PREA Facility Audit Report: Final

Name of Facility: Ferris School
Facility Type: Juvenile
Date Interim Report Submitted: 02/26/2024
Date Final Report Submitted: 07/18/2024

Auditor Certification	
The contents of this report are accurate to the best of my knowledge.	☑
No conflict of interest exists with respect to my ability to conduct an audit of the agency under review.	☑
I have not included in the final report any personally identifiable information (PII) about any inmate/resident/detainee or staff member, except where the names of administrative personnel are specifically requested in the report template.	☑
Auditor Full Name as Signed: Tammy A. Hardy-Kesler	**Date of Signature:** 07/18/2024

AUDITOR INFORMATION	
Auditor name:	Hardy-Kesler, Tammy
Email:	codyemomma@msn.com
Start Date of On-Site Audit:	01/08/2024
End Date of On-Site Audit:	01/11/2024

FACILITY INFORMATION	
Facility name:	Ferris School
Facility physical address:	959 Centre Road, Building 5, Wilmington, Delaware - 19805
Facility mailing address:	

Primary Contact

Name:	Eric Sirmons
Email Address:	eric.sirmons@delaware.gov
Telephone Number:	(302) 388-0644

Superintendent/Director/Administrator	
Name:	Tanya Banks
Email Address:	tanya.banks@delaware.gov
Telephone Number:	(302) 993-3813

Facility PREA Compliance Manager	
Name:	Eric Sirmons
Email Address:	eric.sirmons@delaware.gov
Telephone Number:	O: 302-993-3800

Facility Health Service Administrator On-Site	
Name:	Sarah Ciano
Email Address:	sarah.ciano@delaware.gov
Telephone Number:	(302) 633-3121

Facility Characteristics	
Designed facility capacity:	72
Current population of facility:	25
Average daily population for the past 12 months:	25
Has the facility been over capacity at any point in the past 12 months?	No
Which population(s) does the facility hold?	Males

Age range of population:	13-18
Facility security levels/resident custody levels:	Level 5
Number of staff currently employed at the facility who may have contact with residents:	82
Number of individual contractors who have contact with residents, currently authorized to enter the facility:	7
Number of volunteers who have contact with residents, currently authorized to enter the facility:	13

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:	Carrie Hyla	**Email Address:**	Carrie.Hyla@Delaware.gov

Facility AUDIT FINDINGS

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:	2024-01-08
2. End date of the onsite portion of the audit:	2024-01-11

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:	Survivors of Abuse in Recovery- there was a virtual meeting with the organization.

AUDITED FACILITY INFORMATION

14. Designated facility capacity:	72
15. Average daily population for the past 12 months:	25
16. Number of inmate/resident/detainee housing units:	2
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:	28
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:	6
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:	0

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:	2
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:	82
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:	12

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:	18
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:	11
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?	The auditor reviewed roster and selected based on criteria selected above to ensure diversity in the interviewing pool.
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):	No text provided.
Targeted Inmate/Resident/Detainee Interviews	
58. Enter the total number of TARGETED INMATES/RESIDENTS/DETAINEES who were interviewed:	7
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).	There were no residents identified as physically disabled by the facility. During interviews with medical practitioners there were no residents identified as physically disabled. During site review, there were no residents that appeared to be physically disabled.
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:	7
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).	There were no residents identified as blind or low vision by the facility. During interviews with medical practitioners there were no residents identified as being blind or low vision. During site review, there were no residents that appeared to be blind.
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).	There were no residents identified as deaf or hard of hearing by the facility. During the interview with the medical practitioners, there were no residents identified as 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).	There were no residents identified as limited English proficient. During informal conversation with residents, there were no residents that appeared to have difficult in communicating in English. There were only 28 residents at the facility, so the auditor was able to observe all residents.
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:	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).	Informal interviewing and site review yielded no residents in this targeted category.
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).	During interviews with residents, the auditor asked specifically about resident's identification. There were no residents that identified themselves as either transgender or intersex. During informal conversation with residents, there were no residents that identified themselves as either 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).	For the prior 12 months, there were no allegations of sexual abuse or sexual harassment reported or investigated. There were no investigative files of sexual abuse or sexual harassment for the auditor to identify residents that may have been sexually abused or sexually harassed. Further, interview of both medical and mental health practitioners yielded no residents to interview in this category.
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).	During informal interviews with residents, an inquiry was made regarding isolation. Residents stated that they would be placed on administrative intervention in cases of behavior.
70. Provide any additional comments regarding selecting or interviewing targeted inmates/residents/detainees (e.g., any populations you oversampled, barriers to completing interviews):	During the onsite audit, there were 28 residents. Out of the 28 residents, the auditor interviewed 7 with learning disabilities. There was a resident identified as having a history of prior sexual victimization, but when interviewed he stated that he had not had a history of victimization. At the time of the onsite audit, there were no other targeted groups identified at the facility.

Staff, Volunteer, and Contractor Interviews

Random Staff Interviews

71. Enter the total number of RANDOM STAFF who were interviewed:	13
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
If "Other," describe:	Gender was a consideration for interview in order to determine the practices of searches and announcements by female staff. The facility is an all-male facility.
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 to completing random staff 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):	35
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
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:	1
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:	1
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.	Attempts were made to interview contractors and volunteers via email and telephone. The auditor was able to interview a volunteer and a contractor who supervises several of the other contractors at Ferris School.

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 site review, there was a review of all cameras to ensure that all cameras were operational. The auditor was at the facility during all shifts to interview as well as to review the practices of staff during all shifts.

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.).	There were no barriers to selecting and receiving documentation. The facility provided rosters prior to the onsite audit, and the auditor requested selected documentation be uploaded to the OAS for review prior to onsite audit.

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	0	0	0	0
Total	0	0	0	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	0	0	0	0
Total	0	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	0	0	0	0
Total	0	0	0	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	0	0	0	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:	0
a. Explain why you were unable to review any sexual abuse investigation files:	For the prior 12 months, Ferris School did not have any allegations of sexual abuse and there were no investigations conducted.

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:	0
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:	0
a. Explain why you were unable to review any sexual harassment investigation files:	For the prior 12 months, Ferris School did not have any allegations of sexual harassment, and there were no investigations conducted.
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:	0
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.	No text provided.

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 06/22/23). 3. State of Delaware Department of Services for Children Youth and Their Families Division of Youth Rehabilitative Services PREA Compliance Managers Organizational Chart (2023). 4. State of Delaware Employee Performance Plan PREA Coordinator Section I, B (pp. 1), (4/11/23). 5. Ferris School Organizational Chart (2023) 6. Pre-Audit Questionnaire (PAQ) Interviews: 1. PREA 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: 1. 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. 2. 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. 3. Policy 2.13 III, Section III, 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 G, 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 responding 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 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 the 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 Deputy Director and provides assistance to four PREA compliance managers. The plan also outlines that the PC will coordinate PREA audits, ensure timely submission of PAQ's (Pre Audit Questionnaire), support and monitor corrective actions. The PREA coordinator was appointed to this position on 3/13/23. During an interview, the PREA coordinator reported that she has sufficient time to manage PREA related responsibilities. The PC indicated she works together with four PREA compliance managers through meetings, calls and investigation efforts. 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 3/13/23 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, 77 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 Ferris School Organizational chart, the facility has designated a PREA Compliance Manager that holds the position of Treatment Specialist in the organizational structure and reports directly to the Program Manager. A review of the State of Delaware Employee 2023 PREA Compliance Managers organizational chart, the Treatment Specialist is designated as the PREA Compliance Manager for the facility. The 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 he does have enough time as the PREA compliance manager. The PCM stated he coordinated the facilities efforts to comply with the PREA standards through staff training and resident training (comprehensive) and ensure initial training by YRS. The PCM provided agency documentation onsite as well as 95 supplemental files for the auditor's review. The PCM stated if there were any issues with compliance, he would review with administration and investigators and take corrective action if necessary. The auditors were able to observe the PCM interactions with the facility staff and residents which demonstrated knowledge about his 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 10/2023). 2. Division of Youth Rehabilitative Services DYRS Operating Guidelines for Contracted Children and Family Programs and Services Section V, B, D pp 10-11, (revised 11/01/22). 3. Pre-Audit Questionnaire (PAQ) 4. Natchez Trace Youth Academy PREA Final Report 7/18/2022 5. Abraxas Academy PREA Final Report 5/09/2022

6. Woodland Academy PREA Final Report 5/16/2022.
7. George Junior Republic PREA Final Report 11/10/2023
8. Montour Learning Center PREA Interim Report 12/7/2021
9. Abraxas Youth and Family Services PREA Final Report 9/7/2023
10. YRS Woodard Academy Contract Amended 9/28/2023.
11. CYF Keystone dba Natchez Trace Contract 9/22/2022
12. CYF Diversified Treatment Alternative Contract 8/07/2023
13. CYF George Junior Republic Contract 9/22/2023
14. YRS Cornell Abraxas Group Inc Contract Amended 09/13/2022
15. CYF Kids Peace National Centers Contract 9/22/2023
16. CYF Devereax Foundation Contract 10/3/2022
17. YRS The Whitney Academy Contract 3/23/2023
18. CYF Gulf Treatment Center Contract 8/29/2023

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 16 contracts for confinement of residents. The Division of Youth Rehabilitative Services DYRS Operating Guidelines for Contracted Children and Family Programs and Services Section V, B, and D page 10 and 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 (10/2023), the agency reported they had 16 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 five of the 16 contracts for confinement of the agency’s residents. The contracts reviewed have a section on reporting requirements that specifically requires contractors to maintain compliance with the DSCYF operating guidelines for contracted client programs and services. The DSCYF operating guidelines is located on the agency’s website at https://kidsfiles.delaware.gov/pdfs/dscyf-op-gl-revisions-v11-01-2022.pdf and does require the contractor to comply with the PREA

	standards. The agency reported that seven out of the 16 facilities had less than 51% Juvenile Justice. Since the last PREA audit, the agency had 16 facilities that were under contract. The auditor was able to review six PREA audit reports provided by the agency. The evidence shows that the agency has entered 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, PREA audit reports and agency guidelines. Based upon this analysis, the facility is substantially compliant with this provision and no corrective action is required. 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 seven 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 (10/2023), the 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. Seven providers were listed as having less than 51% juvenile justice youth. During an interview with the agency contract administrator, PREA compliance is required, or contract would not be offered. Language is incorporated in contracts, PREA information is obtained ahead of time before contract request. The auditor reviewed four of the seven 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 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.

115.313	**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. Ferris School Staffing Plan (2023). 3. Ferris School Organizational Chart (2023). 4. Ferris School DYRS Recall of Off-Duty Personnel/Telecommunications 3.14 (6/6/2022) 5. Ferris School DYRS Personnel Selection, Retention and Promotion 3.1 (6/8/2022) 6. Ferris School Staff Schedule (12/2023). 7. Ferris school Shift Reports (1/2023, 2/2023, 7/2023, 11/2023, 2/2024) 8. DYRS Strategic Plan (7/6/2023) 9. Director's Team Meeting Minutes (2/24/2023). 10. Superintendent's Team Meeting Minutes (3/17/2023). 11. Ferris School Freese List 2023. 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 25 and the staffing plan was predicated on that number. At the time of the onsite audit, there were 28 residents at the facility. The facility reported in the last 12 months they have not deviated from the staffing plan. 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 facility staff to student ratio. The shifts are A shift (6:00am -2:00pm), B shift (2:00pm-10:00pm), and C shift (10:00pm-6:00am). The facility has four A shift supervisors on 6:00am-2:00pm shift, five B shift supervisors on 2:00pm-10:00pm, and two C shift supervisors on 10:00pm-6:00am.

	The facility reported they currently employ 82 staff, 7 contractors and 13 volunteers that may have contact with residents. In review of the Ferris School organizational chart, the facility reported that they have a staffing capacity of 104 employees. The facility reported they currently have 77 with 27 vacancies. The current administrative and security staff consist of one superintendent, one assistant superintendent, one administrative specialist II, two program manager, two treatment specialist supervisor, five YRS supervisor, one OSS, one Volunteer Coordinator, one Custodial, two recreation program specialist, eight treatment specialist, six food service, 13 YCS that work on A shift 0600-1400, 10 YCS that work on B shift, 1400-2200 and 10 YCS that work on C shift 2200-0600. 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. The report outlines the number of staff and residents in each cluster. The staffing plan and policy calls for a minimum of one staff per eight residents during A, B shift and one staff to sixteen residents on C shift. The staffing plan requires that staff always be aware of the location of the group and individual residents 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. The C shift has a minimum of one staff to 16 residents with 10-minute checks during sleeping hours. The auditor was able to observe that the residents were never alone. Residents traveled in a group escorted by staff, in the main hallway, in healthcare and intake. Staff utilized radios for communication between other staff. On the first day of the onsite audit, 28 residents resided at the Ferris School. 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. The facility added 40 new cameras in the past 12 months bringing the total number of cameras to 142. During the onsite review, on January 8, 2024, the total number of residents was 28, on January 9, 2024, the total number of residents was 28, on January 10, 2024, the total number of residents was 28, and on January 11, 2024, the total number of residents was 28. The Ferris School has a facility capacity count of 72. There are 142 video monitoring cameras installed throughout the facility. All the cameras can be monitored by staff. The auditor did not observe any cameras in the bathroom. All cameras have a 30-day retention and are retrievable by date and time. 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 they check for compliance of the staffing plan by reviewing shift reports; schedules, action plans; access to cameras, and conducting random checks. The Superintendent indicated that the camera covers blind spots and improved sight

	lines. Overall improvements of the quality of cameras; outside “spaceship cameras” with 360-degree view. During an interview the PREA Compliance Manager stated they added more cameras for blind spots. The evidence shows that the facility provides adequate staffing levels and video monitoring to protect residents against abuse. This was verified through staffing plan, policy, interviews, video monitoring technology, 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 DYRS Strategic Plan, Directors team meeting and Superintendent Meeting minutes that outline the agency’s discussion for staffing plans, update staffing ratios, facility shift checks during the day and at night. The Director’s team meeting was February 24, 2023, and the Superintendents meeting was March 17, 2023. The Director discussed every year the facilities are required to review their staffing plans and bring them to the meeting for review. During interviews, the PREA Compliance Manager stated staffing ratios remain the same. During interviews, the PREA Coordinator states that she is consulted regarding any assessments or adjustments annually during the Director’s meeting with the Superintendents. 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 the 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 logs for the housing units shows that PREA unannounced rounds are documented in the unit log. A review of the video system shows that rounds are being completed. The intermediate higher-level staff do conduct PREA unannounced rounds on all shifts and log such rounds in the unit log. PREA unannounced rounds are documented as PREA tour with a time and notation if any issues were found on the shift briefing reports. During Interview, higher-level staff stated that they do conduct unannounced rounds and document these rounds during shift report and logs. When asked how you prevent staff from alerting other staff, higher level staff indicated they would change up routine. The evidence shows that the higher-level staff conduct unannounced rounds, and they are documented in the logbook and shift briefing reports which was verified through review of the logs, shift reports, 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. Ferris School DYRS Searches -Clothed and Unclothed SOP 9.7 (1/4/2023). 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. PREA Cross Gender Pat Down Searches Training Records 22 staff. Site Review Observations: 1. Intake

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. Staff indicated that the facility conducts cross gender pat searches only during exigent circumstances.

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. In addition, 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. 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.

During an interview, when asked what urgent circumstance would require cross-gender strip searches and visual body cavity searches, 1 out of 1 staff stated fire, natural disaster, any other exigent circumstance.

The evidence shows that the facility does not conduct cross gender strip searches or body cavity searches of residents which was verified by policy, PAQ, 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. Ferris School DYRS Searches -Clothed and Unclothed section I, outlines that cross gender bodily searches and or pat downs are not conducted except in exigent circumstances. If under exigent circumstances cross gender searches and or pat downs are conducted, the facility will document and justify the need for such

searches.

During an interview, when asked are you restricted from conducting cross gender pat down searches except in exigent circumstances, 13 out of 13 staff said yes. When asked to provide an example of a circumstance that would warrant a search, 3 out of 13 staff stated a riot or a weapon.

The auditor was able to observe the intake areas and speak with staff regarding the intake process. There was one new intake during the onsite audit. Staff stated after resident is escorted into the facility intake area, each resident is searched by the same gender staff. Two staff of the same gender would be present during a search with the resident and is not visible by 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, interviews 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 13 random staff, when asked do you or other staff announce your presence when entering a housing unit that houses residents of the opposite gender, all 13 staff stated yes. All 13 staff stated they would announce female on unit, pod, post or cluster. When staff was asked if residents are able to dress, shower and use the toilet without being viewed by staff of the opposite gender, all 13 out of 13 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 11 residents, when asked do female staff announce their presence when they enter your housing area or any area where you shower, change clothes, or perform bodily functions, 8 out of 11 residents stated yes, staff say female on the unit, floor or pod 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 11 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 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 13 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, 12 out of 13 staff stated they were aware of the policy. During the onsite review, the auditor reviewed 14 resident files and interviewed 11 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 training records that 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. During interview with 13 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, 12 out of 13 staff stated they have been trained and received update refresher training. The auditor reviewed training records for staff. One member of staff reported they have not received the training. In review of training records, 29 staff have received training on searches of residents through PREA refresher training online. 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.

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.C.2.d 2. DSCYF Policy 118.II 10-6-2017 3. PAQ 4. Roster of Residents receiving Special Education Services 5. State of Delaware Executive Department Office of Management and Budget Contract NO. GSS19602-LINGUIST Interpretation & Translation Services-Foreign Languages Effective 4-1-2023 6. How to Access and Purchase Contracted Translation Services 7. Quick Glance Interpretation & Translation Services 8. List of Translation Providers 9. Ferris School Resident Safety Guide Spanish 10. Ferris Resident Handbook Spanish 11. PREA video with closed captions Interviews:

1. Director of DYRS
2. PREA Compliance Manager
3. Random Residents
4. Random Staff
5. Site Review:
6. Intake
7. Posters and Audit Postings

Findings (by Provision):

115.316 (a)-1:

DSCYF has taken 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 for residents that are disabled. In agency policy, there is specifics that ensure that disabled residents receive the same equal access to services and information pertaining to the prevention, detection, and response to sexual harassment and sexual abuse. Within PREA Policy 2.13.IV.C.2.d states each facility is to 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.

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 the services needed, the document includes the Quick Glance Interpretation & Translation Services. On the list provided, the auditor located Sign Language Services for residents that are hearing impaired.

Through the issue log the auditor requested a roster of students that received special education services and residents that were limited English proficient. There were several residents listed as receiving special education services at Ferris School (FS). The special education classifications were not indicative of residents that would necessitate assistance or support in understanding the existing PREA delivery of information. During the interviews with all the residents there was no apparent indication of a need for specialized vocabulary on the part of the auditor. There were no residents that had any speech impairment, blindness, overt intellectual disabilities, or hearing impaired.

Interview with the Director of DYRS and the PREA Compliance Manager revealed that there are procedures implemented to ensure that residents with disabilities and limited English proficiency receive information related to PREA. Specifically mentioned was the access to the interpretation and translation services that

	included sign language, and residents with visual impairments could be provided PREA information in larger print. During the onsite review, there were some PREA posters that had large print. During the intake process, staff interviewed was aware of interpretation and translation services that were available. During interviews of targeted residents, the 5 targeted residents with learning disabilities confirmed receiving sexual abuse and sexual harassment information that they were able to understand. The residents stated that they received the information from the resident handbook and/or via the PREA video. The auditor inquired about extra assistance given by staff, and the residents stated that staff would help them if they needed help in understanding their rights concerning sexual abuse and sexual harassment. Also, they could receive help reporting or writing a grievance pertaining to sexual abuse or sexual harassment. The agency substantially meets compliance in this provision. 115.316 (b)-1: In DSCYF Policy 118.II, it is the policy of the Department that all limited English Proficient (LEP) persons must have equal access to Department services, whether they are delivered by the Department or its contractors shall be entitled to language assistance at no cost to themselves. During the onsite audit, there were no residents identified as limited English proficient. It should be noted that Spanish is the second largest spoken language in the state of Delaware. Meaningful access to all aspects of DSCYF's efforts to prevent, detect, and respond to sexual abuse and sexual harassment to residents who are limited English proficient are meet 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. Additionally in the PAQ was the instructions to access the services.Based on contract requirements, the interpreters and translators are screened to ensure individuals providing services were effective, accurate, and impartial both receptively and expressively. During the onsite review, the auditors located PREA information in English and Spanish pertaining to the prevention, detection, and response to sexual harassment, sexual abuse, and retaliation for reporting. Also, there were audit postings throughout the building posted in both English and Spanish. The agency substantially meets compliance in this provision. 115.316 (c)-1-3:

	Review of DSCYF Policy 118.II does not explicitly prohibit the use of resident interpreters, resident readers, or other types of resident assistants. 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 12 out of 13 random staff were aware that residents could not be utilized as translators or interpreters. There were no limited English proficient residents to interview nor documentation in PAQ to determine if resident interpreters, resident readers, or other types of resident assistants were utilized except in limited circumstances. According to random staff, there has not been any limited English proficient residents at Ferris School. According to the information taken from the PAQ, there were no instances in the past 12 months that indicated where resident interpreters, readers, or other types of resident assistants had been used. There was no documentation located by the auditor that there was an extended delay in obtaining another interpreter that could have compromised the resident's safety, first-responder duties, or the investigation of the resident's allegations. The agency substantially meets compliance in this provision. The evidence demonstrates that DSCYF has taken steps to ensure that residents 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. Additionally, there was no utilization of resident interpreters, resident readers, or other types of resident assistants. It was verified by the agency's policies, contracts, resident roster, interviews, and site reviews. Based upon this analysis, the facility is substantially compliant with this standard and no corrective action is required.

115.317	**Hiring and promotion decisions**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. DYRS PREA Policy 2.13.III Revised 5-13-2021 2. DYRS PREA Policy 2.13 Attachment F-DYRS Hiring and Promotion Decisions 3. DYRS PREA Policy 2.13- Attachment G- Prison Rape Elimination Act (PREA)

Acknowledgement Form- Hiring/Contracting
4. DSCYF Policy 313 Revised 12-15-2016
5. DSCYF 318.IV.E Effective 12-15-2016
6. DYRS Policy 2.2 Revised 5-13-2021
7. Letter of Affirmation of NCIC 5 year Checks of Employees of Ferris School 12/1/2023
8. Volunteer Roster
9. Delaware Criminal Justice Information System (DELJIS)
10. Employee Files
11. Volunteer Files
12. Contractor Documentation

Interviews:

1. Human Resources
2. Criminal Background Unit
3. Contractor

Site Review:

1. Employment Files
2. Volunteer Files

Findings (by Provision):

115.317 (a)-1:

DSCYF has implemented 2 policies and 2 forms to address PREA standard 115.317 prohibiting the hiring, promoting, or contracting 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 PREA Policy 2.13 attachment F-Prison Rape Elimination Act (PREA) Acknowledgement Form Hiring and Promotion Decisions is an affirmation completed by employees at promotion and annually with evaluation. This forms specifically addresses sexual abuse and sexual harassment.
- DYRS PREA Policy- Attachment G- Prison Rape Elimination Act (PREA) Acknowledgement Form- Hiring/Contracting which is completed by new-hires and contractors to attest that they have not been engaged in above behaviors. This form addresses both sexual abuse and sexual harassment.
- DYRS Policy 3.18.IV.E-G references that PREA requires pre-employment reference checks for covered employees to determine whether the candidate has engaged in the above stated behaviors. Additionally, the

policy requires a service letter containing employment related information including the nature of the employee's separation from employment, and if there were any reasonably substantiated incidents involving violence, threat of violence, abuse, or neglect, by the person seeking employment toward any other person. Lastly, the policy requires a National Sex Offender Registry Check and Delaware Sex Offender Registry which would be revealed as part of the criminal background check.

- In DSCYF Policy 313 Title 31, Chapter 3, Section 309 of the Delaware Code requires a check of SBI and FBI records and 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.

After reviewing new hire files, the practice of completing required criminal background checks and child registry checks were completed. There were 44 out of 44 criminal background checks completed and child abuse registry consulted.

During the hiring process, the agency had not completed DYRS PREA Policy 2.13 Attachment F- Hiring and Promotion Decisions which inquiries about past conduct. The employee would affirm that they have or have not been investigated for or engaged in sexual abuse or sexual harassment in confinement, community, and civilly or administratively adjudicated.

The agency does not substantially meet compliance for this provision.

115.317(b)-1:

According to the definition of staff in DYRS PREA Policy 2.13. III, contractors are defined as employees. All prohibitions to hiring apply to contractors which include DCYF Policy 318 and DCYF 313. Attachment G of DYRS PREA Policy 2.13 captures the contractor's affirmation that they have or have not been investigated for or engaged in sexual abuse or sexual harassment in confinement, community, and civilly or administratively adjudicated. The human resource representative confirmed that the agency does consider past conduct of sexual abuse and sexual harassment during the hiring process. The auditor was unable to determine the extent of background checks and child registry checks due to the inconsistency of the contractors list provided via email and PAQ.

During an interview with a contractor, the auditor determined that contractor was unclear of onboarding processes and PREA training. The auditor reached out to other contractors, but there was no call back via telephone or email. Additionally, there was limited and inconsistent documentation for contractors.

The agency does not substantially meet compliance for this provision.

115.317(c)-1-2

DSYCF Policy 313.III cites Title31, Chapter 3, Section 309 of the Delaware Code requires of SBI and FBI records and 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. The auditor inquired of the Human Resources and Criminal Background Unit during the hiring process of new employees, volunteers, and contractors if the child abuse registry consulted. Both agreed that the child abuse registry is consulted. There were 44 out of 44 new hire criminal background checks completed, and child abuse registry consulted. In DSYCF 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. 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. FSB does complete pre-employment reference checks, but they do not inquire about the above conduct. The reference check consists of calls made to individuals listed as references by candidates, but not to human resource departments of prior employment of institutions. Additionally, there is no inquiry of above conduct. The agency does not substantially meet compliance for this provision. 115.317(d)-1-2 According to the DYRS Policy 2.13.III.a Definition the FSB contractors 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 contractor roster for FSB. The auditor was unable to determine the extent of background checks and child registry checks due to the inconsistency of the contractors list provided via email and PAQ. During interview with a contractor, the auditor determined that the contractor was unclear

	of onboarding processes and PREA training. The auditor reached out to other contractors, but there was no call back via telephone or email. Additionally, there was limited and inconsistent documentation for contractors. The agency does not substantially meet compliance for this provision. 115.317(e)-1 Provided through the supplemental files of the AOS The PREA Coordinator provided a Letter of Affirmation for the 5-year employee background checks of the FSB. Provided to the auditor was the dates of criminal background checks and child abuse registry. 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 by DELJIS. This practice was confirmed by the Criminal History Unit. The facility meets compliance with this provision. 115.317(f)-1 The auditor reviewed DYRS Policy 2.13 – Attachment F-PREA Acknowledgement Form which is used to 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. In the introduction of the form, it states the agency shall not hire, promote or contract with anyone who may have contact with youth who participated in above behaviors listed. All 22 files contained copies of the DYRS PREA Policy 2.13 Attachment F. There were 13 out of 22 files that were up to date with the attachment, and there were 9 files that were not up to date. It was also confirmed by PREA coordinator that DYRS Policy 2.13 – Attachment F-PREA Acknowledgement Form is completed by employees annually and upon promotion. The auditor is unable to confirm if forms were completed during promotion. The agency does not substantially meet compliance for this provision. 115.317(g)-1 DYRS has established 2 policies wherein material omissions regarding misconduct or false information shall be grounds for termination. Within DSCYF Policy 318.V.C states any false, misleading, or substantive omission of information provided by an applicant during any phase or by any means may be cause for rejection of the application, rescinding an offer, repeating all or part of the hiring process, or dismissal if employed by the State. Found in DYRS Policy 2.2.IV.B.1.a. 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 substantially meets compliance for this provision.

115.317(h)-1

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

The evidence has shown that the agency has established policies and procedures that prohibit the hiring or promotion of employees or contractors who may have contact with residents who have engaged in sexual abuse in confinement, institution settings, community or civilly or administratively adjudicated for said behaviors. The agency through practice and policy has established forms but does not require service letters. The pre-employment reference check consists of selected references and no inquires pertaining to past conduct of sexual abuse and sexual harassment at previous institutions. The agency completes criminal background checks and child abuse registry consult prior to hiring. The agency does complete background checks every 5 years or less, and DELJIS captures incidents of criminal conduct in Delaware. Imposed on employees is a continuing affirmative duty to disclose any misconduct including PREA standard 115.316(a). 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 substantially meet compliance at this time and corrective action is needed.

Corrective action:

1. Prior to employment, candidates are to complete the DYRS PREA Policy 2.13 Attachment F-DYRS Hiring and Promotion Decisions
2. Promoted employees are to complete DYRS PREA Policy 2.13 Attachment F-DYRS Hiring and Promotion Decisions
3. All contractors and volunteers are to complete DYRS PREA Policy-Attachment G- Prison Rape Elimination Act (PREA) Acknowledgement Form-Hiring/Contracting
4. Service Letters are to be completed for all new hires who were employed at an institution. The service letters are to inquire about sexual abuse and sexual harassment towards coworkers, patients, clients, residents or children at prior institutions.

Verification of Corrective Action since the onsite PREA audit:

	In response to the corrective action, the facility submitted documentation via OAS on 4/22/2024, 5/9/2024, 5/14/2024, 6/3/2024 and 6/28/2024 copies of the following: • Completed PREA Policy 2.13 Acknowledgement Forms F • Completed PREA Policy 2.13 Acknowledgement Forms G • Revised PREA Policy 2.13 Acknowledgement Form F- combines Form F and Form G • Global Email from the Agency Head pertaining to the revised PREA Policy 2.13 Acknowledgement Form F • Drafts and revisions of Previous Institution Disclosure, Reference Check, and Consent to Release Information • Email pertaining to the reference checks and/or service letter of prior institutional employment for two of the three new hirers at Ferris School. **Corrective Action Intent** The intent of this corrective action was to ensure that in accordance with the PREA mandates all staff, contractors and volunteers who provide direct services to residents at the Ferris School complete an acknowledgement that they have not • 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 or refuse. • Been civilly or administratively adjudicated to have engaged in the activity described. • Been investigated for or engaged in sexual assault or sexual harassment. This acknowledgement is to be completed upon hire, annually, and upon promotion. Additionally, reference checks and/or service letter of prior institutional employment is to be completed for all new hirers. Based on review of the information received, the auditor finds the facility substantially compliant with this standard.

115.318	**Upgrades to facilities and technologies**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion

Documents:

1. Email 10-6-2021 Exciting DYRS Updates- Facility, Safety, Security Enhancements
2. Email 12-21-2023 Camera Diagnostic

Interviews:

1. Director of DYRS
2. Superintendent

Site Review:

1. Ferris School

Onsite Review:

1. Cameras
2. Doors

Findings (by Provision):

115.318 (a)-1:

Since the last PREA audit, there have been 2 facility enhancements/modifications to Ferris School (FS). There has been no new facility acquired by DYRS. During the interview with the Director of DYRS, it was stated that sexual safety and physical safety are considered when designing, acquiring, and planning modifications to facilities. FS updated the monitoring technology. There were 40 new cameras added as well as updates to existing cameras. The FS has a total of 142 cameras. Specifically, cameras were put in blind spots to prevent and detect sexual abuse and sexual harassment. The network video recording was replaced to lessen the risk of failure. The perimeter fencing around Ferris was enhanced, and the camera capability was enhanced to provide a sight line to the back of the property. Residents participating in outdoor recreation can be seen with clarity. A shaker detection system and enhanced exterior video surveillance was installed to respond to a disturbance to the fencing. Additionally, youth room doors were replaced to ensure security which increases the prevention of sexual abuse. During site review, the auditor tested the capabilities of the monitoring technology and viewed the new doors.

The agency substantially meets compliances with this provision.

115.318 (b)-1:

Since the last PREA audit there have been updates to the video monitoring system. During the interview with the superintendent, it was disclosed that additional

	cameras were added, and there were upgrades to existing cameras. There was a new video network added to improve the performance of the cameras. The capability of capturing footage is up to 30 days which provides information to assist in the ability to prevent and detect sexual abuse. During the site review, the auditor was able to view all 142 cameras with enhanced capabilities. The agency substantially meets compliances with this provision. The evidence demonstrates that DYRS has not acquired a new facility. There have been some modifications of doors, fencing, and cameras to FS since the last PREA audit. Additionally, the facility installed new video monitoring system since the last PREA audit. Considerations were made to improve the prevention and detection of sexual abuse. Based on this analysis, the facility is substantially compliant with this standard and there is no corrective action required.

115.321	**Evidence protocol and forensic medical examinations**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. DYRS PREA Policy 2.13.IV.G.1 2. DYRS PREA Policy 2.13.IV.I.2 3. DYRS Policy 2.13IV.E.4.a-b 4. State of Delaware Memorandum of Understanding for the Multidisciplinary Response to Child Abuse and Neglect 5/2022 pp 93-104 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-Christina Care Hospital 4/2023 7. Affirmation of Compliance with Investigative Standards for Sexual Assaults with Delaware State Police 4/2023 8. Pre-Audit questionnaire (PAQ) 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 has established through memorandum of understandings and affirmations agreements to ensure DSP follows uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions. DYRS PREA Policy 2.13.IV.G.1.a-c requires that all allegations of sexual abuse or sexual harassment are reported to the Child Abuse Hotline and screened for Institutional Abuse investigation. At Ferris School (FS), allegations of criminal behavior will be investigated jointly by Delaware State Police (DSP) and Institutional Abuse (IA). The DYRS does not conduct criminal investigations. 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 FS referred to by the Child Abuse Hotline within the prior 12 months.

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." The US Department of Justice's Office document was not utilized to develop the protocols. The protocol was developed based on best practice. Comparison was made 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

Many of the elements were utilized in the creation of the State of Delaware Memorandum of Understanding for the Multidisciplinary Response to Child Abuse and Neglect 5/2022.

In the Affirmation of Compliance with Forensic Examinations Standards for Sexual Assaults between the Christiana Care Hospital SANE coordinator, DYRS director and the 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)
In DYRS PREA Policy 2.13.IV.I.2, states that resident victims of sexual abuse will be referred to A.I. Dupont or Christiana Care Hospital for New Castle County for medical interventions. Existing is the Affirmation of Compliance with Forensic Examinations Standards for Sexual Assaults between the Christiana Care Hospital SANE coordinator, DYRS director, and 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 prior 12 months from FSB. Interview with SANE Coordinator confirmed that there was an existing agreement with DYRS for forensic examinations for allegations of sexual abuse of residents at FS.

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

115.321(d)

	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, counseling while in custody, and counseling in the community. The agreement requires that qualified staff members provide advocacy services. DYRS Policy 2.13IV.E.4, referenced that youth shall be made aware of community agencies, addresses, and contact information of victim advocates that provide emotional support services related to sexual abuse. Interview of the random youth, it was found the residents were not able to recall victim 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 were referrals for victim advocacy services from FSB within the last 12 months. It should be noted that referral for victim advocacy can be requested by residents with prior victimization in either the community or in another facility. Based on this analysis, the agency substantially meets compliance for this provision. 115.321(e) 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 auditor interviewed SOAR, and it was confirmed by the staff of SOAR that an affirmation existed with DYRS. SOAR stated that the services listed in the affirmation were still available to victims at FS. Also, there was a referral for victim advocacy within the prior 12 months. It should be noted that referral for victim advocacy can be requested by residents with prior victimization in either the community or in another facility. Based on this analysis, the agency substantially meets compliance for this provision. 115.321(f) DSP provides criminal investigations for allegations of sexual abuse at the FS. DYRS and the DSP implemented the Affirmation of Compliance with Investigative Standards for Sexual Assaults 4/2023. Additionally, there is the State of Delaware Memorandum of Understanding for the Multidisciplinary Response to Child Abuse and Neglect 5/2022. 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. Within agency policy, DYRS is responsible for conducting administrative sexual abuse investigations in cases in which the Child Abuse Hotline screens an allegation of sexual abuse. 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 5/2022, the Affirmation of Compliance with Forensic Examinations Standards for Sexual Assaults 4/2023, and the Affirmation of Compliance with Investigative Standards for Sexual Assaults 4/ 2023 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 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: 1Policy 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. Affirmation of Compliance with Investigative Standards for Sexual Assaults with Delaware State Police (4/14/23)
7. Policy 2.12 Division of Youth Rehabilitative Services Professional Practices Reportable Events Section III A-b page 1, (Revised 2/01/23).
8. Child Sexual Abuse Protocol Memorandum of Understanding (5/18/22), (pp. 5)
9. Policy 309 Removal of Employee from the Workplace (11/1/2021)

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. The Agency provided an Affirmation with the Delaware State Police that employs they follow investigative protocol consistent with PREA and investigate crimes that occur at the residential programs for the Department of Children, Youth, and Their Families on the Wilmington Campus.

The facility reported in the PAQ there was no 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 that no sexual abuse or harassment complaints were received by the agency.

The auditor requested the last three years of records and was able to confirm that there was no sexual abuse or sexual harassment reported during the 12 months preceding the onsite audit. In review of the records the auditor was able to confirm the agency’s practice with ensuring that allegations of sexual abuse and sexual harassment are investigated.

During an interview, the agency head stated that they do ensure that administrative and criminal investigations are completed. All allegations are made on the Institutional Abuse Hotline. Administration Investigation starts immediately.

The evidence shows that during the past 12 months there were no allegations reported during the last twelve months preceding the onsite audit. This information

	was verified through the PAQ, interviews, policy, and documentation review. Based upon this analysis, the auditor finds the facility is substantially compliant with this provision and corrective action is not 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), Mandates that reports of child abuse or neglect be made to the appropriate authorities. 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://kids.delaware.gov/policies/ 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. The auditor requested the last three years of investigations. A review of the records confirms the agencies process with documenting referrals and allegations of sexual abuse and sexual harassment. 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 Ferris School. During an interview, facility investigators 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 the legal authority and did not have 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 for reporting sexual abuse and sexual harassment. 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. Based upon this analysis, the auditor finds the facility is substantially compliant with this provision and corrective action is not required. 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.A 2. DSCYF Academy Staff Training PowerPoint Presentation 3. PREA Refresher Training Roster 4. Staff Roster 5. Personnel Files 6. Pre-Audit Questionnaire (PAQ) Interviews:

1. Random Staff
2. Medical Staff
3. PREA Coordinator
4. Training Administrator

Findings (by Provision):

115.331 (a)-1-11:

Though not required, DYRS has implemented Policy 2.13.IV.C.1.a-d to address PREA training for all employees. The policy states that all department staff working with or monitoring programs/services of youth in secure care and community services must receive PREA training. Further, the policy details that the Center for Professional Development will provide training to all new DYRS employees during orientation. Review of new hires' personnel files substantiated the practice of the agency providing PREA training during orientation. All new hirers are provided PREA training during their orientation at the Center for Professional Development. All employees are to complete PREA refresher training every 2 years via the Delaware Learning Center's database. DYRS staff are to re-new this training every two years. Lastly, the training will include, but not limited to, complaint recipient responsibility, how to report and incident, coordinated responses duties, investigations, and how to access victim services.

Training material was provided in the Pre-Audit Questionnaire (PAQ). The initial PREA training is provided in person, and instruction is lead utilizing a PowerPoint presentation which is based on the Moss Group training materials for PREA. Located in the Academy Staff Training on slide 8, there is specific language that addresses the agency's Zero Tolerance Policy. The slide was titled Zero Tolerance Policy. Underneath, the slide read DYRS commits to full compliance with the Prison Rape Elimination Act (PREA). There are 2 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

Agency's zero-tolerance policy for sexual abuse and sexual harassment **Slides 8**
Responsibilities of prevention, detection, reporting, and response policies and procedures **Slides 10-73**
Right of residents to be free from sexual abuse and sexual harassment **Slide 9**
Right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment **Slide 10,51,55, 106**
Dynamics of sexual abuse and sexual harassment **Slides 27-44**
Common reactions of juvenile victims of sexual abuse and sexual harassment **Slides 27-44**
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 **Slides 35-57** How to avoid inappropriate relationships with residents **Slides 89-95** How to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents **Slides 92--95** How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities **Slides 51-53** Relevant laws regarding the applicable age of consent **Slides 12-21** Comparison of staff rosters and the PREA training refresher roster, the auditor was able to determine that 49 of 80 staff members had received the PREA refresher training through the Center of Professional Development. Clarification was sought by the auditor. It appears that there may have been in person PREA Refresher training at the facility. Review of records of medical personnel, there were a total of 20 staff, and there was a total of 13 certificates obtained for the PREA Refresher training. The mental health practitioners, there were 2 completed PREA refresher training per training roster or certificates. Utilizing the PREA protocols for random staff, the auditor found that all 13 random staff interviewed stated that they had received PREA training at orientation, and they had received PREA refresher training. During the interview with the medical practitioner, it was clarified that since the submission of the Pre-Audit Questionnaire 16 medical practitioners received the required PREA refresher training. Out of the 16 staff members, the auditor received 13 certificates in the PAQ. Review of information provided both through PAQ and onsite, there were actually 20 medical staff. The agency does not substantially meet this provision. 115.331(b)-1-2 DYRS provides services to both male and female residents. FS is an all-male facility, but there are times that staff can be utilized on the DSCYF Campus for other facilities that service both males and females. 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 genders. The agency substantially meets the provision. 115.331(c)1-2 In accordance with DYSR Policy 2.13.IV.A.1.b., employees are required to participate in PREA refresher trainings. Based on information obtained from facility staff, they received PREA refresher training. Based on the PAQ and the interview with the training administrator at the Center for Professional Development, the PREA refresher training is prompted online every 22 months. Between the trainings, staff

is not provided with refresher information about current policies regarding sexual abuse and sexual harassment. The PREA refresher training and the PREA search training were given within the same year in very close proximity.

A comparison of the employee roster and the PREA refresher roster has shown that a substantial number of staff have not completed the PREA refresher training. There were 47 out of 80 Youth Rehabilitative Services secure staff that completed the PREA refresher training. There were 13 out of 20 medical staff that completed PREA refresher training, and there were 2 out of 4 mental health practitioners that completed the PREA refresher training. Review of the staff roster and the PREA search training roster, there were 26 out of 80 staff that completed onsite search training. The auditor requested clarification on the number of staff that were responsible for conducting searches.

The agency does not substantially meet the provision.

115.331(d)-1

The auditor received a roster of completion of the PREA refresher training, but this information was not an electronic verification that the employees understood the PREA training, but rather a verification that the staff participated in the training. During the interview with the training administrator, it was clarified that staff electronically sign once they are completed the course. Additionally, an assessment is administered. The participant has up to 5 times to take and pass the assessment. After 5 attempts, staff must take the test in person at the Center for Professional Development.

Review of transcripts of new hirers provided evidence that staff receive comprehensive PREA training during orientation. The training meets all PREA standard requirements of 115.331(a).

The agency substantially meets the provision.

The agency provides training on the agency’s zero-tolerance policy for sexual abuse and sexual harassment. All employees who may have contact with residents are trained in accordance with PREA standard 115.331 (a)1-11. The agency provides PREA refresher training through the Delaware Learning Center’s database. A comparison of the employee roster and the PREA refresher roster has shown that a substantial number of staff have not completed the PREA refresher training. The agency does document and maintain electronic signature and assessment results.

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

Corrective Action:

1. All staff that provide direct services to residents complete the online PREA refresher training.
2. In years in which employees do not receive refresher training, the agency is

to provide refresher information on current sexual abuse and sexual harassment policies. Information can be provided through the Delaware Learning Center’s database with electronic signature and documented on employees’ transcript.

Recommendations:

1. Maintain a copy of transcripts from Delaware Learning System's database in staff files.
2. Maintain files of education staff
3. Develop a system to flag staff that do not pass assessments given by Delaware Learning Center's database.

Verification of Corrective Action since the onsite PREA audit:

In response to the corrective action, the facility submitted documentation via OAS on 4/22/2024 and 5/10/2024. The following documents were submitted:

- Roster of staff refresher training from the Delaware Learning Center
- Affirmation from PREA coordinator that in years in which employees do not receive refresher training, the agency shall provide refresher information on current sexual abuse and sexual harassment policies. Staff will be notified by the Delaware Learning Center when the policy review is to be completed. Completion of the review will be maintained electronically by the training center. The information has been included on the database.
- The agency has implemented a recommendation of flagging when staff does not pass assessments given by the Delaware Learning Center. On a monthly basis, facilities will receive results of training provided by the Delaware Learning Center.

Corrective Action Intent

The intent of this corrective action was to ensure that in accordance with the PREA mandates all staff receive PREA refresher and PREA related information to individuals who provide direct services to residents at Ferris School. 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.A.1
3. Training Roster for Volunteer
4. PREA Acknowledgement Form for Hiring/Promotion
5. PREA Training Volunteer/Contractor Acknowledgement Form

Interviews:

1. Volunteer
2. Contractor
3. Volunteer Coordinator
4. PREA compliance manager

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 2.13IV.A.1, all department staff working directly with or monitoring programs/ services of youth in secure care and community services must receive PREA training. Volunteers and contractors are to be trained on the agency’s zero tolerance policy for sexual abuse and sexual harassment.

According to the interview with the PREA compliance manager, contractors are provided training with the PREA Compliance Manager. The training includes an overview of the PREA Policy 2.13. The contractors signed an acknowledgement form of participation and understanding. There were no contractor files to review.

In the case of the volunteers, the volunteer coordinator provides the same training. Also, included in the volunteer files were initialed training checklist, PREA Acknowledgement Form for Hiring/Promotion, and PREA Training Volunteer/ Contractor Acknowledgement Form.

In the supplemental files of the PAQ, the auditor was provided a separate list of volunteers and contractors. The auditor contacted 7 volunteers by telephone and by email, but there was only 1 volunteer who participated in the telephone interview. It was stated by the volunteer that they had received PREA training during orientation at the facility by the volunteer coordinator.

In the case of contractors, the list provided was different than the PREA acknowledgement forms received. Between the list and the acknowledgements form, there was a total of 11 contractors. There was 1 contractor that responded to the auditor's attempts to contact. Based on the interview, the auditor determined that the contractor had not received PREA training. Due to the lack of consistency with information and lack of contractor files, the auditor could not determine

	whether contractors received PREA training. Based on the analysis, the agency does not meet compliance in this provision. 115.332(b)-1-2 Based on the information provided from the interview of the volunteer coordinator and the provided volunteer files, it appears that volunteers are receiving PREA training that is based on the services that are provided and the level of contact with residents. Additionally, the volunteers are made aware of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment via the PREA Policy 2.13. In the case of the contractors, the auditor was unable to determine the PREA training received due to the interview with the contractor, inconsistencies with documentation/roster, and the lack of contractor files. Based on the analysis, the agency does not meet compliance in this provision. 115.332 (c)-1 The agency maintains documentation confirming that volunteers understand the training that they have received. In the case of the volunteers, the agency inconsistently maintains files pertaining to training of contractors. The auditor concluded that there are inconsistencies with maintaining documentation of the PREA training delivered to contractors. The volunteer coordinator maintains documentation of the volunteers PREA training. Items collected were the PREA Training Volunteer/Contractor Acknowledgement Form, the PREA Acknowledgement Form for Hiring/Promotion, and the PREA training roster for volunteers. The PREA Training Volunteer/Contractor Acknowledgement Form is signed to show that the volunteer or contractor understands the agency's zero tolerance policy, the role as a mandatory reporter, and their reporting responsibilities in cases of sexual harassment or sexual abuse. It is evident that volunteers have received training on the agency's zero-tolerance policy, and the type of training received is based on the services provided and the level of resident contact. The documentation of this training is maintained by the agency. In the case of the contractors, the auditor is unable to confirm PREA training due to lack of contractor files and inconsistencies in the list of contractors. Based on the analysis, the facility does not meet compliance with this standard and corrective action is required at this time. Corrective Action: 1. Provide PREA training to all contractors who have direct contact with residents. 2. Provide PREA curriculum of training provided to contractors based on the services provided and level of contact they have with residents.

3. Maintain documentation confirming the contractors participated and understand the training received.

Recommendation:

1. Maintain a roster of both contractors and volunteers.
2. Maintain an orientation file for contractors and volunteers.
3. Annually provide PREA training to contractors and volunteers that is based on the services provided and level of contact they have with residents.

Verification of Corrective Action since the onsite PREA audit:

In response to the corrective action, the facility submitted documentation via OAS on 4/22/2024, 5/9/2024, 5/10/2024, 5/14/2024, and 6/28/2024. The auditor was provided the following documents:

- Roster of volunteers' and contractors' participation in PREA training
- Curriculum of PREA Training for volunteers and contractors
- Signed Acknowledgement Forms of PREA Training for contractors and volunteers

Corrective Action Intent

The intent of this corrective action was to ensure that in accordance with the PREA mandates for contractors and volunteers that the facility facilitates PREA training to individuals who provide direct services to residents at the Ferris School. Based on the review of the information received, the auditor finds the facility is substantially compliant with this standard.

115.333	Resident education
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. DYRS 2.13.IV.C.2.a-b. 2. DYRS PREA Policy 2.13.IV.C.2.c 3. Policy 2.13.IV.C.2.d 4. Ferris School Handbook p. 9,32-33 5. Ferris School Handbook- Spanish 6. Ferris School Resident Safety Guide

7. Safety Guide PREA Safety Guide-Spanish
8. Residents PREA Orientation Acknowledgement Form
9. Residents PREA Comprehensive Acknowledgement Form
10. PREA Orientation Roster
11. Pre-Audit Questionnaire (PAQ)

Interviews:

1. Intake Staff
2. Random Resident

Site Review:

1. Intake Process 1/11/2024
2. PREA Video

Findings (by Provision):

115.333 (a): 1-3

According to DYRS Policy 2.13.IV.C.2.a-b, all youth in secure care shall receive PREA orientation and/or training. Specifically, the policy states that during the intake process, residents shall receive information explaining the zero- tolerance policy regarding sexual abuse and sexual harassment and how to report incidents or suspicions of sexual abuse or sexual harassment.

At intake, residents are provided the Ferris School Resident PREA Safety Guide, and they viewed the PREA video. The guide provided specifics relating to:

- Agency’s Zero-Tolerance Policy
- Definition of sexual abuse and sexual harassment
- Prevention
- Reporting
- Victim Support Services

Within the last 12 months, there were 54 residents that were given intake. It was found that 29 out of 54 residents signed the intake roster log. After the review of 14 resident files, the auditor determined that 12 out of 14 files had signed Resident PREA Orientation Acknowledgement Forms.

During residents comprehensive PREA training, they are provided the Ferris School Handbook. On pages 32-33, there is information about the agency’s zero-tolerance policy.

While interviewing the intake staff, the auditor was told that residents receive information about the agency’s zero-tolerance policy during the intake process. Also, residents are provided information on how to report incidents or suspicions of

	sexual abuse and sexual harassment during intake. All intakes including those from other facilities obtain information about the agency's zero-tolerance policy on sexual abuse and sexual harassment from the PREA intake orientation, facility handbook, and watching the PREA video. Residents were asked if they had received the facility's rules against sexual abuse and sexual harassment during the intake process. There were 11 residents interviewed, and all residents stated that they had received information pertaining to the agency's zero-tolerance for sexual abuse and sexual harassment. The residents stated that they received the information either through the video or handbook. On the last day of the onsite audit, the auditors had an opportunity to observe an intake on 1/11/2024. The resident was given an opportunity to view a PREA video and answer any questions. Later, he was given the safety guide. There were no residents that were limited English proficient during the onsite audit. The facility does have a translation/language line service if necessary. During interviews with residents, the auditor was informed that additionally assistance is provided for reading and comprehension by staff. The agency substantially meets compliance in this provision. 115.333(b)-1 According to DYRS Policy 2.13.IV.A.2.a-b, all youth in secure care shall receive PREA orientation and/or training. The policy states that within 10 days of the intake the secure care program is responsible for implementing a more comprehensive PREA training. The comprehensive training is provided by the PREA compliance manager. During the comprehensive PREA training residents are provided with the facility handbook, and they are taken to the resident phones and shown how to call the Child Abuse Hotline. The auditor was provided a form titled Ferris School: PREA Comprehensive Education Acknowledgement Form. The document was being utilized to document completion and understanding of the comprehensive PREA training. According to the PAQ, there were 53 residents that completed comprehensive PREA training. The PREA compliance manager uploaded to the supplemental files 46 out 53 Comprehensive PREA Acknowledgement forms. The auditor reviewed 14 resident files. Out of the 14 resident files, there were 13 resident files that contained the completed Comprehensive PREA Acknowledgement forms. During the informal conversation with the intake worker and PREA compliance manager, it was disclosed that within 10 days residents are supposed to receive in-depth PREA training. The auditor inquired to the residents if they were informed about there right not to be sexually abused or sexually harassed, and all 11 residents affirmed that they were aware. The auditor questioned the residents if they were aware of how to report sexual abuse and sexual harassment, and the 11 residents said that they were aware. The 11 residents were also informed that they had a right not to be punished for reporting sexual abuse or sexual harassment.

Residents were asked when they received the information. The residents stated that they learned during their PREA training. When the Auditor reviewed the 46 Residents PREA Comprehensive Acknowledgement Forms, all forms were dated within the 10 days of intake.

The agency substantially meets compliance in this provision.

115.33(c)-1-4

The auditor determined from the documentation submitted and resident files that 46 residents out of 53 received their comprehensive PREA training within 10 days of intake.

DYRS PREA Policy 2.13.IV.C.2.c states that residents transferred to a different facility must immediately be taught about any difference in the policies and procedures at the new facility. In informal conversation during intake, the auditor inquired since the resident came from a DYRS facility does he still receive PREA training. It was stated that the resident would still receive PREA training.

The agency substantially meets compliance in this provision.

115.333(d)-1-5

Resident PREA education is available for limited English proficient residents. Spanish is the second language spoken in Delaware. The following items are available at the Ferris School in Spanish:

1. Ferris School Handbook- Spanish
2. PREA Safety Guide-Spanish

There is an existing contract to provide interpretative and translation services for limited English proficient residents. For residents that are deaf, there are vendors on the state contract that can provide sign language services at no cost to the resident. Ferris School for Boys has the capability to enlarge PREA training materials for residents that are visually impaired. Also, PREA training is available by video with close captioning. During resident interviews, the residents expressed that if assistance is needed in understanding information that staff is always available to help. DYRS Policy 2.13.IV.C.2.d., ensures that youth with disabilities and language barriers are given the same information to prevent, detect, and respond to sexual abuse and sexual harassment in a format supportive of the disability or language barrier. Additionally, DSCYF Policy 118 ensures that individuals do not face discrimination and/or obstacles to receiving benefits or services for which they may be eligible.

The agency substantially meets compliance in this provision.

115.333(e)-1

The auditor was able to confirm that the facility maintains documentation of

	resident participation in PREA related training. PREA-related training information was found in resident files. Also, the PREA compliance manager uploaded to the supplemental files of the PAQ PREA orientation (Intake) roster and copies of the Comprehensive PREA Acknowledgement Forms. The agency substantially meets compliance in this provision. 115.333(f)-1 Ferris School does ensure that the agency's PREA policy is continuously and readily available. During the site review, the auditor observed that there were several PREA related posters throughout Ferris School. Posters for victim service agency, SOAR was visible. The agency substantially meets compliance in this provision. The evidence shows that the Ferris School 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 has demonstrated comprehensive PREA training is provided within 10 days of intake. The DYRS PREA Policy 2.13 does specifically state that residents that are transferred are provided PREA training. The agency does provide PREA education in formats that is accessible to all residents including students that are limited English proficient or disabled. Documentation was provided for the past 12 months of PREA orientation and PREA comprehensive training. Based on the analysis, the facility is substantially compliant with this standard, and there is no corrective action needed at this time.

115.334	**Specialized training: Investigations**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. DYRS Policy 2.13.IV.C.3.a 2. Pre-Audit Questionnaire (PAQ) 3. 2 Moss Group Certificates PREA Juvenile Specialized Investigations Training 4. 3 Acknowledgements of Self-Paced Training of Moss Group PREA Juvenile Specialized Investigations Training Interviews: 1. Institutional abuse investigator (IA)

2. Facility PREA investigator

Findings (by Provision):

115.334 (a)-1

DYRS Policy 2.13.IV.C.3.a specifically states PREA investigators are required to complete specialized training in conducting investigations in confinement settings. This training will include training on techniques for interviewing juvenile sexual abuse victims, proper use of Miranda and Gary warnings, how to collect evidence after sexual abuse incidents and the criteria and evidence needed to substantiate an allegation. During the interview with the IA PREA investigator, the investigator recalled several topics that were included in the Moss Group's virtual training. Due to the inability to obtain training from the NIC website, the PREA facility investigators utilized the investigator training provided from the PRC website to complete self-paced training. The facility PREA investigator was able to recall information from the training as well as well as substantially answer protocol questions related to administrative investigations of allegations of sexual abuse and sexual harassment.

The agency meets this provision.

115.334 (b)-1

During the interviews with PREA investigative staff, it was disclosed that all 4 investigators had received specialized training in conducting sexual abuse investigations in confinement settings. An additional facility PREA investigator was trained after the onsite audit. The instruction was from the Moss Group’s training PREA: Juvenile Specialized Investigations Training. There was recall by both the IA PREA investigator and the facility PREA investigator of training pertaining to securing the crime scene, criteria for substantiating a case, collecting circumstantial evidence, and interviewing of witnesses and alleged perpetrators.

The Moss Group’s course PREA Juvenile Specialized Investigations Training was 6 hours. It contained the following:

- PREA and PREA Investigation Standards
- Conducting Investigations in Confinement
- Techniques for Interviewing Victims
- Miranda and Garrity Use
- Evidence Collection in Confinement
- Substantiating a Case/Prosecutorial Referral

The agency substantially meets compliance in this provision.

115.334(c):

The agency maintains the copies of the certificates for 2 PREA investigators and

	copies of 3 acknowledgements of self-paced training uploaded in the PAQ and supplemental files, there were 2 investigator certificates, and 3 acknowledgements of self-paced training on the supplemental files. The agency substantially meets this provision. 115.334(d): Auditors are not required to audit this provision. The agency substantially meets this provision. DYRS ensures through DYRS Policy 2.13.IV.C.3.a that PREA investigations are conducted by certified and trained investigators in conducting investigations in confinement. The Moss Group training includes subject matter in accordance with PREA provision 115.334(b). The agency maintains documentation of certificates and acknowledgements of completion. Based on this analysis the agency substantially meets this standard, and corrective action is not required at this time.

115.335	**Specialized training: Medical and mental health care**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. DYRS PREA Policy 2.13.III.A 2. DYRS PREA Policy 2.13IV.A.1. 3. DYRS Policy 2.13IV.A.3. 4. Affirmation of Compliance with Forensic Examinations Standards for Sexual Assault 4/12/2023 5. Pre-Audit Questionnaire (PAQ) 6. NIC PREA 201 Certificates Interviews: 1. Medical Staff 2. Mental Health Staff Findings (by Provision): 115.335 (a): -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, staff is defined as any

Department employee, volunteer, contractor, official visitor, or other agency representative (exclude family, friends and other visitors). Further within Policy 2.13IV.A.1. it is quoted that all staff working directly with or monitoring programs/ services of youth in secure care and community services must receive PREA training. DYRS Policy 2.13IV.A.3 is specific to medical and mental health practitioners receiving specialized training. Cited in the policy is the specialized training requirements:

- Detection and the assessment of signs of sexual abuse and sexual harassment.
- The preservation of physical evidence of sexual abuse.
- Responding effectively and professionally to juvenile victims of sexual abuse and sexual harassment
- How and whom to report allegations or suspicions of sexual abuse and sexual harassment.

To comply with the PREA standard for medical and mental health specialized training, DYRS medical and mental health practitioners take the NIC PREA 201 training for medical and mental health practitioners. Documented on the PAQ, there were 18 medical practitioners. Review of employee rosters and training rosters, there were 20 medical staff. Of the 20 medical practitioners, there were 16 certificates for the specialized training received in the Pre-Audit Questionnaire (PAQ). Additionally, there were 4 mental health practitioners that worked regularly at the Ferris School (FS). Review of the roster for mental health and review of the certificates in the PAQ, the auditor determined that 4 out of the 4 mental health practitioners have taken the NIC PREA 201 training.

The agency substantially meets compliance in this provision.

115.335(b)-1

The medical staff at the Ferris School does not perform forensic medical examinations. Forensic examinations are performed at the Christiana Care Hospital or the Nemours Alfred I. Dupont Hospital for Children. In existence, there is an Affirmation of Compliance with Forensic Examinations Standards for Sexual Assault between DYRS and the Christiana Care Hospital. The medical staff stated that they do not perform forensic medical examinations at Ferris School.

The agency substantially meets compliance in this provision.

115.335 (c)-1

The agency maintains documentation of the specialized NIC PREA 201.Medical and mental health practitioners' certificates were made available through the PAQ. In total, there were 20 specialized training for medical and mental health practitioners' certificates made available through the PAQ.

The agency substantially meets compliance in this provision.

	115.335 (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, staff is defined as any Department employee, volunteer, contractor, official visitor, or other agency representative (exclude family, friends and other visitors). Further within Policy 2.13IV.A.1. it is quoted that all staff working directly with or monitoring programs/ services of youth in secure care and community services must receive PREA training. There were 24 medical and mental health practitioners that worked regularly at FS. When reviewing certificates, there were 15 out of the 24 medical and mental health practitioners that received the training mandated for employees by 115.331. The agency does not meet compliance in this provision. DYRS PREA Policy 2.13 does have language that requires specialized PREA training for medical and mental health practitioners. Medical and mental health practitioners are trained in the PREA specialized training for medical and mental health practitioners There were 11 medical and mental health staff in need of PREA refresher training. The agency does maintain documentation of completion of the required specialized training for medical and mental health practitioners. Based upon this analysis, the facility does not meet compliance for this standard and corrective action is required at this time. Corrective Action: 1. All medical and mental health staff complete PREA training in accordance with PREA standard 115.331 and/or 115.332. **Verification of Corrective Action since the onsite PREA audit:** In response to the corrective action, the facility submitted documentation via OAS on 4/22/2024, 4/26/2024, 4/30/2024, and 5/6/2024. The following documents were provided: • Roster of medical and mental health practitioners • Certificates of completion of NIC PREA 201 **Corrective Action Intent:** The intent of this corrective action was to ensure that in accordance with the PREA mandates that medical and mental health practitioners receive specialized PREA training. Based on the review of the information received, the auditor finds the facility substantially compliant with this standard.

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. Policy 3.8 PREA Risk Assessment Classification of Youth Section IV, A, 1, (7/8/21)
3. PREA Risk Assessment and PREA Recommendation Decision Tree
4. 15 Resident Files
5. 11 Risk Assessments
6. 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.

Agency relies on PREA Assessment 3.8 Section IV, A, 1, that outlines upon intake, staff will ask the youth their gender identity. Within 72 hours of admission, facility clinical staff will complete a PREA risk assessment. This information will be used to decide housing, education, and program participation.

The facility reported in the PAQ, 54 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 28 residents admitted to the facility. The auditors reviewed 10 resident PREA screenings and 15 resident files. In review, all residents that were screened at intake were completed within 72 hours of admission to the facility. The PREA risk assessment form provides that the resident is being screened for victimization and abusiveness.

During interviews with residents, all 7 out of 11 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 within 72 hours during the intake process. When asked how often residents' risk levels are assessed, staff stated risk levels are reassessed every six months. In the PAQ the facility reported the average length of stay was 151 days. At the time of the onsite audit, none of the residents had been at the facility for more than six months.

The evidence shows that the agency requires 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 action is not 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's 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 provides a resident's overall risk of sexual victimization or risk of abusiveness towards others. This process is conducted on FOCUS.

In review of the risk assessments, 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, and 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 screening assessment. During an interview with staff responsible for conducting risk screening, when asked what the initial risk screening consider, staff indicated questions of safety and sexual activity. The evidence shows that all of the criteria for the PREA risk screening are included in the risk assessment screening 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 information is ascertained, staff stated they obtain the information verbally and through mental health screening. 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 yes PREA risk assessment; emails are made to Superintendent, Mental Health and Supervisors.

	During an interview with the PREA compliance manager, confirmed that mental health and administration 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 3. Sections IV (Revised 3/5/19). 4. Ferris School Administrative Intervention 9.19 (3/30/2023) 5. 15 Resident Files 6. 11 Risk Assessments 7. Housing Unit Logbooks 8. PREA Risk Assessment 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.

The agency relies on 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 the facility uses information from the risk screening during intake to keep residents safe and free from sexual abuse, staff stated psychologist risk assessment. During interviews with staff responsible for risk screening, when asked how the facility uses information from the risk screening during intake to keep residents safe and free from sexual abuse and sexual harassment, staff stated with housing placement and with superintendent.

The auditor was able to determine that residents identified as having a PREA risk related factor are provided 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 residents 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. During interviews with mental health and medical staff, when asked do residents in isolation receive visits from medical and mental health care, staff stated yes, daily. All residents receive a visit by the mental health clinicians every day. 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, staff stated yes. During the onsite review, the auditor was able to observe the pods. The Ferris School has secure entrances 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 the PREA risk assessment log and housing logbooks that confirmed that no resident was in isolation during the onsite review. The housing 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, the residents would receive daily visits from medical or mental health care clinician and a review twice a month as provided in the agency policy. 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 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 the facility determines housing and program assignments for transgender or intersex residents, staff indicated they assign on a case by case basis. Prior to the onsite review, the auditor reviewed the facility website and obtained information that the facility housed male residents. During the onsite review, the auditor observed 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 within the requirements of the standards, it is recommended the facility determines what procedure is best for the agency. During an interview with the PREA compliance manager, when asked how often placement and programming assignments for each transgender or intersex resident are reassessed to review any threats to safety experienced by the resident, the staff indicated yes they would reassess. 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 they are reassessed every six months. During the onsite audit, the auditor reviewed 15 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 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 15 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 can 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. 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 15 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, files 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 the onsite review, the auditor did observe any housing rooms. A review of 15 resident files and housing 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 not 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 the general population. During an interview, staff the supervise residents in isolation stated they do not isolate residents. During the onsite review, the auditor did observe housing rooms. A review of 15 resident files did not reveal that residents were placed in isolation as outlined in this provision housing 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 review/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. Bilingual PREA Phone Instruction Cards (English and Spanish).
3. Ferris School Resident Handbook (4/19/2023)
4. Title 10 Courts and Judicial Procedure
5. Division of Youth Rehabilitative Services Prisoner Professional Practices Reportable Events 2.12 III.B.1, IV.B.3.b, (Revised 2/1/23).
6. Agency Website www.kids.delaware.gov/yrs/prea
7. DSCYF PREA Academy Training Manual pp. 51-53.
8. Survivors of Abuse in Recovery (SOAR) Memorandum of Agreement (3/29/2023)

Interviews:

1. Random staff
2. Resident
3. PREA compliance manager
4. Just Detention International (JDI) Operations Director
5. Survivors of Abuse in Recovery (SOAR)

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 IV.E-1, 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.

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 7735 option #4. The auditor called the hotline number and was able to confirm that all phones were operational. During Interviews with random staff, all 13 staff interviewed stated that residents have multiple ways to report sexual abuse, sexual harassment, retaliation, and neglect by calling the hotline, reporting to staff, or writing a grievance. During Interviews with Residents, when asked about the multiple ways they can make a report, 7 out of 11 stated they could call the PREA hotline, 5 out of 11 stated they could write a grievance, 2 out of 11 stated they could tell a family member guardian or someone they trust, 4 out of 11 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 policy, resident interviews, staff interviews, PREA phone and posting in the facility. Based upon this analysis, the facility is substantially compliant with this provision and corrective action is not 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 an 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. The Ferris Student Handbook provides residents can report by calling the Child Abuse Hotline at (800) 292-9582, tell a family member or the police. The agency relies on Title 10 courts and judicial procedure 1007 that outlines that the facility does not detain residents for immigration purposes. In a memorandum of agreement, Survivors of Abuse in Recovery (SOAR) has partnered with the Department of Services for Children, Youth and Their Families to provide survivors of sexual abuse with emotional support services and advocates for support during a forensic medical examination. The facility did provide information posted and in written format that would establish residents knew of the way in which they could contact SOAR, a third-party victim advocate. During Interviews, the PREA compliance manager stated residents have access to call the hotline, file a PREA grievance, and tell a staff member. During interviews, auditors were able to speak with SOAR Executive Director, regarding their contact and services with the facility. Staff at SOAR 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. 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 is there someone who does not work at this facility you could report to abut sexual abuse or sexual harassment, 9 out of 11 stated they could call a family member, 3 out of 11 stated they tell their probation officer, 1 out of 11 said they could call the PREA hotline, 1 out of 11 stated they could call the police. During the onsite review, the auditor did observe posting with the SOAR 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 and was able to contact the PREA hotline. The evidence shows that the facility has provided at least one way for a resident to report sexual abuse to a public or private entity or office that is not part of the agency which was verified through interviews, memorandum, policy, and postings in the facility. 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 13 staff stated if a resident alleges sexual abuse and sexual harassment they can do so verbally, in writing anonymously and through third parties. When asked do you document verbal reports, all 13 stated yes. When asked how long do ordinarily takes to document after a resident makes a verbal report, all 13 staff stated immediately. During Interviews with Residents, when asked can you make a report of sexual abuse or sexual harassment either in person or in writing, 10 out of 11 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 verify 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 no 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 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 7735 option #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 PREA 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 random staff, 10 out of 13 staff reported that they can privately report through the PREA hotline, 5 out of 13 staff reported they can tell a

	supervisor, 2 out of 13 stated they can write a letter and 1 out of 3 stated they can report anonymously. 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 SOAR. Document that residents have been educated on SOAR. Collaborate with SOAR 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 Section IV, E, 1, (Revised 5/13/2021). 2. Ferris School Resident Handbook (4/19/2023) 3. Ferris School Emergency Grievance Form 4. Ferris School Grievance Complaint Form 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 addresses 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 auditor reviewed Agency policy Prisoner Rape Elimination Act (PREA) 2.13, that outlines Residents can privately report sexual abuse and sexual harassment,

	retaliation by other residents or staff for reporting sexual abuse or 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 must comply with child abuse reporting laws and will report any incident of sexual abuse and sexual harassment to the Child Abuse Hotline. The Ferris School Resident Handbook does not outline a PREA grievance process and procedure for filing a PREA grievance complaint. The handbook outlines that if a resident files an emergency grievance and it is related to sexual abuse or misconduct, they are directed to complete a green grievance form and the grievance will be addressed immediately. The auditor was able to review 79 Ferris School Resident Grievance Complaints and two emergency grievance complaints. There were two emergency grievances that reported an allegation of sexual abuse and sexual harassment. Neither emergency grievance was processed immediately nor reported to the Child Abuse Hotline. 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 the process if a resident wants to make a complaint on the grievance form. When the resident submits the complaint, the grievance will be processed to the program manager. Any grievance that involves Sexual Abuse or Sexual harassment will be processed immediately and go directly to Child Abuse Hotline (IA). Staff can help a resident make a complaint by calling the Child Abuse hotline. Residents can also submit a Grievance related to sexual abuse to third party, any staff or family members. The evidence shows that emergency grievances that are related to sexual abuse or sexual harassment are not processed immediately or referred to the Child Abuse Hotline as outlined in the agency policy and the Ferris School Resident Handbook. Based upon this analysis, the facility is not substantially compliant with this standard and corrective action is required. Corrective Action: 1. Process all Emergency Grievances involving any incident of sexual abuse or sexual harassment immediately to the Child Abuse Hotline. 2. Provide Auditor with any and all Grievance complaints that involved an incident of sexual abuse or sexual harassment for the next 60 days. 3. Train all staff responsible for processing grievances and emergency grievances that involve any incident of sexual abuse or sexual harassment on the agencies process. 4. Document staff have received training. 5. Provide auditor with documentation that shows staff have been trained on this process.

	Verification of Corrective Action since the onsite PREA audit: In response to the corrective action, the facility submitted documentation via OAS on 4/22/2024, 5/12/2024, 6/28/2024. The following documents were submitted: • Emergency Grievance Training Roster • Emergency Grievance Reporting Memo • Affirmation that there were no emergency grievances for allegations of sexual abuse and sexual harassment since 4/24/2024. **Corrective Action Intent:** The intent of this corrective action was to ensure that in accordance with the PREA mandates that all grievances of sexual abuse, sexual harassment and retaliation for reporting such incidents are reported to the Child Abuse Hotline and to the designated individuals for an investigation in a timely manner. Based on review of the information received, the auditor finds the facility is substantially compliant with this standard.

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. Division of Youth Rehabilitative Services State Managed Facilities Mail, Telephone and Visitation Policy 5.24 (Effective 5/16/16). 3. Ferris School Safety Guide (English and Spanish). 4. Ferris School Resident Handbook (4/19/2023). 5. Title 10 Courts and Judicial Procedure. 6. Ferris School Visitation 15.4 (2/25/2022). 7. Ferris School Telephone Communication with Attorney or Legal Representation 15.3 (9/5/2022). 8. Ferris School Access to Telephone 15.2 (8/3/2023). 9. Ferris School Resident Access to Mail 15.01 (9/21/2013) 10. Memorandum of Agreement Between the Division of Youth Rehabilitative Services and Survivors of Abuse in Recovery, Inc. (3/29/23). Interviews: 1.Resident

2.Superintendent
3.PREA compliance manager
4.Survivors of Abuse in Recovery (SOAR) Director

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 a 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 procedure 1007 that outlines that the facility does not detain residents for immigration purposes.

The Ferris School Resident Safety Guide provides that residents can call Survivors of Abuse in Recovery (SOAR) 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 SOAR victim advocate postings and the Resident safety guide for victim advocacy for rape crisis organizations in the Pod.

During interviews, 8 out of 11 residents stated they knew of an agency but could not provide the name of the agency, 1 out of 11 knew about or how to receive the mailing addresses or phone numbers for contacting SOAR, a victim advocate or rape crisis organizations, none of the residents was aware of a toll-free number for the outside victim advocacy agency SOAR, 2 of the 11 residents knew about communicating to this organization confidentially.

Post onsite audit, the auditor tested the SOAR telephone number at (302)-655-3953

	and was taken through a series of prompts to leave a message on an intake line. During the audit the auditors were able to speak with SOAR Executive Director regarding their contact and services with the facility. Staff at SOAR 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 in the last twelve months. The auditor was able to observe that residents are provided the Ferris Resident Safety Guide in English and Spanish that includes the SOAR contact information. 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 not provide any information about 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 information about SOAR. The Ferris Resident Handbook did not provide any information to the residents about SOAR or any other outside victim advocate for emotional support related to sexual abuse. The Ferris Safety Guide did provide information to residents about SOAR 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 and 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, 1 out of 11 residents reported that they were 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 SOAR 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 can 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 (SOAR). The Memorandum of agreement outlines that SOAR will provide victims of sexual abuse direct advocates for support during forensic examinations, emotional support and counseling. The evidence shows that the agency and SOAR has entered into a memorandum of agreement on 3/29/23 that outlines SOAR will provide victims of sexual abuse direct advocates for support during forensic examinations, emotional support and counseling. 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. The policy 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 visits are available and the facility provides residents access to their family and Attorney virtually via zoom, teams, facetime and telephone.

During the interview, the PREA Compliance Manager stated residents are free to access their attorney upon request. Schedules for parents are at least once a week in person or by telephone. Calls free once a week any additional calls cost.

During interviews with Residents, 10 out of 11 residents knew that they could make a private call to their attorney, all 11 residents knew that they could contact their families.

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 virtually via zoom, teams, facetime and telephone and parents through phone calls, zoom visits, in person visits, and written correspondence. The residents knew that they were allowed access to contact their attorney privately and visit with their parents through a zoom 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 (SOARS) 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. Provide posting or otherwise making victim advocate for emotional support available to residents that would include mailing addresses, phone numbers for rape crisis and victim advocate organizations.
3. Document that all residents have received the education on SOARS.

Verification of Corrective Action since the onsite PREA audit:

In response to the corrective action, the facility submitted documentation via OAS on 4/22/2024 with copies of the following:

- Completed SOAR Training Acknowledgement Forms
- Curriculum utilized for training was the Ferris School Resident Safety Guide uploaded prior to onsite on 11/27/2023

Corrective Action Intent:

The intent of this corrective action was to ensure that in accordance with the PREA mandates as part of the comprehensive PREA training at Ferris School residents are to be educated about the services provided by a victim advocate as well as given the contact information.

	Based on review of the information received, the auditor finds the facility is 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. Ferris School Resident Handbook (4/19/2023) 5. PREA Contacts: https://kids.delaware.gov/youth-rehabilitative-services/prea-contacts/ 6. Delaware Childrens Department (DSCYF) Twitter Page http://twitter.com/thekids. 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 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. Staff can accept any report of sexual abuse and sexual harassment made verbally, in writing, anonymously and from third parties. 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. The agency's website http://kids.delaware.gov/yrs/prea) 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 has a family services reporter portal that allows third parties to make a report electronically. The website also provides information on applicable PREA statutes and policies, Agency contact information, Survivors of Abuse and Recovery, Inc. (SOAR) a victim advocate agency, and facility PREA audit reports. The agency provided a resident handbook that outlines how to report sexual abuse and sexual harassment by calling the child abuse hotline

	(800)-292-9582, completing an emergency grievance form, and telling any staff, family member, or police. The agency also has a twitter page that provides a direct link to the agency website and child abuse hotline number. 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, resident handbook and website information. Based on the review of the policy, resident handbook 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, submitting a report electronically, 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 5. 15 Resident Files Interviews: 1. Superintendent 2. PREA Compliance Manager 3. Medical and mental health staff 4. 13 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, 13 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, 13 random staff knew the agency’s policy or procedure for reporting any information related to a resident 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, 13 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 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 13 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 their supervisors and facility administrators, they would report. 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

	medical/mental health providers stated that they do disclose the limitations and their duty to report as they are mandated reporters. The auditor reviewed 15 resident files and 15 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 he would report it to the hotline, superintendent and DFS. During the interview, the Superintendent stated he would contact the hotline immediately. 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 communicate within 14 days. 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 the past three years of investigations. In review, there were no allegations that were investigated for sexual abuse and sexual harassment in the 12 months preceding the onsite audit. Evidence shows that allegations of sexual abuse are reported to the appropriate agency which was verified through staff interviews, policy and investigative reports. Based upon this analysis, the facility is substantially compliant with this provision and 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 yes, 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 past three years of investigations involving sexual

	abuse or sexual harassment. In review, no allegations were reported to facility investigators in the 12 months preceding the onsite audit. Evidence shows that allegations of sexual abuse are reported to the facility investigators which was verified through staff interviews and investigative reports. 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. 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 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 would take immediate action if they learned that a resident was at substantial risk, relocation, or placed on one-on-one status. During an interview, the superintendent stated immediate action, all things including PREA is considered. During interviews, all 13 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 investigation records that did not reveal an allegation where the agency had to take immediate action for a resident 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 would 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) 3.Investigation Records. 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. The evidence shows that the agency policy outlines that notification would occur within 72 hours after receiving an allegation which was verified through policy, and Investigation records. 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 Agency head reported that they have not received any allegations of sexual abuse. During the interview, the Superintendent reported no allegations have been reported. 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 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. 115.363 (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 all allegations are made through the Institutional abuse hotline. There has been no incident where this has been reported. During an interview, the Superintendent stated it would be the same process to IA. No allegations have been reported. 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. which was verified through policy, staff interviews and Investigation records. 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: 1. Division of Youth Rehabilitative Services Prisoner Rape Elimination Act (PREA) 2.13 Section IV, F 7, (Revised 5/13/21). 2. PREA First Responder Wallet Cards 3. DSCYF Staff First Responder Checklist Duties 4. Ferris School Secure Facilities Coordinated Response 5. DSCYF Academy Staff Training (pp. 56-63) 6. Investigation Records Interviews: 1. Random 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 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 the facility follow the coordinated facility response plan and utilize the first responder cards and the coordinated response flowcharts. The First responder checklist requests that the alleged victim not take any action that could destroy physical evidence, including washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating. In addition, ensure that the alleged abuser does not take any action that could destroy physical evidence, including washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating. The First Responder Cards outlines four steps to be taken by line staff upon learning of an allegation that a juvenile was sexually abused (do not shower, eat, drink, brush their teeth, use the rest room, or change clothes). The First Responder card also requires the alleged perpetrator not to shower, eat, drink, brush their teeth, use the restroom, or change clothes. The first responder is to notify supervisor, mental health, and medical staff for all sexual abuse, ask the alleged victim if they would like to speak with a victim advocate, and complete an administrative report before

	the end of shift. The DSCYF Academy staff training for prevention, detection and response to sexual abuse in detention outlines the duties of a first responders as follows, 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 did not show an allegation of sexual abuse that would require the security first responder to separate 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. In addition, there were no facility staff that acted as a first responder due to no allegations of sexual abuse in the last 12 months. Evidence shows that the agency does have a first responder policy. The facility relies on the policy, first Responder checklist, 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. Although the first responder cards do not outline all the requirements of the standard, the first responder checklist does. Auditor recommends revising the first responder cards to include all the elements as outlined in this provision. 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 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. 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 outline the steps to be taken if the first responder is not a security employee, the non-security employee shall request that the alleged victim not take any actions that could destroy physical evidence, and then notify a security employee. 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 any actions to prevent the destroying physical evidence or notifying a security employee. During interviews, all 13 staff indicated that they would secure area, make the resident staff, call supervisor, hotline, write a report, not allow resident to wash, eat or anything 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 first responder checklist, policy, interviews, investigation records 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. Best Practice Recommendations: 1. The auditor recommends revising the first responder wallet cards to include all the elements to request that the alleged victim not take any actions that could destroy physical evidence as outlined in this provision.

115.365	**Coordinated response**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion

Documents:

1. PREA First Responder Checklist.
2. DSCYF Staff First Responder Duties Wallet Card
3. Ferris School Secure Facilities Coordinated Response

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 Ferris School Coordinated Response and a First Responder checklist and 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, and Administrative Investigation. The PREA Allegation Against Staff immediate response states a supervisor removes the staff member from unit #1 priority, takes youth to medical for physical and mental evaluation, supervisor will direct location to be secured, contacts hotline, IA screens allegation.

PREA allegation against youth immediate response states staff will separate both youth (separate units) on one-on-one supervision, request that the alleged victim not take any actions to destroy physical evidence washing, brushing teeth, changing clothes, urinating, drinking or eating. The plan further outlines that the staff will take victim to medical notify a supervisor notify AOD on duty, contacts hotline and IA screens allegation.

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 Checklist requests that the alleged victim not take any action that could destroy physical evidence, including washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating. In addition, ensure that the alleged abuser does not take any action that could destroy physical evidence, including washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating. The First Responder Cards outlines four steps to be taken by line staff upon learning of an allegation that a juvenile was sexually abused (do not shower, eat, drink, brush their teeth, use the rest room, or change clothes). The First Responder card also requires the alleged perpetrator not to shower, eat, drink, brush their teeth, use the restroom, or change clothes. The first responder is to notify supervisor, mental health, and medical staff for all sexual abuse, ask the alleged victim if they would like to speak with a victim advocate, and complete an administrative report before the end of shift. During an interview, the superintendent stated they would coordinate a response plan, and conduct incident reviews. 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 checklist, cards, and interview with superintendent. Based upon this analysis, the facility is substantially compliant with this standard and no corrective action is required. Best Practice Recommendations: 1. The auditor recommends revising the first responder wallet cards to include all the elements to request that the alleged victim not take any actions that could destroy physical evidence as outlined in this provision.

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 05/22/23). 2.
2. DSC 309-removal-of-employees-from-the-workplace.pdf (delaware.gov)
3. AFSCME Local 3384 and DSCYF MOA (4/30/21)
4. AFSCME Local 2004 and DSCYF MOA (4/30/21)

Interviews:

1. Agency head

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, 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 14 days of a removal from the workplace and if findings indicate termination is warranted the employee may be suspended without pay pending termination.

A review of the 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 yes they have a five-year contract and one contract with two units. Department policy 309 still permits them to release staff from duty.

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. Ferris School Organizational Chart (2023). 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 YRC Supervisor and Master Treatment Specialist that monitors possible retaliation. During interview, staff that monitor for retaliation stated they would monitor those things going unfair, points out anything out of ordinary. If a pattern while under control, pull date and time, or just watch throughout the shift, continue to monitor longer than 90 days if necessary. The evidence shows that the agency has outlined a policy to protect residents and staff from retaliation and has designated staff members 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), all residents and staff who report sexual abuse or sexual harassment or cooperate with the investigation of sexual abuse or sexual harassment are protected from retaliation by other residents or

	staff. 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 days or longer if needed. During an interview, the agency head stated they would follow retaliation process. During an interview, the superintendent stated we separate the residents, conduct retaliation monitoring, and move staff to different posts. During an interview, the retaliation monitor stated they would monitor for retaliation for 90 days and longer if necessary. 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 have 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 we separate the residents, conduct retaliation monitoring, and move staff to different posts. During an interview, the retaliation monitor stated they would monitor for 90 days or longer if necessary. 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 Superintendent, and staff 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): During an interview, the Agency head stated they can separate if necessary; ability to move residents to other facilities or non-contact status.

	During an interview, the retaliation monitor stated they would monitor the residents over a 90-day period and determine if there were any changes in behavior. They would monitor those things that aren't going fair, point out anything out of ordinary. If a pattern while under control, pull date and time, or just watch throughout the shift, moved to a different cluster, and continue to monitor more than 90 days if necessary. The evidence shows that the facility has a process to monitor retaliation for residents through the staff who is responsible for retaliation monitoring. There was no incident during the 12 months preceding the onsite audit where monitoring of a resident by the retaliation monitor was required. 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 any incident of retaliation in the past 12 months. During interviews, the agency head stated they would follow retaliation process. During an interview, the superintendent stated we separate the residents, conduct retaliation monitoring, and move staff to different posts. 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, policy, 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 5/13/2021). 2. Division of Youth Rehabilitative Services Professional Practices Lesbian, Gay, Bisexual, Transgender, Questioning, and Intersex (LGBTQI) 2.20 (Revised 3/5/2019). 3. 13 Resident Files

4. 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. 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. During an interview, mental health staff indicated that mental health staff would check on a resident in isolation daily. During an interview, staff that supervise residents in isolation stated residents would be reviewed daily, 4 hrs., 8 hrs. and 24 hrs. When residents are on cluster restriction, the recreation staff will bring exercise equipment to the clusters. During a review of 15 residential files, the auditor was able to confirm that there were no residents isolated at the facility that were alleged to have suffered from sexual abuse in the last 12 months preceding the onsite audit. A review of the housing logs does not reveal that residents were placed in Isolation. During the onsite review, the auditor was able to observe the pods, entrances, and exits. All areas require a key or remote access to enter. The auditor reviewed housing unit logs that confirm the agency's practice. The logs provide a detailed tracking of the resident, staff, date, time, and activity observed. The evidence shows the agency has a policy to isolate residents at the facility which was verified through interview, observation, policy and documentation review. Residents in isolation would receive daily visits from medical or mental health care clinicians. The evidence shows that residents would be 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 was 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 Policy 2.13.IV.G.1 2. DYRS Policy 2.13IV.G.1.a 3. DYRS Policy 2.13.IV.J.9 4. DYRS Policy 2.13.IV.J.10 5. Affirmation of Compliance with Investigative Standards for Sexual Assaults

4/14/2023

6. State of Delaware Memorandum of Understanding for the Multidisciplinary Response to Child Abuse and Neglect 2022
7. 2 Institutional Abuse (IA) PREA Investigator Certificates- Moss Group PREA Juvenile Specialized Investigation Training
8. 3 Facility PREA investigators Acknowledgements of Self-Paced Training-Moss Group PREA Juvenile Specialized Investigation Training
9. PowerPoint of The Moss Group Training: PREA Juvenile Specialized Investigation Training
10. Notification of Investigation Status Form
11. Sexual Abuse Review of Substantiated and Unsubstantiated Outcomes Form
12. Non-Critical Reportable Event Form
13. PAQ Pre-Audit Questionnaire

Interviews:

1. Delaware State Police (DSP)
2. Institutional Abuse (IA) PREA Investigator
3. Facility PREA Investigator
4. PREA coordinator
5. PREA compliance manager
6. Superintendent

Site Review:

1. Data analyst office- PREA coordinator responsible for duties at time of onsite audit

Findings (by Provision):

115.371 (a):-1

Within DYRS Policy 2.13.IV.G.1, there is a section that addresses investigations in secure care. The policy details that all matters that involve the allegation of any sexual contact as in this policy will be reported to the Child Abuse Hotline. Further, the policy mentions that for matters that could result in criminal action, Institutional Abuse (IA) will conduct a joint investigation with the Delaware State Police. According to interviews of both internal and external PREA investigators and specialized staff listed, there were no reported allegations of sexual abuse or sexual harassment at Ferris School within the last 12 months. Lastly, the PAQ supplied no investigative files of allegations of sexual abuse or sexual harassment allegations. While onsite, the auditor reviewed the Non-Critical Reportable Event Forms, and there were no allegations of incidents that were found to initiate an investigation of sexual abuse or sexual harassment of residents at the facility. Further, the auditor requested documentation of allegations of sexual abuse and sexual harassment for

	the prior 3 years. Again, there were no documented incidents of allegations of sexual abuse or sexual harassment against residents for the prior 3 years. Based on lack of investigative files, the auditor is unable to determine if investigations of sexual abuse or sexual harassment were conducted promptly, thoroughly, or objectively. According to IA PREA investigators, facility PREA investigators, and DSP, all investigations including reports from third-party and anonymous reports of sexual abuse and sexual harassment are conducted. Based on the analysis, the agency substantially meets compliance with this provision. 115.371(b)-1 The facility provided 2 investigators certificates through the PAQ for the Internal Abuse (IA) PREA investigators. The training taken was the Moss Group virtual course PREA Juvenile Specialized Investigation Training. The facility PREA investigators were unable to obtain virtual or in person training. Previously, the agency had facility PREA investigators view the training provided by NIC. According to the PREA coordinator, the website was unavailable. There was a decision to have the facility PREA investigators review the training available on the PRC website. The training from the PRC website was the Moss Group's PowerPoint presentation of PREA Juvenile Specialized Investigation Training. Once completed the self-paced training, the facility required the 3 facility PREA investigators to provide acknowledgement of completion and understanding of The Moss Group's course PREA Juvenile Specialized Investigation Training. Both IA and facility investigators were able to recall receiving training pertaining to interviewing juvenile sexual abuse victims, use of Miranda and Garrity warnings, evidence collection, and the evidence required to substantiate a case administratively and referral for prosecution. Based on the analysis, the agency substantially meets compliance with this provision. 115.371(c)-1 In the cases of investigation that were determined by Child Abuse Hotline to be handled by the facility administratively, the facility PREA investigator would be responsible for handling the investigation. According to the facility PREA investigator, the first steps in initiating an investigation would be to begin interviewing the victim, witnesses, and perpetrator. Also, the collection of any circumstantial evidence including footage as well as review prior reports of sexual abuse by perpetrator. In incidents in which the Child Abuse Hotline assigns an Institutional Abuse (IA) PREA investigator, the process is the same unless the Child Abuse Hotline determines that a criminal offense has occurred. In the case of a criminal offense, there is a joint investigation with DSP and IA. The role of IA in criminal cases of sexual abuse and sexual harassment is supportive and as a liaison between the facility and DSP. Based on the analysis, the agency substantially meets compliance with this provision.

	115.371(d)-1 In the Affirmation of Compliance with Investigative Standards for Sexual Assault, it affirms DSP will not terminate an investigation solely because the source of the allegation recants the allegation. According to IA, DSP, and the facility PREA investigator, the investigation continues and does not terminate if the source of the allegation recants. Based on the analysis, the agency substantially meets compliance with this provision. 115.371(e)-1 According to the IA PREA investigator and Delaware State Police (DSP), there has been no sexual abuse investigation that rose to criminal threshold. Investigations that meet the criminal threshold are jointly investigated by DSP and IA. In the case of compelled interviews, confirmation was made by IA PREA investigator and DSP that the responsibility of consultation with the prosecutor prior to conducting a compelled interview would be done by DSP. Based on the analysis, the agency substantially meets compliance with this provision. 115.371(f)-1 According to the interviews of DSP, IA, and the facility PREA investigators, assessment of the credibility of an alleged victim, witness, or suspect is based on the evidence and 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 investigator and facility PREA investigator the agency does not require a resident that alleges sexual abuse to submit to a polygraph examination or other truth telling device as a condition to proceed with an investigation. During the onsite audit, there were no residents who had reported sexual abuse at the Ferris School to further confirm. Additionally, these actions are also contained in the Affirmation of Compliance with Investigative Standards for Sexual Assault. Based on the analysis, the agency substantially meets compliance with this provision. 115.371(g)-1 During the auditor's inquiry regarding documents contained in investigation files, the facility PREA investigator stated the investigations are documented in written reports. In the Affirmation of Compliance with Investigative Standards for Sexual Assault, it affirms DSP a reporting requirement for DSP. Further inquiry found that an investigative file would include administrative reports, video, interviews, and a narrative with findings and recommendations. Due to the lack of sexual abuse and sexual harassment allegations, the auditor was unable to determine if administrative investigations included an effort to determine whether staff actions or failures to act contributed to the abuse.

	Based on the analysis, the agency substantially meets compliance with this provision. 115.371(h)-1 DYRS has not reported or provided documentation of any criminal investigations. The interview with DSP yielded that criminal investigations would be documented in a report. The liaison (IA) to the facility would be provided with the documented report. The IA PREA investigators would provide that information to the facility superintendent and the PREA compliance manager. Within the Affirmation of Compliance with Investigative Standards for Sexual Assault, it affirms DSP would be responsible for documenting reports. Based on the analysis, the agency substantially meets compliance with this provision. 115.71(i)-1 Cited in DYRS Policy 2.13IV.G.1.a, Institutional Abuse may complete a joint investigation with Delaware State Police or Milford Police for allegations that involve potentially criminal behavior. In both the interview with DSP and the IA 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 Ferris School within the last 12 months. Prior to referring for prosecution, DSP confers with the Attorney General’s Office. Based on the analysis, the agency substantially meets compliance with this provision. 115.371(j)-1 During the onsite audit the PREA coordinator was assisting in the role of the management analyst. The PREA coordinator granted access to the management analyst’s office, and the auditor observed the 2-lock system. The keyless access cabinet contained past years of written reports of sexual harassment and sexual abuse. In DYRS Policy 2.13.IV.J.9 is the agency’s retention policy that PREA data shall be retained for no less than 10 years after the date of its initial collection unless Federal, State, or local law requires otherwise. Based on the analysis, the agency substantially meets compliance with this provision. 115.371(k)-1 According to interviews with both IA 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 auditor was unable to confirm practice due to the lack of allegations of sexual abuse files.

	Based on the analysis, the agency substantially meets compliance with this provision. 115.371(l)-1 The Affirmation of Compliance with Investigative Standards for Sexual Assaults ensures that DSP conducts investigations in accordance with 1157.371(a)-(k). Based on the analysis, the agency substantially meets compliance with this provision. 115.371(m) The auditor confirmed through interviews with the superintendent, PREA compliance manager, and the PREA coordinator that DSP would provide information pertaining to a sexual abuse investigation at the Ferris School to IA. Based on the analysis, the agency substantially meets compliance with this provision. The evidence provided shows that the agency has a policy related to criminal and administrative agency investigations. Due to the lack of sexual abuse and sexual harassment investigative files, the auditor was unable determine the practice of certified PREA investigators conducting investigations of sexual abuse and sexual harassment. Additionally, the auditor was unable to determine the practice of documenting interviews, collecting direct or circumstantial evidence, video footage, or review of prior reports and complaints of alleged perpetrator. Interviews of investigators have confirmed that investigations are not terminated due to the source of the allegation being recanted, and credibility is assessed on an individual basis. Also, investigations are not terminated due to the departure of an alleged abuser or victim from employment or release from the facility. The auditor relied on interviews to determine if the facility reports if staff actions or failures contributed to the sexual abuse. The site review confirmed the practice of maintaining written reports in accordance to115.371(j). DSP and IA both confirmed investigations of sexual abuse and sexual harassment are conducted jointly, and information would be shared with IA of the progress of the investigation. Based on this analysis, the Ferris School does meet the standard.

115.372	**Evidentiary standard for administrative investigations**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents:

1. State of Delaware Memorandum of Understanding for the Multidisciplinary Response to Child Abuse and Neglect: Child Abuse Protocol p.35
2. Pre-Audit Questionnaire (PAQ)
3. Non-Critical Incident Reports

Interviews:

1. Institutional Abuse (IA) PREA investigator
2. Facility PREA investigator

Findings (by Provision):

115.372 (a)-1:

PREA mandates requires 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. Reviewed in the State of Delaware Memorandum of Understanding for the Multidisciplinary Response to Child Abuse and Neglect: Child Abuse Protocol p.35, DFS (IA) will make a finding within 45 days once it has established that a preponderance of the evidence exists.

During onsite audit interviews, the IA PREA investigator stated that evidentiary standard utilized to substantiate allegations of sexual abuse and sexual harassment is the preponderance of the evidence. Further confirmed by the facility PREA investigator, the evidentiary standard applied to substantiate allegations of sexual abuse and sexual harassment is the preponderance of the evidence.

Within the last 12 month, there were no sexual abuse or sexual harassment investigations at Ferris School (FB) documented on the Pre-Audit Questionnaire (PAQ). To further review the application of the evidentiary standard, the auditor further requested files of allegations of sexual abuse and sexual harassment for the prior 36 months. It was reported by PREA Coordinator that there were no allegations of sexual abuse or sexual harassment within the last 36 months at FB. Additionally, the auditor reviewed Non-Critical Incident reports provided by facility. Based on documentation provided, the auditor was unable to determine the practice of applying the evidentiary standard of preponderance of the evidence.

Based on the analysis of the State of Delaware Memorandum of Understanding for the Multidisciplinary Response to Child Abuse and Neglect: Child Abuse Protocol and the interviews with PREA investigators, the auditor has determined that DYRS does not impose a standard higher than a preponderance of the evidence when substantiating allegations of sexual abuse or sexual harassment.

The agency is substantially compliant with this standard and no corrective action is needed at this time.

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. Pre-Audit Questionnaire (PAQ)
4. Issue Log

Interviews:

1. Facility PREA investigator
2. Superintendent
3. Delaware State Police (DSP)
4. Random youth

Findings (by Provision):

115.373 (a):

DYRS Policy 2.13.IV.G.4 requires, “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 referenced Attachment D-Notification of Investigation is in the Pre-audit questionnaire (PAQ). According to the PAQ, there were no investigations of sexual abuse at the Ferris School (FS) in the prior 12 months. Sexual abuse investigation files were requested by the auditor for the prior 36 months, and there were no allegations of sexual abuse or sexual harassment during that time span. Confirmed by facility superintendent and the facility PREA investigator, a notification of outcome would be provided to youth in an investigation of an allegation of sexual abuse.

The facility substantially meets compliance in this provision.

115.373(b):

Information provided in the PAQ and the request of information from the issue log, there were no investigations of allegations of sexual abuse conducted by an outside entity within the last 12 months. During an interview with the Delaware State Police (DSP), there were no allegations of sexual abuse investigated at FS by DSP in the last 12 months.

The facility meets compliance in this provision.

115.373(c-d):

According to DYRS Policy 2.13.IV.G.4.a-b, youth are provided notification of outcome

	of investigation if the alleged abuse was by a staff member unless unfounded, no longer staffed on unit, no longer employed, or indicted/convicted on a charge of sexual abuse. If the alleged abuse was another youth, the youth would be informed when the facility is informed that the alleged abuser has been indicted or convicted on a charge of sexual abuse within the facility. There have been no allegations of sexual abuse at FS within the last 12 months. During interviews with random youth and facility PREA investigator, there were no residents sexually abused by either staff or other youth at FS. The facility meets compliance in this provision. 115.373(e) DYRS Policy 2.13.IV.G.4 requires documentation of notification of outcome for sexual abuse investigations. Additionally, the DYRS Policy 2.13 Attachment D Notification of Investigation is the specific document identified in the policy to be utilized. There were no sexual abuse investigations within the last 12 months, so the auditor was unable to review the practice of documenting incidents of alleged sexual abuse investigations. Additionally, there were no allegations of sexual abuse for the prior 36 months. Again, the auditor was unable to review the practice of resident notifications due to lack of allegations of sexual abuse at FS. The facility meets compliance in this provision. Based on the analysis of DYRS Policy 2.13.IV.G.4 and DYRS Policy 2.13 Attachment D Notification of Investigation and interviews with the superintendent and the PREA coordinator, FS meets compliance with this standard and corrective actions is not required at this time.

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 309 Removal of Employee from the Workplace (Revised 11/1/2021). 3. Delaware Children’s Department Policy 313 Initial Background Checks and Subsequent Arrest and/or Allegations of Child abuse/Neglect (Revised 12/15/2016). 4. 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.

Agency Policy 309 Delaware Children's Department Policy Removal of Employee from the Workplace establishes guidelines for removal of an employee from the workplace when it is determined that their continued presence jeopardizes safety, security, or public confidence in the department. Specifically, behavior that leads to physical or sexual abuse against a child and harassment.

Agency Policy 313 Delaware Children's Department Policy Initial Background Checks and Subsequent Arrest and/or Allegations of Child abuse/Neglect provides that each employee shall have an affirmative duty to immediately inform their supervisor/ manager of any criminal convictions, arrest, or indictment of any investigation of child abuse/neglect. Failure to immediately notify their supervisor/manager could result in discipline up to and including termination.

The evidence shows that agency Policy 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 the PAQ and agency policy.

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.

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 the past three years of 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 the past three years of 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 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 the past three years of 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 Agency Policy 309 Delaware Children's Department Policy Removal of Employee from the Workplace to include sexual harassment.

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 5/13/2021). 2. State of Delaware Memorandum of Understanding for a Multidisciplinary Response. C.1, (5/18/2022). 3. Delaware Children's Department Policy 313 Initial Background Checks and Subsequent Arrest and/or Allegations of Child Abuse/Neglect (Revised 12/15/2016). 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 11/1/2021)
6. 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 abuse and sexual harassment to Child Abuse Hotline.

The facility provided the State of Delaware Memorandum of Understanding for a Multidisciplinary Response 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.

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. 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 and would do so using a different contractor. The auditor reviewed the past three years of 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. Division of Youth Rehabilitative Services Professional Practices Lesbian, Gay, Bi-sexual, Transgender, Questioning, and Intersex (LGBTQI) Policy 2.20 Section IV, E.1 c, (Revised 3/5/19).
3. Ferris School is Student Handbook English and Spanish.
4. Housing Unit Logs
5. Investigation Records
6. 15 Resident Files
7. 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.

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.

A review of the investigative records for the past three years confirms there was no allegation of resident-on-resident sexual abuse during the 12 months preceding the onsite audit.

The evidence shows that there were no administrative or criminal findings of guilt for resident-on-resident sexual abuse in the 12 months preceding the onsite audit, which was verified through PAQ, investigation records, 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 residents are subject to following an administrative or criminal finding that a resident engaged in resident-on-resident sexual abuse, staff stated criminal charges, remove and send back to detention. During interviews, Mental health and medical staff stated they offer therapy and counseling services to residents.

During the onsite review, the auditor went into all areas of the facility. The auditor reviewed housing unit logs. The housing logs provides a detailed tracking of the resident, date, time, activity observed, and staff assigned to each Cluster. 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 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 but this has not happened. 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. 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 were 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 the 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 Ferris Resident Handbook, the facility uses Cognitive Behavioral Training, or CBT. The goal of the program is to change inappropriate behavior. 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 Ferris School Resident Handbook, there is zero tolerance of sexual abuse, assault and harassment in the facility. The facility uses Cognitive Behavioral Training, or CBT. The goal of the program is to change inappropriate behavior. 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, 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. Agency relies on PREA Policy 2.13 Section II, that provides DYRS has a zero tolerance for any incidence of sexual activity with youth in secure care. DYRS commits to full compliance with the Prison Rape Elimination Act. As outlined in the Ferris Resident Handbook, the facility uses Cognitive Behavioral Training, or CBT to change inappropriate behavior. 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, policy, resident handbook, 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. 15 Resident Files
3. 10 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 medical and mental health staff. During an interview, 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, staff stated yes. Meeting with psychiatrist, immediately and up to 72 hours. 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 15 resident file records and 10 intake screening documentation. In review, one of the 10 residents had disclosed prior victimization during risk screening with mental health staff. A review of the record shows that the resident was offered follow-up.

	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 15 resident files and 10 intake documentation and determined that if a resident that disclosed that they previously perpetuated sexual abuse during screening they would be offered a follow up meeting with mental health staff. 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 staff stated that reports are completed in the FOCUS system and filed separately from other files. 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, Assistant Superintendent and Program Manager. The evidence shows that the agency has controlled the level of access that each member of staff has to 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. 115.381 (d): In the PAQ, the agency reported that the 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. During an interview with medical and mental health staff, when asked, do you obtain informed consent from residents before reporting about prior sexual victimization that did not occur in an institutional setting, staff stated they do obtain informed consent. A review of file documentation, medical and mental health staff obtain informed consent for all residents which was verified through the PAQ, staff interviews and documentation review. The evidence shows that medical and mental health staff do obtain informed consent for all residents and mental health and medical staff are mandated reporters. 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.

115.382	**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 (4/13/23).
4. Memorandum of Agreement Between the Division of Youth Rehabilitative Services and Survivors of Abuse in Recovery, Inc. (3/29/23).
5. 15 Resident Files

Interviews:

1. Medical and mental health staff
2. SANE Christiana Care
3. SOAR

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:

Ambulance or paramedic
Physician in charge
Facility superintendent or designee
Deputy director
Parent, guardian or legal guardian.

Prior to the onsite audit, the auditors were able to contact the local hospital sexual assault nurse examiner (SANE) regarding any services they would provide for victims at the facility to confirm the agencies practice. During an interview, SANE

	nurse stated they are always staff 24/7 and have 20 forensic nurses. The SANE stated they offer advocate services for victims (SARC), and response to sexual assault victim within 10 minutes. PREA Policy 2.13 outlines that resident victims 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. (SOAR) that DYRS youth that have been victims of sexual abuse be provided advocates during forensic examinations, emotional support and counseling services related to their victimization. During an interview, staff at SOARS confirmed that they have a memorandum of agreement with DYRS to provide victim advocate during for emotional support but have not had any contact with any residents at the facility or staff at the facility. When asked how 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 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. Medical staff stated the residents would receive these services immediately. When asked is the nature and scope of these services determined by your professional judgement, staff stated it is a standard of care. 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 were offered timely information about access to emergency contraception and sexually transmitted infections prophylaxis, staff stated yes within 24 hours. 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. During an interview, the SANE nurse examiner stated that the services are at no cost to the victim. 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 (4/13/23).
3. Memorandum of Agreement Between the Division of Youth Rehabilitative Services and Survivors of Abuse in Recovery, Inc. (SOARS) (3/29/23) and Website survivorsofabuse.org
4. Christiana Care Christiana Hospital website christianacare.org
5. Ferris Resident Student Handbook English and Spanish
6. 15 Resident files
7. 10 Risk assessments

Interviews:

1. Medical and mental health staff
2. SANE Christiana Care
3. 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, 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.

The Agency provided the Department of Services for Children, Youth and Their Families Affirmation of Compliance with Forensic Examinations Standards for Sexual Assaults that outlines Christiana Care hospital 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 for examination and services.

During interviews with medical staff, when asked what evaluation and treatment of residents who have been victimized entail, staff stated we collaborate with the mental health team providing safety and comfort.

	The auditors interviewed a sexual assault forensic nurse examiner (SANE) 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, 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, 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. (SOAR) 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 SOAR 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, 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 yes. A review of the risk assessments confirms 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. 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 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, they provide counseling, follow-up care, services concerning contraception, and medications depending on the timeline to prevent sexually transmitted infections prophylaxis. Ferris School does not have female residents. 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, 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, 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 were no 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 mental health staff, when asked, do you conduct a mental health evaluation of all known resident-on-resident abusers and offer treatment if appropriate. Mental health staff stated “yes, within one business day”. Risk assessment is completed within 72 hours. The auditors reviewed 15 files and 10 risk assessments did not reveal a resident-on-resident abuse history in 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 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 PREA Policy 2.13.IV.J.1.a.-f 2. Sexual Abuse Incident Review of Substantiated or Un-substantiated Outcomes Form 3. Mock Incident Review 1-4-2024 Interviews: 1. Superintendent 2. PREA compliance manager 3. Incident Review Team Member Findings (by Provision): 115.386 (a)-1-2: Ferris School conducts a sexual abuse incident review at the conclusion of every criminal or administrative sexual abuse investigation unless the allegation has been determined to be unfounded. Cited in the DYRS Policy 2.13.IV.J.1.a.-f, The facility will conduct a sexual abuse incident review within the 30 days of the investigation with the extension of 45 days. The purpose of the review is defined, and the list of positions required for the review. The purpose of the review is to consider whether the allegations or investigation indicated a need for the change policy, motivating factors, examination of the area of allegation, adequacy of staffing, and changes in monitoring technology. Since there were no sexual abuse investigations in the past 12 months to corroborate the practice of utilizing a sexual abuse review team, the facility had a mock incident review on 1-4-2024. During the interview with an incident review team participant, it was noted that during an incident review that motivated factors would be discussed, location of incident would be discussed as well as any changes that might be necessary including monitoring technology and/ or policy changes. Also, there was a mention of the new cameras that were recently installed at Ferris School (FS).

The facility meets compliance in this provision.

115.386(b)-1

Due to lack of sexual abuse allegations, there were no sexual abuse investigative files for the auditor to review to determine the practice of completing an incident review within 30 days of the closing of an investigation. DYRS Policy 2.13.IV.J.1.a., mandates that 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.

The facility meets compliance in this provision.

115.386(c)-1

Within DYRS PREA Policy 2.13.IV.J.1.d, listed the required participants which included upper-level management officials, input from line supervisors, investigators, and medical/mental health practitioners. The policy is in alignment with the requirements of the provision. For the mock incident review, the participants included:

1. Superintendent
2. Assistant Superintendent
3. PREA compliance manager
4. Registered nurse
5. Recreation supervisor (facility PREA investigator)
6. 2 Psychologist
7. 2 Program managers

The facility meets compliance in this provision.

115.386(d)-1

The report of the sexual review team is documented on the Sexual Abuse Incident Review of Substantiated and Unsubstantiated Outcomes form. 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 required information required by 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. In accordance with DYRS Policy 2.13.IV.J.1.e, the team completes the report and submits it to the deputy director, PREA coordinator, PREA compliance manager, and the division management analyst.

Interviews with the superintendent and the member of the incident review team confirmed motivating factors are considered when reviewing allegations of sexual abuse. The auditor determined that the review team and the form utilized assist in determining program needs to further prevent and detect sexual abuse at FS.

The facility meets compliance in this provision.

115.386(e)-1

In accordance with DYRS PREA Policy 2.13, FS would complete a final report of findings from the sexual abuse incident review. Within DYRS Policy 2.13.IV.J.1.f states the facility shall implement the recommendations for improvement or shall document its reasons for not doing so, in the submitted form. Located on the Sexual Abuse Incident Review of Substantiated or Unsubstantiated Outcomes, there is a section on the form with final recommendations.

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 to document the review. The form list variables to consider when reviewing allegations of sexual abuse. The sexual abuse team has upper-level management and input from designated individuals. The review team includes an investigator. Lastly, the facility considers recommendations to implement or document its reasons for not doing so.

	Based on this analysis, the facility is substantially compliant with this standard and there are no corrective actions required.

115.387	Data collection
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. DYRS Policy 2.13.IV.J.1-10 2. DYRS Policy 2.13 Attachment A 3. DYSR Policy 2.13 Attachment B 4. DYRS Policy 2.13 Attachment C 5. DYRS Policy 2.13 Attachment D 6. DYRS Policy 2.13 Attachment E 7. DYRS Policy 2.13.IV.C.1.c 8. 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 for CY 2023 9. Survey of Sexual Violence for 2022 10. Delaware Division of Youth Rehabilitative Services Prison Rape Elimination Act 2022 Annual Report 11. Pre-Audit Questionnaire (PAQ) 12. SSV-2022.pdf (delaware.gov) 13. DSCYF Operating Guidelines 11/01/2022 Interviews: 1. PREA coordinator (Management data analyst) Findings (by Provision): 115.387 (a)-1: DYRS Policy 2.13.IV.J.2-4 requires data collection utilizing standardized instruments. Provided on the Pre-Audit Questionnaire (PAQ) are the 6 attachments to the policy which are forms used to collect the required sexual abuse and sexual harassment

	information. • DYRS Policy 2.13 Attachment A- Sexual Incident Form • DYSR Policy 2.13 Attachment B-Investigative Summary Template • DYRS Policy 2.13 Attachment C- I. Substantiated Sexual Abuse or Sexual Harassment Incident Form: I. Victim Information; II. Perpetrator Information- Youth Perpetrator; III. Perpetrator Information- Adult Perpetrator • DYRS Policy 2.13 Attachment D-Notification of Investigation • DYRS Policy 2.13 Attachment E- Sexual Abuse Incident Review of Substantiated or Unsubstantiated Investigations There were no allegations of sexual abuse or sexual harassment at Ferris School (FS) for the auditor to determine the practice of collection at the facility. Review of the other DYRS facilities investigative files in the management analyst locked files, it was determined that DYRS collects accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions. Uploaded to the PAQ was the Survey of Sexual Violence 2022 and the 2022 PREA Annual Report. The agency substantially meets compliance in this provision. 115.388(b)-1 According to DYRS PREA Policy 2.13.IV.J.7-8, the management analyst will provide a quarterly report to the deputy director to ensure outcome information is accurate and current. Further in the policy, an annual report shall be made available to the public. Additionally, the facility aggregates the incident-based sexual abuse data in preparation for the submission of the Survey of Sexual Violence conducted by the Department of Justice. Provided in the PAQ was the Survey of Sexual Violence 2022 and the 2022 PREA Annual Report. The agency substantially meets compliance in this provision. 115.387(c)-1 The auditor determined that the 6 attachments to the DYRS PREA Policy 2.13 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 substantially meets compliance in this provision. 115.387(d)-1 DYRS Policy 2.13.IV.J.5-6; 9 states that the administrators are responsible for providing the internal investigation outcome for data collection. The Professional Standards Unit will be responsible for reporting Institutional Abuse and/or criminal investigation outcomes for data collection. All PREA data shall be securely stored by the management analyst using a double lock system.

	The agency substantially meets compliance in this provision. 115.387(e)-1 Cited in the DSCYF Operating Guidelines 11/01/2022 V.B., V.D., IX, service providers are required to adopt and comply with all applicable PREA standards and any DSCYF policies or standards related to PREA. Additionally, the guidelines outline documentation and reporting requirements. Uploaded in the PAQ was a copy of the Excel spreadsheet containing all incidents of sexual abuse and sexual harassment reported to DYRS from both Delaware state operated facilities and DYRS contracts for confinement of its residents. The agency substantially meets compliance in this provision. 115.387(f) Located on the agency's website is a copy of the report Survey of Sexual Violence for 2022. The report was submitted prior to June 30, 2020, by DYRS. The agency substantially meets compliance in this provision. The evidence shows that the agency collects accurate, uniform data for every allegation of sexual abuse at facilities under direct control and DYRS contracts for confinement of its residents. The agency utilizes standardized instruments to collect data. 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.

115.388	**Data review for corrective action**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. DYRS Policy 2.13.IV.J.8 2. https://kids.delaware.gov/yrs/prea-reports.shtml 3. DYRS Annual Report CY-2022 Delaware Division of Youth Rehabilitative Services Prison Rape Elimination Act 2022 Annual Report

4. Compliance manager meeting 5/24/2023- Microsoft Team Meeting

Interviews:

1. Director
2. PREA Coordinator

Findings (by Provision):

115.388 (a):

DYRS Policy 2.13.IV.J.8 requires that an annual report shall be readily available to the public through the agency's website. All information must receive prior approval by the Division Director before website posting and will be redacted of personal identifiers before website posting. 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 Compliance Manager Meeting Minutes lead by the PREA coordinator revealed there is time devoted by DYRS to discuss information obtained from the data collected. During the meeting, there was an opportunity to discuss prior audit findings, accessible PREA information, and PREA training.

During inquiry 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 informed the auditor that the information is utilized to identify needs at FS. There was a discussion of the new doors and upgraded monitoring technology installed at FS to improve the prevention, detection, and the response to sexual abuse and sexual harassment. Additionally, the PREA coordinator confirmed the use of data collected to assess and improve effectiveness of its sexual abuse prevention, detection, and response policies. It was further shared that the data and documents related to PREA are maintained with the management analyst under a 2-lock system. Lastly, there was confirmation that the agency's annual report was generated and placed on the agency's website.

115.388(b)-1-2

The DYRS Annual Report CY-2022 (Delaware Division of Youth Rehabilitative Services Prison Rape Elimination Act 2022 Annual Report) summarizes and compares the 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. Found within the report is an assessment of the agency's progress in addressing sexual abuse. Also, there is a comparison of data from past years. 115.388(c)-1-3 The DYRS Annual Report CY-2022 (Delaware Division of Youth Rehabilitative Services Prison Rape Elimination Act 2022 Annual Report) can be located on the agency's website https://kids.delaware.gov/yrs/prea-reports.shtml, and the report is signed by the director of DYRS. During the interview, the director of DYRS stated the annual report must be approved prior to publishing on the website. 115.388(d)-1-2 There were no redactions in the DYRS Annual Report CY-2019 (Delaware Division of Youth Rehabilitative Services Prison Rape Elimination Act 2019 Annual Report). A redaction clause was not necessary. The PREA compliance manager indicated 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 evidence shows that the agency reviews data collected and aggregates to assess and improve the effectiveness of its sexual abuse prevention, detection, response as well as corrective action. This information is developed into a report titled the DYRS Annual Report CY-2022 (Delaware Division of Youth Rehabilitative Services Prison Rape Elimination Act 2022 Annual Report). 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.J.9-10 2. DYRS Policy 2.13.IV.J.8 3. The DYRS Annual Report CY-2022 4. https://kids.delaware.gov/yrs/prea-reports.shtml Interviews:

1. Management analyst (PREA coordinator task with duties)
2. PREA coordinator

Site Review:

1. Management analyst's Office- Double Lock System

Findings (by provision):

115.389(a)

Cited within DYRS Policy 2.13.IV.J.9-10, All PREA data shall be securely stored by the management analyst (PREA coordinator) using a double lock system. While temporarily covering duties of the management analyst, the PREA coordinator acknowledged that incident-based and aggregate data is secured in a double-lock system. DYRS has begun electronically maintaining all incident-based and aggregate data which includes incoming sexual abuse and sexual harassment investigative files. According to the PREA coordinator, electronic access of incident-based and aggregate data is limited to the agency head, PREA coordinator, and management analyst. All remaining investigative files are archived in the upgraded keyless lock system. In the case of PREA risk assessments, those files are maintained with the mental health department, and they are maintained electronically based on role-based access. During the site review, the auditor was given access to the location of the archived incident-based and aggregate data. Documents were secured in a double lock system which included the upgraded keyless locked file cabinet.

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

115.389(b)

DYRS Policy 2.13.IV.J.8 mandates, "An annual report shall be made readily available to the public through the agency website. All information must receive prior approval by the Division Director and will be redacted of personal identifiers before website posting." The DYRS Annual Report CY-2022 is located on the DYRS website https://kids.delaware.gov/yrs/prea-reports.shtml. This report contains incident-based and aggregate data for both the DYRS operated and contracted facilities.

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

115.389(c)

DYRS Policy 2.13.IV.J.8.d states, "The division may redact specific material from the reports when a publication would present a clear and specific threat to the safety and security of a facility but must indicate the nature of the material redacted." Interview with the PREA coordinator confirmed the practice of redacting personal

	identifiers in the DYRS Annual Report. During the auditors review of the DYRS Annual Report CY-2022, there were no personal identifiers located. Information contained in report was statistical information without narrative or specifics of allegations of sexual abuse or sexual harassment incidents. Based on the analysis, the agency substantially meets compliance with this provision. 115.389(d) DYRS Policy 2.13.IV.J.10 requires, “PREA data shall be retained for no less than 10 years after the date of its initial collection unless Federal, State, or local law requires otherwise. During the onsite review, the auditor located incident-based and aggregate data that was beyond 10 years in the double lock system in the management analyst’s office. It is evident that the agency practices maintaining PREA required incident-based and aggregate data Based on the analysis, the agency substantially meets compliance with 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. Final PREA Audit Report for Residential Cottages 2. Final PREA Audit Report New Castle County Juvenile Detention Center 3. Final PREA Audit Report Stevenson House Detention Center 4. Final PREA Report Ferris School for Boys (Last Audit Cycle) 5. Facility Files including Resident, Staff, Medical

6. Resident Grievances and Log
7. Shift Summaries
8. Pre-Audit Questionnaire (PAQ)
9. OAS Supplemental Files
10. Agency's Website- https://kids.delaware.gov/yrs/prea-reports.shtml

Interviews:

1. Specialized Staff
2. Random Staff
3. Targeted Residents
4. Random Residents

Onsite Review:

1. Ferris School

115.401 (a-m):

All four of the division operated facilities final PREA reports were located on the DYRS agency website. The mandated reports are located at https://kids.delaware.gov/yrs/prea-reports.shtml. Published on the website were the past three audit cycles of PREA final reports for all four agency operated facilities. In the past three years, there was one exception due to the Covid-19 Pandemic. There was a postponement of the Residential Cottages. The onsite audit was rescheduled for December 2020, and the final PREA report was completed on July 27, 2021.

Information provided on the DYRS website https://kids.delaware.gov/yrs/prea-reports.shtml, provides evidence of all four division operated facilities PREA final reports being published for public review.

Feris School granted the auditor full access to all areas of the facility. Additionally, the auditor was able to observe daily operations, camera capability/footage, facility logs, shift summaries, and staff/resident files. Both PREA coordinator and PREA compliance manager uploaded all documents requested by auditor via the issue log. The auditor was able to conduct interviews privately with residents and staff at Ferris School. Based on interview with mailroom personnel, residents were afforded the opportunity to send confidential correspondence to the auditor in the same manner as communicating with legal counsel. Post announcements with the auditor's information was available throughout the facility.

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

115.403	Audit contents and findings
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. DYRS Final Audit Reports for Division Operated Facilities 2. DSCYF agency's website https://kids.delaware.gov/yrs/prea-reports.shtml Findings (by Provision): 115.403 (f): Located on the DSCYF agency's website https://kids.delaware.gov/yrs/prea-reports.shtml are all past and present division operated facilities final PREA reports. The PREA final reports published include all cycles and years for the following facilities: **Present** 1. Ferris School 2. New Castle County Detention Center 3. Residential Cottages 4. Stevenson House Detention Center **Past** 1. People Place 2. Chris Stumfels Youth Center The evidence shows that DYRS archives both past and present 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 agency substantially exceeds compliance 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".)	na
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	yes

	staffing levels and determining the need for video monitoring: Any findings of inadequacy from internal or external oversight bodies?	
	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?	yes
115.313 (d)	**Supervision and monitoring**	
	In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: The staffing plan established pursuant to paragraph (a) of this section?	yes
	In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: Prevailing staffing patterns?	yes
	In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: The facility’s deployment of video monitoring systems and other monitoring technologies?	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	yes

	functions of the facility? (N/A for non-secure facilities)	
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)	yes
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	yes

	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?	
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:	yes

	Residents who have speech disabilities?	
	Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Other? (if "other," please explain in overall determination notes.)	yes
	Do such steps include, when necessary, ensuring effective communication with residents who are deaf or hard of hearing?	yes
	Do such steps include, when necessary, providing access to interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary?	yes
	Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Have intellectual disabilities?	yes
	Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Have limited reading skills?	yes
	Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Who are blind or have low vision?	yes
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	yes

	safety, the performance of first-response duties under §115.364, or the investigation of the resident's allegations?	
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	**Hiring and promotion decisions**	

(c)		
	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	yes

	employees?	
	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.)	yes
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 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?	yes
	Have employees received additional training if reassigned from a facility that houses only male residents to a facility that houses only female residents, or vice versa?	no
115.331 (c)	**Employee training**	
	Have all current employees who may have contact with residents received such training?	yes
	Does the agency provide each employee with refresher training every two years to ensure that all employees know the agency's current sexual abuse and sexual harassment policies and procedures?	yes
	In years in which an employee does not receive refresher training, does the agency provide refresher information on current sexual abuse and sexual harassment policies?	yes

115.331 (d)	**Employee training**	
	Does the agency document, through employee signature or electronic verification, that employees understand the training they have received?	yes
115.332 (a)	**Volunteer and contractor training**	
	Has the agency ensured that all volunteers and contractors who have contact with residents have been trained on their responsibilities under the agency’s sexual abuse and sexual harassment prevention, detection, and response policies and procedures?	no
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?	no
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	yes

	comprehensive education to residents either in person or through video regarding: Their rights to be free from sexual abuse and sexual harassment?	
	Within 10 days of intake, does the agency provide age-appropriate comprehensive education to residents either in person or through video regarding: Their rights to be free from retaliation for reporting such incidents?	yes
	Within 10 days of intake, does the agency provide age-appropriate comprehensive education to residents either in person or through video regarding: Agency policies and procedures for responding to such incidents?	yes
115.333 (c)	**Resident education**	
	Have all residents received such education?	yes
	Do residents receive education upon transfer to a different facility to the extent that the policies and procedures of the resident's new facility differ from those of the previous facility?	yes
115.333 (d)	**Resident education**	
	Does the agency provide resident education in formats accessible to all residents including those who: Are limited English proficient?	yes
	Does the agency provide resident education in formats accessible to all residents including those who: Are deaf?	yes
	Does the agency provide resident education in formats accessible to all residents including those who: Are visually impaired?	yes
	Does the agency provide resident education in formats accessible to all residents including those who: Are otherwise disabled?	yes
	Does the agency provide resident education in formats accessible to all residents including those who: Have limited reading skills?	yes
115.333 (e)	**Resident education**	
	Does the agency maintain documentation of resident participation in these education sessions?	yes
115.333 (f)	**Resident education**	

	In addition to providing such education, does the agency ensure that key information is continuously and readily available or visible to residents through posters, resident handbooks, or other written formats?	yes
115.334 (a)	**Specialized training: Investigations**	
	In addition to the general training provided to all employees pursuant to §115.331, does the agency ensure that, to the extent the agency itself conducts sexual abuse investigations, its investigators have received training in conducting such investigations in confinement settings? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).)	yes
115.334 (b)	**Specialized training: Investigations**	
	Does this specialized training include: Techniques for interviewing juvenile sexual abuse victims? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).)	yes
	Does this specialized training include: Proper use of Miranda and Garrity warnings? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).)	yes
	Does this specialized training include: Sexual abuse evidence collection in confinement settings? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).)	yes
	Does this specialized training include: The criteria and evidence required to substantiate a case for administrative action or prosecution referral? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).)	yes
115.334 (c)	**Specialized training: Investigations**	
	Does the agency maintain documentation that agency investigators have completed the required specialized training in conducting sexual abuse investigations? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).)	yes

115.335 (a)	**Specialized training: Medical and mental health care**	
	Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to detect and assess signs of sexual abuse and sexual harassment? (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	yes

	the agency attempt to ascertain information about: Age?	
	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	yes

	pursuant to this standard in order to ensure that sensitive information is not exploited to the resident's detriment by staff or other residents?	
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	yes

	making facility and housing placement decisions and programming assignments?	
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	yes

	entity or office that is not part of the agency?	
	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	yes

	the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws?	
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	yes

	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?	
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	na

	the parents or legal guardians? (N/A if the alleged victim is not under the guardianship of the child welfare system.)	
	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	yes

	accordance with these standards?	
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	yes

	of sexual abuse, does the agency: Act promptly to remedy any such 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: 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?	yes
115.371 (c)	**Criminal and administrative agency investigations**	
	Do investigators gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data?	yes
	Do investigators interview alleged victims, suspected perpetrators, and witnesses?	yes
	Do investigators review prior reports and complaints of sexual abuse involving the suspected perpetrator?	yes
115.371 (d)	**Criminal and administrative agency investigations**	
	Does the agency always refrain from terminating an investigation solely because the source of the allegation recants the allegation?	yes
115.371 (e)	**Criminal and administrative agency investigations**	
	When the quality of evidence appears to support criminal prosecution, does the agency conduct compelled interviews only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution?	yes
115.371	**Criminal and administrative agency investigations**	

(f)		
	Do agency investigators assess the credibility of an alleged victim, suspect, or witness on an individual basis and not on the basis of that individual’s status as resident or staff?	yes
	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	yes

	does not provide a basis for terminating an investigation?	
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	yes

	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?	
	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?	no
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	yes

	cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident?	
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.)	na
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.)	na
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	yes

	cooperates with any investigation arising out of the incident?	
115.383 (h)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	Does the facility attempt to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners?	yes
115.386 (a)	**Sexual abuse incident reviews**	
	Does the facility conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation, including where the allegation has not been substantiated, unless the allegation has been determined to be unfounded?	yes
115.386 (b)	**Sexual abuse incident reviews**	
	Does such review ordinarily occur within 30 days of the conclusion of the investigation?	yes
115.386 (c)	**Sexual abuse incident reviews**	
	Does the review team include upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners?	yes
115.386 (d)	**Sexual abuse incident reviews**	
	Does the review team: Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse?	yes
	Does the review team: Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; gang affiliation; or other group dynamics at the facility?	yes
	Does the review team: Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse?	yes
	Does the review team: Assess the adequacy of staffing levels in that area during different shifts?	yes

	Does the review team: Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff?	yes
	Does the review team: Prepare a report of its findings, including but not necessarily limited to determinations made pursuant to §§ 115.386(d)(1)-(d)(5), and any recommendations for improvement and submit such report to the facility head and PREA compliance manager?	yes
115.386 (e)	**Sexual abuse incident reviews**	
	Does the facility implement the recommendations for improvement, or document its reasons for not doing so?	yes
115.387 (a)	**Data collection**	
	Does the agency collect accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions?	yes
115.387 (b)	**Data collection**	
	Does the agency aggregate the incident-based sexual abuse data at least annually?	yes
115.387 (c)	**Data collection**	
	Does the incident-based data include, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice?	yes
115.387 (d)	**Data collection**	
	Does the agency maintain, review, and collect data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews?	yes
115.387 (e)	**Data collection**	
	Does the agency also obtain incident-based and aggregated data from every private facility with which it contracts for the confinement of its residents? (N/A if agency does not contract for	yes

	the confinement of its residents.)	
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	yes

	publication would present a clear and specific threat to the safety and security of a facility?	
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.)	na

	If this is the third year of the current audit cycle, did the agency ensure that at least two-thirds of each facility type operated by the agency, or by a private organization on behalf of the agency, were audited during the first two years of the current audit cycle? (N/A if this is not the third year of the current audit cycle.)	yes
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