the agency prohibits all sexual activity between residents which was verified by PAQ, Resident handbook, Interviews, and Investigation records. Based upon this analysis, the facility is substantially compliant with this provision and no corrective action is required. Based upon this analysis, the facility is substantially compliant with this standard and no corrective action is required. Best Practice Recommendations: 1. Although a policy is not required, revise the DYRS Academy training and/or Resident Handbook to include the agency prohibit disciplinary action for a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred, even if an investigation does not establish evidence sufficient to substantiate the allegation.

115.381	Medical and mental health screenings; history of sexual abuse
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. Division of Youth Rehabilitative Services Prisoner Rape Elimination Act (PREA) 2.13 Section IV, I.1, (Revised 5/13/21). 2. 12 Resident Files 3. 12 Mental Health PREA Risk Assessment Interviews: 1. Staff Responsible for Risk Screening 2. Medical and Mental Health Staff Findings (by Provision): 115.381 (a): In the PAQ, the agency reported that all residents at this facility who have disclosed any prior sexual victimization during a screening are offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening. In the PAQ, the facility reported in the past 12 months, all residents who would disclose prior victimization during a screening would be offered a follow-up meeting with a medical or mental health practitioner and medical and mental health staff maintains secondary materials documenting compliance. The facility relies on PREA Policy 2.13 Section IV, I.1, which outlines if the PREA assessment indicates that a resident has experienced sexual victimization or has been sexually abusive, whether it happened in an institutional setting or not, the resident will be offered a follow-up meeting with a medical or mental health practitioner as soon as possible, but within 14 days of the assessment. Staff that conduct risk screening are mental health staff, when asked if the screening indicate that a resident has experienced prior sexual victimization whether in an institutional setting or community, do you offer a follow-up meeting, staff reported they would offer a follow up meeting within the 14 days of their initial assessment, we offer them additional services and SOAR. The auditor notes that the agency's practice of mental health staff conducting the risk screening provides an immediate notification to mental health to provide services to the residents is a best practice. The auditor reviewed 12 resident file records and intake screening documentation. In review, one of the 12 residents had disclosed prior victimization during risk screening with mental health staff. The evidence shows that the facility requires that a follow-up meeting is offered to residents that disclose prior victimization and the facility would conduct the follow-up within 14 days of the intake process, which was verified through PAQ, policy, interview and documentation review. Based upon this analysis, the facility is substantially compliant with this provision and no corrective action is required. 115.381 (b): In the PAQ, the agency reported that all residents who have ever previously perpetrated sexual abuse are offered a follow-up meeting with a mental health practitioner within 14 days of the intake screening. In the PAQ, the facility reported in the past 12 months, all residents who would disclose they previously perpetuated sexual abuse during screening are offered a follow-up meeting with a mental health practitioner. Mental health staff maintain secondary materials documenting compliance. It is noted that staff that conduct risk screening are also mental health staff, when asked if the screening indicates that a resident previously perpetuated sexual abuse, do you offer a follow-up meeting, staff reported they would offer a follow up meeting within the 14 days of their initial assessment. The auditor reviewed 12 resident files and intake documentation and determined that 1 out of 12 residents disclosed that they previously perpetuated sexual abuse during screening. The evidence shows that the facility requires that a follow-up meeting is offered to residents that disclose they previously perpetuated sexual abuse and the facility would conduct the follow-up within 14 days which was verified through PAQ,

	interview and documentation review. Based upon this analysis, the facility is substantially compliant with this provision and no corrective action is required. 115.381 (c): In the PAQ, the agency reported that information related to sexual victimization or abusiveness that occurred in an institutional setting is not strictly limited to medical and mental health practitioners, information shared with other staff is strictly limited to informing security and management decisions, including treatment plans, housing, bed, work, education, and program assignments, or as otherwise required by federal, state, or local law. During an interview, the Information System Specialist/FOCUS liaison stated the system has a matrix and each role was built with certain security. A review of the PREA Risk Assessment notifications shows that the information informing security and management decisions, including treatment plans, housing, bed, work, education, and program assignments is only provided to the Superintendent and Assistant Superintendent. The evidence shows that the agency has controlled the level of access that each staff has in the FOCUS database to control and protect sensitive information. In addition. information related to sexual victimization or abusiveness is limited and strictly controlled which was verified by PAQ documentation review and interviews. Based upon this analysis, the facility is substantially compliant with this provision and no corrective action is required.

115.382	Access to emergency medical and mental health services
	Auditor Overall Determination: Meets Standard
	Auditor Discussion

Documents:

1. Policy 2.13 Division of Youth Rehabilitative Services Prisoner Rape Elimination Act (PREA) 2.13 Section IV, I.2, (Revised 5/13/21).
2. Division of Youth Rehabilitative Services Medical Emergencies Policy 7.3 (Effective 9/15/14).
3. Department of Services for Children, Youth and Their Families Affirmation of Compliance with Forensic Examinations Standards for Sexual Assaults (3/6/19).
4. Memorandum of Agreement Between the Division of Youth Rehabilitative Services and Survivors of Abuse in Recovery, Inc. (3/11/19)
5. Facility Coordinated Response Plan
6. 12 Resident Files

Interviews:

1. Medical and mental health staff

Findings (by Provision):

115.382 (a-b):

In the PAQ, the facility reported that resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services, services are determined by medical and mental health practitioner's professional judgement.

In the PAQ, the facility reported that medical and mental health staff maintain secondary materials that document the timeliness of emergency medical treatment and crisis intervention services provided; the response by non-health staff if health staff were not present at the time the incident was reported; and appropriate and timely information and services concerning contraception and sexually infection prophylaxis.

The facility relies on policy 7.3 Medical emergencies, that outlines the physician in charge should be contacted immediately in the event of an emergency. If the youth is not transported to another facility or hospital the physician in charge shall be required to respond to emergencies. The policy provides an order of telephone contacts for emergency:

1. Ambulance or paramedic
2. Physician in charge
3. Facility superintendent or designee
4. Deputy director
5. Parent, guardian or legal guardian.

Prior to the onsite audit, the auditors attempted to make contact with the local hospital sexual assault nurse examiner (SANE) regarding any services they would provide for victims at the facility to confirm the agencies practice. Although the auditor was not able to make contact, the agency provided an affirmation of agreement that confirms the forensic examination protocols for sexual assault of children.

PREA Policy 2.13 outlines that resident victim of sexual abuse will be referred to A.I. Dupont or Christiana Care Hospital for New Castle County for medical interventions. The agency has an affirmation of compliance with forensic examinations standards for sexual assaults with Christiana Care hospital that provides forensic examinations, victims advocate through investigatory interviews, emotional support, crisis intervention and referrals.

The agency also has a Memorandum of Agreement between the Division of Youth Rehabilitative Services and Survivors of Abuse in Recovery, Inc. (SOARS) that DYRS youth that have been victims of sexual abuse be provided advocates emotional support services related to their victimization.

During an interview, staff at SOARS confirmed that they have a memorandum of agreement with YRS to provide victim advocate for emotional support but have not had any contact with any residents at the facility or staff at the facility. When asked how does a resident contact your agency, the SOARS staff stated they would call (302)-655-3953 and after the prompts select extension 1 for the intake department. When asked do you accompany a victim during a forensic examination, staff stated "no" they would go to the hospital for someone in crisis, Staff stated they accompany victims through investigatory interview, emotional support, crisis intervention through telephone and in-person sessions. SOARS staff noted that during the

COVID-19 pandemic they have been utilizing telehealth to communicate with victims.

During an interview with medical staff, when asked do victims of sexual abuse receive timely and unimpeded access to emergency medical treatment and crisis intervention, staff stated that residents do have unimpeded access and they would make sure medical is alerted and contact SOARS. Medical staff stated they residents would receive these services immediately as soon as soon as it is disclosed to them. When asked is the nature and scope of these services determined by your professional judgement, staff stated that the services are determined by their professional judgement.

Review of the facilities coordinated response plan outlines that once facility staff receives a complaint, they would notify a supervisor, the victim would be taken to the medical unit before being transported to A.I Dupont Hospital or Christiana Care formally Wilmington Hospital for examination and services.

The evidence shows that resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services which was verified through PAQ, policy, documentation review and interviews.

Based upon this analysis, the facility is substantially compliant with this provision and no corrective action is required.

115.382 (c):

In the PAQ, the agency reported that resident victims of sexual abuse while incarcerated are offered timely information about access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate.

The facility provided Department of Services for Children, Youth and Their Families Affirmation of Compliance with Forensic Examinations Standards for Sexual Assaults that outlines Christiana Care Hospital employs forensic examination protocols in regards to sexual assaults of children in Delaware that are appropriate for youth, forensic exams are made available without cost to the youth, hospital attempts to make available to the victim a victim advocate from a rape crisis center, qualified agency staff member, qualified community based organization staff member with support through SANE process, investigative interviews, emotional support, crisis intervention, information and referrals.

During an interview with medical and mental health staff, when asked are victims of sexual abuse while incarcerated offered timely information about access to emergency contraception and sexually transmitted infections prophylaxis, staff stated yes, we keep plan B in onsite, STD testing in available and if they need something different, we call the local pharmacy.

The evidence shows that resident victims of sexual abuse while incarcerated are offered timely information about access to emergency contraception and sexually transmitted infections prophylaxis which was verified thought PAQ, MOU, documentation review and interviews.

Based upon this analysis, the facility is substantially compliant with this provision and no corrective action is required.

115.382 (d):

In the PAQ, the agency reported that treatment services are provided to every victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident.

The facility provided Department of Services for Children, Youth and Their Families Affirmation of Compliance with Forensic Examinations Standards for Sexual Assaults that outlines forensic exams are made available without cost to the youth where evidentiary or medically appropriate.

The evidence shows that treatment services are provided to every victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation which was verified through PAQ, MOU, documentation review.

Based upon this analysis, the facility is substantially compliant with this provision and no corrective action is required.

Based upon this analysis, the facility is substantially compliant with this standard and no corrective action is required.

115.383	Ongoing medical and mental health care for sexual abuse victims and abusers
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. Division of Youth Rehabilitative Services Prisoner Rape Elimination Act (PREA) 2.13 Section IV I page 9, (Revised 5/13/21). 2. Department of Services for Children, Youth and Their Families Affirmation of Compliance with Forensic Examinations Standards for Sexual Assaults (3/6/19). 3. Memorandum of Agreement Between the Division of Youth Rehabilitative Services and Survivors of Abuse in Recovery, Inc. (SOARS) (3/11/19) and Website survivorsofabuse.org 4. Christiana Care Christiana Hospital website chirtianacare.org 5. New Castle County Detention Center (NCCDC) Student Handbook English 2018 6. New Castle County Detention Center (NCCDC) Student Handbook Spanish 2022 7. https://kids.delaware.gov/youth-rehabilitative-services/new-castle-cou nty-detention-center/ 8. Resident files 9. Risk assessments Interviews: 1. Medical and mental health staff 2. Resident 3. SANE Christiana Care 4. Survivors of Abuse in Recovery, Inc. (SOARS) Findings (by Provision): 115.383 (a): In the PAQ, the facility reported they 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. The facility relies on PREA Policy 2.13 Section IV, I-3, that non-emergency and mental health care are offered to all residents who are victims of sexual abuse in any juvenile facility. Resident victims will be referred to A.I Dupont or Christiana Care Hospital for New Castle County for medical interventions. Non- emergency and mental health care are offered to all residents who are victims of sexual abuse in any juvenile facility. Department of Services for Children, Youth and Their Families Affirmation of Compliance with Forensic Examinations Standards for Sexual Assaults outlines that Christiana Care hospital that provides forensic examinations, victims advocate through investigatory interviews, emotional support, crisis intervention and referrals. Review of the facilities coordinated response plan outlines that once facility staff receives a complaint, they would notify a supervisor, the victim would be taken to the medical unit before being transported to A.I Dupont Hospital or Christiana Care formally Wilmington Hospital for examination and services. During interviews with medical and mental health staff, when asked what does evaluation and treatment of residents who have been victimized entail, staff stated we collaborate with the team. Residents would go out right away to receive immediate care, SANE/SAFE exam with qualified providers and medical follow up. During an interview, a resident stated he did see a nurse. The auditors interviewed a sexual assault forensic nurse examiner (SAFE) at Christiana Care Hospital regarding any services they would provide for victims at the facility. The forensic nurse stated they do provide SANE exams and have a victim advocate available, counseling services are offered by the hospital, there is a SANE examiner at the hospital 24 hours a day seven days a week and the cost is covered through the sexual assault resource center (SARC) a victim compensation fund and lifeline depending on where they live, they provide counseling, follow-up care, services concerning contraception, and medications depending on the timeline to prevent sexually transmitted infections prophylaxis. The evidence shows that medical and mental health services evaluation and treatment is offered for residents that have been victimized by sexual abuse which is verified through policy, resident interview, interviews with mental health and medical staff, Christiana Care SAFE nurse and documentation review. Based upon this analysis, the facility is substantially compliant with this provision and no corrective action is required.

115.383 (b):

In the PAQ, the facility reported that evaluation and treatment for victims include follow-up services, treatment plans, and when necessary, referrals for continued care following their transfer to another facility or release from custody.

The facility relies on PREA Policy 2.13 Section IV, I-3, that non-emergency and mental health care are offered to all residents who are victims of sexual abuse in any juvenile facility. Resident victims will be referred to A.I Dupont or Christiana Care Hospital for New Castle County for medical interventions. Non- emergency and mental health care are offered to all residents who are victims of sexual abuse in any juvenile facility.

Department of Services for Children, Youth and Their Families Affirmation of Compliance with Forensic Examinations Standards for Sexual Assaults outlines that Christiana Care hospital that provides forensic examinations, victims advocate through investigatory interviews, emotional support, crisis intervention and referrals.

The agency has a Memorandum of Agreement between the Division of Youth Rehabilitative Services and Survivors of Abuse in Recovery, Inc. (SOARS) that DYRS youth that have been victims of sexual abuse be provided advocates for support during a forensic medical examination and emotional support services related to their victimization.

During an interview, staff at SOARS confirmed that they have a memorandum of agreement with the facility to provide victim advocate for emotional support, crisis intervention and individual therapy but have not had any contact with any residents at the facility.

The auditors interviewed a sexual assault forensic nurse examiner (SAFE) at Christiana Care Hospital regarding any services they would provide for victims at the facility. The forensic nurse stated they do provide SANE exams and have a victim advocate available, counseling services are offered by the hospital, there is a SANE examiner at the hospital 24 hours a day seven days a week and the cost is covered through the sexual assault resource center (SARC) a victim compensation fund and lifeline depending on where they live, they provide counseling, follow-up care, services concerning contraception, and medications depending on the timeline to prevent sexually transmitted infections prophylaxis.

The evidence shows that the facility provides evaluation and treatment for victims include follow-up services, treatment plans, and when necessary, referrals for continued care following their transfer to another facility or release from custody which was verified though policy, MOA, interviews.

Based upon this analysis, the facility is substantially compliant with this provision and no corrective action is required.

115.383 (c):

In the PAQ, the facility reported they provide victims with medical and mental health services consistent with the community level of care.

The facility relies on PREA Policy 2.13 Section IV, I-3, that non-emergency and mental health care are offered to all residents who are victims of sexual abuse in any juvenile facility.

During interviews with medical and mental health staff, when asked are medical and mental health services consistent with community level of care, medical staff stated they would say the services are better at the facility. Mental health stated not mental health because they are only person there and they do not see every person. A review of the risk assessments confirm that mental health staff see every resident within 72 hours of admission. The auditor reviewed the agency's website for the facility, the facility website provides that certified providers offer medical, dental and psychological services.

During interviews with residents, one resident stated they had reported sexual abuse at the facility and was seen by medical staff.

The evidence shows that the facility provides victims with medical and mental health services consistent with the community level of care which was verified though policy, documentation review, and interviews.

Based upon this analysis, the facility is substantially compliant with this provision and no corrective action is required.

115.383 (d-e):

In the PAQ, the facility reported that they offer female victims of sexual abusive vaginal penetration while incarcerated pregnancy test.

The facility relies on PREA Policy 2.13 Section IV, I-3, that non-emergency and mental health care are offered to all residents who are victims of sexual abuse in any juvenile facility. Resident victims will be referred to A.I Dupont or Christiana Care Hospital for New Castle County for medical interventions. Non-emergency and mental health care are offered to all residents who are victims of sexual abuse in any juvenile facility.

Department of Services for Children, Youth and Their Families Affirmation of Compliance with Forensic Examinations Standards for Sexual Assaults outlines that Christiana Care hospital that provides forensic examinations, victims advocate through investigatory interviews, emotional support, crisis intervention and referrals.

The auditors interviewed a sexual assault forensic nurse examiner (SAFE) at Christiana Care Hospital regarding any services they would provide for victims at the facility. The forensic nurse stated they do provide SANE exams and have a victim advocate available, counseling services are offered by the hospital, there is a SANE examiner at the hospital 24 hours a day seven days a week and the cost is covered through the sexual assault resource center (SARC) a victim compensation fund and lifeline depending on where they live, they provide counseling, follow-up care, services concerning contraception, and medications depending on the timeline to prevent sexually transmitted infections prophylaxis.

During interviews, medical staff reported that if pregnancy results from sexual abuse while incarcerated the victim would be given information and access to all lawful pregnancy related services upon diagnosis immediately.

Based upon this analysis, the facility is substantially compliant with this provision which is verified by PAQ, policy, and interviews and no corrective action is required.

115.383 (f):

In the PAQ, the facility reported that resident victims of sexual abuse while incarcerated are offered tests for sexually transmitted infections as medically appropriate.

Department of Services for Children, Youth and Their Families Affirmation of Compliance with Forensic Examinations Standards for Sexual Assaults outlines that Christiana Care hospital that provides forensic examinations, victims advocate through investigatory interviews, emotional support, crisis intervention and referrals.

The auditors interviewed a sexual assault forensic nurse examiner (SAFE) at Christiana Care Hospital regarding any services they would provide for victims at the facility. The forensic nurse stated they do provide SANE exams and have a victim advocate available, counseling services are offered by the hospital, there is a SANE examiner at the hospital 24 hours a day seven days a week and the cost is covered through the sexual assault resource center (SARC) a victim compensation fund and lifeline depending on where they live, they provide counseling, follow-up care, services concerning contraception, and medications depending on the timeline to prevent sexually transmitted infections prophylaxis.

The facility reported that there were no sexual abuse allegations at the facility during the last 12 months preceding the onsite audit. A review of investigative information confirms there was no sexual abuse allegations at the facility during the 12 months preceding the onsite audit that warranted test for sexually transmitted infections.

Based upon this analysis, the facility is substantially compliant with this provision which is verified by PAQ, policy, documentation review and interviews and no corrective action is required.

115.383 (g):

In the PAQ, the facility reported that treatment services are 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.

Department of Services for Children, Youth and Their Families Affirmation of Compliance with Forensic Examinations Standards for Sexual Assaults outlines that Christiana Care hospital that provides forensic examinations, victims advocate through investigatory interviews, emotional support, crisis intervention and referrals.

The auditors interviewed a sexual assault forensic nurse examiner (SAFE) at Christiana Care Hospital regarding any services they would provide for victims at the facility. The forensic nurse stated they do provide SANE exams and have a victim advocate available, counseling services are offered by the hospital, there is a SANE examiner at the hospital 24 hours a day seven days a week and the cost is covered through the sexual assault resource center (SARC) a victim compensation fund and lifeline depending on where they live, they provide counseling, follow-up care, services concerning contraception, and medications depending on the timeline to prevent sexually transmitted infections prophylaxis.

During interviews with residents, 1 out of 12 residents stated they had reported sexual abuse at the facility but did not know if they or their family had to pay for any treatment. The facility reported that there were no sexual abuse allegations at the facility during the last 12 months preceding the onsite audit. A review of investigative information confirms there was one sexual abuse allegations at the facility during the 12 months preceding the onsite audit.

Based upon this analysis, the facility is substantially compliant with this provision which is verified by PAQ, policy, documentation review and interviews and no corrective action is required.

115.383 (h):

In the PAQ, the facility reported that the facility attempts to conduct a mental health evaluation of all known resident-on-

	resident abusers within 60 days of learning of such abuse history and offers treatment when deemed appropriate by mental health practitioners. The facility relies on PREA Policy 2.13 Section IV, I-4, a mental health evaluation will be completed of all known resident on resident abusers within 60 days of finding out about the history of abuse. During interviews with medical and mental health staff, when asked, do you conduct a mental health evaluation of all known resident-on-resident abusers and offer treatment if appropriate, yes within one business day. Staff reported this has not happened at the facility. The auditors reviewed 12 files and 12 risk assessments did not reveal a resident-on-resident abuse history that confirms the facilities practice. Based upon this analysis, the facility is substantially compliant with this provision which is verified by PAQ, policy, documentation review and interviews and no corrective action is required Based upon this analysis, the facility is substantially compliant with this standard and no corrective action is required.

115.386	Sexual abuse incident reviews
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. DYRS Policy 2.13.IV.J.1.a-f 2. DYRS Policy 2.13 Attachment E-Sexual Abuse Incident Review of Substantiated or Unsubstantiated Outcomes Form Interviews: 1. Former Superintendent 2. PREA compliance manager 3. Incident Review Team Member (NCCDC PREA Investigator) Findings (by Provision): 115.386(a)-1-2: Included in the DYRS Policy 2.13.IV.J.1, there is specific procedures regarding the timeline and documentation to be used to complete an incident review. The policy specifically says the facility will conduct a sexual abuse incident review within 30 days of completion of the investigation or when directed if the official investigation extends beyond 45 days. All extensions must be approved by the division director. There was one sexual abuse investigation on 5/14/2021 which was unsubstantiated. In review of the sexual abuse investigative file, there was no Sexual Abuse Incident Review of Substantiated or Unsubstantiated Outcomes form located. The auditor was unable to determine the practice of NCCDC conducting incident reviews of substantiated or unsubstantiated sexual abuse investigations. The facility does meet compliance in this provision. 115.386(b)-1 DYRS Policy 2.13.IV.J.1 states the facility will conduct a sexual abuse incident review within 30 days of completion of the investigation or when directed if the official investigation extends beyond 45 days. All extensions must be approved by the division director. There was one sexual abuse investigation dated 5/14/2021. There was no evidence of the incident review being conducted within the sexual abuse investigative file. The facility does not meet compliance in this provision. 115.386(c)-1 In review of a sexual harassment investigative file dated 1/26/2022, the auditor located evidence of a Sexual Abuse Incident Review of Substantiated or Unsubstantiated Investigations form. The facility did not conduct a sexual abuse incident review for the sexual abuse investigation for allegation occurring 5/14/2021.There was a sexual abuse incident review conducted for a sexual harassment investigation occurring 1/20/2022. The participants in the review included a member of the mental health staff, a program manager, and a NCCDC PREA investigator. According to the interview with the former superintendent, NCCDC has an incident review team, and the team includes staff from upper-level management, and it allows input from supervisors, investigators, and medical and mental health practitioners. Though the incident was a sexual harassment instead of sexual abuse, the auditor determined that a sexual abuse incident review team does exist with the appropriate representation mandated by the PREA mandates. The facility substantially meets compliance in this provision. 115.386(d)-1 Attached to the DYRS Policy 2.13 is the Sexual Abuse Incident Review of Substantiated and Unsubstantiated Outcomes form. The form documents the sexual abuse incident review team's meeting. The form includes the following information: • Reportable Incident Date • Facility • PREA Type: Resident on Staff or Resident on Resident • Type of Sexual Violence • Incident Description • Substantiated or Unsubstantiated

- Review Team Members
- As a result of the allegation, is there a need for policy or practice change that would better prevent, detect, or respond to sexual abuse? If yes, what needs to be changed?
- Was the incident motivated by any of the below (check all that apply)
- Were there any physical barriers where the alleged incident occurred that would enable abuse? If yes note under (6) Recommendations
- What was the staffing level at the time of the incident? Was the staffing level adequate? If no, explain:
- Was monitoring technology adequate for that area? If it was not adequate, what is needed? (explain)
- Findings of Team
- Final Recommendation
- Facility Head Comments
- Facility Head Signature and Date
- The completed form is to be copied to the deputy director, PREA coordinator, PREA compliance manager, and the management analyst- Office of the Director

The form contains all information required by PREA Standard 115.386(d) which includes the consideration for policy or practice to better prevent, detect, or respond to sexual abuse. It considers if the allegation was motivated by race, ethnicity, gender identity, LGBQTI status or perceived status, gang affiliation, or other group dynamics. The review team examines the area to assess if there were any physical barriers, and they assess the staffing levels. The team also reviews the monitoring equipment. Lastly, the team completes the report and submits to the deputy director, PREA coordinator, PREA compliance manager, and the management analyst.

During the interviews, it was confirmed by both the former superintendent and PREA compliance manager that sexual abuse incident review team meeting had been conducted. Additionally, factors are considered of the motivation for the allegation of sexual abuse. Also, there is an assessment of staffing levels, policy, procedures, and the monitoring technology. The PREA compliance manager identified that there was a trend of false allegations of sexual abuse or sexual harassment by youth to remove staff from post. The incident review team participant further confirmed that motivations for allegations were considered in addition to whether physical barriers would enable abuse. Also, the adequacy of staffing levels and the need for changes in monitoring technology.

The facility substantially meets compliance on this provision.

115.386(e)-1

Located on the Sexual Abuse Incident Review of Substantiated or Unsubstantiated Outcomes, there is a section on the form with the findings and the final recommendations. Due to the lack of documentation provided on the sexual abuse investigation dated 5/14/2021, the auditor is unable to determine if NCCDC provided recommendations or provided rationale for adherence or not adhering to the recommendations.

The facility does not meet compliance in this provision.

The evidence shows that the facility does have a sexual abuse incident team, and they utilize the Sexual Abuse Incident Review of Substantiated and Unsubstantiated Outcomes form to document the review. The facility did not conduct a sexual abuse incident review for the sexual abuse investigation for allegation occurring 5/14/2021.There was a sexual abuse incident review conducted for a sexual harassment investigation occurring 1/20/2022. The sexual abuse team has upper-level management and input from mental health, and the review team has a PREA investigator participating. The established form lists variables to consider when reviewing allegations of sexual abuse. A determination could not be established if NCCDC considers recommendations to implement or documents its reasons for not doing so.

The facility is not compliant with this standard and corrective actions are required at this time.

Corrective Action:

1. Conduct sexual abuse incident reviews on substantiated and unsubstantiated investigations of sexual abuse.
2. Train sexual abuse incident review team on completion of the Sexual Abuse Incident Review of Substantiated or Unsubstantiated Outcome with emphasize on documenting recommendations of findings of the sexual abuse incident review team along with whether the recommendation will be implemented and if not, the rationale for not implementing the recommendation.

Verification of Corrective Action since the audit:

The facility sent the auditor documentation on 7/27/2022 and 8/8/2022 in response to the corrective actions.

1. DYRS PREA Investigations Training Agenda

2. Provided PREA Resource Center- Specialized Training Investigating Sexual Abuse in Correctional Setting Training Curriculum
3. Provided Staff training acknowledgement
4. Mock Sexual Abuse Incident Review

The following action was taken: DYRS provided PREA investigations training agenda that included PREA Policy 2.13 which includes attachments of the Sexual Abuse Incident Review of Substantiated or Unsubstantiated Investigations. The agency retrained one facility investigator on the PREA investigation training and documented that the staff received the training.

Corrective Action #1and #2

The intent of this corrective action was to ensure that NCCDC has a staff that has been trained to conduct a sexual abuse incident review. The mock sexual abuse incident review created an opportunity for NCCDC to identify the personnel that needs to be involved in the sexual abuse incident review. Additionally, the staff was able to document recommendations of findings and develop rationale for the decision to implement or not implement recommendations.

Based on review of the information received, the auditor finds the facility substantially compliant with this standard.

115.387	Data collection
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. DYRS Policy 2.13.IV.J.2-4 2. DYRS Policy 2.13 Attachment A-Sexual Incident Form 3. DYSR Policy 2.13 Attachment B-Investigative Summary Template 4. DYRS Policy 2.13 Attachment C-Substantiated Sexual Abuse or Sexual Harassment Incident Form 5. DYRS Policy 2.13 Attachment D-Notification of Investigation 6. DYRS Policy 2.13 Attachment E-Sexual Abuse Incident Review of Substantiated or Unsubstantiated Investigations 7. DYRS Policy 2.13.IV.J.6-8 8. Department of Services for Children, Youth and Their Families: Operating Guidelines for Contracted Children and Family Programs and Services 9. Excel spreadsheet containing the incidents of sexual abuse and sexual harassment investigations from the private facilities in which DYRS contracts for confinement of its residents 10. Survey of Sexual Violence for 2020 11. https://kids.delaware.gov/pdfs_archive/prea/SSV-2019.pdf Interviews: 1. Director Findings (by Provision): 115.387 (a)-1: DYRS Policy 2.13.IV.F.1-4 requires data collection utilizing a standardized instrument and a set of definitions. The five attachments to the policy are the forms used to collect the required information. 1. Attachment A-Sexual Incident Form 2. Attachment B-Investigative Summary Template 3. Attachment C-Substantiated Sexual Abuse or Sexual Harassment Incident Form 4. Attachment D-Notification of Investigation 5. Attachment E-Sexual Abuse Incident Review of Substantiated or Unsubstantiated Investigations On 5/13/2021, there was a revision to DYRS Policy 2.13. During this time at NCCDC, there was a sexual abuse allegation that occurred on 5/14/2021. It is apparent from the processing of this investigative file that the application of the revision had not been trained to the staff at NCCDC by that date. DYRS has a standardized instrument and set of definitions that is utilized for all of state operated facilities. The agency does substantially meet compliance in this provision. 115.388(b)-1 According to DYRS Policy 2.13.IV.J.6-8, the Professional Standards Unit will be responsible for reporting institutional abuse and/or criminal investigation outcomes for data collection. With the data the management analyst III will provide a quarterly report to the deputy director to ensure outcome information is accurate and current. Review of the agency website, the agency aggregates the incident-based sexual abuse data in preparation for the submission of the Survey of Sexual Violence conducted by the Department of Justice. The agency does substantially meet compliance in this provision. 115.387(c)-1 Review of the DYRS Policy 2.13 attachments A-D are in alignment with the information necessary to complete the most recent version of the Survey of Sexual Violence (SSV) conducted by the Department of Justice. The agency does substantially meet compliance in this provision. 115.387(d)-1

DYRS Policy 2.13.IV.J. states that the administrators are responsible for providing the internal investigation outcome for data collection. The deputy director will be responsible for reporting IA and/or criminal investigation outcomes for data collection. The policy details the agency shall maintain, review, and collect data from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews. The director confirmed responsibility of providing internal investigation outcome.

The agency does substantially meet compliance in this provision.

115.387(e)-1

Within the Department of Services for Children, Youth and Their Families: Operating Guidelines for Contracted Children and Family Programs and Services, it is stated contracted programs are responsible for reporting according to their contract and the operating guidelines. In the supplemental files of the OAS, the auditor was provided an Excel spreadsheet containing the incidents of sexual abuse and sexual harassment investigations from the private facilities in which DYRS contracts for confinement of its residents.

The agency does substantially meet compliance in this provision.

115.387(f)

Provided on the agency's website is a copy of the Survey of Sexual Violence for 2020.

The agency does substantially meet compliance in this provision.

The evidence shows that the agency collects accurate, uniform data for allegations of sexual abuse at facilities under direct control using a standardized instrument and set of definitions. The agency has demonstrated it annually aggregates the incidence based sexual abuse data. The data contains the minimum of the information to complete the Survey of Sexual Violence. The agency collects information from incident-based documents, reports, investigation files, and sexual abuse incident reviews. The agency collects information from the contacted facilities that contract with DYRS for the placement of residents.

Based upon this analysis, the facility is substantially compliant with this standard no corrective action is required at this time.

115.388	Data review for corrective action
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. DYRS Policy 2.13.IV.J.8.a-d 2. https://kids.delaware.gov/yrs/prea-reports.shtml 3. The DYRS PREA Annual Report CY-2020 Interviews: 1. Director 2. PREA coordinator 3. PREA compliance manager 4. Director's Team Meeting Minutes 2/4/2022 Findings (by Provision): 115.388(a): DYRS Policy 2.13.IV.J.8.a-d requires that an annual report shall be readily available to the public through its website. All information must receive prior approval by the division director before website posting. The director signs document prior to posting on the website. The annual report shall include the following: • Any findings and corrective actions for all allegations identified by facility. • A comparison of the current year's data and corrective actions with those from prior years • An assessment of the Division's progress in addressing sexual abuse. • The Division may redact specific material from 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. Review of the director's team meeting minutes from 2/4/2022 reveal there is time devoted by DYRS to discuss information obtained from the data collected. During the meeting, there was an opportunity to discuss staffing plans and video monitoring system needs or concerns. During interview of the director, the auditor asked how the agency utilizes incident-based sexual abuse data to assess and improve sexual abuse prevention, detection, response policies, practices, and training. The director responded that the information assists reviewing staffing plans and to discuss any necessary security upgrades. It was confirmed by the PREA coordinator that the agency does review the PREA related data collected. It was further shared that the data and documents related to PREA are maintained with the management analyst under a two-lock system. Lastly, there was confirmation that a report was generated and placed on the agency's website. The PREA compliance manager did not confirm that the agency reviews data collected for sexual harassment and sexual abuse. The director confirmed the preparation of the DYRS PREA Annual Report CY-2020 which is a collaborative effort with the Professional Standards Unit. The report compares the incident based sexual abuse and sexual harassment data from the last 3 years the incident based sexual abuse and sexual harassment data. The agency does substantially meet compliance in this provision. 115.388(b)-1-2 The DYRS Annual PREA Report CY-2020 summarizes and compares the last three years of aggregated information of sexual harassment and sexual abuse received from both DYRS operated facilities and contracted facilities. Included on the report is the data analysis which details corrective actions. Within the report is an assessment of the agency's progress in addressing sexual abuse. The agency does substantially meet compliance in this provision. 115.388(c)-1-3 The DYRS Annual PREA Report CY-2020 can be located on the agency website https://kids.delaware.gov/yrs/prea-reports.shtml, and the report is signed by the director of DYRS. The director confirmed the approval of the annual reports that are written pursuant to PREA Standard 115.388.

	The agency does substantially meet compliance in this provision. 115.388(d)-1-2 There were no redactions in the DYRS Annual PREA Report CY-2020. A redaction clause was not necessary. It was confirmed by the PREA compliance manager that redactions would include personal information. The auditor determined that the report did not require personal information so there was no need for redaction. The agency substantially does meet compliance in this provision. The evidence shows that the agency reviews data collected and aggregates to assess and improve the effectiveness of its sexual abuse prevention, detection, response policies and training as well as corrective action. This information is developed into a report titled the DYRS Annual PREA Report CY-2020. The report is approved by the director and made public annually on the agency website. There were no redactions to the report. Based upon this analysis, the facility is substantially compliant with this standard and no corrective action is required.

115.389	Data storage, publication, and destruction
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. DYRS Policy 2.13.IV.F.9-10 2. DYRS Policy 2.13.IV.J.8 3. The DYRS Annual Report CY-2020 4. https://kids.delaware.gov/yrs/prea-reports.shtml Interviews: 1. Management Analyst 2. PREA Coordinator Site Review: 1. Management Analyst's Office 12/16/2021 Findings (by Provision): 115.389 (a)-1: According to DYRS Policy 2.13.F.d.9-10 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. The PREA coordinator further confirmed that all PREA related allegations and reports are maintained in a double lock system in the management analyst office. The auditor was provided pictures of the location of the secured documents which were double locked. According to the management analyst, there has been no changes in the storage of the documents pertaining to allegations of sexual abuse and sexual harassment. There was information provided that the agency will be transferring the documents to an electronic format with a double lock system. The agency substantially meets compliance in this provision. 115.389(b)-1 The DYRS Annual Report CY-2020 summarizes and compares the aggregated information of sexual harassment and sexual abuse received from both DYRS operated facilities and contracted facilities. The agency's practice includes the collection of aggregated sexual abuse data from DYRS operated facilities and contracted facilities. DYRS Policy 2.13.IV.F.8. requires that an annual report shall be made readily available to the public through the agency website. The policy further requires that the annual report must contain any findings or corrective action, comparison current and prior years, an assessment of the Division's process in addressing sexual abuse, and the ability to redact when a publication may create a threat to the safety and security. This information is made public at https://kids.delaware.gov/yrs/prea-reports.shtml. The agency substantially meets compliance in this provision. 115.389(c)-1 Review of the agency website the auditor determined that DYRS has shown a practice of removing all personal identifiers from reports released on the agency website. The auditor was told by the PREA coordinator that personal information would be redacted from reports. Review of PREA related reports on the agency website, demonstrated the practice of redaction of personal identifiers. The agency substantially meets compliance in this provision. 115.389(d)-1 DYRS Policy 213.IV.G.10 requires all PREA data shall be retained for no less than 10 years after the date of its initial collection unless Federal, State, or local laws requires otherwise. The agency substantially meets compliance in this provision. The evidence shows that the agency ensures that incident based, and aggregate data are securely retained. The agency has made public both DYRS operated and contracted facilities aggregated sexual abuse data available to the public annually

	through the website. The agency has insured that there are no personal identifiers on data released to the public, and sexual abuse and sexual harassment documents are maintained for no less than 10 years. The agency substantially meets compliance in this provision. Based upon this analysis, the agency is substantially compliant with this standard and no corrective action is required.

115.401	Frequency and scope of audits
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. DYRS Policy 5.24 2. DYRS Policy 505 3. Pre-Audit Questionnaire (PAQ): 4. Residential Contract Excel Spreadsheet 5. PREA Audits for Contracted Residential Facilities Website: https://kids.delaware.gov/yrs/prea-reports.shtml Interviews: 1. Contract Manager 2. Mailroom Staff Findings (by Provision): 115.401 (a)-1: During the prior three-year audit period, DYRS has ensured that DYRS operated facilities and contracted facilities were audited. During the current three-year audit cycle, the Residential Cottages' PREA audit was rescheduled due to the Covid-19 Pandemic. For the last year of the three-year audit cycle, For all state operated facilities, the final PREA audit reports are located on the DSCYF website https://kids.delaware.gov/yrs/prea-reports.shtml Listed on the website are the DYRS operated facilities PREA final reports along with year completed. Further, it was confirmed by the contract manager that 10 out of 11 contracted residential facilities had completed the PREA final reports for the three year audit cycle. There is one facility in process of obtaining an interim PREA audit report. In the Pre-Audit Questionnaire (PAQ), the contract manager provided an Excel spreadsheet containing PREA related information for all the contracted residential facilities as well as copies of the Final PREA audit reports for those facilities. During the interview with the contract manager, the auditor inquired if there were any changes since the upload of the PAQ. Based on the information provided, the auditor determined that all contracted facilities had provided a final PREA report except for one facility. Currently, the auditor was able to review the interim PREA report. DYRS substantially meets compliance with this provision. 115.401(b)-1 This is the third year of the current audit cycle, and due to the Covid-19 Pandemic, the agency was not able to ensure that at least one-third of each facility type operated by the agency was audited. The PREA audit for the Residential Cottages was rescheduled for the second year. The agency is now on target to complete all state operated facilities PREA audits for the third cycle. DYRS substantially meets compliance with this provision. 115.401(h)-1 DYRS allowed full access to, and the ability to observe, all areas of the New Castle County Detention Center (NCCDC). The auditors were given full access to all areas of the facility. During the onsite audit, there was no active Covid-19 cases in the facility. Auditor was able to complete an observe all areas of the facility both internally and externally. Additionally, the auditor observed the intake process, showers, and video monitoring systems. DYRS substantially meets compliance with this provision. 115.401(i)-1 The auditor was permitted to request and receive copies of any relevant documents, including electronically stored

information from agency's databases and hardcopy files. The auditor requested that all information be uploaded to the Online Audit System through the supplemental file upload. All requests for documents were fulfilled in a timely manner.

DYRS substantially meets compliance with this provision.

115.401(m)

The auditor was permitted to conduct private interviews at NCCDC. Private interviews were conducted in the conference room located in administration as well as a vacant housing unit. Based on selection of the auditors, youth were escorted to the location for private interviews.

DYRS substantially meets compliance with this provision.

115.401(n)-1

In accordance with DYRS Policy 5.24 and DYRS Policy 505, youth are permitted to send information and correspondence to the auditor in the same manner as legal correspondence. Based on information provided by staff that handles youth's mail, all mail is opened, searched, and reviewed for inappropriate pictures or contraband, Outgoing mail is not sealed prior to being handled by staff. Staff ensures that there is no inappropriate material being sent. During all phases of the audit, the lead auditor received no correspondence from youth or staff at NCCDC.

DYRS substantially meets compliance with this provision.

DYRS has ensured that agency operated, and contracted facilities have been audited at least once in the three-year cycle. The auditors were granted full access to all areas of NCCDC. The auditors were permitted to request and receive copies of any relevant documents including electronically stored information on databases. The auditors attest that they were permitted to conduct private interviews with residents. The residents were permitted to send correspondence to the auditor in the same manner as communication with legal counsel.

Based on this analysis the NCCDC is substantially in compliance with Standard 115.401. Currently, there is no corrective action.

115.403	Audit contents and findings
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. DYRS Final Audit Reports Agency Website: 1. https://kids.delaware.gov/yrs/prea-reports.shtml Findings (by Provision): 115.403 (f): The auditor located all the division operated facilities final PREA reports on the agency's website https://kids.delaware.gov/yrs/prea-reports.shtml. All audits for the past three years are available on the agency website. The Residential Cottages are the only exception. Due to the Covid-19 Pandemic, the facility rescheduled the audit until December 2020, and the PREA final audit report was completed on July 27, 2021. The evidence shows that DYRS publishes all PREA final reports for division operated facilities on the agency's website https://kids.delaware.gov/yrs/prea-reports.shtml. Based upon this analysis, the facility is substantially compliant with this standard and no corrective action is required.

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.)	yes
	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?	no
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?	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 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)	yes
	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 aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who are deaf or hard of hearing?	yes
	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?	no
	Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Who are blind or have low vision?	no
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.)	na
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?	yes
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?	no
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).)	no

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? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)	yes
	Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to preserve physical evidence of sexual abuse? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)	yes
	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? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)	yes
	Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How and to whom to report allegations or suspicions of sexual abuse and sexual harassment? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)	yes
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 or the agency does not employ medical staff.)	na
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? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)	yes

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? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)	yes
	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? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners contracted by or volunteering for the agency.)	yes
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?)	yes
	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?)	yes
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.)	na
	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.)	na

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.)	na
	Does the agency ensure that: Such grievance is not referred to a staff member who is the subject of the complaint? (N/A if agency is exempt from this standard.)	na
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.)	na
	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.)	na
	If the resident declines to have the request processed on his or her behalf, does the agency document the resident's decision? (N/A if agency is exempt from this standard.)	na
	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.)	na
	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?	yes
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?	yes
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?	no
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?	yes
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?	yes
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?	yes
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?	yes
	Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The staff member is no longer employed at the facility?	yes
	Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The agency learns that the staff member has been indicted on a charge related to sexual abuse in the facility?	yes
	Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility?	yes
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?	yes
	Following a resident's allegation that he or she has been sexually abused by another resident, does the agency subsequently inform the alleged victim whenever: The agency learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility?	yes
115.373 (e)	**Reporting to residents**	
	Does the agency document all such notifications or attempted notifications?	yes

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?	yes
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?	no
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?	no
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**	
	Is this the first year of the current audit cycle? (Note: a “no” response does not impact overall compliance with this standard.)	no
	If this is the second year of the current audit cycle, did the agency ensure that at least one-third of each facility type operated by the agency, or by a private organization on behalf of the agency, was audited during the first year of the current audit cycle? (N/A if this is not the second year of the current audit cycle.)	no
	If this is the third year of the current audit cycle, did the agency ensure that at least two-thirds of each facility type operated by the agency, or by a private organization on behalf of the agency, were audited during the first two years of the current audit cycle? (N/A if this is not the third year of the current audit cycle.)	yes
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. The review period is for prior audits completed during the past three years PRECEDING THIS AUDIT. The pendency of any agency appeal pursuant to 28 C.F.R. § 115.405 does not excuse noncompliance with this provision. (N/A if there have been no Final Audit Reports issued in the past three years, or, in the case of single facility agencies, there has never been a Final Audit Report issued.)	yes