PREA Facility Audit Report: Final

Name of Facility: Ferris School for Boys
Facility Type: Juvenile
Date Interim Report Submitted: 08/10/2019
Date Final Report Submitted: 10/01/2019

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:** 10/01/2019

AUDITOR INFORMATION	
Auditor name:	Hardy-Kesler, Tammy
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Telephone number:	
Start Date of On-Site Audit:	2019-06-24
End Date of On-Site Audit:	2019-06-26

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

Primary Contact	
Name:	Joshua Fields
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Telephone Number:	302-993-3898

Superintendent/Director/Administrator	
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Facility PREA Compliance Manager	
Name:	
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Facility Health Service Administrator On-Site	
Name:	Sarah Ciano
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Facility Characteristics	
Designed facility capacity:	72
Current population of facility:	28
Average daily population for the past 12 months:	18
Has the facility been over capacity at any point in the past 12 months?	No
Which population(s) does the facility hold?	
Age range of population:	16-18
Facility security levels/resident custody levels:	Level 5
Number of staff currently employed at the facility who may have contact with residents:	94
Number of individual contractors who have contact with residents, currently authorized to enter the facility:	26
Number of volunteers who have contact with residents, currently authorized to enter the facility:	8

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

Agency Chief Executive Officer Information:	
Name:	John Stevenson
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Agency-Wide PREA Coordinator Information			
Name:	Carrie Hyla	**Email Address:**	Carrie.Hyla@Delaware.gov

AUDIT FINDINGS

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

The Prison Rape Elimination Act onsite audit was conducted on June 24-26, 2019 for the Ferris School for Boys (FSB). The facility is in the jurisdiction of the Delaware Department of Services for Children, Youth, and Their Families (DSCYF) and is operated by the Division of Youth Rehabilitative Services (DYRS). It should be noted that DSCYF which operates FSB is the state's child welfare agency. The audit was completed by Tammy A. Hardy-Kesler and the Auditor's Assistant, Renee McKellar of TAHK Consultants. All necessary clearances were completed for entry to the facility. Contract procurement was executed and finalized on August 18, 2018 with TAHK Consultants. Previous onsite audit was completed on May 23-25, 2016. The designated Auditor was Charles J. Kehoe of Midlothian, Virginia. The facility was found to comply with all the PREA standards on August 19, 2016 by Mr. Kehoe. The Final PREA Report was signed on September 21, 2016.

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

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

The Auditor was familiar with FSB and DYRS from the prior PREA audits that was in the process of finalizing at the New Castle County Detention Center. Research was completed on FSB by the Auditor prior to the onsite audit. Searches were made of local news agencies, and there were no articles found pertaining to FSB. Additionally, community agencies were contacted to obtain information on existing memorandums of agreement, understanding, and affirmations.

Further research established that FSB is not operating under any federal consent decrees. This was further confirmed by the PREA Coordinator. Found on DSCYF's website was a comprehensive section dedicated to PREA and the means to report sexual abuse and sexual harassment. The following was made available on the website:

- Survey of Sexual Victimization Report 2008-2017
- All PREA Final Reports of audited state operated facilities from 2015-2018
- DYRS PREA Annual Report from 2012-2017
- PREA Risk Assessment Report from 2015-2017
- Mandatory Reporting Laws Information with form that must accompany the call

Also available on the agency's website was the Mandatory Reporting Law requirement which states that law enforcement, educators, and medical personnel are required to report incidences of any abuse to the Child Abuse Hotline, and all listed are required within 72 hours of the call to complete the mandatory reporting form that must be mailed or faxed to the Delaware Division of Family Services.

The Auditor had not received any confidential correspondence from either residents or staff prior to the onsite audit. The timeframe being referred to was from April 6, 2019 to June 24, 2019. The Auditor continued to check for correspondence until August 2, 2019.

Prior to the onsite visit, the Professional Standards Manager/PREA Coordinator provided the Auditor with the completed Pre-Audit Questionnaire (PAQ) through the PREA Online Audit System (OAS). It should be mentioned that the PREA Coordinator has changed due to retirement of the previous PREA Coordinator. The Interim PREA Coordinator began preparing the PAQ in September of 2018 which was taken over by the present PREA Coordinator. The Auditor received access to the PAQ through the OAS on May 13, 2019. The completed PAQ contained responses to questions pertaining to standards, the facility policies that pertained to PREA, agency wide policies, blueprints, forms, meeting documents, emails, brochures, Spanish and English student handbook, specialized PREA training certificates, invoices, Coordinated Response Plan, First Responder Checklist, memorandum of agreements, memorandum of understandings, affirmations, and operating guidelines for residential contracts funded by DYRS. Prior to the onsite audit, documents were reviewed by Auditor to establish the level of compliance with the PREA standards.

On May 6, 2019 PREA Compliance Manager posted notifications throughout FSB of the upcoming onsite audit scheduled for June 24-26, 2019. The Compliance Manager provided a time stamped photograph of when the notifications were posted. Notifications were provided to inform residents and staff of the onsite audit, as well as the information to send confidential correspondence to the Auditor. During the onsite audit tour of the facility, the notifications were found to be located at the entry of the facility and continued throughout the building, including all housing units. The postings were highly visible in comparison to other papers posted in the facility. The text was typed in a large and simple font. When the posting was sent to the PREA Coordinator, it was explained by the Auditor that staff and residents should be allowed to communicate with the Auditor in the same manner that legal correspondence is handled.

Inquiry was made with Just Detention International (JDI) to obtain if any allegations of sexual harassment or sexual abuse had been reported for FSB in Wilmington, Delaware. On April 8, 2019, a message was received from JDI stating there were no reports of sexual harassment and sexual abuse made within the last 12 months for FSB. A follow up call was made on August 8, 2019, and there were no reports of sexual abuse and sexual harassment during the post audit phase. The Auditor contacted a local community-based group and the Christiana Care Hospital. The Executive Director of Survivors of Abuse in Recovery (SOAR) was contacted on April 30, 2019. It was disclosed that there is an existing memorandum of agreement with DYRS for the state operated facilities. Also, the Director reported there were no requests for services in the last 12 months by DYRS, specifically FSB. Also, the SANE/SAFE Coordinator from the Christiana Care Hospital stated that there was an existing affirmation for forensic examinations between the hospital and DYRS. Both agencies stated that they were not aware of any treatment for sexual abuse or request for victim services by residents detained at FSB.

Communications occurred between the Auditor and the PREA Coordinator frequently by telephone and an issue log maintained through email. It was understood between the Auditor and the PREA Coordinator that the goal of the audit was to ensure the sexual safety of both residents and staff at FSB. The

expectation of the Auditor is that the facility allows unimpeded access to staff, residents, documentation, and the facility plant. Prior to the onsite audit, the PREA Coordinator and the Auditor discussed the schedule for the onsite audit. It was decided that the onsite tour and documentation review of random staff files, random residents' files, logs, and investigation files would occur on the first day. A portion of the interviews of specialized staff, target population, random staff, and random residents would be completed on the last 2 days which convened between the DSCYF Main Campus conference room, the administrative conference room at FSB, the conference room in the secured section of FSB, and a classroom. All four areas were conducive to conduct confidential PREA interviews.

Prior to the onsite audit, the Auditor compared the PREA Compliance Audit Tool to the Pre-Audit Questionnaire that was provided by the PREA Coordinator. The comparison revealed that there was missing information. The Auditor and PREA Coordinator maintained an issue log through email which resulted in the PREA Coordinator uploading missing documentation into the supplemental files of AOS. During the onsite audit the following information was provided by the PREA Compliance Manager and the FSB Compliance Manager staff list and resident list. Randomly utilizing dates, the Auditor requested post assignments, PREA related logs and footage of rounds, resident training documentation, PREA risk assessments, footage of PREA rounds, active/inactive resident files, active and inactive random staff files and all documentation related to prior sexual abuse and sexual harassment allegations. Additionally, there were communications between the PREA Coordinator and the Auditor throughout all the phases of auditing. Lines of communication were done through telephone, email, and onsite request. Auditor was provided with all information requested in a timely manner. Additionally, the Auditor was given full access to FSB.

Preceding the tour and document review, there was an opening meeting with the PREA Coordinator, Superintendent, PREA Compliance Manager, YRC Supervisor, Auditor, and Auditor's Assistant. Further, the Auditor explained the task of collecting evidence of PREA compliance by the review of documentation, interviews, and the facility's practices.

Following the introductory meeting, the Auditor requested to tour FSB. Prior to arriving at the facility, the Auditor requested a fire drill blueprint rather than the original blueprint. The Auditor's preference was due to the detail presented in Fire Drill blueprints. The Auditor sought the location of video monitoring, Child Abuse Hotline Phones, and PREA related posters. Also, practices and procedures were monitored as well. The Auditor was able to observe all aspects of operation from agency level on the main campus to the facility operation, physical layout, and central command video monitoring configuration. During the tour of the facility, the Auditor was accompanied by the Superintendent and PREA Compliance Manager. The facility was toured internally and externally to observe for areas of concern for sexual safety. The Auditor insured that the blueprints provided were in alignment with the actual physical structure. During the onsite tour, the Auditor observed that the building was well maintained, organized, walls were without defacing, classrooms were up to date with interactive whiteboards, and rapport between staff and residents was satisfactory.

While touring, the Auditor noticed that the facility had very good sight lines, and the cameras were in good positioning to capture many angles of view. Throughout the facility, there were PREA posters in both English and Spanish. There were also a few PREA posters created by the residents. At the entryway of FSB, there were PREA related brochures and materials for third-party reporters to access. Located throughout the facility was PREA audit postings in the housing units.
The electronic monitoring was operated to locate any blind spots and areas of concern. FSB has 98 cameras in total. The facility has provided evidence of planning to upgrade and add additional cameras.

There were several blind spots that were identified which entailed further discussion with Superintendent and PREA Compliance Manager. There is limited electronic monitoring located in the outside recreation area leading to the football field, there is no electronic monitoring of the football field, the garden, outside lunch area, and a back-hallway office in the education wing designated as the Coach's office. There is substantial concerns regarding the football field due to the hosting of games from outside entities.

When entering the facility, there is a large entranceway which is monitored by video and personnel. One side of this area is the administrative side of the building that housed the conference room that was utilized for conducting interviews of random staff and facility specialized staff. On the other side of the facility entranceway is the secured side of the facility. Upon entering the secured area, sits Central Command, and on the opposite side is a small interview/meeting room that was utilized for random resident interviews and target interviews. This room is also utilized for interviews with lawyers, and it was stated if necessary, the room could be utilized for victim support services. Additionally, there was an empty classroom that was utilized for interviews.

The facility contains housing clusters which are identified to be the Northern and Southern housing clusters. At the time of the onsite audit, only the Northern housing cluster was in operation. Both housing clusters were toured by the Auditor. In the 2 housing clusters, there are 6 housing units in total. The housing units are identified as A-F. The Southern Cluster containing A-C, and the Northern Cluster containing D-F. Each unit has the capacity of 12 residents each. On each unit, there were 8 single rooms and 2 multi rooms with 2 beds which total 12 beds. Each unit contains PREA posters and a copy of the notice of the onsite audit. Each housing unit contained 2 telephones. The Auditor checked the telephones to see if they were operable. There were 2 telephones in separate locations that were down, and the Auditor was provided evidence that the phones were made inoperable by an accident that occurred to the wiring outside of the facility. Additionally, each unit has individualized bathrooms for residents to groom in privacy without being viewed by staff or other residents. Residents are required to dress and undress in the individualized bathrooms. When the Auditor viewed the electronic monitoring system, residents could not be viewed in the bathroom.

During the onsite tour, the Auditor observed that the Southern housing unit was vacant, and it was in the process of being cleaned and prepared for painting. The centralized activity area of both the cluster and the housing units have adequate electronic monitoring. The electronic monitoring allows for privacy in rooms, as well as bathroom and grooming areas.

Located on the cluster are several rooms that serve many different purposes. Centralized on both housing clusters is a supervisor's office, program classrooms, Quiet Room, laundry area, as well as access to 3 separate housing units. Residents do not have access to the supervisor's office. The office is encased with glass for view in and out of office. Found maintained and secured in the Northern Housing Cluster's supervisor's office was the residents' files.

According to staff, the Quiet Room has 2 functions a cool-down room for students exhibiting difficult behavior or an observation room for residents with medical concerns needing close observation. According to residents, the room is utilized when a resident's behavior is detrimental to themselves and others. Once resident is removed, they may be placed on Administrative Intervention which is not a room restriction, but a heightened supervision maintained only on the housing unit or the cluster. During the time on Administrative Intervention, residents receive visits from medical and mental health practitioners and the administration of the facility.

At FSB, residents are responsible for maintaining the laundry. The facility has a process by which residents are supervised while completing the laundry.

FSB has several program classrooms throughout the facility. The classrooms differ from the classrooms in the education wing. These classrooms are utilized specifically for the several programs and group therapy sessions that are offered at the facility. All rooms have video monitoring. Below find the 9 programs offered at FSB:

1. 7 Challenges
2. Thinking 4 A Change
3. Public Speaking
4. Aggression Replacement Training (ART)
5. Yoga
6. Groves Program
7. Trauma
8. Botvin Life Skills
9. Fatherhood

The kitchen and dining area are located off the clusters. Outside visitation by families is conducted in the dining hall area. The dining area and the kitchen have video monitoring. There is no video monitoring in the kitchen storage area, but residents do not have access to that area. Residents assist with the set up and clean up for meals, but they do not assist with the preparation of meals. Custody staff have set positioning during meals for supervision purposes.

Located near the Intake area are the medical and mental health offices. The Auditor viewed the location where files were stored. All files were locked at the time of tour. The Auditor briefly questioned the Medical Practitioner on the posting of staff during medical services. During examinations, there are two medical personnel available in the examining room. The residents are always accompanied by custody staff when coming to the medical office. In as far as classification of residents, the medical or mental health staff provides an email to administration regarding gender conforming or non-conforming and the classification of residents into housing units based on PREA risk assessment. While onsite, the Auditor reviewed correspondence between the medical and mental health personnel and administration. It is a notation stating considerations if a resident could potentially be victimized or an abuser.

Upon entering a housing unit, the Auditor observed that female staff announced their presence before entering the unit. The cross-gender announcement was made on several occasions. Signage was at each door regarding opposite gender announcement. This practice of announcing presence was further confirmed by the interviews with random staff and residents.

On the housing cluster, the Auditor located the grievance collection areas. Within each location was a writing utensil, as well as blank grievance sheets and PREA grievance sheets. Based on the information obtained during the tour and the interviews, residents can complete a grievance sheet regarding sexual abuse and sexual harassment, and the information is immediately called into the Child Abuse Hotline. It does not go through the established grievance process.

There were no scheduled intakes on June 24-26, 2019. The Auditor requested that the YRC demonstrate the intake process. The demonstration included the unclothed search and the initial information given to residents regarding PREA. During the mock unclothed search, the Auditor was shown the positioning of

intake worker and the verbal commands given to residents during the search.

The Auditor located the phones utilized to contact the Child Abuse Hotline to report all allegations of sexual harassment, abuse, and retaliation. Residents at FSB can report instances of sexual abuse and sexual harassment on the housing units. The Auditor randomly checked the Child Abuse Hotline phones, and 2 phones were inoperable, but Auditor was provided evidence of the external accident that occurred. During prior audits for DYRS, the phone system allowed for direct access to Child Abuse Hotline. There were a few steps before the connection was made to the hotline. The Auditor spoke to the operator within several seconds of placing call. The first dispatcher was not aware of PREA, the second dispatcher was knowledgeable of the Auditors responsibility to check that phones were accessible and operational for residents if the need arose to report allegations of sexual harassment and sexual abuse.

During the tour of FSB, it was noted that there were no areas of isolation. According to the random residents interviewed, they have not witnessed or been placed in isolation. They have been placed on Administrative Intervention but was not restricted to room, but rather restricted to the cluster or housing unit. During the tour of facility, there were mobile beds that were used when a resident has to be in close proximity to staff.

At the time of the onsite audit, there were 24 residents detained at FSB. Out of the 24 residents, there were 16 residents interviewed. There were no open allegations of sexual abuse or sexual harassment and no residents available from earlier allegations of sexual abuse and sexual harassment. The last time that there were allegations of sexual abuse and sexual harassment was in 2016 during the last PREA Audit at FSB. There were 12 residents selected for random interview, and 4 residents interviewed that identified in a targeted group. There were no residents that identified as limited English proficient, physically disabled, but there were 4 that were either cognitively impaired or a significant learning disability which was identified by the Principal. Out of the 4 there was a resident that experienced being placed on Administrative Intervention. Additionally, there were no residents that identified as blind, deaf, or hard of hearing. It was disclosed to the Auditor by IA, there were no residents residing at the facility that had allegations or open investigations in process of sexual harassment, sexual abuse, or retaliation. There were no barriers by FSB in obtaining information about the identification of residents in targeted groups. In random review of the PREA Risk Assessments, the Auditor was not able to identify any residents that were identified as LGBQTI. The average length of stay at FSB is approximately 177 days. This factor impedes the ability to interview residents that were either victims or perpetrators of sexual abuse or sexual harassment at FSB.

In the administrative conference room at FSB, the Auditor conducted confidential interviews with randomly selected staff, and the facility's specialized staff. The random residents and residents from target groups were interviewed in the conference room on the secured side of the facility and one of the program classrooms. Upon arrival to the facility, the PREA Manager and PREA Facility Investigator made available the list of staff and residents. On the final day of the onsite audit, the PREA Coordinator had prepared the schedule and the list of specialized staff.

Established PREA Protocols were utilized for interviewing selected staff and residents of FSB and DYRS. The Auditor wanted a cross section sampling of random staff. Selection was based on shift, length of employment, and position. Staff from all three shifts were representative of random staff interviewed. The Auditor also interviewed staff that were hired within the year as well as staff that were at the facility for over 10 years. When interviewing the staff that held the position as YCR, it was found that the position encompassed at least two responsibilities identified as specialized staff according to PREA. The position

required first responders and intake responsibilities. The Auditor interviewed 16 random staff and 14 specialized staff. In total, there were 46 interviews conducted during the onsite audit. There were 2 community groups, 1 Delaware State Police Representative, and 2 volunteers interviewed by telephone. The contracted staff interviewed was the Medical Practitioner from Christiana Care Hospital. There are 3 shifts that operate within the facility. It should be noted that the Auditor met with staff from all 3 shifts. Review of the Workload Assessment of May 2019 (Staffing Plan), the plan exceeded requirements of the PREA standards for staff to resident ratios. There was no deviation of the staffing plan, confirmed by random review of staff post assignments and random log review. The FSB enforces the freeze or retention of staff if there is any risk of possible staff shortage on a shift. According to random staff, freeze is the procedure that is utilized if there is a potential for staff shortage.

For the random residents, the Auditor wanted a cross section of the population. Random resident selection was based on age and time at facility. Target residents were selected based on PREA Risk Assessments completed by Medical and Mental Health Practitioners and residents identified by administration as meeting the criteria as a member of the target population. The Auditor interviewed 4 residents that identified as learning disabled and another resident that was placed on Administrative Intervention. During the onsite audit, there were no residents identified as having prior sexual victimization and limited English proficient. It should be noted that the FSB does not utilize isolation. Residents are placed on Administrative Intervention on an active housing unit for safety and security of facility.

The Auditor interviewed the following positions that were in alignment with the required specialized staff list: Other titles listed are community-based interviews.

Agency Head
PREA Coordinator
YRC Supervisor-PREA Compliance Manager
Contracts Manager
Management Data Analyst
Criminal History Unit Representatives
Human Resource Representatives
Medical Practitioner – Contracted Employee
Mental Health Practitioner
Training Coordinator
2 Institutional Abuse Investigators
Principal
2 Volunteer via telephone
Christiana Care Hospital SANE/SAFE Coordinator via telephone
Executive Director SOARS via telephone
Representative of Delaware State Police via telephone (Investigations)

On the last day of the onsite audit, the Auditor began interviews of specialized staff. Specialized staff interviews provided details of operational processes and practices within the agency and the facility. To ascertain evidence of compliance with PREA standards, the PREA Resource Center Interview Protocols were utilized as well as additional questioning when necessary.

DYRS has a process for collection of all data pertaining to any sexual harassment and sexual abuse that occurs at either a state operated facility or a contracted residential facility. The Management Analyst is

responsible for maintaining the documentation. The agency makes all aggregated reporting available to the public on the agency's website without disclosing any personal identifiers.

Staff were asked questions pertaining to the DYRS PREA Policy 2.13, which indicates zero-tolerance for any incidences of sexual activity, definitions of terms utilized in the policy, procedures, prevention, reporting by staff, reporting by resident, investigations, victim services, data collection, training, forms, and first responder responsibility.

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

Interviews with staff and residents both revealed high levels of proficiency in retention of information pertaining to PREA. The staff could recall first responder responsibilities, methods to report for both residents and staff, and the agency's stance on zero-tolerance for sexual abuse and sexual harassment. Residents could recall methods to report incidents of sexual abuse and sexual harassment, their right to be free from sexual abuse and sexual harassment, and when they received their trainings. Review of training records proved that both staff and residents had signed that they had received training and received documentation on the PREA standards. In the case of the residents, the records revealed that they received an initial introduction to PREA at intake and they did not obtain the comprehensive PREA training within 10 days of intake. Residents did receive another training, but in most cases it was several weeks to months following intake.

The remainder of the specialized staff was interviewed at the facility. At the time of the onsite audit, school was not in session. The Principal of the school program came to the facility for an interview. The principal provided details pertaining to the operation of the school program.

The Auditor was able to reach 2 volunteers by telephone. The volunteers disclosed that they had received PREA Training at FSB. The Auditor reviewed the signed form that they had received and understood the training. Also, the volunteers stated that during their service hours they would always be escorted with staff. Also, it was shared criminal background checks were completed prior to starting service hours.

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

The two investigator's interviews were with the Agency's Institutional Abuse Investigators. During the interviews, there was a detailed account of the process by which investigations are handled in the case of allegations of sexual harassment and sexual abuse within FSB. The Institutional Abuse Unit (IA) and the Delaware State Police (DSP) investigates allegations of sexual abuse at FSB. Further, there was a

discussion of the process in the preservation of evidence. Towards the end of the interview, there was a dialogue surrounding the case if a victim recants, and it was found that if a victim recants, it is the obligation of the investigator to continue the investigation. The investigators attested that they had not received any allegations of sexual abuse and sexual harassment for several years from FSB.

The administrative investigations are the responsibility of the administrators and the designated facility PREA investigator, and civil investigations are the responsibility of IA. All criminal investigations are investigated by DSP. The Auditor did review the sexual harassment and sexual abuse allegations from 2016. These allegations occurred in 2016 during the last PREA audit.

It was further established that there were no sexual abuse or sexual harassment allegations in progress with the Management Data Analyst and the PREA Coordinator or the PREA Compliance Manager. During the last 12 months, there were no administrative or criminal cases of sexual abuse or sexual harassment referred to prosecution, indicted, acquitted, or convicted.

During the onsite audit, there was a review of resident and staff files pertaining to PREA required mandates, as well as electronic training files and criminal background checks. The selection of 10 resident files that were interviewed included the 2-residents identified in the target population, as well as 2 inactive files. The resident files included signed documentation of the completed initial PREA training, and the Auditor reviewed the comprehensive PREA trainings which was out of compliance due to the dates the residents received the training. There were 12 PREA risk assessments reviewed. Staff personnel files selected were 10 of the random staff interviewed. Staff files had all signatures indicating that training was attended and comprehended. Also, the files contained a yearly affirmation/promotion form signed by staff that they had not participated in, were convicted of or adjudicated of any sexual abuse or sexual harassment within the previous year.

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

Criminal Background checks could not be verified beyond the capabilities of DELJIS, which only obtains Delaware State Criminal History. Auditor received the documentation that appropriate 5 year background checks were completed.

Upon completion of the on-site audit on June 26, 2019 there was an exit meeting held at 3:00 p.m. with the Auditor, Auditor's Assistant, Agency Director, PREA Coordinator, Superintendent, Assistant Superintendent and the PREA Compliance Manager. The items that were requested at that time was the list of contractors and volunteers with contact information. The PREA Coordinator uploaded the documentation that the criminal background checks were completed. Contact information of participants were obtained by Auditor's assistant so that all means of communication were exchanged.

During the meeting, the Auditor mentioned that according to all random residents interviewed that the residents felt safe from sexual harassment and sexual abuse at FSB. Lastly, the Auditor thanked the administrators and the residential staff for their continued efforts in maintaining the implementation of the Prison Rape Elimination Act at FSB.

During the post onsite audit phase, there was continued communication to obtain documentation as well as ask any questions pertaining to the audit. The Auditor continued to check the P.O. Box for any communication from FSB staff and/or residents. The Auditor had not received any confidential correspondence from either residents or staff from May 6, 2019 to August 2, 2019.

AUDIT FINDINGS

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

The Ferris School for Boys (FSB) is located on the campus of the Delaware Department of Services for Children, Youth, and Their Families. FSB is operated within the jurisdiction of the Division of Youth Rehabilitative Services which is under the umbrella of the Department of Services for Children, Youth and their Families.

FSB is one of three facilities operated by the Division of Youth and Rehabilitative Services on this campus. The campus is located on the outer limits of the city of Wilmington, Delaware. The campus is located across the street from the DuPont Company's World Headquarters. Majority of the city is urban with the outer limits being suburban. The other two facilities operated by DYRS on the campus are the Residential Cottages and the New Castle County Detention Center.

DYRS provides services to residents that are identified by family court as needing detention, treatment, probation, and aftercare services. Upon release from FSB, residents can be further released to a step-down facility onsite-Residential Cottages, a therapeutic program, adult facility, electronic monitoring, or parent/guardian. While detained at FSB, residents receive risk and needs assessments, education, medical care, 7-Challenges, Thinking 4 a Change, Public Speaking, Aggression Replacement Training, Yoga, Groves Program-Credit Recovery, Trauma, Botvin Life Skills and the Fatherhood Program. Majority of the residents are detained by the Family Courts of the counties of Delaware.

The agency's mission is to guide youth involved in juvenile justice to a successful future and support public safety. The facility's mission is Ferris School will provide a safe, healthy and secure total learning environment that will enable the students to successfully transition back to their families and the community.

The facility utilizes direct supervision and real time electronic monitoring. There are 98 cameras throughout the facility. The retention of footage is approximately 25-30 days. The facility significantly exceeds the PREA standards for staff to resident ratios. The facility has a protocol of mandatory overtime or freeze to prevent staff shortage.

The facility is located close to the front entranceway of the DSCYF Campus. The facility is within a few hundred yards from the main corridor.

The entrance of FSB is large. There is a waiting area with benches. On the counters were informational items pertaining to PREA and other social services available to families. On the left is the swipe entrance into the administrative wing and beyond the security desk is the entrance to the secured facility.

Central Command has one desk with several monitors to view the 98 cameras. The cameras were all operational during onsite audit. The 98 cameras are adequately placed to ensure that sight lines are captured so that any allegation of sexual abuse and sexual harassment can be prevented, detected, and

if necessary, captured for evidence. There were several blind spots both internally and externally.

FSB has a food service department which is state operated. Residents do assist with the set up and cleanup of meals. In the dining area, there is video monitoring and custody staff are positioned for supervision purposes.

There are a northern and a southern housing clusters which contain 3 housing units each. Additionally, the clusters have programming rooms, a quiet room, laundry areas and supervisor's office. During the onsite audit the southern cluster was closed for cleaning and painting.

In the housing units, the toilet and showers are individualized. The door must be unlocked for resident to enter. Upon entering the shower, resident must be dressed. After showering, the resident must be dressed prior to exiting. Also, the toilet must be unlocked prior to resident entering, and resident who exit must be fully dressed. Due to the configuration, resident can not be viewed during toileting and showering. The configuration of the toilet and shower improves the ability to detect, prevent, and respond to sexual abuse and sexual harassment. Additionally, the configuration allows for transgender and intersex resident to toilet and shower privately in accordance with the PREA standard.

The facility's education department is separate from the housing units. All classrooms have video monitoring. The classrooms are equipped with interactive whiteboards. Additionally, there is a large library. The video monitoring can capture in between the stacks of books.

FSB has a large gymnasium with a weight room. The areas are monitored with video to prevent, detect, and respond to sexual abuse and sexual harassment. The facility has an outside recreation area that is equipped with cameras. The football field lacks cameras as well as the garden that's in the vicinity. There is video monitoring in route to the field, but there is no video monitoring on the field.

Since the last PREA audit in 2016, FSB has not made any significant upgrades to cameras, but has been in the planning stages. The Auditor was provided evidence of the planning process. It would be beneficial to go forward with the plans of upgrading and adding cameras in order to prevent, detect, and respond to incidences of sexual harassment and sexual abuse.

FSB is a level V adjudicated secure detention center for males. The facility contains 6 housing units. At the time of the audit, the population total was 24 males. Race and ethnicity resulted in 23 Black resident and 1 White youth. The facility's capacity is 72. Intake for new residents is on Thursdays.

FSB has 6 housing units; all are dedicated to males. At the time of the onsite audit, the Southern housing cluster was closed. The Auditor observed the cluster being cleaned and prepared for painting. The building has 48 single rooms and there are 12 multiple occupancy rooms.

The medical suite is best described as an infirmary. In the instance of a sexual abuse, a forensic sexual medical exam would be conducted at Christiana Care Hospital or A.I. Dupont Hospital. There is a dental lab located in the medical suite. Residents are escorted by custody staff to the medical suite, and the medical practitioner detailed that 2 medical practitioners are in the exam room during examinations. Also, there was a double lock file area for residents' medical files.

In the Intake area, there is an area to shower, as well as provide PREA intake and other required assessments.

It was reported that there are 15 volunteers and 20 individual contractors who are authorized to enter facility.

During the onsite visit, there was 91 employees at FSB. Reported on the Pre-Audit Questionnaire, in the last 12 months there were 12 staff hired at FSB.

AUDIT FINDINGS

Summary of Audit Findings:
The summary should include the number of standards exceeded, number of standards met, and number of standards not met, along with a list of each of the standards in each category. If relevant, provide a summarized description of the corrective action plan, including deficiencies observed, recommendations made, actions taken by the agency, relevant timelines, and methods used by the auditor to reassess compliance. Auditor Note: No standard should be found to be “Not Applicable” or “NA”. A compliance determination must be made for each standard.

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

The Auditor determined the following:
Exceeds Standard-0
Meets Standard- 43
Does Not Meet Standard-0

The following standards were found to be in need of corrective action:
115.333 Resident Education
115.365 Coordinated Response
115.367 Agency Protection Against Retaliation

Corrective Action 115.333- Completed within the 180 day corrective action period.
PREA Standard 115.333 requires that residents receive comprehensive training within 10 days of intake. The PREA Coordinator and the PREA Compliance Manager at FSB will create a plan to implement comprehensive PREA training within 10 days of intake to residents at FSB. The plan and documented rosters will be made available to the Auditor within 60 days of the Interim Report. Auditor was provided the curriculum and documented rosters of comprehensive PREA training.

Corrective Action 115.365
PREA Standard 115.365 requires that an agency has a specific coordinated response plan for each facility.-Completed during the 180 day corrective action period. With the assistance of the PREA Coordinator and PREA Compliance Manager FSB will create a coordinated response plan specific to FSB. This plan will be made available to the Auditor within 60 days of the Interim Report. Additionally, evidence of the planning process will be submitted to the Auditor. Facility specific institutional plan (FSB Coordinated Response Plan) was provided to Auditor.

Corrective Action 115.367-Completed within the 180 day corrective action period.
PREA Standard 115.367 mandates that facilities are to have a designated person or department responsible for monitoring retaliation.
FSB is to designate individuals or a department to monitor retaliation. The individuals or department is to be trained in monitoring retaliation at FSB. The training can be done by either the PREA Compliance Manager or Agency Training Coordinator. The Auditor shall be provided the signature page and the agenda from training for evidence. This evidence will be provided to the Auditor within 60 days of the Interim Report. The designated person was trained for the responsibilities of monitoring retaliation. The

Auditor was provided the signed training roster and the training curriculum, Training on Protection from Retaliation.

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
	DYRS Policy 2.13.I-IV PREA Policy Interviews PREA Coordinator (PC) PREA Compliance Manager (PCM) Residents Rehabilitative Services Organizational Chart Ferris School for Boys' Organizational Chart The State of Delaware Employee Performance Plan for both PC and PCM 115.311(a) Upon review of DYRS Policy 2.13 PREA, the Auditor ascertained that the PREA policy was complete. It expressly contains the purpose, policy, definitions, procedures, prevention, and investigations within DYRS to address sexual abuse and sexual harassment. Documented in DYRS Policy 2.13. II, is written evidence of the agency's zero tolerance for sexual abuse and sexual harassment in the operation of facilities and contracted facilities. The policy states, "DYRS has a zero tolerance for any incidence of sexual activity with residents in our care. DYRS commits to full compliance with the Prison Rape Elimination Act (PREA). Any type of forced or unwanted sexual activity, touching or sexual harassment between residents or any type of sexual activity or sexual harassment between staff and residents, including consensual is criminal and prohibited." Outlined within DYRS Policy 2.13.IV is the agency's approach to prevention, detection, and response to sexual abuse, sexual harassment, and retaliation. As part of prevention, DYRS requires that the administrators and supervisors maintain facility staff to resident ratios. In addition, it states that classification and assessment tools will be utilized to determine supervision needs of residents for the protection of victims and those known to be perpetrators. During Intake, staff is required to make a notation of residents' conformity or non-conformity to their gender. Types of supervision would include housing decisions, movement throughout the facility, and all routine and non-routine activities. In addition, all shifts supervisors and program managers are to conduct and document unannounced and announced PREA rounds to identify and deter sexual abuse and sexual harassment by both staff and residents. These rounds are to be highlighted in the unit logbook. When staff enter the housing units of the opposite gender, they are to alert residents by knocking on the door, as well as announcing their gender to ensure residents requiring privacy has ample time and notice. The policy also mentions residents with disabilities and limited English proficiency are to be provided the same information to prevent, detect, and respond to sexual abuse, sexual harassment, and retaliation. Mandatory reporting is contained within the policy. All staff are required to report any allegations of sexual abuse and sexual harassment to the Child Abuse Hotline included is the telephone number. Failure to report any sexually related incidents will result in disciplinary action up to and including termination and/or criminal prosecution. Also, contracted programs

are responsible for reporting according to their contract and the operating guidelines provided by DCSYF. Further, the policy identifies the means by which residents can report sexual abuse and sexual harassment to the Child Abuse Hotline and to third parties. It also identifies the means by which staff can also make a report.

Further contained in the policy is the procedures to ensure that staff and residents are trained in the detection, reporting, responses, and accessing victim services for sexual abuse and sexual harassment. Staff is provided training by the Professional Development Center and Ferris School for Boys (FSB).

According to the policy if sexual abuse and sexual harassment are detected, there will be an investigation which is prompted by a call to the Child Abuse Hotline. The Child Abuse Hotline would then contact the Institutional Abuse Unit (IA). For matters which could result in criminal action, Institutional Abuse and the Delaware State Police would conduct a joint investigation. Incidents that are not accepted by the Institutional Abuse Unit for investigation will receive an internal administrative review. The policy summarizes the medical procedures taken during an investigation of sexual abuse and sexual harassment. For allegations within an in-state contracted facility, they must report to the Child Abuse Hotline, law enforcement, and contractual compliance based on reportable events, and out-of-state procedures require that the facility comply with that state's child abuse and neglect agency.

DYRS Policy 2.13.IV addresses the response to sexual abuse and sexual harassment. In secure care, there is an incident review team whose purpose is to review if the facility needs to change policy, procedure, identify motivation of incident, examination of area to determine if there were physical barriers which enabled abuse, staffing ratios, and the need for upgrade to monitoring technology. Findings of the team are to be reported to the division's management analyst. This section of the policy highlights the response to an instance of sexual abuse and sexual harassment, counseling services will be made available to residents. Moreover, residents are to be provided information to contact community agencies.

In accordance with DYRS Policy 2.13, all documents pertaining to allegations of sexual abuse and sexual harassment are to be distributed to all agency heads as well as the Management Data Analyst within 24 hours. The policy requires on a quarterly basis that a report be generated which ensures that outcome information is accurate and current. Yearly, an annual report will be available to the public through the website which will include findings and corrective action, comparison of data from the previous year, and an assessment of the progress in addressing sexual abuse and sexual harassment. This information may be redacted when necessary to protect the safety and security of a facility. All PREA related allegations and documentations shall be secured by the Management Data Analyst for 10 years.

115.311(b)
DYRS employs a Professional Standards Manager which entails the responsibilities of the PREA Coordinator (PC) for the entire agency. During the interview with the PREA Coordinator, it was stated that the responsibilities pertaining to PREA could be successfully executed. Embedded within the State of Delaware Employee Performance Plan for the Professional Standards Manager is the duties and responsibilities associated with being a PREA Coordinator. The document establishes the role of developing standards and mandates in

order to maintain compliance with PREA standards agency wide. According to the PREA Coordinator, there is nothing impeding the successful execution of these responsibilities. The position is afforded time and resources by DYRS. The position can be found in the Residents Rehabilitative Services Director's Office organizational chart, and the position is located within the second level of leadership in the agency.

115.311(c)
The PREA Compliance Manager (PCM) reports directly to the Superintendent at FSB. The PCM at FSB additionally serves in the capacity as the YRS Supervisor. According to the PCM, DYRS affords the position the necessary time and resources to successfully complete the requirements of the position. The position is designated on the facility's organizational chart, and the individual serves in the capacity of authority to be able to coordinate the facility's efforts to comply with the PREA standards.

DYRS has demonstrated that it has met the standard 115.311. The agency has a written comprehensive PREA policy which outlines the means of detection, prevention, and responding to incidents of sexual abuse and sexual harassment. Additionally, the policy contains the purpose, definitions, procedures, prevention, reporting, investigations, victim services, and data collection. DYRS employs both a PREA Coordinator which is agency wide as well as a PREA Compliance Manager which is facility specific. Both the PC and the PCM stated that they were both afforded adequate time and resources to successfully implement and comply with the PREA standards. Both positions were located on the agency's and facility's organizational charts, and both positions held the authority to facilitate the PREA standards in their capacity.

115.312	Contracting with other entities for the confinement of residents
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	DSCYF Operating Guidelines for Contracted Children and Family Programs and Services 5/1/2018 List of DYRS Residential Contracts with Facility's Contact Information, Population and Audit Status Revised 6/26/19 Interview Contract Manager 115.312(a) During the onsite audit, DYRS was found to be in contract with 22 residential facilities in which 13 of those residential facilities are required to adopt and comply with the mandates of the PREA standards. Established in the DSCYF Operating Guidelines for Contracted Children and Family Programs and Services is the requirements of the facilities to adopt and comply with the PREA guidelines. All thirteen facilities have completed at least the first and second cycle of PREA Audits. There were 9 contracts for residential confinement that were below the threshold of 51% of the population being juvenile justice, which in turn did not meet the requirement to adopt and comply with the PREA standards. 115.312(b) Within the DSCYF Operating Guidelines, there is a clause that states, In addition to "self-monitoring requirements" and submission to PREA state and federal audits, providers will allow DSCYF announced and 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. During the interview with the contract manager, it was found by the Auditor that onsite visits are made to facilities that are contracted for residential confinement. Additionally, DYRS requires that PREA audits are scheduled and once completed that DYRS is provided with the audit findings to include interim and final reports. It appears that there has been a diligent effort on the part of the Contract Manager to maintain all records of contracts and PREA related documentation. The data was readily available and maintained on an Excel Spreadsheet. Additionally, DYRS has demonstrated from the DSCYF Guidelines the contractor's obligation to adopt and comply with PREA standards. Also, the guidelines require that contract's for residential confinements allow for contract monitoring by DSCYF representatives. Further, based on the DSCYF guidelines obligating residential confinement contracts to adhere to the requirement of adopting and complying to the PREA standards, as well as the allowance of contract monitoring, the agency meets the standard 115.312.

115.313	Supervision and monitoring
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	FSB Workload Assessment (Staffing Plan) 5/1/19 Shift Schedules Ferris Leadership Meeting 4/24/19 Director Team Meeting Minutes 11-28-18 PREA Policy 2.13.IV.B.1 Interviews Random Staff Random Log Review Post Assignment Review Auditor Selected Random Footage of Unannounced and Announced Rounds 115.313(a) As mentioned in the DYRS PREA Policy 2.13, “It is the responsibility of the program administration and shift supervisors to maintain facility staff to resident ratio in accordance with individual facility policies.” In the case of FSB, the Workload Assessment is the staffing plan, which was completed on May 5, 2019. Detailed in the document are the shift, placement of staff, roles of staff, and the number of staff and supervisors. The daily particulars of the location and duties of staff is captured on the FSB Daily Post Assignments and summarized on the FSB Shift Briefing Worksheet. It appears from random observation of various post assignments and Shift Briefing Worksheets that the minimum ratio mandated by the PREA guidelines are significantly exceeded. Noted below is the workload assessment based on a full staff of 104 employees. The Auditor was advised during the onsite audit, that there were 91 staff members. A Shift Staffing 5 Supervisors 19 Youth Rehabilitative Counselors B Shift Staffing 4 Supervisors 25 Youth Rehabilitative Counselors/Treatment Specialist C Shift Staffing 2 Supervisors 10 Youth Rehabilitative Counselors/Treatment Specialist Administration Superintendent Assistant Superintendent 2 Program Managers 1 Substance Abuse Administrator 1 Casual Seasonal Adolescent Treatment Coordinator Management Analyst II Administrative Assistant

Operational Support Specialist
Food Service Director
Food Service Supervisor
9 Food Service Workers- 5 full time and 4 casual seasonal
Recreation Specialist Supervisor
Recreation Specialist
Administrative Specialist
Custodian casual seasonal
Volunteer Services Coordinator

The following information was obtained from the workload assessment (staffing plan). Relief factor is 1.67 in order staff one position for one year. Since the submission of the workload assessment thru the PREA Audit Questionnaire, there were 12 additional staff hired. At the time of the onsite audit, there were 91 employees.

According to the PREA Audit Questionnaire, the staffing plan was predicated on the average daily number of 18.
No judicial findings of inadequacy, Federal investigative agencies findings of inadequacy or any internal/external oversight bodies findings of inadequacy were detected by Auditor.
Since the last PREA audit in 2016, FSB has maintained 98 cameras. During the onsite tour and the monitoring of the central command center, it was noted that there were several locations that would benefit from video monitoring.

115.313(b)
During the random review of unit logs and post assignment reports, there were no indications of deviation from staffing plan. Additionally, interview with random staff and specialized staff revealed there were no occasions where there was a deviation from staffing plan. Additionally, FSB institutes the process of freezing employees, if necessary, to ensure the staffing plan is maintained. According to agency and facility leadership, there was no occasions of exigent circumstances.

115.313(c)
At the time of the onsite audit, FSB was not obligated by law or judicial consent decree to maintain staffing ratios of 1:8 during resident waking hours and 1:16 during youth sleeping hours. Both agency head, PC, and facility leadership confirmed that there were no existing obligating laws or judicial consent decree regarding staffing ratios. The Auditor searched public records to collaborate with interviews with agency head, PC, and facility leadership. It is evident upon review of the random daily post assignments and random unit logs that the FSB significantly exceeds the ratios for compliance with PREA standards. There were no documented exigent circumstances nor were there any reports during all interviews.

115.313(d)
Though DYRS was in the process of hiring a PC, the agency continued to comply with PREA standards by collaborating to discuss staffing plans with agency heads and facility leaders. This adherence is evident in several documented minutes.

115.313(e)
It is required within the DYRS Policy 2.13.IV.B.4 that supervisors and program managers

	conduct and document unannounced rounds to identify and deter sexual abuse and sexual harassment. This practice shall be implemented on all shifts and highlighted in the unit logbooks as it occurs. Additionally, staff is prohibited from alerting other staff members that the rounds are occurring unless it is related to the legitimate operational functions of the facility. Based on random review of logbooks, it was evident that announced and unannounced rounds were conducted frequently by supervisors, and many times they were highlighted. After requesting random video footage, it was apparent that in many cases the logs were signed, and rounds were satisfactory in nature. The Assistant Superintendent gave detailed instructions on the process to complete an unannounced PREA round. FSB meets the standard of 115.313 supervision and monitoring. The facility demonstrated that it operated from a staffing plan. There were no exigent circumstances which caused a deviation from the staffing plan in the last 12 months. The facility has significantly exceeded the PREA compliance of 1:8 ratio during waking hours and 1:16 ratio during sleeping hours. Currently, FSB has no existing laws or judicial consent decrees to maintain staffing ratios. Though DYRS was looking to replace the PC, the agency and facility continued to maintain compliance by having documented meetings regarding staff planning. There were consistent PREA unannounced rounds with highlighted follow-up in the log.

115.315	Limits to cross-gender viewing and searches
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Pre-Audit Questionnaire Interviews Random Staff Random Resident Agency Head PREA Coordinator PREA Compliance Manager Superintendent Training Coordinator PREA Policy 2.13 DYRS Policy 5.14 Random Review of Unit Logs Random Shift Summaries Onsite Tour Staff Training Material-Moss Group PowerPoint Presentation 115.315(a) DYRS Policy 5.14.IV.D.3 and DYRS Policy 2.20 both discuss resident searches at FSB. Within the policies are the specifics of types of searches, when searches are to be conducted, how to perform these searches, and who should conduct said searches. DYRS Policy 5.14.IV.D.3 does not specifically state searches are only in exigent circumstances, but in the DYRS Policy 2.20. IV.G.4, there is a specific clause which states that cross-gender searches are to be conducted only in exigent circumstances. Furthermore, DYRS Policy 5.14.IV.F cited that body cavity searches can only be performed by medical personnel in a hospital setting. There were no documented exigent circumstances at FSB in the past 12 months according to reviewed random unit logs, random shift summaries and interviews. Interviewed random and targeted resident confirmed that they were only searched by same sex staff, and interviewed random staff attested that they had not performed any cross-gender searches in the last 12 months. Medical staff interviewed stated that there was no cross-gender cavity searches within the past 12 months. 115.315(b) Elaborated further in DYRS Policy 2.20.IV.G.4 in the absence of an exigent circumstance cross-gender pat searches can not be performed on resident. According to reviewed documentation and interviews with random staff and resident, there was no instance of any non-exigent or exigent cross-gender cavity searches. 115.315(c) In an emergent situation that requires a cross-gender search, DYRS Policy 2.20.IV.G. states that following the emergency, written documentation must be completed to explain the exigent circumstance and include the resources and why the policy deviation was necessary. The documentation must be reviewed and approved by the program’s manager immediately following the emergency and submitted to the Deputy Director, Division PREA Coordinator and

the program's PREA Compliance Manager. According to the Agency Head, PC, PCM, and the Superintendent, there were no exigent circumstances in the past 12 months. In review of random logs and interviews with staff and residents, there were no exigent circumstances in the past 12 months that would have resulted in cross-gender strip searches, cross-gender visual body cavity searches, or cross-gender pat searches at FSB.

115.315(d)
To ensure that residents are afforded the opportunity to shower, perform bodily functions, and change clothing without non-medical staff of the opposite gender viewing their breasts, buttocks or genitalia, DYRS implemented procedures and Policy 2.13.IV.B.5. The policy states that staff of the opposite gender specifically female staff at FSB, must alert residents announcing their gender to ensure the residents, requiring privacy, has ample notice/time. During the onsite tour of FSB, the Auditor observed posters at the entrance of all residential living units that stated the procedure to enter the unit. Also, resident confirmed during interviews that this practice was adhered to by all female staff. During staff interviews, it was stated by all staff that the practice of knocking and announcing by female staff was the procedure for entering living units at FSB. During time in the Central Command, the Auditor had an opportunity to verify that residents could not be viewed by video monitoring that residents could not be viewed in either bathrooms or rooms.

115.315(e)
Through policy, FSB prohibits staff from searching or physically examining a transgender or intersex resident to solely determine resident's genital status. Stated in DYRS Policy 2.20.IV.G.2, LGBQTI resident will not be physically searched in a manner that is humiliating or degrading or for the sole purpose of determining the resident's physical anatomy. If a resident's gender is unknown, it will be determined during conversations with the resident, by reviewing medical records, or as a part of a broader medical examination conducted in private by a medical practitioner. At the time of the onsite visit, there were no residents identified by the PREA risk assessment as transgender or intersex for the Auditor to confirm that they had not been searched solely for the purpose of determining the resident's genital status. In speaking with the Medical and Mental Health Practitioners, the Auditor determined that in past cases of residents that identified as transgender or intersex in DYRS operated facilities that information regarding genital status was disclosed during the PREA risk assessment, which is administered by the medical and mental health office. According to unit logs and interviews, there were no searches conducted for the sole purpose of determining the genital status of either transgender or intersex resident.

115.31(f)
Utilizing the material provided by the Moss Group, all custody staff are provided training on how to conduct cross-gender pat down searches and searches of transgender and intersex resident in a manner which is both professional and the least intrusive. Both the Training Coordinator and the PREA Coordinator confirmed that 100% of staff had received initial training as well as follow up training. The Auditor reviewed training records to confirm that staff had received necessary trainings. Also, random staff disclosed during interviews that they had received recent refresher training on all searches. During interviews with random staff, they were either asked to explain a cross-gender search or a search of a transgender or intersex resident. Staff was able to complete this task satisfactorily. Moreover, DYRS had recently reviewed Policy DYRS 2.20 and Policy DYRS 5.14 on 3/12/19.

	For PREA standard 115.315 limits to cross-gender viewing and searches, DYRS has demonstrated meeting the standard. FSB has not conducted any non-exigent cross-gender strip searches, cross-gender visual body searches, nor cross-gender pat-down searches in the past 12 months. There have been no exigent circumstances which necessitated any need to conduct any cross-gender searches in the past 12 months. This has been confirmed through documentation review and interviews. The facility does maintain a policy that prohibits cross-gender searches, cross-gender visual body cavity searches, and cross-gender pat-down searches. Within the policy, the facility must document all instances of cross-gender searches as well as report to agency heads, PREA Coordinator, PREA Compliance Manager, and the Superintendent. The facility has implemented policies and procedures to ensure residents are able to shower, perform bodily function, and change clothing without opposite gender viewing breast, buttocks or genitalia. Additionally, the facility has demonstrated adherence to knocking and announcing by opposite gender prior to entering living units. Also, this practice is quoted in policy. Further, confirmed by Auditor, staff are unable to view through video monitoring equipment residents in either the shower or rooms. DYRS established a policy that prohibits the search of transgender and intersex residents solely to determine genital status. The facility has provided training utilizing the Moss Group's training material. The facility has documented completion of training and continued to provide refresher training.

115.316	Residents with disabilities and residents who are limited English proficient
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Interview Superintendent PCM Principal Random Staff Government Support Services Contract DYRS Policy 2.13.IV.B.6 DSCYF Policy 118 List of Translation Providers Interview with 4 Resident with Disabilities Student Handbook-Spanish PREA Brochure-Spanish 115.316(a) When it comes to the dissemination of information, it is established in DYRS Policy 2.13.IV.B.6 that each facility is to ensure that residents with disabilities of any kind (visual, hearing, limited English proficiency, etc.), are given the same information to prevent, detect, and respond to sexual abuse and sexual harassment in a format supportive of the disability. DYRS has an existing contract with Government Support Services to provide translation and interpretation services. During the onsite tour, the Auditor observed posters and the audit posting in Spanish displayed throughout the housing units and other high traffic areas in the facility. The Auditor was given details in the Intake area of the communication services that a deaf resident would be provided. American Sign Language services were listed amongst the services provided by vendors. In reviewing the contract with Government Support Services, there were 5 vendors that provided American Sign Language, and 15 vendors that provided language interpretive and translation services. For visually impaired residents, the PREA training materials can be formatted to a larger font. According to the Principal, there were no residents that were identified as significantly visually impaired or deaf in the last 12 months. In order to access FSB's ability to provide PREA information to residents with learning disabilities, the Auditor interviewed the Principal. The Principal identified residents who were classified as learning disabled, and those that needed special education services. The Principal explained that residents having difficulty reading were aided in the comprehension of the FSB Student Handbook and PREA training material by education staff, YRCs, and YRTs. The Auditor chose 4 of the residents identified as cognitively impaired or learning disabled to be interviewed. It was found that all 4 of the residents understood FSB's zero tolerance for sexual abuse and sexual harassment, and the residents demonstrated proficiency in the procedures in how and who to report any instances of sexual harassment and sexual abuse. Additionally, they were aware of the means to report instances of sexual abuse and sexual harassment. 115.316(b) DYRS has an existing contract with Government Support Services to provide residents that

are limited English proficient with interpreters and translators in many different languages. This contract is provided to all state agencies, school districts, municipalities, volunteer fire companies, and political subdivisions. The agency does not vet these vendors for effectiveness, accuracy, impartiality, or use of specialized vocabulary. Through demographic studies that have been completed by the Delaware Department of Education, Spanish is the most prevalent second language spoken in Delaware. Both the FSB's Spanish version of the Student Handbook and the PREA Brochure were made available through the Pre-Audit Questionnaire. At the time of the on-site audit, there were no residents that were limited English proficient. According to the Superintendent, and the PCM, there were no residents that were limited English proficient in the last 12 months. Additionally, there were no cases documented in the Pre-Audit Questionnaire.

115.316(c)
In accordance with agency policy, only in exigent circumstances are residents permitted to provide translation and interpretive services. DSCYF Policy 118.IV.B.b.i states absent emergency circumstances when it is not possible to wait for telephonic interpretation assistance, Department personnel shall not use children, family members, friends, neighbors, or service recipients to provide language assistance services in any context. According to interviews of random staff, there were no residents within the last 12 months identified as limited English proficient.

DSCYF has demonstrated meeting standard 115.316 in the ability to provide disabled residents and limited English proficient residents equal opportunity to benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment. Specifically, disabled residents have means to access American Sign Language if they are deaf. Residents that have limited vision or blindness can be provided reformatted PREA training material. For those residents that have limited reading ability, the PREA training material is written simplistically. Based on the Auditor's experience as an educator, the PREA training material is on the 4th grade reading level. The Principal stated that students that have difficulty reading are assisted by staff to understand the material.

Four (4) residents that were identified by the Principal as learning disabled were selected by the Auditor to be interviewed in order to confirm that disabled residents were provided the opportunity to benefit from the agency's effort to prevent, detect, and respond to sexual abuse and sexual harassment. The residents were able to explain the FSB zero-tolerance on sexual abuse and sexual harassment and the various means to report in the case of sexual abuse or sexual harassment.

Additionally, DSCYF has an established procedure for limited English proficient residents a means of benefitting from the agency's efforts in preventing, detecting, and responding to sexual abuse and sexual harassment. The agency has an existing contract that provides onsite, written, and telephonic interpretation and translation services. Since Spanish was found to be the second language spoken in Delaware, the FSB is proactive by having both the Spanish version of the Student Handbook and the PREA Brochure readily available at FSB. Lastly, DSCYF has demonstrated through policy that resident interpreters and translators are prohibited unless there is an emergency which prevents the ability to access the vendors provided.

115.317	Hiring and promotion decisions
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	DYRS Policy 2.13.III DSCYF Policy 318.IV.2 DSCYF Policy 318.XI.A-E DSCYF Policy 313 DYRS Policy 2.2.IV.B.1.a Human Resource Applicant Statement Review of Random Staff Files Review of Termination Files PREA Policy 2.13 Attachment F (PREA Acknowledge Form) Interviews Human Resource Representative Criminal Background Unit 2 Volunteers 115.317(a) Within the DYRS Policy 2.13, staff is defined as any Department employee, volunteer, contractor, official visitor, or other agency representative excluding family, friends, and other visitors. When interpreting policy regarding PREA mandates, the agency's policies and procedures pertain to all listed individuals. DSCYF Policy 318.XI.A-E was specifically established to comply with the PREA mandates that address the hiring and promotion of staff. All individuals that provide services to residents are to have criminal background checks, which are to be completed by the State Bureau of Identification (SBI), the Federal Bureau of Investigation and the Delaware State Child Abuse Registry. In DSCYF Policy 3.18 further details Department hiring managers are expected to conduct pre-employment checks as part of the employee selection process. Specifically in DSCYF Policy 3.18IV.E, it is stated if the background check results disclose that a person had been convicted or the employer verifies information of a sexual offense the Criminal History Unit may conduct a Sex Offender Registry check for further information. Lastly in policy 318.XI.A-C, a PREA Check is required for all candidates being considered for all positions in DYRS, including community programs and secure care. All candidates are required to sign a Human Resource Applicant Statement. By signing this statement perspective employees are attesting that they have not participated in the following: 1. Involvement in sexual abuse within facilities. 2. Engagement of sexual activity in the community. 3. Being civilly or administratively adjudicated of any of the above activities. A PREA Check is obtained by the Hiring Manager reviewing the candidate's resume/application to identify prior employment in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (defined as any residential facility/program that houses juveniles (pre-trial and post adjudicated), seniors disabled or chronically ill or handicapped) and then contacting prior employer to verify the information on

the PREA Statement. The Human Resources Department conducts the PREA Check. The PREA Check results must be assessed in accordance with the law and policies. If there is negative, inaccurate, or omitted information on a PREA Check, the selected candidate may be ineligible for employment or continued employment with DSCYF.

Once an employee is hired, there is a requirement annually to complete the PREA Acknowledgement Form. By signing this form staff is acknowledging that they have not participated in the following:

1. Involvement in sexual abuse within facilities.
2. Engagement of sexual activity in the community.
3. Being civilly or administratively adjudicated of any of the above activities.
4. Being investigated for or engaged in sexual assault or sexual harassment.

115.317(b)
As stated, prior, all Department employees, volunteers, contractors, official visitors, or other agency representatives excluding family, friends, and other visitors are considered staff within the scope of DYRS Policy 2.13, which pertains to PREA mandates. DSCYF Policy 318.XI.A-E specifically includes volunteers who may have contact with residents. The same hiring and promotional practices are required. Two(2) volunteers were contacted by telephone, both stated that they were required to go through all criminal background checks that agency employees were required to complete. The Human Resource Representative confirmed that volunteers are required to complete all criminal background checks prior to volunteering services.

115.317(c)
Within DSCYF Policy 313.III, there is a referral to Title 31, Chapter 3, Section 309 of the Delaware Code. The code requires that 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 access or unsupervised direct access to children and/or adolescents under the age of 18. This code also applies to Child-Serving Entities. Also, the code mentions the checks are completed by the Department's Criminal History Unit prior to employment or during conditional periods of employment. The Unit will make the determination based on established criteria whether a prospective employee or current employee is eligible or ineligible or prohibited from employment.

Recorded on the Pre-Audit Questionnaire were 24 persons hired in the past 12 months that were required to complete the PREA Background Check, which included criminal checks completed by the State Bureau of Investigations, Federal Bureau of Investigations, Child Abuse Registry, and DELJIS.
In addition, DSCYF Policy 318.V require pre-employment reference checks to obtain the following information:

1. Involvement in sexual abuse within facilities.
2. Engagement of sexual activity in the community.
3. Being civilly or administratively adjudicated of any of the above activities.
4. Being investigated for or engaged in sexual assault or sexual harassment.

Information provided to the Human Resource Department by employee may be verified by contacting current and former employees.

During the interview with the Criminal Background Unit, there was further discussion of the process by which the DSCYF maintains knowledge of employee's criminal infractions beyond employees disclosing the infraction. The Auditor was told that to obtain employee's criminal infraction status, the Criminal History Unit employs the use of DELJIS, the Delaware Criminal Justice Information System. If an employee of DSCYF commits a crime, they are flagged by DELJIS. During the interview with a representative from the Human Resource Department, it was found that DELJIS only captures criminal infractions within the state of Delaware.

115.317(d)
As stated, prior, all Department employees, volunteers, contractors, official visitors, or other agency representatives excluding family, friends, and other visitors are considered staff within the scope of DYRS Policy 2.13, which pertains to PREA mandates. DSCYF Policy 318.XI.A-E includes volunteers who may have contact with residents. The same hiring and promotional practices are required. According to the Pre-Audit Questionnaire, there were 18 criminal background checks completed for contractors at FSB in the last twelve months.

115.317(e)
DSCYF utilizes DELJIS to maintain the criminal background records checks of employees. Unfortunately, this system does not capture any charges other than the offenses in the state of Delaware. During the interview with the Human Resource Representatives the systems capabilities were discussed. DSCYF Policy 313.VI.A does not specifically put a timeframe of every 5 years on the criminal background check. The Auditor ascertains from interviews with the Agency Head, Criminal Background Unit, and the Human Resource the lack of a timeframe is due to the design of the information system that constantly captures or updates information in the event of a criminal infraction by employees. Since DELJIS does not collect offenses outside of Delaware, the PREA coordinator completed the FBI criminal background checks for the past 5 years. It has been discussed by the Agency Head that there is a possibility that DELJIS will have the ability to capture offenses outside of Delaware in the future.

115.317(f)
Coinciding with employees' annual evaluations and promotions, employees are required to sign the PREA Acknowledgement Form. Signing of this form constitutes the continuing affirmation of duty to disclose any misconduct. The PREA Acknowledgement Form is an attachment to DYRS Policy 2.13. During the onsite audit, the Auditor located these forms in all 10 of the employees' files reviewed.

115.317(g)
During the interview with the Human Resource Representative, it was disclosed in the instance of an omission regarding conduct or false information is provided by an employee it is considered grounds for termination. Additionally, DSCYF Policy 3.13.VIII.a states that employees have an affirmative duty to immediately inform their supervisor or manager of any criminal convictions, arrests, investigations or indictment of themselves or any investigation of child abuse/neglect or entry into the Child Protection Registry. Failure to immediately notify supervisor/manager of any of the above, including final disposition, could result in discipline,

up to and including termination. In DYRS Policy 2.2.IV.B.1.a, the same language is reiterated pertaining to the responsibility of employees to inform supervisor of any allegations or convictions of a criminal nature including child abuse/neglect.

115.317(h)
Upon receipt of a request for information regarding a former employee by an institutional employer, DSCYF does disclose that information with the written consent of the former employee. During the interview with the Human Resource Employee, it was confirmed. DSCYF Policy 313 requires that designated Department employees are to provide a Service Letter request. Referenced is the State policy which requires that background checks be provided as outlined in the Guidelines for Reference Checks, Human Resources Management, State Labor Relations & Employment Practices. Delaware has laws that protect employers who disclose accurate, documented, and truthful information about current or former employees.

FSB meets the PREA standard 115.317 hiring and promotion decisions. The facility was found in compliance with the 5-year background criminal checks. The DSCYF prohibits the hiring and the promotion of individuals who have engaged in sexual abuse in confinement; engaging in sexual activity in the community facilitated by force, threats, coercion or victim did not consent or unable to consent; or has been civilly or administratively adjudicated in activity described. Secondly, the agency policy requires consideration of any incidents of sexual harassment in the decision to hire or promote all employees, which includes contractors and volunteers. Additionally, the agency's hiring practices highlighted in policy includes the completion of SBI and FBI criminal background checks and a check of the Child Abuse Registry. Additionally, DSCFY also may contact all institutional employers for information pertaining to substantiated allegations of sexual abuse or resignation during a pending investigation of an allegation of sexual abuse. Prospective employees are required to attest on the Human Resource Applicant Statement they have not been involved in sexual abuse in confinement and in the community, nor have they been civilly or administratively adjudicated of sexual abuse. Per policy in the instances of material omissions regarding misconduct or false information is considered grounds for termination by DSCYF. When requested, the agency provides information to an institutional employer regarding substantiated allegations of sexual abuse or sexual harassment involving a former employee.

115.318	Upgrades to facilities and technologies
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Director's Meeting Minutes Interview Agency Head PREA Compliance Manager Superintendent Onsite Tour FSB Technology Plan 115.318(a) Since the last PREA audit in 2016, DSCYF has not acquired any new facility or made any substantial expansion or modification to FSB. In review of the Director's Meeting Minutes, there was no notation of any plans for a new facility nor substantial expansion or modification to existing facilities. When the Auditor inquired of the Agency Head, it was confirmed that DSCYF did not acquire a new facility nor were there any plans for a new facility. Additionally, it was disclosed there were no substantial expansions or modifications at FSB. During the onsite tour of the facility, the Auditor observed that the Southern housing cluster was closed. It appeared that the area was being cleaned and prepped for painting. 115.318(b) FSB has not upgraded the electronic monitoring system since the last audit in 2016. At the time of the last PREA audit it was documented that the facility maintained 98 cameras, and the number of cameras remain the same. During the last audit, there was documentation of deficiencies and blind spots in capturing footage at FSB. During the 2019 onsite audit, FSB has several areas that need to be addressed due to the facility maximizing the usage of the physical property to add more activities for the residents at the facility. Due to the lack of cameras, the Auditor was unable to view the football field, the outside eating area for the residents, nor the garden. When these areas are in use, there are numerous custody staff positioned in the area. It was further confirmed by the Agency Head, the Superintendent, and the random staff that the practice of positioning staff was utilized in these specific areas. The Auditor reviewed cameras from the command center, and all cameras were found to be operational. During the Superintendent interview, there was a discussion regarding the technology plan for the facility. It was disclosed that there is a plan to increase and upgrade the cameras at the facility. The Auditor was provided the plan onsite. The technology plan would provide coverage for the areas that are considered deficient as well as improve visibility with the planned camera upgrades. The Superintendent felt that the upgrades would exponentially improve the overall operation of the facility and enhance the facility's ability to prevent, detect, and respond to incidents of sexual abuse and sexual harassment at FSB. FSB's sight lines and lighting were satisfactory. The facility's video electronic monitoring does not capture resident toileting or showering. The video footage is maintained. DSCYF meets the standard of 115.318 upgrades to facilities and technologies. According to Agency Head the facility has not acquired any new facilities or made a substantial expansion or modification since the last PREA audit in 2016. The technology plan for additional cameras

	and upgrades does take into consideration the overall improvement to operation and the agency's ability to prevent, detect, and respond to incidents of sexual abuse and sexual harassment.

115.321	Evidence protocol and forensic medical examinations
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Interviews Institutional Abuse FSB PREA Investigator (via telephone) Delaware State Police Representative (via telephone) Random Staff Christiana Care Sane Coordinator (via telephone) PREA Coordinator DSCYF Child Sexual Abuse Protocol Affirmation of Compliance with Forensic Examinations Standards for Sexual Assaults-Christiana Care Hospital DYRS Policy 2.13.D.1-2.b. Pre-Audit Questionnaire Memorandum of Agreement Between the Division of Residents Rehabilitative Services and Survivors of Abuse in Recovery, Inc. Affirmation of Compliance with Investigative Standards for Sexual Assaults 115.321(a) During the onsite audit, the FSB PREA Investigator was employed temporarily at another facility on the DSCYF campus. The Superintendent corroborated that the FSB PREA Investigator was going to be returning to that facility. Further, it was stated that the FSB Investigator would be made available if the need arose. FSB has three investigative entities which include the internal FSB PREA Investigator (PI), the DSCYF Institutional Abuse Unit (IA), and the Delaware State Police (DSP). During the interviews with both PI and IA, the following was confirmed. Administrative sexual abuse investigations are handled internally by the PI and IA. When IA determines that a sexual abuse allegation is of a criminal nature the investigation is turned over to the DSP with the assistance of IA. All allegations of sexual abuse and sexual harassment must be called into the Child Abuse Hotline. From the hotline, the allegation is dispatched to the DSCYF Institutional Abuse Investigators who determine if the case meets the threshold to investigate criminally. If the decision is made by IA to have the incident of sexual abuse or sexual harassment investigated administratively, the investigation is returned to the PI and the administrators of the facility. The interviews with IA and PI both are further verified in DYRS Policy 2.13.D.1-2.b. The policy outlines that matters of sexual abuse and sexual harassment are to be reported to the Child Abuse Hotline. In the case of matters that could result in criminal action, IA will conduct a joint investigation with the DSP. Also, DSCYF requires the Child Abuse Protocol be utilized in conducting investigations of allegations of sexual abuse and sexual harassment. The protocol defines civil offenses such as exploitation, pornography, sexual abuse, torture, and verbal innuendo. Criminal offenses are defined as indecent exposure, Incest, unlawful sexual contact, rape, sexual extortion, trafficking, child pornography, solicitation of a child, sexual relations in detention facility, violation of privacy, and lewdness. The protocol includes the guidelines for mandatory

reporting. Further, the protocol outlines the procedures used during investigations. The protocol makes mention of the PREA mandate pertaining to the ability for residents to privately report sexual abuse and sexual harassment by another child or staff member. Also, it documented that DYRS staff must make an immediate report to the appropriate law enforcement jurisdiction for allegations of sexual abuse involving children in state operated and contracted facilities (includes child on child and staff on child).

115.321(b)
The DSCYF Child Sexual Abuse Protocol is based on the U.S Department of Justice's Office of Violence Against Women publication, "A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents." Within the DSCYF Protocol, there is a list of specific investigative actions that are age appropriate. Additionally, the list provides the responsible agency for each specific investigative action. One of the actions clearly states that the DYRS/Contractors are to adhere to the Prison Rape Elimination Act-Juvenile Facility Standards. Also, listed is the collection of evidence as well as photo and video documentation of crime scene. Another item is the collection of sexual assault evidence. Located in the document is the Minimal Facts Interview Protocol for First Responders which includes establishing rapport, questioning to get the what, where, who, when, and any witnesses or other victims.

Questioning of Random Staff by the Auditor resulted in staff being fairly knowledgeable of the investigative entities which are responsible for the allegations of sexual abuse and sexual harassment at FSB.

During a telephone conference with the Delaware State Police Representative, it was further validated the utilization of the Child Sexual Abuse Protocol and was indeed based on the "National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents." It was also added that the DSP is sensitive to the specifics of investigating sexual abuse involving children and adolescents. The Affirmation of Compliance with Investigative Standards for Sexual Assaults specifically speaks to the agreement between DSCYF and the DSP in the protocols utilized in the state operated facilities.

115.321(c)
Residents that experience sexual abuse at FSB would access forensic medical examinations at Christiana Care Hospital (CCH). Forensic examinations are not provided at FSB. During a telephone interview with the Christiana Care SANE Coordinator, it was stated that Sexual Assault Nurse Examiners (SANE) are staffed around the clock at the hospital. There are over 20 certified SANE/SAFE at the hospital. In the instance there were no SANEs available, the hospital has qualified medical practitioners that could perform a forensic medical examination. Additionally, the affirmation reads that in the absence of a SANE that is certified to work with children, Christiana Care Hospital would transfer the child to A.I. Dupont Hospital. The Affirmation of Compliance with Forensic Examinations Standards for Sexual Assault documents the procedures as well as the services provided to residents who experience sexual abuse. The affirmation specifically states that residents are to receive services without financial cost to the victim.

Additionally, DYRS Policy 2.13.IV.D.2 cites that medical personnel gathering physical evidence or engaged in legitimate medical treatment while investigating prison rape will do so in a

hospital setting. All medical interventions for PREA related incidents in New Castle County will be referred to A.I. Dupont or Christiana Care Hospital. It should be mentioned that the affirmation is only with CCH.

According to the Pre-Audit Questionnaire, there were no forensic medical exams performed in the past 12 months by a SANE/SAFE or qualified medical practitioner, and it was further collaborated with the Medical Practitioner at FSB. The SANE/SAFE Coordinator stated that there was no knowledge of any forensic exams from FSB conducted.

115.321(d)
According to DYRS 2.13.IV.E., FSB would make counseling services available to all residents involved in non-consensual sex, abusive sexual contact, or sexual harassment. Those residents evaluated and treated at Christiana Care Hospital would receive counseling services at the hospital. While the residents remain in custody at FSB or as a follow-up, the residents would receive counseling from the Division of Prevention and Behavioral Health (DPBH) psychologist or the DYRS contracted medical provider. Upon release, the residents would be made aware of community agencies, addresses and contact numbers of mental health practitioners that provide emotional support services related to sexual abuse. Also, this information is found in the PREA brochures that are in different areas within the facility. Lastly, the Division shall enter into a Memorandum of Agreement with one or more such agencies to ensure a statewide service agreement. As a result of the DYRS policy, A Memorandum of Agreement Between the Division of Youth Rehabilitative Services and Survivors of Abuse in Recovery, Inc. was established. The documented agreement was renewed on March 11, 2019.

According to the random review of PREA Risk Assessments by the Auditor, there were no residents that reported sexual abuse while at FSB. Also, the Random Residents interviewed stated that they had not reported sexual abuse. Medical and Mental Health Practitioners did not disclose any allegations of sexual abuse, sexual harassment, or retaliation of any resident.

115.321(e)
The Memorandum of Agreement Between the Division of Youth Rehabilitative Services and Survivors of Abuse in Recovery, Inc., SOAR specifically documents that residents will be provided direct mental health care to residents in the physical custody of a DYRS residential program who have been the victim of sexual abuse. In addition, direct mental health services including crisis intervention, emotional support and information or referrals will be provided. During another audit at a DYRS facility, the Auditor sought further clarification if the clause in the memorandum included support during the forensic medical examination and investigatory interviews. The SOAR Executive Director clarified that if the residents requested support during the examination and investigatory interviews a representative would be made available.

115.321(f)
Administrative sexual abuse allegations are investigated by IA. Stated in the DSCYF Sexual Abuse Protocols the IA investigators are required to adhere to the procedures outlined. Listed within the document are several mandates. If it is determined the offense is criminal, IA is to investigate jointly with DSP. IA is to collect evidence both DNA and any available physical evidence including available electronic monitoring data. Consideration for victims of sexual abuse to receive access to forensic medical examinations. Alleged victims, perpetrators, and

witnesses are to be interviewed. The investigation does not solely terminate if a victim recants. According to the protocol, a documented report of the investigation is to be made available.

During the interview with both IA investigators, they further confirmed that the Child Sexual Abuse Protocol would be followed in the instance of sexual abuse at FSB. Both IA investigators explained that they were responsible for the collection of DNA and other physical evidence. Additionally, they stated that if a victim recants that the investigation does not terminate solely because of the recantation.

115.321(g)
DSCYF and DYRS are responsible for the administrative investigations of allegations of sexual abuse, however, matters of criminal allegations of sexual abuse are the responsibility of the Delaware State Police (DSP). Existing between the Division of Youth Rehabilitative Services and the Delaware State Police is the Affirmation of Compliance with Investigative Standards for Sexual Assaults. Within the affirmation, DSP is affirming the responsibility of investigating criminal allegations of sexual abuse in the DSCYF state operated facilities. DSP will follow a uniform evidence protocol. Secondly, all victims of sexual assault have access to forensic medical examinations. DSP is to gather and preserve direct and circumstantial evidence including any available physical and DNA evidence and any available electronic monitoring data; shall interview alleged victims, suspected perpetrators, and witnesses as well as review prior complaints and reports of sexual abuse involving suspected perpetrator. The investigation will not terminate solely because the source of the allegation recants the allegation. Criminal reports are to be documented in a written report that contains a thorough description of physical, testimonial, documentary evidence and attached copies of all documentary evidence where feasible. Lastly, the curriculum is reviewed at a frequency to ensure compliance with national standards/concerns. Understanding and compliance to the affirmation was further confirmed with the DSP Representative by telephone.

For the standard of 115.321 evidence protocol and forensic medical examinations, DSCYF meets compliance. The agency follows the Child Sexual Abuse Protocol which complies with PREA mandates. The protocol is developmentally appropriate, and it is adapted from the “National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents.” DSCYF requires that both IA and DSP follow uniform protocols when investigating allegations of sexual abuse at DSCYF state operated facilities. Additionally, DSCYF ensures that residents are provided victims access to forensic medical examinations by SANE at the CCH, and if a SANE certified with children is not available the established affirmation allows for the resident to be transferred to A.I. Dupont. The agency has documented its efforts to provide a SANE through the Affirmation of Compliance with Forensic Examinations Standards for Sexual Assaults with CCH. Also, DSCYF has provided documentation of the agreement to make available victim advocacy through the Memorandum of Agreement Between the Division of Youth Rehabilitative Services and Survivors of Abuse in Recovery (SOAR), Inc. Both in the affirmation and interview with the Executive Director of SOAR, SOAR will provide the victim upon request support during the forensic medical examination process and the investigatory interviews. The victim will also be provided emotional support, crisis intervention, information, and referrals. If SOAR is not available, DYRS has documented in DYRS 2.13.IV.E. that the agency would provide victim advocacy through DPBH or the qualified medical practitioner.

115.322	Policies to ensure referrals of allegations for investigations
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Interviews Agency Head Superintendent PREA Coordinator (PC) FSB PREA Investigator (PI) (via Telephone) DSCYF Institutional Abuse Investigators (AI) Delaware State Police Representative (via telephone) DYRS Policy 2.13 Attachment A Attachment B Attachment C Attachment D DYRS Policy 2.2 Reportable Events Coordinated Plan Child Sexual Abuse Protocol https://Kids.delaware.gov/yrs/prea-reports.shtml 115.322(a) DYRS has two policies to ensure that an administrative and criminal investigation are completed for all allegations of sexual abuse and sexual harassment. DYRS Policy 2.13 was established to specifically meet the mandates required in the PREA standards. Referenced in the clause pertaining to investigations in secure care, all matters that involve the allegation of any sexual contact as defined in this policy will be reported to the Child Abuse Hotline. It is further cited for matters which could result in criminal action, Institutional Abuse will conduct a joint investigation with the Delaware State Police. In the event of staff misconduct, the policy states staff sexual misconduct will be reported to the Child Abuse Hotline to address all matters involving staff actions that may not be of criminal nature, yet still violates PREA, such as conversations or correspondence of a romantic or sexual nature. According to policy, allegations that are not accepted by IA receive an internal administrative review. For those allegations which are investigated by IA and DSP, the program administrator is notified of the outcome of the case by the notification form, and the resident will be notified of the outcome of the allegations. Attached on DYRS Policy 2.13 is 4 documents that are completed in the event of sexual abuse or sexual harassment. Find below the description of each attachment. Attachment A- Sexual Violence Incident Form is completed for all allegations of sexual abuse and sexual harassment. The form identifies date, time, facility, location, victims, perpetrators, and the type of sexual violence. Attachment B- Sexual Violence Form is completed for each victim. The form identifies victim, demographics of victim, physical injury sustained, status of medical treatment, and reporter(s) of incident.

Attachment C- Sexual Violence Form is completed for each perpetrator resident on resident. The nature of the incident, and sanctions.

Attachment D- Sexual Violence Form is completed for adult perpetrator adult on resident. The nature of incident, employment status, job description, and sanctions imposed.

The second policy that ensures that investigations are completed is DYRS Policy 2.12. The purpose of DYRS Policy 2.12 Reportable Events is to ensure that information regarding significant events is addressed effectively and timely. The policy listed the critical and non-critical incidents that must be reported and documented. There were two incidents that were PREA related that were identified in the policy. One of the critical reportable events identified was in the event of institutional abuse or child abuse resulting in the arrest of an employee or provider in a Department operated or contracted program for the maltreatment of a child active with the Department. Further in the policy, an incident listed located under non-critical reportable events was the allegations of institutional abuse.

Both the Agency Head and Superintendent were familiar with the policy and procedure in completing investigations of sexual abuse and sexual harassment. The Superintendent was able to detail the steps necessary for allegations of sexual abuse and sexual harassment noting they are investigated as well as reported to both the Agency Head, Superintendent, PREA Coordinator, and PREA Compliance Manager. The FSB PREA Investigator also seemed to be knowledgeable of the procedures required to comply with the PREA mandates.

In the last 12 months, FSB has no allegations of sexual abuse, sexual harassment, or retaliation. The Auditor did review the allegation that occurred during the last PREA audit at FSB, and it was determined that the allegation was handled in accordance with the PREA standards. The Auditor also reviewed all terminations and resignations in lieu of termination for the last 12 months to ensure there were no allegations of sexual abuse and sexual harassment at FSB.

115.322(b)
Legal authority of the Delaware State Police (DSP) to conduct criminal investigations at DYRS state operated facilities is located in DYRS Policy 2.13.IV.D.1.c. Specifically stated for matters which could result in a criminal action, Institutional Abuse will conduct a joint investigation with the DSP. The Auditor interviewed a Delaware State Police Representative who confirmed that in allegations of sexual abuse which could result in a criminal action the DSP has the legal authority to conduct the criminal investigations at FSB. The legal authority to conduct criminal investigations is found in the Child Sexual Abuse Protocols. On page 83 of the Child Sexual Abuse Protocol, it is stated that DYRS staff and its contractors must also make an immediate report to the appropriate law enforcement jurisdiction for allegations of sexual abuse involving children in state operated or contracted residential facilities.

Information pertaining to the Prison Rape Elimination Act including the established PREA policy, DYRS Policy 2.13 is located at https://Kids.delaware.gov/yrs/prea-reports.shtml.

Investigations of allegations of sexual abuse and sexual harassment including administrative and criminal investigations are documented on the attachments of DYRS Policy 2.13.

115.322(c)
DSP responsibilities which can be found in 115.322(a) are outlined in the DYRS Policy 2.13IV.D.1.b-h. The entire policy is located on the DSCYF website https://Kids.delaware.gov/yrs/prea-reports.shtml.

115.322(d)
The documentation governing the conduct of administrative and criminal investigations of sexual abuse and sexual harassment in DSCYF operated state juvenile facilities is in the Child Sexual Abuse Protocols coupled with the DYRS Policy 2.13.

115.322(e)
According to the Agency Head DSP is the only outside agency responsible for conducting criminal investigations of allegations of sexual abuse and sexual harassment at the DYRS state operated juvenile facilities specifically FSB. Additional online research by Auditor revealed there was no Department of Justice component responsible for investigating allegations of sexual abuse and sexual harassment. Additionally, there was no litigation located pertaining to sexual harassment, sexual abuse, or retaliation.

DYRS meets compliance 115.322 policies to ensure referrals of allegations for investigations. There are two DYRS policies that address the protocols for criminal and administrative investigations. Attached to DYRS Policy 2.13 are 4 forms utilized to conduct and document investigations. Further, the agency's website contains the PREA related policy and the responsibilities of DSP.

115.331	Employee training
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	DYRS Policy 2.13 DYRS Policy 2.20 Affirmation of Compliance with Forensic Examinations Standards for Sexual Assaults Certificates of Medical Staff and Mental Health Practitioners PREA Training Material Staff Training Records DYRS New Employee Training Interviews Random Staff Medical Practitioner Mental Health Practitioner Agency Training Coordinator Pre-Audit Questionnaire 115.331(a) DYRS trains all staff in accordance with DYRS Policy 2.13. The training clause states that all department staff working directly with or monitoring programs/services of residents in secure care and community services must receive PREA training. Training for all staff is reiterated in DYRS Policy 2.20.IV.J, which states that all staff shall receive training on how to communicate effectively and professionally with residents, including LGBQTI or gender non-conforming residents. Trainings can be either instructor lead or online. However, new employee orientation is instructor lead, and refreshers can be either instructor lead or online. Presently, the DYRS utilizes the training from the Moss Group. During the interview with the Agency Training Coordinator, Auditor was advised of the plan to implement the training created by Just Detention International. The training is delivered through PowerPoint Presentation. Detailed in the presentation is material referencing the DYRS zero-tolerance policy for sexual abuse and sexual harassment. Below is the outline of the slides utilized for refresher training and new employee training. DSCYF PREA Training PowerPoint Presentation Includes the following: Subject Matter Slide Numbers Prevention, Detection, Reporting and Response to Policies and Procedures 89-118 Right of Residents to be Free from Sexual Abuse and Sexual Harassment 16-23 Residents and Employees to be Free from Retaliation for Reporting Sexual Abuse and Sexual Harassment Module 2 Dynamics of Sexual Abuse and Sexual Harassment in Juvenile Facilities 24 Common Reactions of Juvenile Victims of Sexual Abuse and Sexual Harassment 56-60 How to Detect and Respond to Signs of Threatened and Actual Sexual Abuse and How to Distinguish Between Consensual Sexual Contact and Sexual Abuse Module 5 How to Avoid Inappropriate Relationship with Residents 76-86

	How to Communicate Effectively and Professionally with Residents, Including lesbian, gay, bisexual, transgender, intersex, or gender non-conforming residents 42-47 How to Comply with Relevant Laws Related to Mandatory Reporting of Sexual Abuse to Outside Authorities Module 2 Relevant Laws Regarding the Applicable Age of Consent Module 2 During interviews with Random Staff, the Auditor found the staff was well versed on all the subject matter included on the information presented in the DSCYF PREA Training PowerPoint. 115.331(b) FSB serves only males. All staff members are trained to work with all males.

115.332	Volunteer and contractor training
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Interview 2 Volunteers by telephone Medical Practitioner-Contracted Vendor Guidelines for Contracts Pre-Audit Questionnaire Training Records DYRS Policy 2.13 115.332(a) In accordance with DYRS Policy 2.13, all contractors and volunteers are considered staff. Further located in the policy is a mandate requiring all staff to be PREA trained at orientation with a refresher every two years. According to the Pre-Audit Questionnaire, there are 10 medical practitioners contracted through Christiana Care Hospital, and there are 28 volunteers and contractors from the community. 115.332(b) The Auditor interviewed both a contracted employee and a volunteer. They were interviewed utilizing the established PREA protocols. During the interviews, they were able to explain DYRS zero-tolerance of sexual abuse and sexual harassment. Both were knowledgeable of the ways to report incidences of sexual abuse and sexual harassment. Additionally, they were able to explain means to prevent, detect, and respond to sexual abuse and sexual harassment. The Medical Practitioner further explained the responsibility of being a mandatory reporter. 115.332(c) While on site, the Auditor reviewed the training logs provided by the Medical Practitioner. All required PREA training had been completed. FSB has met the standard of 115.332 volunteer and contractor training. The contractor and volunteer both demonstrated proficiency in their knowledge of the agency's zero-tolerance of sexual abuse and sexual harassment. Additionally, they were able to identify how to prevent, detect, report, and respond to sexual abuse and sexual harassment. Lastly, the FSB provided signed rosters and signed forms of understanding for review during the onsite audit of both documentation of both contractors and volunteers participating in PREA mandated training.

115.333	Resident education
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	DYRS Policy 2.13 Ferris School Resident Handbook Ferris School Resident Safety Guide PREA Initial Acknowledgement Form Signed Acknowledgement Form for Comprehensive PREA Training Curriculum of Intake PREA Training Curriculum of Comprehensive PREA Training Onsite Tour Interview Resident Handbook Interviews Random Residents PREA Compliance Manager 115.333(a) Cited in DYRS Policy 2.13.IV.A.2.a-b, all resident in secure care shall receive PREA orientation and/or training. The unambiguously states that during the intake process, resident shall receive information explaining the zero-tolerance rule regarding sexual abuse and sexual harassment and how to report incidents. Residents are given the PREA brochure at intake. According to the Pre-Audit Questionnaire, there were 41 resident that were admitted in the last 12 months who received PREA information at intake. During the onsite audit, the Auditor reviewed the resident training material which consisted of a video and the Ferris School Resident Handbook. From the Auditor's experience as an educator, it was determined the training material was age appropriate and comprehensive. 115.333(b) According to the Pre-Audit Questionnaire in the last 12 months, the Auditor reviewed the training records, and it was found that residents did receive comprehensive training, but it was not within 10 days of intake. At the time of the onsite audit, all residents had received comprehensive training. The PREA Compliance Manager was made aware that the PREA Standard requires that residents receive the comprehensive training within 10 days. According to the DYRS Policy 2.13, the facility is responsible for a comprehensive PREA training to include rights to be free from sexual abuse, sexual harassment, retaliation, response to incidents, definitions associated with policy, available victim services, and the investigation process. According to the PREA Compliance Manager, the intake and comprehensive PREA training are both instructor lead and supplemented with a video. During the review of 10 random active resident folders and 2 inactive random resident folders, the Auditor determined the facility located documented copies of signed training forms from completed comprehensive training. Also, the Auditor determined that the resident handbook and PREA brochure contained comprehensive information regarding the prevention, detection, reporting, and victim support information. Both the resident handbook and the PREA Safety Guide was age appropriate

115.33(c)
During the onsite audit, there were no residents that needed comprehensive training. All resident had obtained training. During the random interview of residents, the Auditor inquired if residents had receive PREA training from FSB though they had received at the local detention center. Residents that FSB had retrained them even though they had received PREA training at prior facility. The PREA Compliance Manger confirmed residents from other facilities within DYRS must retrain in both the intake and comprehensive PREA training upon arriving at FSB.

115.333(d)
In order to ensure that all residents have access to all services offered by DSCYF, the agency implemented the language access policy, DSCYF Policy 118. The policy and the vendor list of service providers can provide interpretation and translation services to limited English proficient resident and parents. Also, deaf resident who can only communicate by American Sign Language can be assisted by the service providers. According to PREA Compliance Manager who is responsible for training residents, confirmed that the option does exist for written PREA training material to be formatted for visually impaired resident. In DYRS Policy 2.13.IV.B.6, does address that residents with learning disabilities or may have difficulty reading be provided the same opportunity to benefit from the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment. According to the Principal, residents with limited reading ability are assisted by staff to understand the PREA training. It should be noted that 4 disabled students were interviewed by the Auditor, and it was assessed that they were knowledgeable of PREA.

115.333(e)
It was confirmed during the Auditor's review of both 10 active and 2 inactive resident folders that there was intake PREA documentation available, but there was no comprehensive documentation available in the folders. Upon request, the PREA Compliance Manager provided the Auditor a copy for review of the student roster that received the comprehensive training. The comprehensive training was not within the 10-day requirement.

11 5.333(f)
During the onsite tour of FSB, the Auditor located several locations in which PREA information was readily available to resident, staff, and third-party reporters. Upon entry to the facility, there was the Ferris School Resident Safety Guide which was available to visitors. Throughout the facility including living units, there were numerous PREA posters.

During the corrective action period, FSB met PREA standard 115.333 resident education. The facility has proven by interview with intake staff and reviewed signed documentation by resident that PREA training occurs at intake. The Ferris School Resident Safety Guide was provided at intake was age appropriate and written at approximately the fourth-grade level. Comprehensive PREA training occurs, but not within 10 days of intake. During the corrective action period, the facility implemented providing comprehensive PREA training within 10 days of intake. During the review of both active and inactive resident files, the Auditor located within the file there was initial PREA training, but the PREA Compliance Manager provided the roster with the resident signatures. There were no evidence of forms of completion and understanding of the comprehensive PREA training. During the corrective action period, the facility provided copies of the completed forms of completion for comprehensive PREA training. Examination of training material proofed that PREA training materials were age

	appropriate and comprehensive. Residents with prior PREA Training from other facilities disclosed that during their intake they received PREA training and they received more comprehensive training at a later date. During the onsite audit, all residents met compliance in receiving both intake and comprehensive PREA training. FSB provides access to PREA training to all residents. There is an established language access policy as well as an existing contract for interpretation and translation services for limited English proficient and American Sign Language. All written items are written at fourth grade reading level, and resident are further given assistance in reading according to the Principal. For residents with vision impairment, all documents can be enlarged. FSB maintains initial PREA Orientation Acknowledgement Form of completed PREA Training in resident files, but there is no forms for comprehensive PREA training. Information pertaining to PREA is very accessible throughout the facility. Displayed on the facility's walls are PREA related posters in both English and Spanish. Also, Ferris School Safety Guide is in both English and Spanish are available at the entryway of the facility. There is also an English and Spanish version of the Ferris School Resident Handbook. Corrective Action 115.333- Completed within the 180 day corrective action period. PREA Standard 115.333 requires that residents receive comprehensive training within 10 days of intake. The PREA Coordinator and the PREA Compliance Manager at FSB will create a plan to implement comprehensive training within 10 days of intake to residents at FSB. The plan and documented rosters will be made available to the Auditor within 60 days of the Interim Report. The Auditor was provided the curriculum and the documented rosters of comprehensive PREA training facilitated within 10 days of intake.

115.334	Specialized training: Investigations
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Interview 2 Institutional Abuse Investigators 1 FSB Investigator Delaware State Police Representative Investigators' Certificates Pre-Audit Questionnaire 115.334(a) DYRS Policy 2.13 and DYRS Policy 208 do not contain the PREA mandate of investigators being trained in conducting sexual abuse investigations in confinement. The two policies list the procedures in conducting a sexual abuse investigation. Though there is no specific policy requiring the mandated PREA training for investigators, all three investigators have received mandated trainings in conducting investigations of sexual abuse in confinement. It should be noted there are 2 Institutional Abuse Investigators and 1 FSB Investigator. 115.334(b) In reviewing the certificates of completion, the Auditor discovered that the IA investigators had completed PREA Investigations Training facilitated by the Delaware Department of Corrections. The facility PREA Investigator had received training by the National Institute of Corrections titled PREA: Investigating Sexual Abuse in a Confinement Setting. During the interviews, all three investigators attested to receiving training in techniques in interviewing juvenile sexual abuse victims, the use of proper Miranda and Garrity warnings, sexual abuse collection in confinement settings, as well as the criteria and evidence required to substantiate an allegation for administrative action or referral for prosecution. 115.334(c) DYRS maintains documentation of the investigator's completion of required training. The PREA Coordinator uploaded copies of the certificates to the Auditor through the Pre-Audit Questionnaire. 115.334(d) Discussion by telephone with the Delaware State Police Representative pertained to the professional development provided to investigators conducting sexual abuse investigations in confinement. It was stated that DSP has ongoing professional development for officers who conduct investigations of sexual abuse. Though the PREA mandate for specialized training for investigators does not exist in the submitted policies located in the PRE-Audit Questionnaire, DYRS meets the standard of 115.334 specialized training: investigations. All three of the agency's investigators have taken the required PREA mandated trainings for investigators, which includes interviewing juvenile victims, use of Miranda and Garrity warnings, sexual abuse evidence collection, and criteria and evidence to substantiate a case for administrative action or prosecution. Proof of

	completion was submitted through the PRE-Audit Questionnaire. Dialogue with the DSP assured Auditor that investigators were receiving professional development to conduct sexual abuse investigations at FSB.

115.335	Specialized training: Medical and mental health care
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Certificates of Medical Specialized Training DYRS Policy 2.13 Affirmation with Christiana Care Hospital Pre-Audit Questionnaire Interview Medical Practitioners Mental Health Practitioners 115.335(a) The medical staff at FSB are contracted through Christiana Care Hospital. Under DYRS Policy 2.13.III, staff is defined as any Department employee, volunteer, contractor, or official visitor, or other agency representative. Further in policy, it is stated that all department staff working directly with or monitoring programs/services of residents in secure care and community services must receive PREA training. The training will include, but not be limited to, complaint recipient responsibility, how to report an incident, investigations, and how to access victim services. Disclosed on the Pre-Audit Questionnaire were 10 medical and mental health practitioners who work at FSB. During the onsite audit, all medical and mental health practitioners had completed PREA training. 115.335(b) Pursuant to DYRS Policy 2.13 and the Affirmation with Christiana Care Hospital, all forensic medical examinations are to be completed at the CCH by SANE/SAFE. If there is no qualified staff at CCH, residents would receive these services at A.I. Dupont Hospital. The medical staff at FSB do not perform forensic medical examinations. 115.335(c) FSB maintains the documentation that medical and mental health practitioners have completed mandated PREA training. The certificates were uploaded to the Pre-Audit Questionnaire. 115.335(d) The Medical and Mental Health Practitioners have received online refresher of the same PREA training that Department employees receive. During the interview with the Mental Health Practitioner and the Medical Practitioner, it was determined the training was the same online training that all Department staff received. The PREA training included prevention, detection, reporting, responding, and victim support. FSB has met the standard of 115.335 specialized training: medical and mental health care. At FSB, mental health and medical practitioners are considered employees according to DYRS Policy 2.3.III. All Department staff are required to complete PREA training, as well as a refresher every two years. Review of training documentation during onsite audit confirmed that all mental health and medical practitioners had received PREA training. It was further

	collaborated with both mental health and medical practitioners that all staff had received training. In accordance with policy, forensic examinations are completed in a hospital setting. DSCYF has an established affirmation with CCH to conduct forensic examinations.

115.341	Obtaining information from residents
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	DYRS Policy 2.13.IV Interview Mental Health Practitioner-DPBHS- Division Employees Memorandum of Understanding between the Division of Prevention and Behavioral Health Services and the Division of Youth Rehabilitative Services Completed PREA Risk Assessments Pre-Audit Questionnaire 115.341(a) Within DYRS Policy 2.13, residents are to be assessed for the risk of sexual abuse victimization or sexual abusiveness towards other residents. Specifically, its stated that classification or assessment tools will be utilized to determine supervision needs of residents for the protection of victims and those known to be perpetrators. Also, a subjective judgement shall be made by the program's initial intake staff person to include a one sentence note to staff, stating if the residents' presentation conforms or does not conform to their gender. Additionally, the assessment is further detailed in the Memorandum of Understanding between the Division of Prevention and Behavioral Health Services and the Division of Youth Rehabilitative Services. It should be noted the mental health practitioners at FSB are interdivision employees from the Division of Prevention and Behavioral Health Services. It should further be noted that the FOCUS database contains residents' court records, case files, facility behavioral records, and other information relevant to the residents. In the memorandum, the following is documented. 1. Review available information including information from the FOCUS database for each resident admitted to DYRS facility 2. Meet with admitted resident within 1 business day of admission 3. Utilize information obtained from review and interview to determine resident's risk factors for sexual abuse or victimization. Also, the memorandum requires that screenings should be completed in 1 business day. The PREA standards allow for the screening to occur in 72 hours. After reviewing 12 random completed PREA Risk Assessments, the Auditor determined that the assessments were completed within 1 day of intake. Also, it was determined by the Auditor there is always available mental health and medical practitioner daily to complete assessments. In the prior 12 months, there were 41 residents that were screened at FSB for the risk of sexual victimization or the risk of being sexually abusive. The agency requires resident's risk level be reassessed in DYRS Policy 2.13.IV.B.3.a. Cited in policy, placement and programming assignments for each transgender residents, intersex residents, residents assessed as high risk for being victimized or offending or in need of protective housing shall have a review by the facility's assessment team at least twice a month to ascertain whether any threats to safety were experienced by the resident. The practice of

assessing residents within 1 business day and reassessing residents twice a month was further confirmed with the mental health and medical practitioner.

115.341(b)
FSB utilizes the PREA risk assessment as the facility's objective screening instrument. This form assesses the required PREA risk factors which are also listed on the Memorandum of Understanding between the Division of Prevention and Behavioral Health Services and the Division of Youth Rehabilitative Services.

115.341(c)
FSB's PREA Assessment Tool identifies the following risk factors:
1. Prior sexual history
2. Age
3. Current sex related charge and sexual offense history
4. Any non-conforming appearance or identification with LGBQTI
5. How does resident identify their gender?
6. How does residents identify their sexual orientation?
7. Age inappropriate level of emotional and cognitive ability
8. Physical size and stature
9. Mental illness or mental disabilities
10. Physical disabilities
11. Resident's own perception of vulnerability
12. History of traumatic experiences
13. Other information about resident that may indicate heightened need for supervision, safety precautions, or separation from certain other residents

FSB's assessment contains all 11 criteria set by the PREA standards. The Auditor reviewed 12 PREA Risk Assessments. There were 10 reviewed of active resident files, and the others were of 2 inactive files. Both the medical and mental health practitioner explained the process of completing the PREA Risk Assessments. Also, they added that all information is confidential, and it is only accessible to the Administrators as a notation on the FOCUS Database. The notation could identify the resident as risk of being a victim or risk of being a perpetrator or possibly both. The PREA Compliance Manager confirmed receiving information regarding a resident's risk status, but not the full battery of risk factors.

115.341(d)
All information on the PREA Risk Assessment is obtained during the screening within the 1st business day. As previously stated, the memorandum requires that mental health practitioner is to review available information when a resident is admitted into the facility, including information from the database FOCUS. Finally, they are to utilize information from reviewing FOCUS and the interview to identify risk factors.

115.341(e)
The Auditor had an opportunity to review the information that was disseminated through FOCUS to the Superintendent and the Assistant Superintendent. No other staff member has access to this information through the database. The information provided was very limited in scope. It only identified if a resident was at risk for sexual victimization or at risk of being a perpetrator of sexual abuse. No other risk factors were disclosed.

	FSB meets the standard of 115.341 obtaining information from residents. DYRS has demonstrated that there is a policy and memorandum of understanding that requires the screening of residents' risk of being a sexual abuse victim or perpetrator of sexual abuse. FSB meets the time frame of providing screening services within 72 hours. Also, the policy states that a resident identified with risk for victimization or perpetrator should be reassessed twice a month. Both the 1 business day and screenings were confirmed with mental health practitioner. The PREA Risk Assessment is administered within 1 business day, and the tool that is utilized is objective, and it meets all 11 criteria set by the PREA standards. Residents are interviewed by mental health practitioner in order to obtain information to complete risk assessment. Also, information is gathered from the FOCUS database which has a detailed history of the resident. With the use of FOCUS, the mental health practitioners can provide the outcome of the risk assessment without disseminating risk factors to other staff. The only notation given to the Superintendent and the Assistant Superintendent is the risk assessment outcome of whether a resident is a risk for sexual abuse victimization or risk of perpetrator of sexual abuse.

115.342	Placement of residents
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	DYRS PREA Risk Assessment DYRS Policy 2.13 DYRS Policy 2.20 FS Policy 9.19 Protective Custody Memorandum of Understanding between the Division of Prevention and Behavioral Health Services and the Division of Youth Rehabilitative Services Onsite Tour Interviews Mental Health Practitioner Superintendent PREA Compliance Manager Random Staff Random Residents 115.342(a) Once the PREA Risk Assessment is completed, it is submitted through the FOCUS database to the Superintendent and the Assistant Superintendent. According to the Assistant Superintendent, the information from FOCUS is in fact utilized for decisions regarding housing, education, and program assignments. The practice of notating on FOCUS was further confirmed during the interview by the mental health practitioner, Superintendent, and Assistant Superintendent. Additionally, the practice is cited in DYRS Policy 2.13.IV.B.2-3. Specifically, the policy states Classification or assessment tools will be utilized to determine supervision needs of resident for the protection of victims and those known to be perpetrators. This form of protective supervision includes housing decisions, movement throughout the facility, all routine and non-routine activities. Additionally, DYRS Policy 2.20.IV.E.1 states DYRS shall use all information obtained during intake, referral documentation, mental health assessment to make housing, bed, program, education, and work assignments for resident with the goal of keeping all residents safe and free from sexual abuse and sexual assaults. 115.342(b) DYRS Policy 2.20 IV.E.1.c addresses the concern of isolation of resident as a last resort when less restrictive measures are inadequate to keep them and other residents safe. The Auditors concern is the verbiage is absent that all residents can be placed in isolation, but specifically identifies residents who are LGBQTI. Within the policy, DYRS staff shall not deny residents daily large muscle exercise and any legally required educational programming or special education services. Also, residents in isolation shall receive daily visits from medical and mental health practitioners. According to the Pre-Audit Questionnaire, there were no residents placed in isolation due to concerns of sexual victimization. In the last 12 months, there were no residents denied large muscle exercise, legally required educations, or special education. FSB utilizes Administrative Intervention (AI) when there are safety concerns like behavior. When residents are on AI they are not restricted in their room but rather restricted to housing unit or cluster. The Auditor questioned the length of time that students are sanctioned to AI,

and the residents answered the most time they had seen was approximately 2 days. Further, the Auditor questioned the Superintendent and found that residents were sanctioned to cluster or unit for no more than 3 days, but they did receive all required large muscle movement and required education. During the onsite tour, the Auditor was shown the Quiet Room which is utilized for a few minutes until a resident regains composure. Random Residents and Random Staff were questioned about the use of the Quiet Room, and both groups corroborated that the room is utilized for short periods of time for either close medical observation or until a resident complies with positive behavior. During the onsite audit, there was no school. During the onsite audit, the Auditor reviewed program logs and was able to locate notations that residents had received visits by medical and mental health practitioners.

Inquiry was made by the Auditor of both the Mental Health and Medical practitioner regarding residents being placed in isolation based on risk of being sexually victimized. Also, there were no scenarios in the last 12 months that a resident was isolated due to concerns of sexual victimization.

115.342(c)
According to PREA Compliance Manager residents that identified as LGBQTI are not placed in a housing unit, bed, or other assignments based solely on identification or status. At the time of onsite audit, there were no residents during the Random Resident interview that identified to Auditor as LGBQTI. DYRS Policy 2.20.IV.E.1.d. states LGBQTI residents shall not be placed in particular housing, bed, or other assignments based solely on the basis of such identification or status, nor shall DYRS consider LGBQTI identification or status as an indicator of likelihood of being sexually abusive.

115.342(d)
According to DYRS Policy 2.20.IV.E.1.e. and interviews with the Superintendent and PREA Compliance Manager, FSB decisions regarding housing and programming assignments of transgender or intersex residents are considered on a case by case basis. Considerations taken by administration are based on health and safety of residents and the management and security of facility. At the time of the onsite audit there were no residents that were self-identified to the Auditor or through PREA Risk Assessment identified as intersex or transgender residents.

115.342(e)
According to the DYRS Policy 2.20.IV.E.1.f., placement and programming assignments for transgender and intersex residents shall be reassessed by the interdisciplinary team at least twice each year to review any threats to safety experienced by residents. During the interview with the Mental Health Practitioner, it was confirmed that the database, FOCUS, has the ability to alert the Mental Health Practitioner when it is time to reassess an individual.

115.342(f)
Further in DYRS Policy 2.20.IV.E.1.e., it is stated a transgender or intersex resident’s views with respect to his/her own safety shall be given serious consideration. FSB’s Superintendent stated that a resident’s view of his/her safety is considered. There were no transgender or intersex residents detained at the time of the onsite audit.

115.342(g)

During the onsite tour of FSB, the Auditor's inspection of the shower and toilet configuration found them to be private. Auditor inspected the showers and the bathrooms to determine the level of privacy, and it was found that all residents can shower and use the bathroom separately from other residents. Specifically, in DYRS Policy 2.20.IV.F. transgender and intersex residents shall be given the opportunity to shower and use the bathroom separately from other residents.

115.342(h)
There is a provision within DYRS Policy 2.20.IV.E.1.h. that allows for a resident to be isolated only as a last resort when less restrictive measures are available to keep them and other residents safe, and FSB would be required to provide documentation of the facility's concern for the resident's safety and the reason no alternative means of separation can be arranged. During the interview with random staff, there were no residents placed in insolation within the last 12 months.

115.342(i)
According to DYRS Policy 2.20.IV.E1.i, residents who are placed in isolation as a last resort are to be afforded the opportunity to have a review every 30 days to determine whether there is a continued need for separation from the general population. According to the Superintendent and the PREA Compliance Manager, there has been no residents who have been placed in isolation due to being sexually abusive in the last 12 months.

DYRS meets the standard in 115.342 placement of residents. The FSB utilizes the PREA risk screening to make decisions on housing, programming, and education. Agency requires through policy that residents who are in isolation due to victimization are provided large muscle exercise, special education services, and educational programming.

115.351	Resident reporting
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Interviews Random Staff Random Residents DYRS Policy 2.13 Reportable Events PREA Training Materials for Staff PREA Training Materials for Residents Title 10 Pre-Audit Questionnaire 115.351(a) DYRS has demonstrated efforts in providing opportunities for residents to report incidents of sexual abuse, sexual harassment, retaliation, as well as staff dereliction of duties while being detained at FSB. Resident reporting procedures are published in policy. Cited in DYRS Policy 2.13.IV.C.2.b-c, residents in state managed programs can report any sexual contact between resident on resident and staff on resident to any staff or the Child Abuse Hotline. The Child Abuse Hotline will also serve as the designated 24 hour, 7 days a week resource for a resident to report abuse while a resident of the program. Each facility will develop procedures that define multiple ways for residents to privately report sexual abuse, sexual harassment and/or retaliation by other residents. The specific procedures listed were confidential phone access and emergency PREA grievance form. Random staff were able to identify that residents could report sexual abuse, sexual harassment, and retaliation by either reporting to staff or utilizing the Child Abuse Hotline. In incidents of sexual abuse, sexual harassment, or retaliation random residents stated resident could make a report to parents, staff, PREA grievance form, and the Child Abuse Hotline. During the tour of the facility, the Auditor noticed there were telephones accessible to residents which listed the procedure to contact the Child Abuse Hotline. Also, the Auditor saw the PREA grievance forms and writing utensils to complete forms. There were grievance boxes available. 115.351(b) DSCYF is the parent agency of DYRS. DSCYF is the child welfare agency for the state of Delaware, and it operates and manages the Child Abuse Hotline. When a resident reports an incident of sexual abuse, sexual harassment, and retaliation to the Child Abuse Hotline, the report would be made outside of DYRS, but within DSCYF. DYRS does not detain resident for the sole purpose of civil immigration. Title 10.1007 lists the reasons that a resident can be detained, and there is no clause that allows for resident to be detained at DYRS operated facilities for the purpose of civil immigration. 115.351(c) Found in DYRS Policy 2.13.IV.C.1.a-b. is a clause that specifically states the requirement of mandatory reporters. According to the policy, all staff are required to report allegations and instances of non-consensual sexual acts, abusive sexual contact, and sexual harassment to

the Child Abuse Hotline. Failure to report any sexually related incident will result in disciplinary action up to and including termination and/or criminal prosecution. Further, the requirement for staff to provide written documentation of incidents of sexual abuse, sexual harassment, and retaliation is citied in DYRS Policy 2.12.III.B.3.a-b. The policy requires both critical and non-critical incidents of reportable events shall be documented in writing within 24 hours of incident. It should be noted that incidents of sexual abuse, sexual harassment, and retaliation fall in both critical and non-critical incidents. The policy outlines the following processes in handling both types of incidents. Written documentation of the incident should be completed by the supervisor on duty. Once the written documentation is completed, it is to be submitted to the facility administrator. The document shall be reviewed by the administrator, and then forwarded to the director's office within 24 hours of DYRS first learning of the incident.

115.351(d)
During the tour of the facility, the Auditor located grievance boxes. The form is easily accessible to resident along with a writing utensil. Residents can complete a grievance form and submit it to staff member or place it in the grievance boxes. The PREA Grievance Forms are not a part of the grievance process, but it is the written reporting mechanism for resident. The form is not a grievance, so it does not follow the grievance process, it is immediately handled, and staff and resident are to report incident immediately on the Child Abuse Hotline. According to the Pre-Audit Questionnaire attached documents, reporting methods are provided to resident during the comprehensive orientation in the student handbook.

115.351(e)
DYRS staff reported to Auditor that there are several means in which they can report confidential incidents of sexual abuse, sexual harassment, retaliation, and staff dereliction of duties. All staff reported utilizing the Child Abuse Hotline and reporting directly to supervisor. None of the staff mentioned utilizing the online portal on the agency's website to confidentially report incidents of sexual abuse, sexual harassment, retaliation, and staff dereliction of duties. The procedures for reporting incidents are located in DYRS Policy 2.13.IV.C.2.d and in PREA training materials provided during orientation and every 2 year refreshers.

It is evident that DYRS has met compliance in standard of 115.351resident reporting. DYRS has established internal opportunities for resident and staff to report sexual abuse, sexual harassment, retaliation by either resident or staff, and dereliction of duties or violation of responsibilities that may have contributed to incidents. Residents can report incidents by either the Child Abuse Hotline, staff, or PREA Grievance Forms. Residents are provided an opportunity to report outside of FSB to the Child Abuse Hotline operated by DSCYF. In the case of staff, reports can be made confidentially through the Child Abuse Hotline, DSCYF's website, and supervisors. Within the DYRS Policy 2.13, staff is required to provide written documentation of all incidents of sexual abuse, sexual harassment, retaliation, and dereliction of duties associated with incidents.

115.352	Exhaustion of administrative remedies
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Emergency PREA Grievance Form Interview Superintendent 115.352(a) FSB does not have an administrative procedure to address resident grievances for sexual abuse, sexual harassment, retaliation, or staff dereliction of duties that may have caused an incident. All incidents are reported to the Child Abuse Hotline. Residents are provided an Emergency PREA Grievance Form. This form is only utilized to give residents a written opportunity to confidentially report. The form is immediately given to staff and called into the Child Abuse Hotline. It is not processed through an administrative grievance procedure. The standard does not apply to FSB.

115.353	Resident access to outside confidential support services and legal representation
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Interviews Superintendent PREA Compliance Manager Random Residents Random Staff FSB Safety Guide (Referred to by residents as PREA Brochure) DYRS Policy 2.13 Memorandum of Agreement between DYRS and SOARS DYRS Policy 5.24 Title 10:1007 115.353(a) Contained in the FSB Safety Guide referred to by residents as the PREA Brochure contains the list of victim support groups that provide support services related to sexual abuse and sexual harassment. On the last page of the brochure, the Auditor located the names of agencies and contact information. DYRS states in policy that in addition to the internal counseling services provided in the facility, all residents shall be made aware of community agencies, addresses and contact numbers of mental health practitioners that provide emotional support services related to sexual abuse. Additionally, the DYRS has a memorandum of agreement with SOARS for victim support services. Information pertaining to immigrant services is not available, because Title 10:1007 prohibits the detainment of residents for the sole purpose of civil immigrations. During the interview with random residents, the Auditor assessed the residents to know that victim support services were available, but they could not recall the specifics. Majority of residents had a degree of knowledge of how to access information. Most residents said their first recourse would be to call the Child Abuse Hotline (PREA Phone). Residents were aware that in speaking with an advocate that there were limits to confidentiality. Additionally, the PREA Compliance Manager showed the Auditor several locations that private interviews which included the conference area when entering FSB and several program classrooms within the facility. Further confirmed during the random resident interviews and the Medical and Mental Health Practitioners interviews, there were no residents detained at FSB that represented the target population of residents who experienced sexual abuse at FSB. 115.353(b) On the back panel of the FSB Safety Guide, it is stated the identity of a victim reporting sexual assault, harassment, or abuse, and the facts of the report itself, shall be limited to those who have a need to know in order to make decisions concerning the victims welfare and for law enforcement. From the random resident interviews, it appeared to the Auditor that the residents have an understanding that confidentiality is limited. 115.353(c)

According to the Executive Director of SOARS, A Memorandum of Agreement Between the Division of Youth Rehabilitative Services and Survivors of Abuse in Recovery, Inc. has been established since the last PREA audit in 2016. A renewal of the agreement between the agencies was made in March of 2019.

115.353(d)
Residents are given opportunities to meet with their families, outside service agencies, and their attorneys. Further confirmation was obtained during random staff and resident interviews. The purpose of DYRS Policy 5.24 is to promote family engagement and recognizes the need and right for residents to maintain contact with persons outside the facility by correspondence, telephone or visitation and asserts that he/she may do so with a reasonable degree of privacy. The policy details the way visitation, correspondence, and telephone calls are provided within the facility. Legal correspondence is never opened by staff, and residents have unlimited access to their attorney at any reasonable time. Incoming and outgoing mail is not read unless there is clear evidence that justifies action, but it must be opened and read in front of youth. Residents can telephone parents/guardians. The Resident Handbook details the visitation schedule and the rules of visitation. The Superintendent detailed the specifics of visitation and the access to guardians, attorneys, and outside agencies. If necessary, special visits can be accommodated. Random residents disclosed they were given regular scheduled visits with their family. The interviews were in alignment with DYRS Policy 5.24.

For the standard 115.353, FSB meets compliance in resident access to outside confidential support services and legal representation. In the event residents would have access to outside victim support advocates and services. Though residents do not easily recall the providers of victim support and advocacy, they were able to detail where the information could be in the case of sexual abuse and sexual harassment. Also, located on the FSB Safety Guide is information regarding confidentiality when accessing victim support services. DYRS has a longstanding and a renewed memorandum of agreement with SOARS to provide victim support services. To ensure engagement by both guardians and attorneys DYRS has a policy that addresses the access to correspondence, telephone calls, and visitation by residents with a satisfactory level of privacy.

115.354	Third-party reporting
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	DYRS Policy 2.13 https://kids.delaware.gov/yrs/prea.shtml Interviews Random Staff Random Youth Superintendent Pre-Audit Questionnaire 115.354(a) An inquiry was made of the Random Staff regarding receiving third-party reports of sexual abuse, sexual harassment, and retaliation. In all interviews, staff stated that the third-party report would be called in to the Child Abuse Hotline and reported to immediate supervisors. Absent within DYRS Policy is the specifics on the ways that a third party could report incidences of sexual abuse, sexual harassment, retaliation, and staff dereliction of duties that may cause an incident. Basically, it refers to staff reporting all allegations of Child Abuse to the Child Abuse Hotline. In the completed Pre-Audit Questionnaire, the PREA Coordinator cited that third party reporting can be located at https://kids.delaware.gov/yrs/prea.shtml. At the top of webpage under Prison Rape Elimination Act, there is a large textbox stating, To report any sexual abuse or sexual harassment allegations regarding DYRS youth call Delaware Child Abuse Hotline 1-800-292-9582 or your local law enforcement agency. If a third-party selected the link on the bottom of the page titled child abuse, the party can submit an online report of incidents. When an inquiry was made of the detained residents of how their guardians or attorneys would make a report of sexual abuse and sexual harassment, the residents responded Child Abuse Hotline. The Superintendent concurred with the handling of the third-party reporting with the adding of required documentation being completed. FSB demonstrates meeting compliance in 115.354 third-party reporting. The facility has a procedure that all reports of sexual abuse, sexual harassment, retaliation, and staff dereliction of duties be reported to the Child Abuse Hotline. Documentation must be completed following a report of an incident of sexual abuse, sexual harassment, and retaliation. Additionally, DYRS has distributed publicly information the steps to report incidents of sexual abuse and sexual harassment on behalf of a resident on the agency’s website.

115.361	Staff and agency reporting duties
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Interviews Agency Head Random Staff Medical Health Practitioner Mental Health Practitioner PREA Compliance Manager Superintendent DYRS Policy 2.13 DYRS Policy 2.2 Critical Incident Report Non-Critical Incident Report Pre-Audit Questionnaire 115.361(a) Delaware law mandates any person, agency, organization or entity to make an immediate oral report to the Department of Services for Children, Resident and Their Families, Division of Family Services, when they know of, or suspect, child abuse or neglect under Chapter 9 of Title 16 of the Delaware Code and to follow-up with any requested written reports DYRS details mandatory reporting in the agency policy. Specifically, in DYRS Policy 2.13.IV.C.1.a, all staff are required to report any allegations and instances of Non-consensual sexual acts, abusive sexual contact, and sexual harassment to the Child Abuse Hotline. Instances of retaliation against either staff or resident is addressed in two policies. Cited in DYRS Policy 2.2.IV.A.21, each employee must report, without reservation, any corrupt or unethical behavior which could affect either a juvenile or the integrity of the organization. DYRS Policy 2.13.2.f states retaliation from resident or staff will result in disciplinary action and be subject to the full progression of sanctions and/or referral for criminal prosecution. For instances of staff's dereliction of duties that may have been a contributing factor to sexual abuse, DYRS Policy 2.13.C.2.d. states each facility will also develop procedures for how staff can report sexual abuse, harassment and staff neglect or violation of responsibilities that may have contributed to any of these incidents. According to all random staff interviewed, they are required by DYRS to report to the Child Abuse Hotline all instances of sexual abuse, sexual harassment, retaliation, and staff's dereliction of duties that may have been a contributing factor. 115.261(b) The staff which includes employees, contractors, and volunteers are required to follow mandatory reporting laws. Within DYRS Policy 2.13.IV.C.1.a, all staff are required to report any allegations and instances of Non-consensual sexual acts, abusive sexual contact, and sexual harassment to the Child Abuse Hotline. Majority of the staff were able to recall the agency's training on the zero-tolerance policy on sexual abuse and sexual harassment. Additionally, many staff knew their responsibilities of preventing, detecting, reporting instances of sexual abuse and sexual harassment. Also, they were able to detail the responsibilities as a first responder to sexual abuse and sexual harassment. The staff were aware of the reactions of sexual abuse and sexual harassment. A further inquiry was made regarding servicing

residents that identified as LGBQTI, as well as residents that were gender non-conforming. Based on the answers, staff proved to have been proficiently trained in providing service to residents that were identified as being LGBQTI. The staff was able to detail how to complete a search of a resident that identified LGBQTI. During the onsite audit there were no residents identified as LGBQTI for the Auditor to confirm the practice.

115.361(c)
During the interview with both Medical and Mental Health Practitioners, it was disclosed that information is not disseminated to all staff. According to staff, DYRS requires staff to maintain confidentiality regarding sexual abuse and sexual harassment, and information dissemination is limited. Outlined in DYRS Policy 2.2.IV.A.23, employees must maintain the integrity of confidential information. Employees will not seek personal data beyond that needed to perform job responsibilities and will not reveal case information to anyone not having proper professional use. Information is tiered in the FOCUS database in order to keep dissemination limited.

115.361(d)
Both the Mental Health and the Medical Practitioner disclosed to the Auditor that they inform resident of their duty to report. Examples of limitations to confidentiality were also shared with the Auditor. For example, the PREA Risk Assessment is not disclosed, but necessary information of vulnerability or propensity to victimize is shared with administration in order to make necessary housing decisions. Both practitioners participated in the PREA training in which they were instructed to detect, respond, and report allegations of sexual abuse and sexual harassment. In DYRS Policy 2.2, it stated that employees must be diligent in their responsibility to record and make available for review any and all case information which could contribute to sound decisions affecting a juvenile and public safety. Stated prior, DYRS Policy 2.13 requires all staff to report instances of sexual abuse to the Child Abuse Hotline.

115.361(e)
Both Agency Head and Superintendent shared that the expectation in handling of instances of sexual abuse or sexual harassment are to be reported to the Child Abuse Hotline. All instances should follow the Coordinated Plan. Further, if a resident is under the child welfare system, the caseworker must be contacted regarding the allegations. If a child is not a part of the child welfare system, the guardian shall be contacted and the representing attorney.

115.361(f)
Prior to beginning an investigation of sexual abuse and sexual harassment at FSB, the allegation must be first reported to the Child Abuse Hotline. At that point, Institutional Abuse Unit (IA) is contacted, and the facility's designated PREA Investigator and AI will work jointly in investigating the allegation. If it is determined by IA that the incident is of a criminal nature, IA will conduct the investigation with the Delaware State Police (DSP). According to the Agency Head and Superintendent, there have been no allegations of sexual abuse or sexual harassment at FSB that originated from state-operated facilities or contracted facilities.

DYRS meets the standard of 115.361 in the staff and agency reporting duties. In DYRS policy staff is required to report allegations of sexual abuse, sexual harassment, retaliation, and staff dereliction of duties that may have contributed to allegations. Also, in DYRS policy and Delaware Law, staff is required to comply to mandatory reporting laws. Also, staff is prohibited

	by policy of revealing information pertaining to allegations of sexual abuse. Information disseminated is for the sole use of professional duties. Both medical and mental health professionals also are required to report all allegations of sexual abuse and sexual harassment. Additionally, the practitioners inform residents that there are limitations to confidentially, and the practitioners have a duty to report. Lastly, the Superintendent ensures notification of the caseworker of residents who are under the supervision of the child welfare agency (DSCYF), and in the case of residents not under the supervision of child welfare, the Superintendent informs guardians and the resident's attorney.

115.362	Agency protection duties
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	DYRS Policy 2.13 Coordinated Response Plan Pre-Audit Questionnaire Interviews Agency Head Superintendent Random Staff 115.362(a) When FSB learns of a resident being of substantial risk of imminent sexual abuse, the facility has prepared to respond by removing resident from harm by relocating either housing unit or cluster. During the interview with the Superintendent, it was detailed how to secure the resident. Resident would be immediately placed in protective custody with an assigned designated staff. Following the resident would be assessed by mental and medical health practitioners. Lastly, there will be a meeting to discuss programming, housing, and if necessary, relocation. According to Pre-Audit Questionnaire and Superintendent, there were no instances of a resident being in substantial risk of imminent sexual abuse. Random staff confirmed the agency trained response to learning a resident is in substantial risk of imminent sexual abuse. The resident should be separated with a staff member, and once resident is secured, they are to contact supervisor. The Agency Head of DYRS stated in the event of a resident being in imminent risk of sexual abuse, it is expected that staff respond immediately by removing resident into protective custody. Lastly, DYRS Policy 2.13.IV.C.2.e establishes if a resident fear for his/her safety in their current setting, he/she can request a temporary transfer to another location either housing unit or cluster. FSB demonstrated meeting the standard in 115.362 agency protection duties. DYRS has developed a Coordinated Response Scenarios that is a graphic organizer of the process and procedures that should be taken in the event of a substantial risk of sexual abuse or allegations of sexual abuse and sexual harassment. All staff including the Agency Head to random staff that were interviewed expressed that they are to respond to imminent risk of sexual abuse immediately. Additionally, DYRS 2.13 addresses the resident's fear for his/her safety, and the procedures and options that are available to the Superintendent in handling instances of imminent risk of sexual abuse.

115.363	Reporting to other confinement facilities
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	DYRS Policy 2.13 Pre-Audit Questionnaire Interviews Agency Head Superintendent Management Data Analyst PREA Coordinator PREA Compliance Manager Superintendent Assistant Superintendent 115.363(a) According to the interviews with the Management Data Analyst, PREA Coordinator, PREA Compliance Manager, Superintendent, and Assistant Superintendent there were no reports or allegations made of sexual abuse or sexual harassment occurring at another facility of confinement by a Resident or 3rd party. In review of the information reported on the Pre-Audit Questionnaire, there were no reports of allegations of sexual abuse while a Resident was confined at another facility. Further, the Auditor requested to see all records pertaining to sexual abuse and sexual harassment from all state operated and state contracted facilities in order to confirm the information obtained from interviews and the PAQ. Also, the Auditor asked the Superintendent to outline the response if this type of allegation occurred. The Superintendent referenced the DYRS Policy 2.13.IV.C.3 which requires the Superintendent to notify the facility administrator/agency and the investigative bodies where the incident allegedly occurred. The Agency Head stated in the instance of a report of sexual abuse occurring in another confinement facility the Superintendent is to notify the administrator of the facility where the alleged abuse happened and the investigative agencies in the jurisdiction. Specifically cited in DYRS Policy 2.13.IV.3 the facility administrator is to contact the administrator or agency office of the alleged incident. 115.363(b) As stated prior, there were no instances of sexual abuse or sexual harassment to confirm practice. According to DYRS Policy 2.13.IV.3, the notification of alleged sexual abuse shall be provided as soon as possible but no later than 72 hours after learning of alleged incident. 115.363(c) Additionally, DYRS requires in DYRS Policy 2.13.IV.3 the reporting facility administrator shall document the notification to both the agency administrator and the investigative agency of alleged incident. The notification must show both the DYRS Director and the DYRS PREA Coordinator have been copied on notification. Both the Agency Head and the Superintendent statements were in alignment with the DYRS policy. 115.363(d)

	FSB has not experienced an incident wherein an allegation of sexual abuse occurred at another confinement facility and was reported to the facility. The Auditor is unable to confirm the practice. For the standard of 115.363 reporting to other confinement facilities, FSB meets compliance. The facility has not experienced a report of a Resident being sexually abused at another confinement facility. It is evident based on the responses given by the Agency Head and Superintendent; they comprehend the procedures and responsibilities required by the DYRS policy and PREA standards. When in comparison, the DYRS policy governing the handling of this type of allegation of sexual abuse is in alignment with the PREA standards.

115.364	Staff first responder duties
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Coordinated Response Scenarios First Responder Checklist Pre-Audit Questionnaire Staff PREA Training Material Non-Critical Incident Report Interviews Random Staff (First Responders) FSB PREA Investigator (Telephone) 115.364(a) Absent a policy for first responders, the PREA Coordinator listed on the Pre-Audit Questionnaire the Coordinated Response Scenario, First Responder Checklist and PREA Training Materials as a replacement for a policy addressing first responder responsibilities. In the past 3 years, there have been no allegations of sexual abuse. The FSB Investigator disclosed that there were no allegations of sexual abuse or sexual harassment at FSB. At FSB, all staff working directly with residents could possibly serve as a first responder to an instance of sexual abuse. All staff is required to be trained in the responsibilities of a first responder to sexual abuse and sexual harassment. In the absence of allegations of sexual abuse and sexual harassment, the DYRS Policy 2.13 requires that staff is trained utilizing one of the scenarios in the Coordinated Response Scenario. According to the Superintendent, staff was trained utilizing the Coordinated Response Scenarios, First Responder Checklist, and the Staff PREA Training. In the Coordinated Response Scenarios, there are 2 scenarios that are specific to secure care. Scenario #2 details that supervisor receives emergency PREA grievance of a staff on resident sexual abuse allegation. The supervisor removes staff member from unit and directs that crime scene be secured. Supervisor proceeds to call Child Abuse Hotline. In Scenario #3, line staff receives report of a resident on resident sexual abuse allegation. Staff separates resident and alleged victim, and alleged perpetrator is placed on 1 on 1 supervision. Residents are prohibited from washing. The scene of the incident was secured, and staff notified supervisor. During the interviews of random staff, it was found that that were proficient recalling the first responder duties of 1. Separating victim and abuser 2. Do not allow victim and abuser to take any actions that would destroy physical evidence 3. Secure scene 115.364(b) DYRS does not have a policy that addresses first responder duties for staff members that are not custody staff, but this subject is addressed in the Staff PREA Training that is given for FSB staff which includes contractors and vendors. On page 100 Module 6 of the PREA Training,

	there are 4 key duties that are highlighted that include respond to victim; report to proper authorities which include Child Abuse Hotline/YRS administration and lastly refer victim to medical, mental health, and classification. Further, the training includes crime scene reporting of incident, secure crime scene, investigative process, and report writing. It should be noted that custody staff supervises resident during appointments and activities with medical practitioners, mental health practitioners, contractors, and volunteers. Random staff were versed on their responsibilities as a first responder. As stated prior, the Auditor was told the staff would first separate victim and abuser followed by securing the scene to preserve evidence. Victim and abuser would be prohibited from doing anything that could destroy evidence and they would be supervised one on one by a staff. The staff would report to immediate supervisor and call the Child Abuse Hotline. DYRS has demonstrated meeting compliance in the standard of 115.364 staff first responder duties. DYRS does not have a first responder policy. Though the policy is non-existent, DYRS created 3 documents. The documents detail the steps that should be taken in the instances of sexual abuse and sexual harassment. The Coordinated Response Scenarios is a graphic organizer of the steps taken in various situations. According to the document, the staff is responding in accordance to the PREA mandates. Also, there is a First Responder Checklist which list the responsibilities in a bullet format. The last document is the Staff PREA Training which details each of the first responder's responsibilities. Finally, the training material also reiterates the responsibility of those that are not custody staff.

115.365	Coordinated response
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Pre-Audit Questionnaire (PAQ) Coordinated Response Scenarios FSB Coordinated Response Scenarios- facility specific institutional plan First Responder Checklist Note to File from Superintendent Documenting Training utilizing Coordinated Response Scenarios Interview Superintendent PREA Coordinator 115.365(a) After reviewing the Pre-Audit Questionnaire, the Auditor found the FSB was utilizing the agency wide Coordinated Response Scenarios. The DYRS has developed an agency wide institutional plan which is entitled the Coordinated Response Scenarios. The plan outlines the responses by first responders, medical and mental health practitioners, investigators, facility leadership, and agency leadership. The plan is not specific to FSB, and the PREA standards require that the plan is specific to the facility. Within DYRS Policy 2.13, a facility that has not received any allegations of sexual abuse or sexual harassment, must utilize the scenarios as a means of training for staff. During the interview with the Superintendent, the Auditor was provided documentation of the training of FSB staff utilizing the Coordinated Response Scenarios. The documentation further confirmed the use of the agency wide plan to coordinate actions of staff first responders, medical and mental health practitioners, investigators, and facility leadership. Additionally, a conversation with the PREA Coordinator also concurred that the plan was agency wide. In addition, DYRS has developed a First Responder Checklist that is also agency wide. The checklist is a quick reference of first responder's responsibilities during an instance of sexual abuse or sexual harassment. After corrective action, FSB does meet compliance in the coordinated response. FSB developed an institutional plan that was specific to the facility. Corrective Action 115.365-Completed within the 180 day corrective action period. PREA Standard 115.365 requires that an agency has a specific coordinated response plan for each facility. With the assistance of the PREA Coordinator and PREA Compliance Manager FSB will create a coordinated response plan specific to FSB. This plan will be made available to the Auditor within 60 days of the Interim Report. Additionally, evidence of the planning process will be submitted to the Auditor. During the corrective action period, there were discussions between the Auditor and PREA Coordinator pertaining to the development of the plan. FSB provided the Auditor with the

	facility specific institutional plan, FSB Coordinated Response Plan.

115.366	Preservation of ability to protect residents from contact with abusers
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	State of Delaware, Bargaining Unit 11 7.1.17-6.30.19 with addendum 7.1.2018 Interview Agency Head Union Representative of AFSME Local 3384 115.366(a) The DYRS has entered into a collective bargaining agreement since the last PREA Audit with Merit Employee Compensation Unit 11 Bargaining Coalition-The American Federation of State, County, and Municipal Employees, AFL-CIO, Council 81 Local 247 and Local 3384 (July 1, 2017-June 30, 2019) with Addendum (July 1, 2018-June 30, 2019). The Auditor interviewed the Union Representative of AFSME Local 3384. It was reported there is no agreement that prevents the removal or termination of an individual that has committed acts of sexual harassment or sexual abuse. According to Agency Head, there are no collective bargaining agreements that limit DYRS ability to remove an employee for alleged sexual abuse from contact of youth pending the outcome of an investigation or impede the extent discipline is warranted in instances of sexual abuse. 115.366(b) Within Unit 11 Bargaining Coalition-The American Federation of State, County, and Municipal Employees, AFL-CIO, Council 81 Local 247 and Local 3384, there were no clauses that were inconsistent with the PREA standards of 115.372 which relates to the utilization of the standard preponderance of the evidence or a lower standard of proof for administrative investigations and PREA standard 115.376 which relates to disciplinary sanctions up to and including termination for violating agency sexual abuse and sexual harassment policies. . The Auditor did not locate in the agreement a requirement to remove the expungement of the no-contact assignment form personnel records of unsubstantiated allegations of sexual abuse. There are two clauses cited that does not limit DYRS from suspending individuals that are alleged of sexual abuse until the outcome of the investigation, as well as dismissing individuals with substantiated allegations of sexual abuse. 7.7 If the employee appeals such suspension or dismissal, the suspension or dismissal shall be delayed pending the State's determination. It is determined that the employee's continued presence o the job presents a potential danger to persons or property, or would severely interfere with the operations, said delay will be voided. 22.8 When employees continued presence on the job poses a threat to the safety or security of staff, inmates, the public or operations, they may be suspended immediately with or without pay pending completion of an investigation and the issuance of a notice letter. DYRS meets compliance for the standard of 115.366 preservation of ability to protect residents from contact with abusers. DYRS is not limited by collective bargaining agreement from suspending individuals with alleged sexual abuse allegations. Additionally, DYRS is not limited to terminating employment of an individual that has substantiated allegations of sexual abuse.

115.367	Agency protection against retaliation
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	DYRS Policy 2.13 Pre-Audit Questionnaire Training on Protection from Retaliation Training Roster for Training on Protection from Retaliation Interview Agency Head Superintendent 155.367(a) DYRS Policy 2.13IV.C.2.f addresses retaliation of residents and staff who report allegations of sexual abuse and sexual harassment or cooperate with sexual abuse or sexual harassment. The clause states that retaliation from resident or staff will result in disciplinary action and subjection to the full progression of sanctions and/or referral for criminal prosecution. Cited in the Pre-Audit Questionnaire it was stated that all staff should be monitoring for retaliation. It is mandated in the PREA standards that the facility shall have either a designated staff or department to monitor for retaliation. In the PAQ, the facility does have a designated staff to monitor retaliation, but the Superintendent admitted that the designation was not shared with the staff or residents of FSB. During the corrective action period, the designated person was trained to assume the duties to monitor retaliation at FSB. 115.367(b) Auditor questioned the measures taken when there is suspected retaliation as a result of allegations of sexual abuse or sexual harassment. It was determined by Auditor from the interviews with the Agency Head and the Superintendent that housing changes for residents would be made for either the victim or the perpetrator of retaliation. At this time there are 3 different housing units available, but once the facility is fully operational, there will be 6 housing units where a resident can be relocated. If there is an instance of staff retaliation, employment location would be a consideration for either the victim or the perpetrator of retaliation. In the case of a staff member needing to be relocated, there are several juvenile facilities operated by DYRS on the same campus as FSB. Stated prior, DYRS Policy 2.13 provides a provision for referral for criminal prosecution that could result in termination of employment. 115.367(c) Due to FSB not having any allegations of sexual abuse or sexual harassment in the last 12 months, there is no evidence of a 90-day monitoring for the retaliation of allegations of sexual abuse or sexual harassment. During the corrective action period, there was curriculum developed to address 90-day monitoring. Within the Training for Protection from Retaliation, there is language that addresses the 90-day monitoring. 115.367(d) There is no evidence or policy that requires periodic status checks of residents that have experienced retaliation from a report of sexual abuse or sexual harassment. Residents at FSB

	are pro.vided regular appointments with the mental health practitioners. During the corrective action period, curriculum was written to address the periodic status checks of residents that have experienced retaliation from a report of sexual abuse or sexual harassment. 115.367(e) As stated prior in the standard, DYRS Policy 2.13IV.C.2.f retaliation from resident or staff will result in disciplinary action and be subject to the full progression of sanctions and/or referral for criminal prosecution. This policy would apply to individuals who cooperate with the investigation of allegations of sexual abuse and sexual harassment. After corrective action, DYRS does meet the standard of 115.367. FSB has a designated staff that monitors for retaliation. Additionally, the FSB has curriculum that addresses a 90-day monitoring of retaliation resulting from substantiated and founded allegations of sexual abuse and sexual harassment. There is victim support available from the Mental Health Practitioners at FSB. The clause in DYRS Policy 2.13 regarding prohibiting retaliation applies to all individuals including those who cooperated with a sexual abuse or sexual harassment investigation. Corrective Action 115.367- Completed within the 180 day corrective action period. PREA Standard 115.367 mandates that facilities are to have a designated person or department responsible for monitoring retaliation. FSB is to designate individuals or a department to monitor retaliation. The individuals or department is to be trained in monitoring retaliation at FSB. The training can be done by either the PREA Compliance Manager or Agency Training Coordinator. The Auditor shall be provided the signature page and the agenda from training for evidence. This evidence will be provided to the Auditor within 60 days of the Interim Report. FSB provided the training curriculum, Training on Protection from Retaliation and the signed training roster.

115.368	Post-allegation protective custody
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.368 Post-allegation protective custody DYRS Policy 2.13 DYRS Policy 2.20 FS Policy 9.19 Interview Superintendent Random Staff Medical Practitioners Mental Health Practitioners Onsite Tour Random Review of Resident Files Pre-Audit Questionnaire Random Resident Files 115.368(a) According to FS Policy 9.19, residents are to be placed on protective custody to protect a resident from sexual or physical assault. Also, protective custody can only be utilized for 72 hours without the written approval of the Superintendent. A more acceptable plan must be developed to address the protective need in place of continued confinement in a room. In DYRS Policy 2.13, the policy does not specifically state information regarding isolation, but it does address transgender resident, intersex resident, resident assessed as high risk for being victimized or offending or in need of protective housing. Isolation is cited in DYRS Policy 2.2.IV.E.1.c.The policy specifically addresses residents identified as LGBQTI. Stated in the policy resident may be isolated from others only as a last resort when less restrictive measures are inadequate to keep them and other resident safe, and then only until an alternative means of keeping all resident safe can be arranged. The policy does require that resident receive large-muscle exercise and any legally required educational programming or special education services. It was confirmed by the medical and mental health practitioners that they would be required to visit residents in isolation at least once a day. Presently, resident on Administrative Intervention receive visits from the Medical and Mental Health Practitioners. During the onsite audit, there were residents placed on isolation due to suffering from sexual abuse. There were no residents who were isolated due to sexual abuse reported on the Pre-Audit Questionnaire. Auditor reviewed random case files of residents that were identified by PREA Risk Assessment. It was determined that files reviewed by the Auditor found no residents that were placed in isolation who were either a victim or perpetrator of sexual abuse. It is required in policy that a concern must be documented if a resident is placed in isolation and the reasons why alternative means of separation can not be arranged. DYRS Policy 2.13.VIB.2.a exceeds the PREA standard of a resident in isolation be reviewed every 30 days. In the DYRS policy, resident are to be reviewed twice a month to assess any continued threats to safety experienced by resident.

	The Auditor inquired about the use of isolation at the FSB, the Superintendent stated that isolation is not a practice at FSB, but in the case of imminent danger of sexual abuse isolation would be instituted only if there is no other means of supervision. At FSB residents are placed on Administrative Intervention for behavior and security concerns, residents are maintained on housing units or clusters. Protective custody is a means at FSB to protect a resident from imminent threat of sexual abuse. They are not confined to their rooms. According to random staff, all staff are required to monitor resident that are on Administrative Intervention and Protective Custody. This leads the Auditor to believe there would not be specific staff that would monitor isolation or protective custody, because at FSB are all staff are responsible, and residents are not confined to rooms. They are restricted to the housing cluster or housing unit The Auditor interviewed a resident that was placed in the quiet room and on Administrative Intervention. The resident admitted that his behavior was a significant factor in his placement in the Quiet Room and Administrative Intervention. The resident disclosed that he was only in the Quiet Room for a few minutes until he would cooperate with staff's instruction. Resident was immediately placed on Administrative Intervention in which the resident claimed to have been on sanction for a day. The resident was not confined to room, the resident was restricted to the housing unit. According to the Superintendent, protective custody would be to protect a resident who has been sexually abused and a resident that is in imminent risk of sexual abuse. This is in alignment with the facility policy. FSB meets the standard of 115.368 post allegation protective custody. The facility established in policy that isolation is only as a last resort when there is no less restrictive measures are adequate. Resident are provided large muscle exercise, all legally required education, and special education services would be provided. The facility exceeds the requirement set by the PREA standards in reviewing resident in insolation twice a month to access the level of threat. Currently, FSB does not practice isolation. For a resident to be placed in isolation, a PREA Risk Assessment must be completed by FSB mental health practitioner to make the housing determination.

115.371	Criminal and administrative agency investigations
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	DYRS Policy 2.13 Investigators' Certificates Non-Critical Incident Reports Affirmation of Compliance with Investigative Standards for Sexual Assault DYRS and DSP Sexual Violence Incident Form Sexual Abuse Incident Review of Substantiated and Unsubstantiated Outcomes Forms Review of Sexual Abuse and Sexual Harassment Files from PREA Audit 2016 Interviews IA Investigators Superintendent PREA Coordinator Delaware State Police Representative Data Management Analyst 115.371(a) DYRS Policy 2.13.IV.D details criminal and administrative agency investigations. The policy reiterates that all allegations of sexual contact will be reported to the Child Abuse Hotline. Also, any matters that result in criminal action, Institutional Abuse will conduct the investigation jointly with the Delaware State Police (DSP). During the interviews with the 2 investigators, the Auditor understood that the Child Abuse Hotline immediately contacts the Institutional Abuse Investigators. If the Child Abuse Hotline determines the case is a criminal action, IA will jointly investigate with the DSP. If the allegation does not meet the threshold for a criminal investigation, the processing of the investigation is turned back over to FSB. If the allegation is determined to not reach the threshold of criminal actions, the allegations were handled administratively. According to DYRS Policy 2.13, the FSB Administrators and/or FSB Investigator are responsible for administrative investigations and the completion of the Non-Critical Incident Report. During the last 12 months, FSB has not had any allegations of sexual abuse or sexual harassment. 115.371(b) The 2 investigators utilized by DYRS have received the specialized training. Copies of the certificates of completion of the specialized training was uploaded to the Pre-Audit Questionnaire. Additionally, an inquiry was made from the PREA protocols regarding the specialized training that the investigators received. The investigators stated they received training in techniques for interviewing juvenile sexual abuse victims, use of Miranda, Garrity, and Weingarten warnings, evidence collection in confinement, and criteria to substantiate if a case is administrative or criminal. During the interviews with IA, they were unable to identify the designated person or department who monitored retaliation at FSB. The Superintendent was able to identify the monitor of retaliation, but the selection was not disseminated to the staff at FSB or to IA.

115.371(c)
Based upon the investigator responses from past PREA audits, it appears that there answers to the PREA protocols are consistent at all the facilities on the DCYSF Campus. According to the investigators, sexual abuse investigations are done immediately. The IA investigators are scheduled for 1st shift, the Division of Family Services (DFS) monitors the rest of the investigations on second and third shift. The IA Investigator gave the following information when investigating allegations of sexual abuse:

Provide medical care and obtain forensic examination by SANE/SANE
Criminal-Delaware State Police Investigation Unit Troop #2- DSP Detective Assigned
Consult with DSP Prior to compelled interviews
Interview Victim, Perpetrator, and Witnesses
Review Footage and review Logs for Checks
Review FOCUS Database to check criminal history, specifically sexual abuse history
Review Mental Health Records
Complete Required Documentation of Investigation
Non-Critical Incident Reports
Sexual Violence Incident Form
Sexual Abuse Incident Review of Substantiated and Unsubstantiated Outcomes Forms

In the last 12 months, FSB has not had any allegations of sexual abuse that have reached the threshold of criminal prosecution. According to the IA Investigators, evidence weight is a little less when receiving sexual abuse allegations from third-party or anonymously, but the same evidence collection process is utilized.

115.371(d)
According to the statements made by investigators, an investigation is not terminated due to victim or witnesses recanting the allegation of sexual abuse. In the Affirmation of Compliance with Investigative Standards for Sexual Assaults, the DSP will not terminate an investigation solely because the source of the allegation recants the allegation. It was further stated by the investigators and written in the affirmation when an outside agency such as DSP is involved, the role of IA is to jointly investigate the allegation.

115.371(e)
When there is an investigation that produces evidence to support criminal prosecution the IA Investigators stated that a consultation is held with DSP prior to compelled interviews. This consultation is made to ensure obstacles do not impede criminal prosecution.

115.371(f)
At the time of the onsite audit, there were no Residents who reported a sexual abuse. Investigators disclosed that assessing credibility is determined by corroborative evidence, history, and consistency of details of allegation. Residents do not submit to polygraph at FSB.

115.371(g)
Based on review of prior PREA audits, the IA investigators are consistent across the DSCYF Campus in their investigative process. During an investigation, IA is reviewing logs and footage to determine if there was a dereliction of duties that may have resulted in the sexual abuse or sexual harassment.

Upon completion of administrative investigation, the FSB Administrator of the facility PREA investigator documents the investigation on the Non-Critical Reportable Event Form. Documented on this form is the victim's information, facility name, date, facility investigator's name, type of incident, event, injuries, procedural violations, precautions, outstanding request/notifications, time facility was briefed, follow-up issues, persons notified, and copied staff. Specifically, located on the form is a prompt regarding procedural violations which can be utilized to identify any staff dereliction of duties. Attached to this form is the Sexual Violence Incident Form. Another form utilized is the Sexual Abuse Incident Review of Substantiated and Unsubstantiated Outcomes which is completed by the Review Team after the investigation. On this form, there is a prompt pertaining to staff ratios at the time of incident and whether the monitoring technology was adequate.

115.371(h)
FSB has not had any documented criminal investigations of sexual abuse. At the time of the onsite audit, there were no documents to review from a criminal investigation. According to the Pre-Audit Questionnaire, there were no documented criminal investigations of sexual abuse.

115.371(i)
According to the IA Investigators, there have been no substantiated allegations of conduct that was criminal that was referred for prosecution. There have been no criminal investigations of sexual abuse at FSB since the last PREA Audit in 2016. This information was also reported on the Pre-Audit Questionnaire.

115.371(j)
The DYRS Data Analyst maintains all sexual abuse and sexual harassment allegation files in accordance with DYRS Policy 2.13.IV.F.6-7, which states all data collected throughout the division on PREA allegations and all associated reports shall be securely stored by the Management Analyst using a double lock system, and will be retained for no less than 10 years after the date of initial collection unless Federal, State, or local law requires otherwise.

115.371(l)
The Affirmation of Compliance with Investigative Standards for Sexual Assault DYRS and Delaware State Police details the procedures in conducting investigations. The details are aligned with the PREA standards.

115.371(m)
The Affirmation of Compliance with Investigative Standards for Sexual Assault DYRS and Delaware State Police specifically states as a state agency, DSCYF is required to cooperate with DSP investigations.

FSB meets compliance in criminal and administrative agency investigations. The facility has established DYRS 2.13 to address criminal and administrative agency investigations. Additionally, the investigators stated that anonymous and third-party allegations of sexual abuse are investigated. The IA investigators have received specialized training in conducting investigations involving juvenile victims. The investigators' responsibilities include collecting evidence, conducting interviews, and reviewing prior reports and complaints of sexual abuse. Investigations are not terminated due to the recant of allegations. Consultation with DSP

	occurs prior to conducting compelled interviews. DYRS Policy 2.13 does not permit a resident to be administered a polygraph examination. All factors are investigated including staff dereliction of duties that may have contributed to a sexual abuse or sexual harassment. Administrative investigations are documented utilizing a form. All documentation pertaining to allegations of sexual abuse and sexual harassment are maintained by the Management Data Analyst for 10 years. All DSP investigations are according to the Affirmation of Compliance with Investigative Standards for Sexual Assault DYRS and Delaware State Police.

115.372	Evidentiary standard for administrative investigations
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Child Abuse Protocol Interviews Institutional Abuse Investigators FSB PREA Investigator (telephone) 115.372(a) In the last 3 years, there have been no sexual abuse allegations to confirm the practice at FSB imposing a standard of a preponderance of the evidence for determining whether allegations of sexual abuse or sexual harassment are substantiated. During interviews, the IA Investigators and the FSB PREA Investigators stated they impose the standard of a preponderance of the evidence in determining sexual abuse and sexual harassment allegations. It should be noted that the Institutional Abuse Unit is under the umbrella of the Division of Family Services. On page 98 of the Child Abuse Protocol, it is cited that the Division of Family Services (DFS) will make a finding once it has established that a preponderance of the evidence exists. For standard 115.372 evidentiary standard for administrative investigations, DSCYF has demonstrated meeting the standard. The evidentiary standard of preponderance of the evidence is found in the agency's Child Abuse Protocol, and the agency and facility investigators confirmed imposing the evidentiary standard. The FSB has not had any allegations of sexual abuse or sexual harassment so there was an inability to confirm the practice.

115.373	Reporting to residents
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Interviews Superintendent Investigators DYRS Policy 2.13 DYRS Policy 2.13 Attachment E Notification of Investigation Status Form Sexual Abuse Incident Review of Substantiated or Unsubstantiated Outcomes Pre-Audit Questionnaire PREA Mock Incident Review Affirmation of Compliance with Investigative Standards for Sexual Assault between DYRS and DSP 115.373(a) The Auditor ascertained from the interview of the Superintendent at FSB that in the instance of an allegation of sexual abuse and sexual harassment that a resident would be verbally notified. Documented in the PREA Mock Incident Review, the Auditor located in the follow-up section that the Assistant Superintendent would notify the resident of the outcome of the allegations. DYRS Policy 2.13 requires that residents are to be notified of the outcomes of sexual abuse and sexual harassment allegations. DYRS Policy 2.13.IV.D.1.i cites upon notification from Institutional Abuse or Law Enforcement, the program administrator will ensure that the resident is notified of the outcome of the case via the Notification Form. Notification of Investigation Status Form is an attachment to DYRS Policy 2.13. and it is to be utilized when informing resident of the outcomes of an allegation. Due to the absence of sexual abuse and sexual harassment allegations in the last 3 years, the Auditor was unable to verify practice. Residents are usually no longer then a year at FSB. 115.373(b) DYRS facilities conduct administrative investigations utilizing the agency's investigators. As stated previously in Audit Report, allegations of a criminal nature would be conducted jointly between Institutional Abuse Investigators and the Delaware State Police. In the case of an IA and DSP investigation, IA would be responsible for obtaining all updated status reports in accordance to the existing Affirmation of Compliance with Investigative Standards for Sexual Assault DYRS and DSP. 115.373(c) DYRS does not specify the terms of notification for staff on resident sexual abuse allegations. According to DYRS Policy 2.13.IV.D.1.i, the program administrator will ensure that the resident is notified of the outcome of the case utilizing the Notification Form. 115.373(d) The Auditor was only able to confirm through policy that residents are informed of the

	outcomes of allegations of sexual abuse and sexual harassment by the notification form. 115.373(e) FSB utilizes the Notification of Investigation Status Form to document all notifications of sexual harassment and sexual abuse. In the past 12 months, there have been no allegations of sexual abuse or sexual harassment so there have been no notifications. FSB meets compliance for 115.373 reporting to residents. DYRS has a policy that addresses notifying resident of outcomes of allegations of sexual abuse and sexual harassment. There is a form specifically tasked to obtain relevant information regarding the allegation. Also, DYRS has a policy that requires documentation of notifications.

115.376	Disciplinary sanctions for staff
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	DYRS Policy 2.13 DYRS Policy 309 DYRS Policy 313 DSCYF Policy 208 Delaware Department of Human Resources Policy on Sexual Harassment Prevention Pre-Audit Questionnaire Interview Superintendent Human Resource Department Representative 115.376(a) There are several policies utilized by DYRS for disciplinary sanctions up to and including termination for violating agency sexual abuse and sexual harassment. DYRS Policy 2.13.IV.C.1.b, states that failure to report any sexual related incident will result in disciplinary action up to and including termination and/or criminal prosecution. Further found in DYRS Policy 2.13.IV.C.2.f, retaliation from Resident or staff will result in disciplinary action subject to full progression of sanctions and/or referral for criminal prosecution. Lastly in Policy DYRS 2.13.IV.D.e-f, for all incidents that occur in Delaware's state operated facilities, the State will pursue personnel actions that honor due process and decision making that is in the best interest of the child. Upon completion of an investigation, the facility administrator will make a recommendation for training and/or disciplinary action as necessary after consulting with the Human Resource Unit. Another policy that DYRS applies is DYRS Policy 313, and its purpose is to provide a uniform standard of guidance and expectations relative to criminal charges/convictions and child abuse/neglect investigations/substantiations of prospective or current employees, subsequent to an employee's initial hire by setting guidelines for employee conduct. DYRS Policy 309 specifically is for the removal of employees from the workplace. The policy lists the allegations of events that may lead to removal from the workplace. In Delaware Department of Human Resources Policy on Sexual Harassment Prevention states that State employees are strictly prohibited from engaging in any form of sexual harassment. It further states, any employees, who, after a complete and impartial investigation, is found to have engaged in such conduct will be subject to appropriate disciplinary action, up to and including termination. 115.376(b) Reported on the Pre-Audit Questionnaire, there have been no staff that have violated the sexual abuse and sexual harassment policies at FSB. Based on the discussion with the Superintendent and the Human Resource Unit Representative, there was no staff member terminated for sexual abuse or sexual harassment. Based on the policies established by DYRS, termination is the presumptive disciplinary sanction for staff who have engaged in

sexual abuse. There has been no staff that has been terminated or resigned for violating DYRS sexual abuse or sexual harassment policies at FSB.

115.376(c)
Prior to disciplinary action, DYRS Administrators consult with the Human Resource Unit. This was confirmed during an interview with the Human Resource Unit Representative. Stated in DYRS Policy 2.13.IV.D.e-f, all incidents that occur in Delaware's state operated facilities, the State will pursue personnel actions that honor due process and decision making that is in the best interest of the child. Upon completion of an investigation, the facility administrator will make a recommendation for training and/or disciplinary action as necessary after consulting with the Human Resource Unit.

115.376(d)
In policy, terminations and resignations in lieu of termination for sexual abuse and sexual harassment are reported to law enforcement agencies and relevant licensing agencies. It is cited in DSCYF Policy 208.V.E-F, formulate findings and cite concerns based upon the information obtained during the investigation. The findings and concerns will be distributed to the appropriate Division or external entity. Documented on the Pre-Audit Questionnaire, there was no instances that DSCYF had to report findings of sexual abuse or sexual harassment to law enforcement or a licensing agency for the last 12 months.

DYRS meets compliance in the standard of 115.376 disciplinary sanctions for staff. Policies are established that allow for disciplinary sanctions up to and including termination for violating agency sexual abuse and sexual harassment. In all policies, termination is the presumptive disciplinary sanction for staff who have engaged in sexual abuse. Prior to disciplinary sanctions, the human resource department is consulted. Stated within policy terminations and resignation prior to termination resulting from sexual abuse or sexual harassment will be reported to law enforcement agencies and relevant licensing agencies.

115.377	Corrective action for contractors and volunteers
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	DYRS Policy 2.13 DYRS Policy 313 DSCYF Policy 305 DSCYF Policy 309 DSCYF Policy 208 Child Abuse Protocol Interview Superintendent Volunteers Contractors Medical Practitioner Criminal Background Unit Representative 115.377(a) DYRS Policy considers volunteers and contractors as equivalent to DYRS employees. In DYRS Policy 2.13.III.A for the purpose of this policy, staff is defined as any Department Employee, volunteer, contractor, official visitor, or other agency representative. The Auditor interpreted the agency was taking the position of disciplinary actions are not discriminate of role or position at FSB or any DYRS operated facility. Any individual with allegations of committing sexual abuse and sexual harassment will be removed from FSB. The policy also mentions the failure to report any sexually related incident will result in disciplinary action up to and including termination and/or criminal prosecution. Section C:1 of the Child Abuse Protocol states that DYRS staff and contractors must also make an immediate report to the Child Abuse Hotline and law enforcement jurisdiction for all allegations of sexual abuse involving children in state operated or contracted residential facilities including child on child and staff on child. According to Criminal History Unit, DYRS requires background checks of all volunteers and contractors prior to providing services. In the purpose clause of DYRS Policy 313, it is mentioned to ensure that no individual will be hired or retained if he/she poses a potential for risk or harm to children/residents served by the Department. Within DYRS Policy 313 there is a reference to Title 31, Chapter 3, Section 309 of the Delaware Code which requires a check of State Bureau of Investigations and the Federal Bureau of Investigations records and the 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. Additionally, DYRS Policy 305.V.A.1, states that volunteers/interns shall only begin their volunteer/internship work after required criminal history background checks and drug screening have been completed. During the last 12 months, there were no contractors or volunteers alleged of committing sexual abuse at FSB nor were there any reports made to law enforcement or relevant licensing bodies for contractors or volunteers engaging in sexual abuse of residents at FSB.

	115.377(b) DSCYF Policy 309 requires that employees, which includes contractors and vendors, be removed from the workplace when there are allegations of physical or sexual abuse against a resident. The Superintendent mentioned that the Child Abuse Hotline would be notified in all cases of sexual abuse and sexual harassment. Institutional Abuse Investigators make the determination of administrative or criminal. Perpetrator of sexual abuse whether FSB staff, contractor, or volunteer would be removed until investigation is complete, and based on the findings of the investigators, there will a determination of outcomes. In the last 12 months, there were no instances of volunteers or contractors committing sexual abuse, so there was no opportunity to review practice. DYRS meets compliance in 115.377 corrective action for contractors and volunteers. The agency has created policy to address the reporting of contractors and volunteers who engage in sexual abuse of residents at FSB to be reported to law enforcement and relevant licensing bodies. The policies require SBI and FBI background checks and the local child abuse registry to be checked. FSB takes the same remedial measures and prohibits contact with contractors and volunteers as FSB employees.

115.378	Interventions and disciplinary sanctions for residents
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	DYRS Policy 2.13 DYRS Policy 2.20 FS 9.19 Pre-Audit Questionnaire Cognitive Behavior Treatment Interview Superintendent Assistant Superintendent Mental Health Practitioner 115.378(a) In the case of an allegation of sexual abuse and sexual harassment, FSB would follow DYRS Policy 2.13.IV.C.2.h regarding sanctions for substantiated allegations of sexual abuse and sexual harassment by a resident. The following of this policy was confirmed with the Superintendent and Assistant Superintendent. Sexual harassment and sexual abuse shall be addressed in the behavioral management program and medical follow-up. Documented on the Pre-Audit Questionnaires, there has been no administrative or criminal finding of resident on resident sexual abuse at FSB in the past 12 months. 115.378(b) FSB does not utilize the practice of isolation. Isolation is not used as a disciplinary sanction at FSB. Isolation is only used as a last resort to protect a resident from eminent risk of sexual abuse in accordance to DYRS Policy 2.20.IV.E.2.c. Listed in the Pre Audit Questionnaire is policy FS 9.19 which states protective custody (PC) is defined as the segregation of a resident from other residents due to the threat of danger or extreme risk presented by others that is not disciplinary in action. More specifically, PC may be used to protect a resident from sexual or physical assault or other forms of abuse. It is only to be used for no more than 72 hours without the consent of the Superintendent, and a more acceptable plan must be developed to address the protective need instead of continued confinement. The sanctions/discipline utilized are via the Cognitive Behavior Treatment (CBT). 115.378(c) At FSB, all discipline/sanctions are determined utilizing Cognitive Behavior Treatment (CBT). Residents are acclimated to the model upon arrival to the FSB. The facility utilizes mental and medical professionals to inform FSB administration to determine the resident's mental disabilities or mental illness that may contribute to the actions. FSB has a regular dedicated meeting where residents are discussed. 115.378(d) DYRS Policy 2.13.IV.C.2.i, highlights sexual harassment and sexual abuse shall be addressed in the behavioral management programs, given appropriate medical follow-up and compliance with all reporting procedures.

115.378(e)
Garnered from DYRS policy a resident will receive discipline/sanction for committing sexual misconduct against a staff if the staff member did not consent. The same procedures apply to investigations and discipline of all sexual abuse and sexual harassment allegations. The allegation must be reported to the Child Abuse Hotline. A determination will be made regarding investigative process whether the case is to be processed by administration, Institutional Abuse, or by the Delaware State Police. If the actions of the resident is criminal, the case would proceed to the prosecutor. In either case of administrative or criminal findings, the resident would be disciplined/sanctioned utilizing the Cognitive Behavior Treatment Model.

115.378(f)
When a resident reports an allegation of sexual abuse and sexual harassment in good faith, DYRS Policy 2.13IV.C.2.i prohibits the disciplinary action of the resident.

115.378(g)
DYRS prohibits consensual sexual activity between resident in DYRS Policy 2.13.IV.C.2.h. The behavior is addressed through the established behavioral management program.

FSB meets compliance in 115.378 interventions and disciplinary sanctions for residents. Upon the administrative or criminal finding of engaging in resident on resident sexual abuse, FSB utilizes Cognitive Behavior Treatment to address discipline/sanctions for sexual abuse and sexual harassment. FSB does not utilize isolation for punitive measures. PC is utilized in the occasion of imminent risk of sexual abuse. The facility utilizes the Cognitive Behavior Treatment, but also consults with mental health to determine the resident's mental disabilities and mental illness. If a staff member is sexually abused by a resident and the staff is found to be non-consensual, the resident can be disciplined both administratively and criminally. Resident will not be disciplined in making a good faith report of sexual abuse or sexual harassment that results in being unsubstantiated.

115.381	Medical and mental health screenings; history of sexual abuse
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Memorandum of Understanding between the Division of Prevention and Behavioral Health Services and the Division of Resident Rehabilitative Services PREA Risk Assessment Pre-Audit Questionnaire Resident Records Interviewed Mental Health Practitioner Medical Practitioner 115.381(a) On 2/21/19, the Memorandum of Understanding between the Division of Prevention and Behavioral Health Services and the Division of Resident Rehabilitative Services was renewed. The memorandum was established to facilitate a collaborative partnership in order to comply with the PREA standards. The document does not require that a Resident identified as having prior sexual victimization be offered follow-up services in 14 days of intake. According to the Pre-Audit Questionnaire within the last 12 months, 100% of the residents identified as prior sexual abuse victims were offered an opportunity for a follow-up meeting. Secondary documentation such as case notes of residents receiving 14-day follow up is located on the agency's database, FOCUS. Only the Mental Health Practitioner and the Medical Practitioner have access to resident case notes from follow-up sessions and the PREA Risk Assessment located on the database. 115.381(b) Memorandum of Understanding between the Division of Prevention and Behavioral Health Services and the Division of Resident Rehabilitative Services does not include providing follow-up services to residents who had previously perpetrated sexual abuse. In the past 12 months on the Pre-Audit Questionnaire, a 100% of residents at FSB were identified as being offered follow-up services within 14 days of intake. Evidence was located on documents reviewed from FOCUS of the 14-day follow-up after intake being offered and provided to residents. Additionally, this information was also reviewed onsite and on the Pre-Audit Questionnaire. 115.381(b) According to the Medical and Mental Health Practitioner, access to information relating to resident being sexually victimized and/or sexually abusive is maintained in FOCUS. The database restricts access to this information to only the medical and mental health departments. The Mental Health Practitioner stated that the information is only disseminated solely for security and management purposes. 115.381(d) Majority of residents at FSB are under the age of 18. The Mental Health and Medical Practitioner stated informed consent was obtained prior to reporting any information from anyone 18 years or older. It was further disclosed to the Auditor that residents are informed that confidentiality is limited regarding self-harm and elopement.

	FSB does meet compliance in 115.381. The Auditor was able to review the practice of documenting on Focus the follow up of residents receiving 14-day follow-up after intake for cases of prior sexual victimization or sexual abuse. There is no specific policy or documentation requiring the 14-day follow-up after intake for residents identified as having been sexually victimized and residents identified as a sexual abuser. It is evident from the interview with both Medical and Mental Health Practitioners that documentation regarding Resident PREA Risk Assessments are limited to the department.

115.382	Access to emergency medical and mental health services
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Child Sexual Abuse Protocols Medical and Mental Health Staff PREA Risk Assessment Affirmation of Compliance with Forensic Examinations Standards for Sexual Assault DYRS Policy 7.3 Interview SANE/SAFE Coordinator (telephone) Medical Practitioner Mental Health Practitioner 115.382(a) In DYRS policy and the Child Sexual Abuse Protocol residents that experience sexual abuse shall be offered timely, unimpeded access to emergency medical treatment and crisis intervention. DYRS 7.3 details the procedures for a medical emergency. Personnel shall be trained to respond within 4 minutes. Staff is to determine medical emergency and notify appropriate medical personnel or medical emergency services. Within the policy is the sequence of calls: 1. Ambulance or Paramedic 2. Physician in charge 3. Facility Superintendent or designee 4. Deputy Director 5. Parent, guardian, or legal custodian On page 94 of the Child Abuse Protocols, it is mentioned that PREA requires that residents who experience sexual abuse in state operated or contracted facilities have access to forensic medical examinations. PREA also requires that DYRS staff and its contractors ensure that residents have timely access to emergency medical treatment, including emergency contraception and sexually transmitted infectious prophylaxis. According to DYRS Policy 2.13.IV.2.a all gathering of physical evidence and treatment are to be done by SANE/SAFE in a hospital setting by either Christiana Care Hospital or A.I. Dupont Hospital. Documentation of incident would be maintained by the Mental Health and Medical Practitioners at FSB. During the onsite audit there were no residents identified as being sexually abused at FSB. This was further confirmed by the Medical and Mental Health Practitioner at FSB. 115.382(b) Previously, it was mentioned that first responder duties include separating victim and seeking medical attention so if there is no qualified medical or mental health practitioners available onsite, the staff recourse is to refer to DYRS Policy 7.3 which requires the staff to seek medical services which would be at the hospital. 115.382(c) Affirmation of Compliance with Forensic Examinations Standards for Sexual Assault is

	between Christiana Care Hospital and DYRS. Through this agreement, forensic examinations are made available without consideration of cost to resident where evidentiary or medically appropriate by SANE/SAFE. Further, the affirmation does not readily list the services that are provided, but the Child Sexual Abuse Protocols does list the services. In addition, the Auditor concluded since the affirmation is based on the National Protocol for Sexual Assaults Medical Forensic Examinations Adults/Adolescents the services provided include offering timely information about emergency contraception and sexually transmitted infections prophylaxis. During the interview with the SANE/SAFE Coordinator and the Medical Practitioner, it was further confirmed that these services would be made available to residents who experienced sexual abuse at FSB. 115.382(d) Further in the Child Abuse Protocol, there is mention of the Division of Prevention and Behavioral Health Services (DPBHS) providing outpatient treatment and supportive services to residents who are uninsured or insured by Medicaid. Also, the DYRS existing memorandum of agreement with SOAR makes available victim services. The affirmation does state that the hospital attempts to make available to the victim, a victim advocate from a rape crisis center. The advocate would provide support through the forensic medical examination process, investigatory interviews, assist in emotional support, crisis intervention, information, and referrals. DYRS meets the standard for 115.382 access to emergency medical and mental health services. Based on policy, residents are provided timely and unimpeded access to emergency medical treatment and crisis intervention. Practice of the access to emergency medical and mental health services was not available, because there were no residents who reported sexual abuse. Random staff stated that first responder protocols would immediately begin based on the training and the DYRS policy. Lastly, residents are provided services in accordance to the Affirmation of Compliance with Forensic Examinations Standards for Sexual Assault which is based on the National Protocol for Sexual Assaults Medical Forensic Examinations Adults/Adolescents.

115.383	Ongoing medical and mental health care for sexual abuse victims and abusers
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Child Sexual Abuse Protocol DYRS Policy 2.13 Interview Medical Practitioner Mental Health Practitioner Affirmation of Compliance with Forensic Examinations Standards 115.383(a) Residents at FSB would be offered medical and mental health care in the incidence of sexual abuse. DYRS Policy 2.13 requires that Residents are provided the services. Additionally, the Child Sexual Abuse Protocol outlines the medical and mental health services required. It is also stated that medical services such as forensic examination will be provided in a hospital setting. 115.383(b) Contained within the Child Sexual Abuse Protocol are requirements that residents receive follow-up services, treatment plans and necessary referrals to continue care. Specifically, it is written the child and family should be connected to any needed behavioral health and social services in order to reduce trauma, promote healing and improve outcomes. Disclosed by both Medical and Mental Health Practitioners released residents who experienced sexual abuse at FSB would be provided information to seek medical and mental health support. DYRS Policy 2.13.E.2 details that if a resident needs services in the community that contact information will be made available. 115.383(c) Based on interviews with the Medical and Mental Health Practitioners, the medical and mental health services provided were equal if not better than the services rendered in the community. It was also shared residents appeared to utilize the services at FSB more frequently than in the community. When the Auditor inquired, residents almost all agreed they were satisfied with the services. 115.383(d&e) N/A All Male Facility 115.383(f & g) Through the Affirmation of Compliance with Forensic Examinations Standards for Sexual Assault and the Child Abuse Protocol, victims of sexual abuse will be offered tests for sexually transmitted infections. Treatment services would be provided without financial cost and without conditions. 115.383(h) The Memorandum of Understanding between the Division of Prevention and Behavioral Health Services and the Division of Residents Rehabilitative Services does not state the

	specifics of providing resident on resident abusers a 60-day follow up. There is no language in the document that speaks to these services being provided, but the facilities practice of providing 14-day follow-up without policy or written documentation, leads the Auditor to ascertain that if deemed necessary the mental health practitioners at FSB would follow-up with a mental health evaluation. In the goal section of the document, it is stated that that the primary goal is to identify youth at risk for being sexually victimized, as well as those at risk for sexually victimizing others in order to limit such risk. FSB meets the standard 115.383 ongoing medical and mental health care for sexual abuse victims and abusers through policy and memorandum of agreement. FSB offers medical, mental health evaluations, and treatment to residents who experience being a victim of sexual abuse. Residents would obtain follow-up services and treatment. Upon release from FSB, residents would be provided referrals to continue care. The facility provides services equivalent to the services provided in the community. The medical services provided are provided by a community provider. Additionally, services be will provided without cost or conditions.

115.386	Sexual abuse incident reviews
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Review of Sexual Abuse Incident Review of Substantiated or Unsubstantiated Outcomes DYRS Policy 2.13 PREA Mock Incident Review-FSB 6/4/19 Interview Superintendent Medical Practitioner Mental Health Practitioner 115.386(a) FSB utilizes an Incident Review Team to discuss incidents of sexual abuse and sexual harassment. Per DYRS 2.13IV.D.4 incident reviews are to occur within 30 days of the report of the investigation or 45 days if investigation is extended. The review is to be done for all allegations of sexual abuse and sexual harassment. In the event, there is no sexual abuse or sexual harassment allegation, the facility is to have a mock incident review. Since there were no allegations in the past 12 months, the facility completed a PREA Mock Incident Review. The team was convened to review an investigation to determine if there are needs or changes to prevent, detect, or respond to sexual abuse or sexual harassment for example: 1. Change policy or practice 2. Motivating factor for incident or allegation 3. Were there any physical barriers that may have enabled abuse 4. Adequacy of staffing levels 5. Assess monitoring technology to supplement supervision by staff This information is located on the Sexual Abuse Incident Review of Substantiated or Un-Substantiated Outcomes Form. On the mock incident, the Superintendent detailed the areas of concern. 115.386(b) Since there were no allegations of sexual abuse and sexual harassment, FSB facilitated the PREA Mock Incident Review. It was completed the same day of the alleged incident. The Sexual Abuse Incident Review of Substantiated and Unsubstantiated Outcomes does indicate that the review is to be completed within 30 days of incident. 115.386(c) In accordance with the PREA standards and the DYRS Policy.IV.D.4.d. the review team is to consist of upper level management officials, with input from line supervisors, investigators, and medical and mental health practitioners. The participants in the PREA Mock Incident Review included the following: Superintendent Assistant Superintendent PREA Compliance Manager

	Registered Nurse 2 Treatment Supervisors 2 Psychologists Food Service Director 2 Program Managers 115.386(d) Review of the form utilized for the review team, there is a section titled Findings of Team. PREA standard requires that the findings are shared with facility head and the PREA Compliance Manager. Both the Superintendent and the PREA Compliance Manager participate on the review team. There is a section for Final Recommendations. 115.386(e) DYRS Policy 2.13.IV.D.4.f requires the review team to prepare a report of findings and any recommendations for improvement and submit the report to the Agency Head, PREA Compliance Manager, Deputy Director, and the Management Analyst. Recommendations shall be implemented or shall document its reasons for not doing so in the report. The Auditor found the mock incident completed a Sexual Abuse Incident Review of Substantiated or Unsubstantiated Outcomes, and the form contained information required by the DYRS policy as well as the PREA standard. For the standard 115.386 sexual abuse incident review FSB does meet the standard. The facility has all the required members of the Incident Review Team participating in the mock review. FSB does conduct a sexual abuse incident review of all criminal and administrative sexual abuse investigations, and when there are no allegations of sexual abuse or sexual harassment the facility facilitates a mock review. The Sexual Abuse Incident Review of Substantiated or Unsubstantiated Outcomes requires that review is done within 30 days of the conclusion of the investigation. The review does consider all required factors listed in the PREA standards. The form that the team utilizes includes findings, recommendations, and it documents if recommendations are implemented. If the recommendations are not implemented there is a section where the reason can be documented.

115.387	Data collection
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Operating Guidelines for Contracted Children and Family Programs and Services DYRS Policy 2.13 Attachment A- Sexual Violence Incident Form Details Information of Allegation Attachment B-Sexual Violence Incident Form Victim Attachment C- Sexual Violence Incident Form Youth on Youth Perpetrator Attachment D- Sexual Violence Incident Form Staff on Adult Perpetrator Interview Management Data Analyst 115.387(a) The Auditor was unable to review records for FSB, because the facility has not had any sexual abuse or sexual harassment allegations in the past 3 years. The Management Analyst met with the Auditor recently for another PREA audit on the campus. During the interview with the Management Data Analyst it was determined that the state operated facilities document information pertaining to sexual abuse and sexual harassment allegations utilizing the attached forms on DYRS Policy 2.13. These attachments are utilized at all the DYRS state operated facilities. Attachment A is the Sexual Violence Incident Form which captures the pertinent information such as date, time, facility, and location. It lists the number of victims and perpetrators. Lastly, the form identifies the type of sexual violence whether the allegation is nonconsensual sexual act, abusive sexual act, or sexual harassment. The remainder of the forms are utilized to identify specifically the victim, resident perpetrator, or adult perpetrator. The policy requires that administrators provide internal investigation outcomes for data collection. 115.387(b) The Management Data Analyst is responsible for aggregating the incident sexual abuse and sexual harassment data and providing the data quarterly to the Deputy Director per DYRS Policy 2.13.IV. 115.387(c) The information obtained from the attachments to DYRS 2.13 provide the data to complete the annual Survey of Sexual Violence required by the Department of Justice. 115.387(d) According to the Management Data Analyst, all documentation is maintained, reviewed, and collected from the Non-Critical Incident Reports, Incident Review Forms, and Sexual Abuse Incident Forms and attachments. This information is collected to provide aggregated data to the public via the agency's website as well as the annual Survey of Sexual Violence required by the Department of Justice. 115.387(e) During the interview with the Management Data Analyst, the Auditor reviewed data from state operated facilities and contracted facilities. Within the Operating Guidelines for Contracted

Children and Family Programs and Services, contracted facilities are to provide incident based and aggregated information to DYRS.

115.387(f)
The Management Data Analyst provides requested data to the Department of Justice annually. Additionally, the information is published on the agency's website.

DYRS meets compliance for the standard 115.387 data collection. The agency collects uniformed data for every allegation of sexual abuse and sexual harassment. Quarterly, the agency aggregates data, and utilizes information to complete the Survey of Sexual Violence. The Management Data Analyst maintains, reviews, and collects data from the Non-Critical Incident Reports, Incident Review Forms, and Sexual Abuse Incident Forms and attachments. Also, the agency collects data from both the state operated and private contracted facilities for the confinement of its residents. Lastly, the Management Data Analyst provides requested data to the Department of Justice.

115.388	Data review for corrective action

Auditor Overall Determination: Meets Standard

Auditor Discussion

DYRS Policy 2.13
Interviews
Agency Head
Director's Meeting Minutes November 2019
https:/kids/Delaware.gov/yrs/prea-reports.shtml

115.388(a)
Based on the notes obtained from the Director's meeting held on November 28, 2018, the Agency Head reviewed information on the data as it relates to sexual abuse and sexual harassment. In reviewing the minutes, there was a discussion regarding PREA staffing levels, investigations, determination of findings, and the types of PREA reports that should be generated and shared with the public going forward. According to Agency Head during the interview, information obtained from data is utilized to make necessary improvements such as staffing, policy, training, or making upgrades to the facility. The new Agency Head will be approving the Annual Report for CY2018. It was disclosed to the Auditor that there will be some changes and additions to the report.

115.388(b)
Per DYRS Policy 2.13.IV.F.1-5, the agency is responsible for reviewing collected information on sexual abuse and sexual harassment in the state operated and contracted facilities in order to report publicly. The report should include findings along with current year's data and corrective actions. In addition, an assessment of the agency's progress regarding sexual abuse was not included. When reviewing the documents on the Agency's website, there were DYRS PREA Annual Reports dating back to CY2012, but the reports lack comparison of years or specific corrective actions.

	115.388(c) DYRS Annual Reports are publicly available on https:/kids/Delaware.gov/yrs/prea-reports.shtml. The annual report was approved by the previous Agency Head. According to the Agency Head, there will be changes in the information contained in the Annual Report like comparative information and corrective action information. 115.388(d) There were no personal identifiers included on the reports for the privacy of the individuals involved in the allegations of sexual abuse and sexual harassment. The agency did not specify redaction. DYRS meets compliance for the standard of 115.388 data review for corrective action. The agency demonstrated use of data for decision making and discussion. DYRS publishes the data for the public review on the agency's website. All Annual Reports from CY2012 are available. The Annual Report was approved and published to the public by the previous Agency Head. Information was redacted from the reports in order to protect the privacy of residents and staff.

115.389	Data storage, publication, and destruction
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	DYRS Policy 2.13 Interview Management Data Analyst 115.389(a) During the onsite audit of FSB, the Data Management Analyst was interviewed. Recently, the position was interviewed for the PREA audit of the New Castle County Detention Center. There were no changes to the Auditor's findings from the last audit. As the PREA Coordinator has recently taken on the position, the Auditor again decided to interview the Management Data Analyst. The position has historical knowledge of the data utilization, collection, maintenance, and publishing. The agency ensures the incident-based and aggregate data are securely retained. During the interview with the Management Data Analyst, the Auditor asked to view the location of the documentation. The documents were found to be secured. In DYRS Policy 2.13.IV.F.6-7, it is cited that all data collected throughout the division on PREA allegations and all associated reports shall be securely stored by the Management Analyst using a double lock system. The Management Data Analyst showed the Auditor the locking system. 115.389(b) Mentioned in DYRS Policy 2.13, aggregated data from private contracted residential facilities is contained on the annual report and made public via the agency's website. The Auditor reviewed the Annual Reports on the website, it was found that private contractors provided the aggregated data required. 115.389(c) Review by the Auditor of all Annual Reports on the agency's website reveal there were no personal identifiers on the information published. 115.389(D) Upon review of the files in the Management Data Analyst office, there were files that were available beyond 2012. DYRS Policy 2.13.IV.F.7 states that files are to be retained for no less than 10 years unless Federal, State, or local law requires the destruction. DYRS meets compliance in the standard of 115.389 data storage, publication, and destruction. DYRS ensures that all information and data is securely retained in a double lock system. Annually, sexual abuse and sexual harassment data is aggregated for state operated facilities and contracted facilities to be published to the public on the Agency's website. Prior to information being made public, all personal identifiers are removed. Sexual Abuse data is retained for at least 10 years unless federal, state, or local law prohibits.

115.401	Frequency and scope of audits
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.401(a) After reviewing the Department of Services for Children, Youth, and their Families' website, the Auditor has determined that the agency has complied with the auditing of all the state operated facilities on an every 3-year cycle since August 20, 2013. Below find names of facilities and year and cycle. New Castle County Detention Center Year 3 Cycle 2-Final Report Ferris School for Boys Year 3 Cycle 2- Final Report Residential Cottages Year 1 Cycle 2-Final Report Stevenson House Detention Year 2 Cycle 2-Final Report 115.401(b) DSCYF has met the PREA mandate of having at least two-thirds of each facility type audited during the first two years of the audit cycle. 115.401(h) During the onsite audit at FSB, the Auditor was given full access to the entire facility. There was an issue log maintained via email by the Auditor and the PREA Coordinator. The PREA Coordinator provided all documents requested on issue log, and they were uploaded to the PREA Audit System. Additional information was obtained during onsite portion of the audit. Information was provided in a timely manner. During the onsite audit the Auditor was provided with logbooks, electronically stored information, post assignments, residents population list, and staffing list. 115.401(m) The Auditor was permitted to conduct private interviews with residents in the interview room and program classrooms at FSB. Both rooms were adequate to hold confidential interviews with residents. Staff interviews were held in the administration conference room, and the room was adequate to hold confidential interviews. 115.401(n) Information was posted throughout the building which detailed the onsite audit. The posting included the Auditors name and mailing address. The PREA Coordinator confirmed that residents would be permitted to send confidential correspondence to the Auditor in the same manner as communicating with legal counsel. The postings were displayed throughout facility within six weeks of onsite audit, and the Auditor was provided time stamped pictures of the postings. DSCYF meets compliance in the standard 115.401 frequency and scope of audits. All state operated audits have been either completed for this cycle or they are scheduled for this cycle. The agency has also ensured that two-thirds of each facility type has been completed by the third cycle. The Auditor had full access to the facility and ability to observe all areas of FSB. The PREA Coordinator and the Auditor maintained an email issue log, and the PREA

	Coordinator provided all requested documents via the PREA Audit System. While onsite, the Auditor was provided requested documentation and electronically stored information.

115.403	Audit contents and findings
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.403(f) DSCYF has published final reports for state operated facilities on the agency's website https://kids.delaware.gov/yes/prea-reports.shtml . Below find the name of the facility, date of final report, or status. New Castle County Detention Center October 14, 2016 & September 29, 2109 Ferris School for Boys September 21, 2016 & October 1, 2019 Residential Cottages December 14, 2015 & August 8, 2017 Stevenson House Detention December 31, 2015 & July 18, 2018 DSCYF meets the standard of 115.403 audit contents and findings. The agency has published to the public all the state operated facilities' final reports.

Appendix: Provision Findings

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

115.311 (b)	Zero tolerance of sexual abuse and sexual harassment; PREA coordinator	
	Has the agency employed or designated an agency-wide PREA Coordinator?	yes
	Is the PREA Coordinator position in the upper-level of the agency hierarchy?	yes
	Does the PREA Coordinator have sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards in all of its facilities?	yes

115.311 (c)	Zero tolerance of sexual abuse and sexual harassment; PREA coordinator	
	If this agency operates more than one facility, has each facility designated a PREA compliance manager? (N/A if agency operates only one facility.)	yes
	Does the PREA compliance manager have sufficient time and authority to coordinate the facility's efforts to comply with the PREA standards? (N/A if agency operates only one facility.)	yes

115.312 (a)	Contracting with other entities for the confinement of residents	
	If this agency is public and it contracts for the confinement of its residents with private agencies or other entities including other government agencies, has the agency included the entity's obligation to adopt and comply with the PREA standards in any new contract or contract renewal signed on or after August 20, 2012? (N/A if the agency does not contract with private agencies or other entities for the confinement of residents.)	yes

115.312 (b)	Contracting with other entities for the confinement of residents	
	Does any new contract or contract renewal signed on or after August 20, 2012 provide for agency contract monitoring to ensure that the contractor is complying with the PREA standards? (N/A if the agency does not contract with private agencies or other entities for the confinement of residents OR the response to 115.312(a)-1 is "NO".)	yes

115.313 (a)	Supervision and monitoring	
	Does the agency ensure that each facility has developed a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse?	yes
	Does the agency ensure that each facility has implemented a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse?	yes
	Does the agency ensure that each facility has documented a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse?	yes
	Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: The prevalence of substantiated and unsubstantiated incidents of sexual abuse?	yes
	Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Generally accepted juvenile detention and correctional/secure residential practices?	yes
	Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any judicial findings of inadequacy?	no
	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?	no
	Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any findings of inadequacy from internal or external oversight bodies?	no

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

115.315 (a)	Limits to cross-gender viewing and searches	
	Does the facility always refrain from conducting any cross-gender strip or cross-gender visual body cavity searches, except in exigent circumstances or by medical practitioners?	yes

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

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

115.315 (d)	Limits to cross-gender viewing and searches	
	Does the facility implement policies and procedures that enable residents to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks?	yes
	Does the facility require staff of the opposite gender to announce their presence when entering a resident housing unit?	yes
	In facilities (such as group homes) that do not contain discrete housing units, does the facility require staff of the opposite gender to announce their presence when entering an area where residents are likely to be showering, performing bodily functions, or changing clothing? (N/A for facilities with discrete housing units)	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 determine genital status during conversations with the resident, by reviewing medical records, or, if necessary, by learning that information as part of a broader medical examination conducted in private by a medical practitioner?	yes

115.315 (f)	Limits to cross-gender viewing and searches	
	Does the facility/agency train security staff in how to conduct cross-gender pat down searches in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs?	yes
	Does the facility/agency train security staff in how to conduct searches of transgender and intersex residents in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs?	yes

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

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

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

115.316 (b)	Residents with disabilities and residents who are limited English proficient	
	Does the agency take reasonable steps to ensure meaningful access to all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment to residents who are limited English proficient?	yes
	Do these steps include providing interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary?	yes

115.316 (c)	Residents with disabilities and residents who are limited English proficient	
	Does the agency always refrain from relying on resident interpreters, resident readers, or other types of resident assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the resident's safety, the performance of first-response duties under §115.364, or the investigation of the resident's allegations?	yes

115.317 (a)	Hiring and promotion decisions	
	Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997)?	yes
	Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse?	yes
	Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has been civilly or administratively adjudicated to have engaged in the activity described in the bullet immediately above?	yes
	Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997)?	yes
	Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse?	yes
	Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has been civilly or administratively adjudicated to have engaged in the activity described in the two bullets immediately above?	yes

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

115.317 (c)	Hiring and promotion decisions	
	Before hiring new employees who may have contact with residents, does the agency: Perform a criminal background records check?	yes
	Before hiring new employees who may have contact with residents, does the agency: Consult any child abuse registry maintained by the State or locality in which the employee would work?	yes
	Before hiring new employees who may have contact with residents, does the agency: Consistent with Federal, State, and local law, make its best efforts to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse?	yes

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

115.317 (e)	Hiring and promotion decisions	
	Does the agency either conduct criminal background records checks at least every five years of current employees and contractors who may have contact with residents or have in place a system for otherwise capturing such information for current employees?	yes

115.317 (f)	Hiring and promotion decisions	
	Does the agency ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in written applications or interviews for hiring or promotions?	yes
	Does the agency ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in any interviews or written self-evaluations conducted as part of reviews of current employees?	yes
	Does the agency impose upon employees a continuing affirmative duty to disclose any such misconduct?	yes

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

115.317 (h)	Hiring and promotion decisions	
	Unless prohibited by law, does the agency provide information on substantiated allegations of sexual abuse or sexual harassment involving a former employee upon receiving a request from an institutional employer for whom such employee has applied to work? (N/A if providing information on substantiated allegations of sexual abuse or sexual harassment involving a former employee is prohibited by law.)	yes

115.318 (a)	Upgrades to facilities and technologies	
	If the agency designed or acquired any new facility or planned any substantial expansion or modification of existing facilities, did the agency consider the effect of the design, acquisition, expansion, or modification upon the agency's ability to protect residents from sexual abuse? (N/A if agency/facility has not acquired a new facility or made a substantial expansion to existing facilities since August 20, 2012, or since the last PREA audit, whichever is later.)	na

115.318 (b)	Upgrades to facilities and technologies	
	If the agency installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology, did the agency consider how such technology may enhance the agency's ability to protect residents from sexual abuse? (N/A if agency/facility has not installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology since August 20, 2012, or since the last PREA audit, whichever is later.)	yes

115.321 (a)	Evidence protocol and forensic medical examinations	
	If the agency is responsible for investigating allegations of sexual abuse, does the agency follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.)	yes

115.321 (b)	Evidence protocol and forensic medical examinations	
	Is this protocol developmentally appropriate for youth? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.)	yes
	Is this protocol, as appropriate, adapted from or otherwise based on the most recent edition of the U.S. Department of Justice's Office on Violence Against Women publication, "A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents," or similarly comprehensive and authoritative protocols developed after 2011? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.)	yes

115.321 (c)	Evidence protocol and forensic medical examinations	
	Does the agency offer all residents who experience sexual abuse access to forensic medical examinations, whether on-site or at an outside facility, without financial cost, where evidentiarily or medically appropriate?	yes
	Are such examinations performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) where possible?	yes
	If SAFEs or SANEs cannot be made available, is the examination performed by other qualified medical practitioners (they must have been specifically trained to conduct sexual assault forensic exams)?	yes
	Has the agency documented its efforts to provide SAFEs or SANEs?	yes

115.321 (d)	Evidence protocol and forensic medical examinations	
	Does the agency attempt to make available to the victim a victim advocate from a rape crisis center?	yes
	If a rape crisis center is not available to provide victim advocate services, does the agency make available to provide these services a qualified staff member from a community-based organization, or a qualified agency staff member?	yes
	Has the agency documented its efforts to secure services from rape crisis centers?	yes

115.321 (e)	Evidence protocol and forensic medical examinations	
	As requested by the victim, does the victim advocate, qualified agency staff member, or qualified community-based organization staff member accompany and support the victim through the forensic medical examination process and investigatory interviews?	yes
	As requested by the victim, does this person provide emotional support, crisis intervention, information, and referrals?	yes

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

115.321 (h)	Evidence protocol and forensic medical examinations	
	If the agency uses a qualified agency staff member or a qualified community-based staff member for the purposes of this section, has the individual been screened for appropriateness to serve in this role and received education concerning sexual assault and forensic examination issues in general? (Check N/A if agency attempts to make a victim advocate from a rape crisis center available to victims per 115.321(d) above.)	yes

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

115.322 (b)	Policies to ensure referrals of allegations for investigations	
	Does the agency have a policy in place to ensure that allegations of sexual abuse or sexual harassment are referred for investigation to an agency with the legal authority to conduct criminal investigations, unless the allegation does not involve potentially criminal behavior?	yes
	Has the agency published such policy on its website or, if it does not have one, made the policy available through other means?	yes
	Does the agency document all such referrals?	yes

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

115.331 (a)	Employee training	
	Does the agency train all employees who may have contact with residents on: Its zero-tolerance policy for sexual abuse and sexual harassment?	yes
	Does the agency train all employees who may have contact with residents on: How to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures?	yes
	Does the agency train all employees who may have contact with residents on: Residents' right to be free from sexual abuse and sexual harassment	yes
	Does the agency train all employees who may have contact with residents on: The right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment?	yes
	Does the agency train all employees who may have contact with residents on: The dynamics of sexual abuse and sexual harassment in juvenile facilities?	yes
	Does the agency train all employees who may have contact with residents on: The common reactions of juvenile victims of sexual abuse and sexual harassment?	yes
	Does the agency train all employees who may have contact with residents on: How to detect and respond to signs of threatened and actual sexual abuse and how to distinguish between consensual sexual contact and sexual abuse between residents?	yes
	Does the agency train all employees who may have contact with residents on: How to avoid inappropriate relationships with residents?	yes
	Does the agency train all employees who may have contact with residents on: How to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents?	yes
	Does the agency train all employees who may have contact with residents on: How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities?	yes
	Does the agency train all employees who may have contact with residents on: Relevant laws regarding the applicable age of consent?	yes

115.331 (b)	Employee training	
	Is such training tailored to the unique needs and attributes of residents of juvenile facilities?	yes
	Is such training tailored to the gender of the residents at the employee's facility?	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?	yes

115.331 (c)	Employee training	
	Have all current employees who may have contact with residents received such training?	yes
	Does the agency provide each employee with refresher training every two years to ensure that all employees know the agency's current sexual abuse and sexual harassment policies and procedures?	yes
	In years in which an employee does not receive refresher training, does the agency provide refresher information on current sexual abuse and sexual harassment policies?	yes

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

115.332 (a)	Volunteer and contractor training	
	Has the agency ensured that all volunteers and contractors who have contact with residents have been trained on their responsibilities under the agency's sexual abuse and sexual harassment prevention, detection, and response policies and procedures?	yes

115.332 (b)	Volunteer and contractor training	
	Have all volunteers and contractors who have contact with residents been notified of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents (the level and type of training provided to volunteers and contractors shall be based on the services they provide and level of contact they have with residents)?	yes

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

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

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

115.333 (c)	Resident education	
	Have all residents received such education?	yes
	Do residents receive education upon transfer to a different facility to the extent that the policies and procedures of the resident's new facility differ from those of the previous facility?	yes

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

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

115.333 (f)	Resident education	
	In addition to providing such education, does the agency ensure that key information is continuously and readily available or visible to residents through posters, resident handbooks, or other written formats?	yes

115.334 (a)	Specialized training: Investigations	
	In addition to the general training provided to all employees pursuant to §115.331, does the agency ensure that, to the extent the agency itself conducts sexual abuse investigations, its investigators have received training in conducting such investigations in confinement settings? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).)	yes

115.334 (b)	Specialized training: Investigations	
	Does this specialized training include: Techniques for interviewing juvenile sexual abuse victims? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).)	yes
	Does this specialized training include: Proper use of Miranda and Garrity warnings? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).)	yes
	Does this specialized training include: Sexual abuse evidence collection in confinement settings? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).)	yes
	Does this specialized training include: The criteria and evidence required to substantiate a case for administrative action or prosecution referral? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).)	yes

115.334 (c)	Specialized training: Investigations	
	Does the agency maintain documentation that agency investigators have completed the required specialized training in conducting sexual abuse investigations? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).)	yes

115.335 (a)	Specialized training: Medical and mental health care	
	Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to detect and assess signs of sexual abuse and sexual harassment?	yes
	Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to preserve physical evidence of sexual abuse?	yes
	Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to respond effectively and professionally to juvenile victims of sexual abuse and sexual harassment?	yes
	Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How and to whom to report allegations or suspicions of sexual abuse and sexual harassment?	yes

115.335 (b)	Specialized training: Medical and mental health care	
	If medical staff employed by the agency conduct forensic examinations, do such medical staff receive appropriate training to conduct such examinations? (N/A if agency medical staff at the facility do not conduct forensic exams.)	no

115.335 (c)	Specialized training: Medical and mental health care	
	Does the agency maintain documentation that medical and mental health practitioners have received the training referenced in this standard either from the agency or elsewhere?	yes

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

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

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

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

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

115.341 (e)	Obtaining information from residents	
	Has the agency implemented appropriate controls on the dissemination within the facility of responses to questions asked pursuant to this standard in order to ensure that sensitive information is not exploited to the resident's detriment by staff or other residents?	yes

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

115.342 (b)	Placement of residents	
	Are residents isolated from others only as a last resort when less restrictive measures are inadequate to keep them and other residents safe, and then only until an alternative means of keeping all residents safe can be arranged?	yes
	During any period of isolation, does the agency always refrain from denying residents daily large-muscle exercise?	yes
	During any period of isolation, does the agency always refrain from denying residents any legally required educational programming or special education services?	yes
	Do residents in isolation receive daily visits from a medical or mental health care clinician?	yes
	Do residents also have access to other programs and work opportunities to the extent possible?	yes

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

115.342 (d)	Placement of residents	
	When deciding whether to assign a transgender or intersex resident to a facility for male or female residents, does the agency consider on a case-by-case basis whether a placement would ensure the resident's health and safety, and whether a placement would present management or security problems (NOTE: if an agency by policy or practice assigns residents to a male or female facility on the basis of anatomy alone, that agency is not in compliance with this standard)?	yes
	When making housing or other program assignments for transgender or intersex residents, does the agency consider on a case-by-case basis whether a placement would ensure the resident's health and safety, and whether a placement would present management or security problems?	yes

115.342 (e)	Placement of residents	
	Are placement and programming assignments for each transgender or intersex resident reassessed at least twice each year to review any threats to safety experienced by the resident?	yes

115.342 (f)	Placement of residents	
	Are each transgender or intersex resident's own views with respect to his or her own safety given serious consideration when making facility and housing placement decisions and programming assignments?	yes

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

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

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

115.351 (a)	Resident reporting	
	Does the agency provide multiple internal ways for residents to privately report: Sexual abuse and sexual harassment?	yes
	Does the agency provide multiple internal ways for residents to privately report: 2. Retaliation by other residents or staff for reporting sexual abuse and sexual harassment?	yes
	Does the agency provide multiple internal ways for residents to privately report: Staff neglect or violation of responsibilities that may have contributed to such incidents?	yes

115.351 (b)	Resident reporting	
	Does the agency also provide at least one way for residents to report sexual abuse or sexual harassment to a public or private entity or office that is not part of the agency?	yes
	Is that private entity or office able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials?	yes
	Does that private entity or office allow the resident to remain anonymous upon request?	yes
	Are residents detained solely for civil immigration purposes provided information on how to contact relevant consular officials and relevant officials at the Department of Homeland Security to report sexual abuse or harassment?	no

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

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

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

115.352 (a)	Exhaustion of administrative remedies	
	Is the agency exempt from this standard? NOTE: The agency is exempt ONLY if it does not have administrative procedures to address resident grievances regarding sexual abuse. This does not mean the agency is exempt simply because a resident does not have to or is not ordinarily expected to submit a grievance to report sexual abuse. This means that as a matter of explicit policy, the agency does not have an administrative remedies process to address sexual abuse.	yes

115.352 (b)	Exhaustion of administrative remedies	
	Does the agency permit residents to submit a grievance regarding an allegation of sexual abuse without any type of time limits? (The agency may apply otherwise-applicable time limits to any portion of a grievance that does not allege an incident of sexual abuse.) (N/A if agency is exempt from this standard.)	na
	Does the agency always refrain from requiring an resident to use any informal grievance process, or to otherwise attempt to resolve with staff, an alleged incident of sexual abuse? (N/A if agency is exempt from this standard.)	na

115.352 (c)	Exhaustion of administrative remedies	
	Does the agency ensure that: A resident who alleges sexual abuse may submit a grievance without submitting it to a staff member who is the subject of the complaint? (N/A if agency is exempt from this standard.)	na
	Does the agency ensure that: Such grievance is not referred to a staff member who is the subject of the complaint? (N/A if agency is exempt from this standard.)	na

115.352 (d)	Exhaustion of administrative remedies	
	Does the agency issue a final agency decision on the merits of any portion of a grievance alleging sexual abuse within 90 days of the initial filing of the grievance? (Computation of the 90-day time period does not include time consumed by residents in preparing any administrative appeal.) (N/A if agency is exempt from this standard.)	na
	If the agency determines that the 90 day timeframe is insufficient to make an appropriate decision and claims an extension of time (the maximum allowable extension of time to respond is 70 days per 115.352(d)(3)) , does the agency notify the resident in writing of any such extension and provide a date by which a decision will be made? (N/A if agency is exempt from this standard.)	na
	At any level of the administrative process, including the final level, if the resident does not receive a response within the time allotted for reply, including any properly noticed extension, may a resident consider the absence of a response to be a denial at that level? (N/A if agency is exempt from this standard.)	na

115.352 (e)	Exhaustion of administrative remedies	
	Are third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, permitted to assist residents in filing requests for administrative remedies relating to allegations of sexual abuse? (N/A if agency is exempt from this standard.)	na
	Are those third parties also permitted to file such requests on behalf of residents? (If a third party, other than a parent or legal guardian, files such a request on behalf of a resident, the facility may require as a condition of processing the request that the alleged victim agree to have the request filed on his or her behalf, and may also require the alleged victim to personally pursue any subsequent steps in the administrative remedy process.) (N/A if agency is exempt from this standard.)	na
	If the resident declines to have the request processed on his or her behalf, does the agency document the resident's decision? (N/A if agency is exempt from this standard.)	na
	Is a parent or legal guardian of a juvenile allowed to file a grievance regarding allegations of sexual abuse, including appeals, on behalf of such juvenile? (N/A if agency is exempt from this standard.)	na
	If a parent or legal guardian of a juvenile files a grievance (or an appeal) on behalf of a juvenile regarding allegations of sexual abuse, is it the case that those grievances are not conditioned upon the juvenile agreeing to have the request filed on his or her behalf? (N/A if agency is exempt from this standard.)	na

115.352 (f)	Exhaustion of administrative remedies	
	Has the agency established procedures for the filing of an emergency grievance alleging that a resident is subject to a substantial risk of imminent sexual abuse? (N/A if agency is exempt from this standard.)	na
	After receiving an emergency grievance alleging a resident is subject to a substantial risk of imminent sexual abuse, does the agency immediately forward the grievance (or any portion thereof that alleges the substantial risk of imminent sexual abuse) to a level of review at which immediate corrective action may be taken? (N/A if agency is exempt from this standard.)	na
	After receiving an emergency grievance described above, does the agency provide an initial response within 48 hours? (N/A if agency is exempt from this standard.)	na
	After receiving an emergency grievance described above, does the agency issue a final agency decision within 5 calendar days? (N/A if agency is exempt from this standard.)	na
	Does the initial response and final agency decision document the agency's determination whether the resident is in substantial risk of imminent sexual abuse? (N/A if agency is exempt from this standard.)	na
	Does the initial response document the agency's action(s) taken in response to the emergency grievance? (N/A if agency is exempt from this standard.)	na
	Does the agency's final decision document the agency's action(s) taken in response to the emergency grievance? (N/A if agency is exempt from this standard.)	na

115.352 (g)	Exhaustion of administrative remedies	
	If the agency disciplines a resident for filing a grievance related to alleged sexual abuse, does it do so ONLY where the agency demonstrates that the resident filed the grievance in bad faith? (N/A if agency is exempt from this standard.)	na

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

115.353 (b)	Resident access to outside confidential support services and legal representation	
	Does the facility inform residents, prior to giving them access, of the extent to which such communications will be monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws?	yes

115.353 (c)	Resident access to outside confidential support services and legal representation	
	Does the agency maintain or attempt to enter into memoranda of understanding or other agreements with community service providers that are able to provide residents with confidential emotional support services related to sexual abuse?	yes
	Does the agency maintain copies of agreements or documentation showing attempts to enter into such agreements?	yes

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

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

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

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

115.361 (c)	Staff and agency reporting duties	
	Apart from reporting to designated supervisors or officials and designated State or local services agencies, are staff prohibited from revealing any information related to a sexual abuse report to anyone other than to the extent necessary, as specified in agency policy, to make treatment, investigation, and other security and management decisions?	yes

115.361 (d)	Staff and agency reporting duties	
	Are medical and mental health practitioners required to report sexual abuse to designated supervisors and officials pursuant to paragraph (a) of this section as well as to the designated State or local services agency where required by mandatory reporting laws?	yes
	Are medical and mental health practitioners required to inform residents of their duty to report, and the limitations of confidentiality, at the initiation of services?	yes

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

115.361 (f)	Staff and agency reporting duties	
	Does the facility report all allegations of sexual abuse and sexual harassment, including third-party and anonymous reports, to the facility's designated investigators?	yes

115.362 (a)	Agency protection duties	
	When the agency learns that a resident is subject to a substantial risk of imminent sexual abuse, does it take immediate action to protect the resident?	yes

115.363 (a)	Reporting to other confinement facilities	
	Upon receiving an allegation that a resident was sexually abused while confined at another facility, does the head of the facility that received the allegation notify the head of the facility or appropriate office of the agency where the alleged abuse occurred?	yes
	Does the head of the facility that received the allegation also notify the appropriate investigative agency?	yes

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

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

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

115.364 (a)	Staff first responder duties	
	Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Separate the alleged victim and abuser?	yes
	Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Preserve and protect any crime scene until appropriate steps can be taken to collect any evidence?	yes
	Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Request that the alleged victim not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating, if the abuse occurred within a time period that still allows for the collection of physical evidence?	yes
	Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Ensure that the alleged abuser does not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating, if the abuse occurred within a time period that still allows for the collection of physical evidence?	yes

115.364 (b)	Staff first responder duties	
	If the first staff responder is not a security staff member, is the responder required to request that the alleged victim not take any actions that could destroy physical evidence, and then notify security staff?	yes

115.365 (a)	Coordinated response	
	Has the facility developed a written institutional plan to coordinate actions among staff first responders, medical and mental health practitioners, investigators, and facility leadership taken in response to an incident of sexual abuse?	yes

115.366 (a)	Preservation of ability to protect residents from contact with abusers	
	Are both the agency and any other governmental entities responsible for collective bargaining on the agency's behalf prohibited from entering into or renewing any collective bargaining agreement or other agreement that limits the agency's ability to remove alleged staff sexual abusers from contact with any residents pending the outcome of an investigation or of a determination of whether and to what extent discipline is warranted?	yes

115.367 (a)	Agency protection against retaliation	
	Has the agency established a policy to protect all residents and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other residents or staff?	yes
	Has the agency designated which staff members or departments are charged with monitoring retaliation?	yes

115.367 (b)	Agency protection against retaliation	
	Does the agency employ multiple protection measures for residents or staff who fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations, such as housing changes or transfers for resident victims or abusers, removal of alleged staff or resident abusers from contact with victims, and emotional support services?	yes

115.367 (c)	Agency protection against retaliation	
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor the conduct and treatment of residents or staff who reported the sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff?	yes
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor the conduct and treatment of residents who were reported to have suffered sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff?	yes
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Act promptly to remedy any such retaliation?	yes
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor: Any resident disciplinary reports?	yes
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor: Resident housing changes?	yes
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor: Resident program changes?	yes
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor: Negative performance reviews of staff?	yes
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor: Reassignments of staff?	yes
	Does the agency continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need?	yes

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

115.367 (e)	Agency protection against retaliation	
	If any other individual who cooperates with an investigation expresses a fear of retaliation, does the agency take appropriate measures to protect that individual against retaliation?	yes

115.368 (a)	Post-allegation protective custody	
	Is any and all use of segregated housing to protect a resident who is alleged to have suffered sexual abuse subject to the requirements of § 115.342?	yes

115.371 (a)	Criminal and administrative agency investigations	
	When the agency conducts its own investigations into allegations of sexual abuse and sexual harassment, does it do so promptly, thoroughly, and objectively? (N/A if the agency does not conduct any form of administrative or criminal investigations of sexual abuse or harassment. See 115.321(a).)	yes
	Does the agency conduct such investigations for all allegations, including third party and anonymous reports? (N/A if the agency does not conduct any form of administrative or criminal investigations of sexual abuse or harassment. See 115.321(a).)	yes

115.371 (b)	Criminal and administrative agency investigations	
	Where sexual abuse is alleged, does the agency use investigators who have received specialized training in sexual abuse investigations involving juvenile victims as required by 115.334?	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 (f)	Criminal and administrative agency investigations	
	Do agency investigators assess the credibility of an alleged victim, suspect, or witness on an individual basis and not on the basis of that individual's status as resident or staff?	yes
	Does the agency investigate allegations of sexual abuse without requiring a resident who alleges sexual abuse to submit to a polygraph examination or other truth-telling device as a condition for proceeding?	yes

115.371 (g)	Criminal and administrative agency investigations	
	Do administrative investigations include an effort to determine whether staff actions or failures to act contributed to the abuse?	yes
	Are administrative investigations documented in written reports that include a description of the physical evidence and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings?	yes

115.371 (h)	Criminal and administrative agency investigations	
	Are criminal investigations documented in a written report that contains a thorough description of the physical, testimonial, and documentary evidence and attaches copies of all documentary evidence where feasible?	yes

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

115.371 (j)	Criminal and administrative agency investigations	
	Does the agency retain all written reports referenced in 115.371(g) and (h) for as long as the alleged abuser is incarcerated or employed by the agency, plus five years unless the abuse was committed by a juvenile resident and applicable law requires a shorter period of retention?	yes

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

115.371 (m)	Criminal and administrative agency investigations	
	When an outside entity investigates sexual abuse, does the facility cooperate with outside investigators and endeavor to remain informed about the progress of the investigation? (N/A if an outside agency does not conduct administrative or criminal sexual abuse investigations. See 115.321(a).)	yes

115.372 (a)	Evidentiary standard for administrative investigations	
	Is it true that the agency does not impose a standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated?	yes

115.373 (a)	Reporting to residents	
	Following an investigation into a resident's allegation of sexual abuse suffered in the facility, does the agency inform the resident as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded?	yes

115.373 (b)	Reporting to residents	
	If the agency did not conduct the investigation into a resident's allegation of sexual abuse in an agency facility, does the agency request the relevant information from the investigative agency in order to inform the resident? (N/A if the agency/facility is responsible for conducting administrative and criminal investigations.)	yes

115.373 (c)	Reporting to residents	
	Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The staff member is no longer posted within the resident's unit?	yes
	Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The staff member is no longer employed at the facility?	yes
	Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The agency learns that the staff member has been indicted on a charge related to sexual abuse in the facility?	yes
	Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility?	yes

115.373 (d)	Reporting to residents	
	Following a resident's allegation that he or she has been sexually abused by another resident, does the agency subsequently inform the alleged victim whenever: The agency learns that the alleged abuser has been indicted on a charge related to sexual abuse within the facility?	yes
	Following a resident's allegation that he or she has been sexually abused by another resident, does the agency subsequently inform the alleged victim whenever: The agency learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility?	yes

115.373 (e)	Reporting to residents	
	Does the agency document all such notifications or attempted notifications?	yes

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

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

115.376 (c)	Disciplinary sanctions for staff	
	Are disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) commensurate with the nature and circumstances of the acts committed, the staff member's disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories?	yes

115.376 (d)	Disciplinary sanctions for staff	
	Are all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, reported to: Law enforcement agencies, unless the activity was clearly not criminal?	yes
	Are all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, reported to: Relevant licensing bodies?	yes

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

115.377 (b)	Corrective action for contractors and volunteers	
	In the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer, does the facility take appropriate remedial measures, and consider whether to prohibit further contact with residents?	yes

115.378 (a)	Interventions and disciplinary sanctions for residents	
	Following an administrative finding that a resident engaged in resident-on-resident sexual abuse, or following a criminal finding of guilt for resident-on-resident sexual abuse, may residents be subject to disciplinary sanctions only pursuant to a formal disciplinary process?	yes

115.378 (b)	Interventions and disciplinary sanctions for residents	
	Are disciplinary sanctions commensurate with the nature and circumstances of the abuse committed, the resident's disciplinary history, and the sanctions imposed for comparable offenses by other residents with similar histories?	yes
	In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident is not denied daily large-muscle exercise?	yes
	In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident is not denied access to any legally required educational programming or special education services?	yes
	In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident receives daily visits from a medical or mental health care clinician?	yes
	In the event a disciplinary sanction results in the isolation of a resident, does the resident also have access to other programs and work opportunities to the extent possible?	yes

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

115.378 (d)	Interventions and disciplinary sanctions for residents	
	If the facility offers therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse, does the facility consider whether to offer the offending resident participation in such interventions?	yes
	If the agency requires participation in such interventions as a condition of access to any rewards-based behavior management system or other behavior-based incentives, does it always refrain from requiring such participation as a condition to accessing general programming or education?	yes

115.378 (e)	Interventions and disciplinary sanctions for residents	
	Does the agency discipline a resident for sexual contact with staff only upon a finding that the staff member did not consent to such contact?	yes

115.378 (f)	Interventions and disciplinary sanctions for residents	
	For the purpose of disciplinary action, does a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred NOT constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation?	yes

115.378 (g)	Interventions and disciplinary sanctions for residents	
	Does the agency always refrain from considering non-coercive sexual activity between residents to be sexual abuse? (N/A if the agency does not prohibit all sexual activity between residents.)	yes

115.381 (a)	Medical and mental health screenings; history of sexual abuse	
	If the screening pursuant to § 115.341 indicates that a resident has experienced prior sexual victimization, whether it occurred in an institutional setting or in the community, do staff ensure that the resident is offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening?	yes

115.381 (b)	Medical and mental health screenings; history of sexual abuse	
	If the screening pursuant to § 115.341 indicates that a resident has previously perpetrated sexual abuse, whether it occurred in an institutional setting or in the community, do staff ensure that the resident is offered a follow-up meeting with a mental health practitioner within 14 days of the intake screening?	yes

115.381 (c)	Medical and mental health screenings; history of sexual abuse	
	Is any information related to sexual victimization or abusiveness that occurred in an institutional setting strictly limited to medical and mental health practitioners and other staff as necessary to inform treatment plans and security management decisions, including housing, bed, work, education, and program assignments, or as otherwise required by Federal, State, or local law?	yes

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

115.382 (a)	Access to emergency medical and mental health services	
	Do resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services, the nature and scope of which are determined by medical and mental health practitioners according to their professional judgment?	yes

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

115.382 (c)	Access to emergency medical and mental health services	
	Are resident victims of sexual abuse offered timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate?	yes

115.382 (d)	Access to emergency medical and mental health services	
	Are treatment services provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident?	yes

115.383 (a)	Ongoing medical and mental health care for sexual abuse victims and abusers	
	Does the facility offer medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility?	yes

115.383 (b)	Ongoing medical and mental health care for sexual abuse victims and abusers	
	Does the evaluation and treatment of such victims include, as appropriate, follow-up services, treatment plans, and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody?	yes

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

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

115.383 (h)	Ongoing medical and mental health care for sexual abuse victims and abusers	
	Does the facility attempt to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners?	yes

115.386 (a)	Sexual abuse incident reviews	
	Does the facility conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation, including where the allegation has not been substantiated, unless the allegation has been determined to be unfounded?	yes

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

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

115.386 (d)	Sexual abuse incident reviews	
	Does the review team: Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse?	yes
	Does the review team: Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; gang affiliation; or other group dynamics at the facility?	yes
	Does the review team: Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse?	yes
	Does the review team: Assess the adequacy of staffing levels in that area during different shifts?	yes
	Does the review team: Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff?	yes
	Does the review team: Prepare a report of its findings, including but not necessarily limited to determinations made pursuant to §§ 115.386(d)(1)-(d)(5), and any recommendations for improvement and submit such report to the facility head and PREA compliance manager?	yes

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

115.387 (a)	Data collection	
	Does the agency collect accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions?	yes

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

115.387 (c)	Data collection	
	Does the incident-based data include, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice?	yes

115.387 (d)	Data collection	
	Does the agency maintain, review, and collect data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews?	yes

115.387 (e)	Data collection	
	Does the agency also obtain incident-based and aggregated data from every private facility with which it contracts for the confinement of its residents? (N/A if agency does not contract for the confinement of its residents.)	yes

115.387 (f)	Data collection	
	Does the agency, upon request, provide all such data from the previous calendar year to the Department of Justice no later than June 30? (N/A if DOJ has not requested agency data.)	yes

115.388 (a)	Data review for corrective action	
	Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Identifying problem areas?	yes
	Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Taking corrective action on an ongoing basis?	yes
	Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Preparing an annual report of its findings and corrective actions for each facility, as well as the agency as a whole?	yes

115.388 (b)	Data review for corrective action	
	Does the agency's annual report include a comparison of the current year's data and corrective actions with those from prior years and provide an assessment of the agency's progress in addressing sexual abuse?	no

115.388 (c)	Data review for corrective action	
	Is the agency's annual report approved by the agency head and made readily available to the public through its website or, if it does not have one, through other means?	yes

115.388 (d)	Data review for corrective action	
	Does the agency indicate the nature of the material redacted where it redacts specific material from the reports when publication would present a clear and specific threat to the safety and security of a facility?	yes

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

115.389 (b)	Data storage, publication, and destruction	
	Does the agency make all aggregated sexual abuse data, from facilities under its direct control and private facilities with which it contracts, readily available to the public at least annually through its website or, if it does not have one, through other means?	yes

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

115.389 (d)	Data storage, publication, and destruction	
	Does the agency maintain sexual abuse data collected pursuant to § 115.387 for at least 10 years after the date of the initial collection, unless Federal, State, or local law requires otherwise?	yes

115.401 (a)	Frequency and scope of audits	
	During the prior three-year audit period, did the agency ensure that each facility operated by the agency, or by a private organization on behalf of the agency, was audited at least once? (Note: The response here is purely informational. A "no" response does not impact overall compliance with this standard.)	yes

115.401 (b)	Frequency and scope of audits	
	Is this the first year of the current audit cycle? (Note: a “no” response does not impact overall compliance with this standard.)	no
	If this is the second year of the current audit cycle, did the agency ensure that at least one-third of each facility type operated by the agency, or by a private organization on behalf of the agency, was audited during the first year of the current audit cycle? (N/A if this is not the second year of the current audit cycle.)	no
	If this is the third year of the current audit cycle, did the agency ensure that at least two-thirds of each facility type operated by the agency, or by a private organization on behalf of the agency, were audited during the first two years of the current audit cycle? (N/A if this is not the third year of the current audit cycle.)	yes

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

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

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

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

115.403 (f)	Audit contents and findings	
	The agency has published on its agency website, if it has one, or has otherwise made publicly available, all Final Audit Reports within 90 days of issuance by auditor. The review period is for prior audits completed during the past three years PRECEDING THIS AGENCY AUDIT. In the case of single facility agencies, the auditor shall ensure that the facility's last audit report was published. The pendency of any agency appeal pursuant to 28 C.F.R. § 115.405 does not excuse noncompliance with this provision. (N/A only if there have been no Final Audit Reports issued in the past three years, or in the case of single facility agencies that there has never been a Final Audit Report issued.)	yes