PREA Facility Audit Report: Final

Name of Facility: Stevenson House Detention Center
Facility Type: Juvenile
Date Interim Report Submitted: 12/01/2024
Date Final Report Submitted: 03/20/2025

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:** 03/20/2025

AUDITOR INFORMATION	
Auditor name:	Hardy-Kesler, Tammy
Email:	codyemomma@msn.com
Start Date of On-Site Audit:	10/14/2024
End Date of On-Site Audit:	10/17/2024

FACILITY INFORMATION	
Facility name:	Stevenson House Detention Center
Facility physical address:	750 North DuPont Boulevard, Milford, Delaware - 19963
Facility mailing address:	750 North Dupont Boulevard, Milford, Delaware

Primary Contact

Name:	Joshua Fields
Email Address:	joshua.fields@delaware.gov
Telephone Number:	302-424-8173

Superintendent/Director/Administrator	
Name:	Katherine Kenney
Email Address:	Katherine.Kenney@delaware.gov
Telephone Number:	(302) 424-8112

Facility PREA Compliance Manager	
Name:	Joshua Fields
Email Address:	Joshua.Fields@delaware.gov
Telephone Number:	302-933-3898

Facility Health Service Administrator On-Site	
Name:	Sarah Ciano
Email Address:	sarah.ciano@delaware.gov
Telephone Number:	302-484-8142

Facility Characteristics	
Designed facility capacity:	55
Current population of facility:	26
Average daily population for the past 12 months:	27
Has the facility been over capacity at any point in the past 12 months?	No
What is the facility’s population designation?	Both womens/girls and mens/boys

In the past 12 months, which population(s) has the facility held? Select all that apply (Nonbinary describes a person who does not identify exclusively as a boy/man or a girl/woman. Some people also use this term to describe their gender expression. For definitions of "intersex" and "transgender," please see https://www.prearesourcecenter.org/standard/115-5)	
Age range of population:	12-18
Facility security levels/resident custody levels:	Level 5
Number of staff currently employed at the facility who may have contact with residents:	80
Number of individual contractors who have contact with residents, currently authorized to enter the facility:	5
Number of volunteers who have contact with residents, currently authorized to enter the facility:	5

AGENCY INFORMATION	
Name of agency:	Delaware Division of Youth Rehabilitative Services
Governing authority or parent agency (if applicable):	Department of Children, Youth And Their Families
Physical Address:	1825 Faulkland Road , Wilmington , Delaware - 19805
Mailing Address:	
Telephone number:	3026332620

Agency Chief Executive Officer Information:	
Name:	Renee Ciconte

Email Address:	renee.ciconte@delaware.gov
Telephone Number:	302-633-2620

Agency-Wide PREA Coordinator Information			
Name:	Carrie Hyla	Email Address:	Carrie.Hyla@Delaware.gov

Facility AUDIT FINDINGS

Summary of Audit Findings

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

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

Number of standards exceeded:	
2	• 115.331 - Employee training • 115.403 - Audit contents and findings

Number of standards met:
41

Number of standards not met:	
0	

POST-AUDIT REPORTING INFORMATION	
GENERAL AUDIT INFORMATION	
On-site Audit Dates	
1. Start date of the onsite portion of the audit:	2024-10-14
2. End date of the onsite portion of the audit:	2024-10-17
Outreach	
10. Did you attempt to communicate with community-based organization(s) or victim advocates who provide services to this facility and/or who may have insight into relevant conditions in the facility?	(●) Yes ( ) No
a. Identify the community-based organization(s) or victim advocates with whom you communicated:	Attempted to contact Survivors of Abuse in Recovery(SOAR)
AUDITED FACILITY INFORMATION	
14. Designated facility capacity:	55
15. Average daily population for the past 12 months:	27
16. Number of inmate/resident/detainee housing units:	6
17. Does the facility ever hold youthful inmates or youthful/juvenile detainees?	( ) Yes ( ) No (●) Not Applicable for the facility type audited (i.e., Community Confinement Facility or Juvenile Facility)

Audited Facility Population Characteristics on Day One of the Onsite Portion of the Audit	
Inmates/Residents/Detainees Population Characteristics on Day One of the Onsite Portion of the Audit	
18. Enter the total number of inmates/ residents/detainees in the facility as of the first day of onsite portion of the audit:	31
19. Enter the total number of inmates/ residents/detainees with a physical disability in the facility as of the first day of the onsite portion of the audit:	0
20. Enter the total number of inmates/ residents/detainees with a cognitive or functional disability (including intellectual disability, psychiatric disability, or speech disability) in the facility as of the first day of the onsite portion of the audit:	17
21. Enter the total number of inmates/ residents/detainees who are Blind or have low vision (visually impaired) in the facility as of the first day of the onsite portion of the audit:	0
22. Enter the total number of inmates/ residents/detainees who are Deaf or hard-of-hearing in the facility as of the first day of the onsite portion of the audit:	0
23. Enter the total number of inmates/ residents/detainees who are Limited English Proficient (LEP) in the facility as of the first day of the onsite portion of the audit:	0
24. Enter the total number of inmates/ residents/detainees who identify as lesbian, gay, or bisexual in the facility as of the first day of the onsite portion of the audit:	1

25. Enter the total number of inmates/ residents/detainees who identify as transgender or intersex in the facility as of the first day of the onsite portion of the audit:	0
26. Enter the total number of inmates/ residents/detainees who reported sexual abuse in the facility as of the first day of the onsite portion of the audit:	0
27. Enter the total number of inmates/ residents/detainees who disclosed prior sexual victimization during risk screening in the facility as of the first day of the onsite portion of the audit:	3
28. Enter the total number of inmates/ residents/detainees who were ever placed in segregated housing/isolation for risk of sexual victimization in the facility as of the first day of the onsite portion of the audit:	0
29. Provide any additional comments regarding the population characteristics of inmates/residents/detainees in the facility as of the first day of the onsite portion of the audit (e.g., groups not tracked, issues with identifying certain populations):	No text provided.
Staff, Volunteers, and Contractors Population Characteristics on Day One of the Onsite Portion of the Audit	
30. Enter the total number of STAFF, including both full- and part-time staff, employed by the facility as of the first day of the onsite portion of the audit:	80
31. Enter the total number of VOLUNTEERS assigned to the facility as of the first day of the onsite portion of the audit who have contact with inmates/residents/detainees:	5

32. Enter the total number of CONTRACTORS assigned to the facility as of the first day of the onsite portion of the audit who have contact with inmates/residents/detainees:	5
33. Provide any additional comments regarding the population characteristics of staff, volunteers, and contractors who were in the facility as of the first day of the onsite portion of the audit:	No text provided.

INTERVIEWS

Inmate/Resident/Detainee Interviews

Random Inmate/Resident/Detainee Interviews

34. Enter the total number of RANDOM INMATES/RESIDENTS/DETAINEES who were interviewed:	10
35. Select which characteristics you considered when you selected RANDOM INMATE/RESIDENT/DETAINEE interviewees: (select all that apply)	☒ Age ☒ Race ☒ Ethnicity (e.g., Hispanic, Non-Hispanic) ☒ Length of time in the facility ☒ Housing assignment ☒ Gender ☐ Other ☐ None
36. How did you ensure your sample of RANDOM INMATE/RESIDENT/DETAINEE interviewees was geographically diverse?	In order to ensure a geographically diverse sample of residents, the auditor reviewed the census provided on the first day of onsite. At the time of onsite there were no female residents, and there were only two housing units open. The auditor selected residents from both housing units.

37. Were you able to conduct the minimum number of random inmate/resident/detainee interviews?	(●) Yes ( ) No
38. Provide any additional comments regarding selecting or interviewing random inmates/residents/detainees (e.g., any populations you oversampled, barriers to completing interviews, barriers to ensuring representation):	There were no barriers to selecting or interviewing random residents.
Targeted Inmate/Resident/Detainee Interviews	
39. Enter the total number of TARGETED INMATES/RESIDENTS/DETAINEES who were interviewed:	10
As stated in the PREA Auditor Handbook, the breakdown of targeted interviews is intended to guide auditors in interviewing the appropriate cross-section of inmates/residents/detainees who are the most vulnerable to sexual abuse and sexual harassment. When completing questions regarding targeted inmate/resident/detainee interviews below, remember that an interview with one inmate/resident/detainee may satisfy multiple targeted interview requirements. These questions are asking about the number of interviews conducted using the targeted inmate/resident/detainee protocols. For example, if an auditor interviews an inmate who has a physical disability, is being held in segregated housing due to risk of sexual victimization, and disclosed prior sexual victimization, that interview would be included in the totals for each of those questions. Therefore, in most cases, the sum of all the following responses to the targeted inmate/resident/detainee interview categories will exceed the total number of targeted inmates/residents/detainees who were interviewed. If a particular targeted population is not applicable in the audited facility, enter "0".	
40. Enter the total number of interviews conducted with inmates/residents/detainees with a physical disability using the "Disabled and Limited English Proficient Inmates" protocol:	0
40. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/detainees in this category:	[x] Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. [ ] The inmates/residents/detainees in this targeted category declined to be interviewed.

40. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	During interviews with facility administration, medical, and mental health staff, there were no residents identified as physically disabled.
41. Enter the total number of interviews conducted with inmates/residents/ detainees with a cognitive or functional disability (including intellectual disability, psychiatric disability, or speech disability) using the "Disabled and Limited English Proficient Inmates" protocol:	7
42. Enter the total number of interviews conducted with inmates/residents/ detainees who are Blind or have low vision (i.e., visually impaired) using the "Disabled and Limited English Proficient Inmates" protocol:	0
42. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/ detainees in this category:	☒ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.
42. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	During interviews with facility administrators, medical, and mental health staff, there were no residents identified as Blind or low vision. During site review, there were no residents that appeared Blind or low vision.
43. Enter the total number of interviews conducted with inmates/residents/ detainees who are Deaf or hard-of-hearing using the "Disabled and Limited English Proficient Inmates" protocol:	0

43. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/ detainees in this category:	☒ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.
43. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	During the onsite audit, there were no residents identified by facility administration, mental and medical staff did not identify residents that were Deaf or hard of hearing.
44. Enter the total number of interviews conducted with inmates/residents/ detainees who are Limited English Proficient (LEP) using the "Disabled and Limited English Proficient Inmates" protocol:	0
44. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/ detainees in this category:	☒ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.
44. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	There were no residents identified as being limited English proficient by the facility administration, medical or mental health staff. During informal conversation with staff and residents, there were no residents that were identified as limited English proficient.
45. Enter the total number of interviews conducted with inmates/residents/ detainees who identify as lesbian, gay, or bisexual using the "Transgender and Intersex Inmates; Gay, Lesbian, and Bisexual Inmates" protocol:	0

45. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/ detainees in this category:	☐ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☒ The inmates/residents/detainees in this targeted category declined to be interviewed.
46. Enter the total number of interviews conducted with inmates/residents/ detainees who identify as transgender or intersex using the "Transgender and Intersex Inmates; Gay, Lesbian, and Bisexual Inmates" protocol:	0
46. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/ detainees in this category:	☒ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.
46. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	There were no residents identified as being transgender by the facility administration, medical or mental health staff. During the review of risk assessments, there were no residents identified as transgender.
47. Enter the total number of interviews conducted with inmates/residents/ detainees who reported sexual abuse in this facility using the "Inmates who Reported a Sexual Abuse" protocol:	0
47. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/ detainees in this category:	☒ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.

47. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	There were no residents who had reported sexual abuse at the facility during the time of onsite audit. The auditor reviewed the investigation files of allegations of sexual abuse, and it was found that the resident had been released from the facility.
48. Enter the total number of interviews conducted with inmates/residents/ detainees who disclosed prior sexual victimization during risk screening using the "Inmates who Disclosed Sexual Victimization during Risk Screening" protocol:	2
49. Enter the total number of interviews conducted with inmates/residents/ detainees who are or were ever placed in segregated housing/isolation for risk of sexual victimization using the "Inmates Placed in Segregated Housing (for Risk of Sexual Victimization/Who Allege to have Suffered Sexual Abuse)" protocol:	0
49. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/ detainees in this category:	☒ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.
49. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	Review of risk assessments, files of allegations of sexual abuse, and informal conversation, there were no residents placed in isolation or administrative intervention due the risk of sexual victimization and/or allege to have suffered sexual abuse.

50. Provide any additional comments regarding selecting or interviewing targeted inmates/residents/detainees (e.g., any populations you oversampled, barriers to completing interviews):	The auditor oversampled residents that were identified as cognitive or functional disability. These residents are easily identifiable through educational accommodation requirements.

Staff, Volunteer, and Contractor Interviews

Random Staff Interviews

51. Enter the total number of RANDOM STAFF who were interviewed:	15
52. Select which characteristics you considered when you selected RANDOM STAFF interviewees: (select all that apply)	■ Length of tenure in the facility ■ Shift assignment ■ Work assignment ■ Rank (or equivalent) ☐ Other (e.g., gender, race, ethnicity, languages spoken) ☐ None
53. Were you able to conduct the minimum number of RANDOM STAFF interviews?	● Yes ○ No
54. Provide any additional comments regarding selecting or interviewing random staff (e.g., any populations you oversampled, barriers to completing interviews, barriers to ensuring representation):	There were no barriers to exceeding the required random staff interviews.

Specialized Staff, Volunteers, and Contractor Interviews

Staff in some facilities may be responsible for more than one of the specialized staff duties. Therefore, more than one interview protocol may apply to an interview with a single staff member and that information would satisfy multiple specialized staff interview requirements.

55. Enter the total number of staff in a SPECIALIZED STAFF role who were interviewed (excluding volunteers and contractors):	35

56. Were you able to interview the Agency Head?	(●) Yes ( ) No
57. Were you able to interview the Warden/Facility Director/Superintendent or their designee?	(●) Yes ( ) No
58. Were you able to interview the PREA Coordinator?	(●) Yes ( ) No
59. Were you able to interview the PREA Compliance Manager?	(●) Yes ( ) No ( ) NA (NA if the agency is a single facility agency or is otherwise not required to have a PREA Compliance Manager per the Standards)

60. Select which SPECIALIZED STAFF roles were interviewed as part of this audit from the list below: (select all that apply)	☒ Agency contract administrator ☒ Intermediate or higher-level facility staff responsible for conducting and documenting unannounced rounds to identify and deter staff sexual abuse and sexual harassment ☐ Line staff who supervise youthful inmates (if applicable) ☐ Education and program staff who work with youthful inmates (if applicable) ☒ Medical staff ☒ Mental health staff ☐ Non-medical staff involved in cross-gender strip or visual searches ☒ Administrative (human resources) staff ☒ Sexual Assault Forensic Examiner (SAFE) or Sexual Assault Nurse Examiner (SANE) staff ☒ Investigative staff responsible for conducting administrative investigations ☒ Investigative staff responsible for conducting criminal investigations ☒ Staff who perform screening for risk of victimization and abusiveness ☐ Staff who supervise inmates in segregated housing/residents in isolation ☒ Staff on the sexual abuse incident review team ☒ Designated staff member charged with monitoring retaliation ☒ First responders, both security and non-security staff ☒ Intake staff

	☐ Other
61. Did you interview VOLUNTEERS who may have contact with inmates/ residents/detainees in this facility?	◉ Yes ○ No
61. Enter the total number of VOLUNTEERS who were interviewed:	1
61. Select which specialized VOLUNTEER role(s) were interviewed as part of this audit from the list below: (select all that apply)	☒ Education/programming ☐ Medical/dental ☐ Mental health/counseling ☐ Religious ☐ Other
62. Did you interview CONTRACTORS who may have contact with inmates/ residents/detainees in this facility?	◉ Yes ○ No
62. Enter the total number of CONTRACTORS who were interviewed:	2
62. Select which specialized CONTRACTOR role(s) were interviewed as part of this audit from the list below: (select all that apply)	☐ Security/detention ☒ Education/programming ☐ Medical/dental ☐ Food service ☐ Maintenance/construction ☐ Other
63. Provide any additional comments regarding selecting or interviewing specialized staff.	There were no barriers to interviewing specialized staff.

SITE REVIEW AND DOCUMENTATION SAMPLING

Site Review

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

64. Did you have access to all areas of the facility?	(●) Yes ( ) No

Was the site review an active, inquiring process that included the following:

65. Observations of all facility practices in accordance with the site review component of the audit instrument (e.g., signage, supervision practices, cross-gender viewing and searches)?	(●) Yes ( ) No
66. Tests of all critical functions in the facility in accordance with the site review component of the audit instrument (e.g., risk screening process, access to outside emotional support services, interpretation services)?	(●) Yes ( ) No
67. Informal conversations with inmates/ residents/detainees during the site review (encouraged, not required)?	(●) Yes ( ) No
68. Informal conversations with staff during the site review (encouraged, not required)?	(●) Yes ( ) No

69. Provide any additional comments regarding the site review (e.g., access to areas in the facility, observations, tests of critical functions, or informal conversations).	Auditor had access to all areas of the facility including central control to view cameras. All telephones accessed by residents were functional. The auditor had several opportunities to have informal conversation with both staff and residents. Interpretation services were available. Outside emotional support services were posted. During corrective action, the facility added the contact information for the Child Abuse Hotline and the outside emotional support services (SOAR) in the resident handbook. Auditor reviewed the risk screening process. The facility provides single cells and individual accommodations for toilets and showering.

Documentation Sampling

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

70. In addition to the proof documentation selected by the agency or facility and provided to you, did you also conduct an auditor-selected sampling of documentation?	(●) Yes ( ) No
71. Provide any additional comments regarding selecting additional documentation (e.g., any documentation you oversampled, barriers to selecting additional documentation, etc.).	There were no barriers to collecting additional documentation.

SEXUAL ABUSE AND SEXUAL HARASSMENT ALLEGATIONS AND INVESTIGATIONS IN THIS FACILITY

Sexual Abuse and Sexual Harassment Allegations and Investigations Overview

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

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

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

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

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

Sexual Abuse and Sexual Harassment Investigation Outcomes

Sexual Abuse Investigation Outcomes

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

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

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

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

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

Sexual Harassment Investigation Outcomes

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

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

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

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

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

Sexual Abuse and Sexual Harassment Investigation Files Selected for Review

Sexual Abuse Investigation Files Selected for Review

78. Enter the total number of SEXUAL ABUSE investigation files reviewed/ sampled:	1

79. Did your selection of SEXUAL ABUSE investigation files include a cross-section of criminal and/or administrative investigations by findings/outcomes?	(●) Yes ( ) No ( ) NA (NA if you were unable to review any sexual abuse investigation files)
Inmate-on-inmate sexual abuse investigation files	
80. Enter the total number of INMATE-ON-INMATE SEXUAL ABUSE investigation files reviewed/sampled:	0
81. Did your sample of INMATE-ON-INMATE SEXUAL ABUSE investigation files include criminal investigations?	( ) Yes ( ) No (●) NA (NA if you were unable to review any inmate-on-inmate sexual abuse investigation files)
82. Did your sample of INMATE-ON-INMATE SEXUAL ABUSE investigation files include administrative investigations?	( ) Yes ( ) No (●) NA (NA if you were unable to review any inmate-on-inmate sexual abuse investigation files)
Staff-on-inmate sexual abuse investigation files	
83. Enter the total number of STAFF-ON-INMATE SEXUAL ABUSE investigation files reviewed/sampled:	1
84. Did your sample of STAFF-ON-INMATE SEXUAL ABUSE investigation files include criminal investigations?	( ) Yes ( ) No (●) NA (NA if you were unable to review any staff-on-inmate sexual abuse investigation files)

85. Did your sample of STAFF-ON-INMATE SEXUAL ABUSE investigation files include administrative investigations?	(●) Yes ( ) No ( ) NA (NA if you were unable to review any staff-on-inmate sexual abuse investigation files)
Sexual Harassment Investigation Files Selected for Review	
86. Enter the total number of SEXUAL HARASSMENT investigation files reviewed/sampled:	0
86. Explain why you were unable to review any sexual harassment investigation files:	According to the facility and the documentation provided, there were no allegations of sexual harassment in the prior 12 months
87. Did your selection of SEXUAL HARASSMENT investigation files include a cross-section of criminal and/or administrative investigations by findings/outcomes?	( ) Yes ( ) No (●) NA (NA if you were unable to review any sexual harassment investigation files)
Inmate-on-inmate sexual harassment investigation files	
88. Enter the total number of INMATE-ON-INMATE SEXUAL HARASSMENT investigation files reviewed/sampled:	0
89. Did your sample of INMATE-ON-INMATE SEXUAL HARASSMENT files include criminal investigations?	( ) Yes ( ) No (●) NA (NA if you were unable to review any inmate-on-inmate sexual harassment investigation files)

90. Did your sample of INMATE-ON-INMATE SEXUAL HARASSMENT investigation files include administrative investigations?	○ Yes ○ No ● NA (NA if you were unable to review any inmate-on-inmate sexual harassment investigation files)
Staff-on-inmate sexual harassment investigation files	
91. Enter the total number of STAFF-ON-INMATE SEXUAL HARASSMENT investigation files reviewed/sampled:	0
92. Did your sample of STAFF-ON-INMATE SEXUAL HARASSMENT investigation files include criminal investigations?	○ Yes ○ No ● NA (NA if you were unable to review any staff-on-inmate sexual harassment investigation files)
93. Did your sample of STAFF-ON-INMATE SEXUAL HARASSMENT investigation files include administrative investigations?	○ Yes ○ No ● NA (NA if you were unable to review any staff-on-inmate sexual harassment investigation files)
94. Provide any additional comments regarding selecting and reviewing sexual abuse and sexual harassment investigation files.	No text provided.

SUPPORT STAFF INFORMATION

DOJ-certified PREA Auditors Support Staff

95. Did you receive assistance from any DOJ-CERTIFIED PREA AUDITORS at any point during this audit? REMEMBER: the audit includes all activities from the pre-onsite through the post-onsite phases to the submission of the final report. Make sure you respond accordingly.	○ Yes ● No

Non-certified Support Staff

96. Did you receive assistance from any NON-CERTIFIED SUPPORT STAFF at any point during this audit? REMEMBER: the audit includes all activities from the pre-onsite through the post-onsite phases to the submission of the final report. Make sure you respond accordingly.	● Yes ○ No
96. Enter the TOTAL NUMBER OF NON-CERTIFIED SUPPORT who provided assistance at any point during this audit:	2

AUDITING ARRANGEMENTS AND COMPENSATION

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

Standards
Auditor Overall Determination Definitions
• Exceeds Standard (Substantially exceeds requirement of standard) • Meets Standard (substantial compliance; complies in all material ways with the stand for the relevant review period) • Does Not Meet Standard (requires corrective actions)
Auditor Discussion Instructions
Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor’s analysis and reasoning, and the auditor’s conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

115.311	Zero tolerance of sexual abuse and sexual harassment; PREA coordinator
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. DYRS PREA Policy 2.13 2. Youth Rehabilitative Services Director’s Office Organizational Chart (Effective 06/22/23). 3. State of Delaware Department of Services for Children Youth and Their Families Division of Youth Rehabilitative Services PREA Compliance Managers Organizational Chart (2024). 4. State of Delaware Employee Performance Plan PREA Coordinator Section I, B (pp. 1), (1/11/24). 5. Stevenson House Detention Center Organizational Chart 6. Pre-Audit Questionnaire (PAQ) Interviews:

1. PREA coordinator
2. PREA compliance manager

Site Review Observations:

1. Observation of the PREA coordinator and PREA compliance manager performing duties onsite.

Findings (by Provision):

115.311 (a) 1-5:

According to the pre-audit questionnaire (PAQ), DYRS responded that the agency has a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment in facilities it operates directly or under contract. The agency has a written policy mandating zero-tolerance against all forms of sexual abuse and sexual harassment. Agency Policy 2.13 Division of Youth Rehabilitative Services (DYRS) Prison Rape Elimination Act, section II titled Policy, establishes zero-tolerance for any incidence of sexual activity with youth, sexual abuse and sexual harassment. Any type of forced or unwanted sexual activity, touching or sexual harassment between youth or any type of sexual activity or sexual harassment between staff and youth including consensual is criminal and prohibited. Any incidents of sexual abuse and sexual harassment will be reported to the Child Abuse Hotline. This policy applies to all staff, including department employees, volunteers, contractors, official visitors, or other agency representatives.

Agency Policy 2.13 (DYRS) Prisoner Rape Elimination Act, Section IV titled details the agency's approach to preventing, detecting, and responding to sexual abuse and sexual harassment.

The agency's policy outlines prevention of sexual abuse and sexual harassment through the staffing plan, video monitoring and maintaining minimum staff ratio of 1:8 during the day and a minimum staff ratio of 1:16 at night.

Further, the policy details detection through staff announcement of the opposite gender in the housing unit, documented unannounced rounds of superintendents, assistant superintendent, supervisors, program and managers on all three shifts to deter sexual abuse and sexual harassment. Additionally, the agency conducts National Criminal Information Center (NCIC) checks on all facility staff every five years and child abuse registry checks are conducted. Staff complete intake screening for residents, risk assessments, and PREA training for staff.

The agency's policy addressed responding to sexual abuse and sexual harassment through resident and staff reporting, first responder duties, staff training, resident orientation and comprehensive training, child abuse hotline, emergency PREA grievance, investigations, disciplinary action, terminations and or criminal prosecution, medical and mental health treatment, incident review team, victim services, community emotional support services, and data collection. DYRS PREA

Policy 2.13 provides and outlines the agency's approach to preventing, detecting, and responding to sexual abuse and sexual harassment.

- DYRS PREA Policy 2.13 III. B. Definitions defines sexual abuse of a resident by another resident and sexual abuse of a resident by a staff member, contractor or volunteer as outlined in the PREA: Juvenile Facility Standards: United States Department of Justice Final Rule.
- DYRS PREA Policy 2.13.IV.G-H. includes sanctions for staff and residents found to have participated in prohibited behavior of sexual abuse and sexual harassment that includes disciplinary sanctions up to and including termination for staff and disciplinary sanctions for residents upon an administrative or criminal finding.
- DYRS PREA Policy 2.13.VI. outlines the agencies response for preventing detecting and responding to sexual abuse and sexual harassment.

The agency is substantially compliant with this provision and no corrective action is required.

115.311 (b) 1-3:

Based on the information provided on the PAQ, DYRS employees or designates an upper-level, agency-wide PREA coordinator. DYRS PREA Policy 2.13. III.G., provides that the PREA coordinator acts as the agency representative on PREA related issues and provides assistance to the PREA compliance managers. The PREA coordinator will develop, implement, and oversee the agency's efforts to comply with the PREA standards in all facilities. In review of the Pre-Audit Questionnaire (PAQ) and the DYRS Director's Office organizational chart, the agency employs an upper-level agency-wide PREA coordinator that holds the position of Professional Standards Manager. The PREA coordinator performance plan outlines that the Professional Standards Manager/PREA coordinator reports directly to the agency DYRS Deputy Director and provides assistance to four PREA compliance managers. The plan also outlines that the PREA coordinator will coordinate PREA audits, ensure timely submission of PAQ, support and monitor corrective actions. The PREA coordinator was appointed to this position on 3/13/23. The PREA coordinator indicated during the onsite interview that there is adequate time to manage PREA related duties including assisting four PREA compliance managers. The duties include facilitating meetings, calls, and resources during investigation efforts.

For the PREA audit, the PREA coordinator completed and submitted documentation in the PAQ, scheduled agency related specialized interviews and interviewed with the PREA auditor. During the onsite audit, the PREA coordinator demonstrated knowledge of tasks associated with the position, agency policy, and practices and efforts for compliance with the PREA standards.

The PREA coordinator has worked in her position since 3/13/23 and has led the agency's efforts towards compliance with the PREA standards. In the (PAQ), the PREA coordinator provided audit documentation, supplemental file documentation, scheduled required interviews with facility staff. The completion of these duties

	demonstrated the PREA coordinator has sufficient time and authority to oversee the agency's efforts in complying with PREA. The agency is substantially compliant with this provision and no corrective action is required. 115.311 (c): 1-4: DYRS PREA Policy 2.13.III. F., details the position of the PREA compliance manager. The policy provides that the PREA compliance manager will ensure PREA compliance operationally and its readiness for all related PREA standards. In review of the SHDC Organizational chart, the facility has designated a PREA Compliance Manager that holds the position of program manager in the organizational structure and reports directly to the superintendent. A review of the State of Delaware Employee 2024 PREA Compliance Managers organizational chart, the program manager is designated as the PREA Compliance Manager for the facility. The Department of Services for Children Youth and Their Families Division of Youth Rehabilitative Services PREA compliance managers Organizational Chart, the agency operates four facilities and has designated a PREA Compliance manager at each facility. The PREA compliance manager confirmed sufficient time is allotted to complete required tasks to adhere to PREA compliance. The task includes providing comprehensive training to residents, PREA training to staff, and maintaining PREA documentation. The PREA compliance manager submitted supplemental files via the OAS for review. When addressing issues of PREA compliance, it was reported the course of action would be to review and change the format to comply within 10 days and to provide training. The agency is substantially compliant with this standard and no corrective action is required. The evidence shows the agency has a zero tolerance PREA policy that outlines the agencies efforts in preventing detecting and responding to sexual abuse and sexual harassment. The evidence shows that the agency has designated an upper-level agency-wide PREA coordinator and a facility level PREA compliance manager which was verified through the agency policy, organizational charts, performance plans and interviews with both PREA coordinator and the PREA compliance manager. The PREA compliance manager works closely with the PREA Coordinator and is leading the facilities' efforts to comply with the PREA standards. Based on this analysis, the agency is substantially compliant with this standard and no corrective action is required.

115.312	**Contracting with other entities for the confinement of residents**
	Auditor Overall Determination: Meets Standard

	Auditor Discussion
	Documents: 1. Division of Youth Rehabilitative Services DYRS Contracts Table (updated 2/2024). 2. Division of Youth Rehabilitative Services DYRS Operating Guidelines for Contracted Children and Family Programs and Services Section V, B, D pp 10-11, (revised 11/01/22). 3. Pre-Audit Questionnaire (PAQ) 4. Natchez Trace Youth Academy PREA Final Report 7/18/2022 5. Abraxas Academy PREA Final Report 5/09/2022 6. Woodland Academy PREA Final Report 5/16/2022. 7. George Junior Republic PREA Final Report 11/10/2023 8. Montour Learning Center PREA Interim Report 12/7/2021 9. Abraxas Youth and Family Services PREA Final Report 9/7/2023 10. Summit Academy Interim Report 11. VisionQuest RAD- Newark Interim Report 12. VisionQuest RAD-Milford Interim Report 5/23/2022 13. White Deer Run Cove Prep Interim Report 14. YRS Woodard Academy Contract Amended 9/28/2023. 15. CYF Keystone dba Natchez Trace Contract 9/22/2022 16. CYF Diversified Treatment Alternative Contract 8/07/2023 17. CYF George Junior Republic Contract 9/22/2023 18. YRS Cornell Abraxas Group Inc Contract Amended 09/13/2022 19. CYF Kids Peace National Centers Contract 9/22/2023 20. YRS The Whitney Academy Contract 3/23/2023 21. CYF Gulf Coast Treatment Center Contract 8/29/2023 22. CYF White Deer Run Contract 6/27/2024 Interviews: 1. Agency contract administrator Findings (by Provision): 115.312 (a) 1-4: The agency reported in the Pre-Audit Questionnaire (PAQ) that they have entered into or renewed 14 contracts for confinement of residents. The Division of Youth Rehabilitative Services DYRS Operating Guidelines for Contracted Children and Family Programs and Services Section V, B, and D page 10 and 11, establishes that providers shall comply with all applicable PREA standards and any DSCYF policies or standards related to PREA for preventing, detecting, monitoring, investigating and eradicating any form of sexual abuse within DSCYF contracted or subcontracted facilities. In addition to "self-monitoring requirements" and submission to PREA state or federal audits, providers will allow DSCYF announced or unannounced,

	compliance monitoring to include "on-site" monitoring. Failure to comply with PREA, including PREA Standards and DSCYF PREA related policies or standards, may result in a loss of business until the provider comes into compliance with PREA standards and/or subsequent contract termination. In review of the DYRS residential contracts table dated (8/2024), the agency reported 14 contracts with agencies for the confinement of residents and eight contracts required contractors to adopt and comply with the PREA standards. The DYRS residential contracts list the agencies and facilities, contact information, website, PREA compliance manager, and status of compliance under the standard. The auditor reviewed six of the 14 contracts for confinement of the agency's residents. The contracts reviewed have a section on reporting requirements that specifically requires contractors to maintain compliance with the DSCYF operating guidelines for contracted client programs and services. The DSCYF operating guidelines is located on the agency's website at https://kidsfiles.delaware.gov/pdfs-/dscyf-op-gl-revisions-v11-01-2022.pdf and does require the contractor to comply with the PREA standards. The agency reported that six out of the 14 facilities had less than 51% juvenile justice. Since the last PREA audit, the agency has had 14 facilities that were under contract. The auditor was able to review five final PREA audit reports. The agency is substantially compliant with this provision and no corrective action is required. 115.312 (b) 1-2: The Division of Youth Rehabilitative Services DYRS Operating Guidelines for Contracted Children and Family Programs and Services Section V, D page 11, establishes self-monitoring requirements and submission to PREA state or federal audits. Providers will allow DSCYF announced or unannounced compliance monitoring to include on-site monitoring. In the PAQ, the agency reported that five facilities are less than 51% juvenile justice and do not require the agency to monitor the contractor for compliance with PREA standards. In review of the DYRS residential contracts dated (8/2024), the agency has a list of all contracts that includes the contract information for the provider, PREA compliance manager information, website and status of PREA final audit report. Six providers were listed as having less than 51% juvenile justice youth. The agency contract administrator stated that PREA compliance results had been received from contracting agencies, and those results that were not completed were within the contracting agency's three-year cycle. The agency is substantially compliant with this provision and no corrective action is required. The evidence shows that the agency has entered contracts for confinement of residents and that those contracts require the providers to adopt and comply with the PREA standards as verified through the review of the PAQ, supplemental files, contracts, provider website, PREA audit reports and agency guidelines. DYRS does require monitoring of a contractors' compliance with the PREA standards with the

providers unless the provider is less than 51% juvenile justice. This was verified through review of the PAQ, supplemental files, agency guidelines, provider website and interview with agency contract administrator.

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

115.313 Supervision and monitoring

Auditor Overall Determination: Meets Standard

Auditor Discussion

Documents:

1. DYRS PREA Policy 2.13
2. SHDC Staffing Plan 8/16/2024
3. SHDC Organizational Chart (2024).
4. SHDC Staff Schedule
5. Auditor Requested Shift Summaries
6. DYRS Strategic Plan 2023-2026
7. Director's Team Meeting Minutes 5/7/2024
8. DYRS Facility Minimum Staffing Sheet
9. Auditor Requested Video Uploads of Unannounced Rounds
10. Auditor Requested Shift Logs of Unannounced Rounds

Interviews:

1. Superintendent
2. PREA compliance manager
3. PREA coordinator
4. Intermediate or higher-level facility staff

Site Review Observations:

1. Facility video camera system and observation of camera placement

Findings (by Provision):

115.313 (a-c):

DYRS reported in the Pre-audit questionnaire (PAQ) that each facility it operates develops, documents, and makes its best efforts to comply on a regular basis with a staffing plan that provides for adequate levels of staffing and video monitoring in

order to protect residents against sexual abuse. The facility reported that the average daily number of residents at the facility was 27. At the time of the onsite audit, there were 31 residents at the facility, and on the last day of the onsite audit, there were 30 residents. The facility reported in the last 12 months they have not deviated from the staffing plan. The maximum capacity for the facility is 55 residents.

The facility relies on PREA Policy 2.13.IV. A.1.a-b, (pp. 4) that provides that the administration and supervisors have a responsibility to maintain facility staff to resident ratio. The shifts are A shift (7:00am -3:00pm), B shift (3:00pm-11:00pm), and C shift (11:00pm-7:00am). The facility has three A shift supervisors on 7:00am-3:00pm shift, three B shift supervisors on 3:00pm-11:00pm, and two C shift supervisors on 11:00pm-7:00am.

According to the staff roster made available through PAQ, the facility reported they currently have 80 staff. On the volunteer/ contractor, there were five contractors and five volunteers that may have contact with residents. Based on the information provided on the SHDC Organizational Chart, there are 64 employees as of 6/7/2024. In review of the SHDC organizational chart the staffing consists of

- Superintendent
- Assistant Superintendent
- Administrative Specialist III
- Administrative Specialist I
- Program Manager
- Management Analyst
- 8 YCS Supervisors
- Family Crisi Therapist
- Recreational Specialist
- Volunteer Service Coordinator
- 46 YCS Staff
- Laundry Room Staff
- Custodian

A review of the facility shifts reports for A, B and C shifts, the facility has a log report that outlines the movement of residents. The report details the number of staff and residents at each housing unit. The staffing plan and policy calls for a minimum of one staff per eight residents during A and B shift. The staffing plan requires that staff always be aware of the location of the group and individual residents by conducting random head counts. Residents are never left unsupervised in any area. Staff must conduct periodic headcounts to ensure the earliest possible detection of a missing resident and movement must be noted in the unit logbook. The C shift has a minimum of one staff to 16 residents with 15-minute checks during sleeping hours.

During onsite review, the auditor was able to observe that the residents were never alone. Majority of all interactions, there were two staff present. Residents traveled in

a group escorted by staff, in the main hallway, cafeteria, classrooms, healthcare and intake. Staff utilized radios for communication between other staff. On the first day of the onsite audit, 31 residents resided at SHDC. The auditor was able to review the camera system in central control and observe all areas of the facility and camera placement.

In the PAQ, the facility reported they have a video monitoring system. The facility replaced 49 cameras in June 2024. During the onsite review, there were a total of 98 cameras. All the cameras can be monitored by staff. The auditor did not observe any cameras in the bathroom. All cameras have a 30-day retention and are retrievable by date and time.

During interviews with the superintendent and the PREA compliance manager, it was confirmed that the facility has a documented staffing plan that considers staffing levels, video monitoring and the criteria set by the PREA mandates. Specifically, the staffing plan considered accepted detention and correctional practices, any findings of inadequacy, resident population, staff positions, blind spots, programming schedule, any applicable laws, and sexual abuse unsubstantiated and substantiated findings at SHDC.

The facility reported in the PAQ that there were no instances of deviating from the staffing plan. Additionally, it was noted that to ensure compliance with the staffing plan, staff are frozen on shift as needed.

Based on the information obtained from the shift summaries, it appears that the facility adheres to the staffing plan. SHDC uploaded to the PAQ the shift summaries requested by the auditor.

The facility is substantially compliant with this provision and no corrective action is required.

115.313 (d):

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

The agency provided the DYRS Strategic Plan that is updated every six months. During the December 2023 update, there was a information pertaining to existing established staffing for each agency operated facility. Mentioned was the vacancies and the status of staffing plan for specifically SHDC. During the Director’s Team Meeting minutes held on 5/17/2024, there were agenda items that focused on staffing and minimum duties; ratios and direct care; and juvenile facilities supervision. According to the minutes, there was a specific discussion pertaining to sending feedback on staffing plans.

Review of the documents provided showed the agency’s annual practices of considering staffing plans. Within the DYRS Strategic Plan, there can be found the

agency's plan for the next three years to improve the facility's prevention, detection, and response to sexual abuse and sexual harassment at all four of the DYRS operated facilities.

During interviews, the PREA Coordinator states that she is consulted regarding any assessments or adjustments to the staffing plan, and annually and as needed during the Director's meeting with the Superintendents. Additionally, the PREA coordinator is responsible for several goals related to PREA in the DYRS Strategic Plan. Each goal has periodic updates that are made as the agency continues to meet related to the strategic plan.

The facility is substantially compliant with this provision and no corrective action is required.

115.313 (e):

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

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

A review of the logs for the housing units shows that PREA unannounced rounds are documented in the unit log. The facility provided the auditor with requested logs identifying unannounced rounds. Additionally, the facility uploaded video by auditor's request showing that rounds are being completed and documented. The intermediate higher-level staff do conduct PREA unannounced rounds on all shifts and log such rounds in the unit log. PREA unannounced rounds are documented as PREA in the unit log with the name of the person conducting, time and date.

During the interview with higher-level staff, it was confirmed that they do conduct and document unannounced rounds. The auditor inquired about how you prevent staff from alerting other staff, and the response was the unannounced rounds are conducted randomly. In the PAQ, the facility provided footage for seven unannounced rounds. All six randomly selected videos of unannounced rounds were done appropriately and documented.

The facility is substantially compliant with this provision and no corrective action is required.

It is evident that the facility does meet with the PREA coordinator to discuss the staffing plan to ensure compliance, which was verified by interviews, superintendent's meeting minutes, and the agency's strategic plan. SHDC provides

adequate staffing levels and video monitoring to protect residents against sexual abuse and sexual harassment. It was verified through staffing plan, policy, interviews, video monitoring technology, staff, and supervisor shift assignments summaries. Lastly, the higher-level staff is consistent with completing and correctly documenting unannounced rounds. The unannounced rounds are documented, and it was verified through review of the logs, policy, video footage, and interviews.

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

115.315 Limits to cross-gender viewing and searches

Auditor Overall Determination: Meets Standard

Auditor Discussion

Documents:

1. DYRS PREA Policy 2.13
2. DYRS State Managed Facilities Searches of Youth, Visitors and Facilities 5.14
3. DYRS LGBTQI Policy 2.20
4. DYRS Policy 5.7 State Managed Facilities Youth Supervision and Movement
5. Male Staff Announce Sign and Female Announce Sign
6. PREA Cross Gender Pat Down Searches Training- Video 3 Parts
7. Pre-Audit Questionnaire (PAQ)

Interviews:

1. Random staff
2. Resident

Site Review Observations:

1. Intake

Findings (by Provision):

115.315 (a):

Reported in the pre-audit questionnaire (PAQ) DYRS reported that they do not conduct cross gender strip or cross gender visual body cavity searches of residents. In the past 12 months there were no cross-gender strip or cross gender visual body cavity searches of residents. It was stated during interviews with staff that cross gender pat searches would only be conducted during exigent circumstances.

According to DYRS Policy 5.14.3 A, unclothed searches are conducted by a minimum of two-line staff of the same gender without touching the youth. In addition, youth shall never be subjected to a body cavity search unless authorized by the medical authority, when directed this shall occur in the hospital setting and completed by hospital staff.

Further DYRS Policy LGBTQI 2.20.IV.G. 3-4, outlines that LGBTQI shall be asked about their preference of being searched. If the youth does not express a preference the same gender staff shall conduct the search.

During an interview, when asked what urgent circumstances would require cross-gender strip searches and visual body cavity searches, all 15 staff were able to identify an exigent circumstance.

When interviewed, all residents stated that they had not been subjected to cross-gender strip or cross gender visual body cavity searches.

The facility is substantially compliant with this provision and no corrective action is required.

115.315 (b-c):

SHDC reported in the PAQ that the facility does not conduct cross gender pat searches of residents unless there is an exigent circumstance. The facility reported in the past 12 months they had no cross-gender pat searches and none that involve an exigent circumstance.

DYRS Policy 2.20 LGBTQI outlines that cross-gender searches should not occur except in exigent circumstances. In an exigent circumstance, a written report must be completed, reviewed, and approved by the program manager immediately following and submitted to the deputy director, PREA coordinator and PREA compliance manager.

During an interview, when asked are you restricted from conducting cross gender pat down searches except in exigent circumstances, 15 out of 15 staff said yes. When asked to provide an example of a circumstance that would warrant a search, all 15 were able to give an example of an exigent circumstance.

All 10 residents stated that they had not been pat down searched by the opposite gender.

Durning the onsite audit, there was no intakes to determine the practice. The staff responsible for intake did explain that there is the same gender staff during the intake process, and there is always two staff during the intake process.

The facility is substantially compliant with this provision and no corrective action is required.

115.315 (d):

According to the PAQ, SHDC has implemented policies and procedures that enable

	residents to shower, perform bodily functions, and change clothing without non-medical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks including video monitoring. The facility relies on DYRS Policy 5.7.IV.E.1, that details that staff shall not observe youth of the opposite sex when they are dressing and or undressing, bathing, or using toilet. DYRS Policy PREA 2.13.IV.A.3 requires staff of the opposite gender to alert the youth via knocking on the door and then announce their gender. During interviews with 15 random staff, when asked do you or other staff announce your presence when entering a housing unit that houses residents of the opposite gender, all 15 staff stated yes. All 15 staff stated they would announce female or male on unit. When staff was asked if residents are able to dress, shower and use the toilet without being viewed by staff of the opposite gender, all 15 out of 15 staff stated yes. During site review, the auditor observed a door on the shower and bathroom. Residents go into the shower area dressed and must come out fully dressed. Also, observed outside of each housing unit was a posting stating “MALE/FEMALE STAFF ANNOUNCE PRESENCE BEFORE ENTERING THE HOUSING UNIT”. Copies of postings and locations were also uploaded to the PAQ. During interviews with 10 residents, when asked do female/male staff announce their presence when they enter your housing area or any area where you shower, change clothes, or perform bodily functions, 10 out of 10 residents stated yes, staff say female on the unit and when asked are you or other residents ever naked in full view of a female or male staff when using the toilet, showering or changing clothes, 10 out of 10 residents stated no. During the onsite review, the auditor observed a housing unit during showers. The housing unit bathrooms, shower area and toilets were individual with a door. The doors must be locked and unlocked by staff. The auditor informally asked staff about the use of the shower, toilet and how residents change clothes, staff confirmed that only one resident can shower at a time and use the restroom at one time. Residents are required to change in the shower area and get dressed before they come out of the shower area. This procedure was observed by the auditor. The facility is substantially compliant with this provision and no corrective action is required. 115.315 (e): SHDC reported they have a policy prohibiting staff from searching or physically examining a transgender or intersex resident for the sole purpose of determining the resident's genital status. In the last 12 months, the facility reported that no such search occurred. DYRS Policy LGBQTI 2.20.IV.G.2 outlines that LGBTQI youth will not be physically

	searched in a manner that is humiliating or degrading or for the sole purpose of determining the youth's physical anatomy. If a youth's gender is unknown, it will be determined during conversations with the youth, by reviewing medical records, or as a part of a broader medical examination conducted in private by a medical practitioner. During interviews with 15 random staff, when asked are you aware of the policy prohibiting staff from searching or physically examining a transgender or intersex resident for the purpose of determining the resident's genital status, 15 out of 15 staff stated they were aware of the policy. During the onsite review, the auditor reviewed 12 resident files and interviewed 10 residents and determined there were no transgender or intersex residents at the facility during the onsite audit. The auditor informally questioned medical and mental health practitioners as well as requested a list of residents that identified as LGBQTI. The facility is substantially compliant with this provision and no corrective action is required. 115.315 (f): In the PAQ, SHDC reported security staff have received training on conducting cross-gender pat down searches and searches of transgender and intersex residents in a professional and respectful manner, consistent with security needs. Agency policy 2.20 LGBTQI section IV J, (1-2), outlines that all staff shall receive training on how to communicate effectively and professionally with youth including LGBTQI or gender nonconforming youth. The facility uploaded videos of staff participating in search training. During interview with 15 random staff, when asked did you receive training on how to conduct a cross gender pat down search and searches of transgender or intersex residents in a professional and respectful manner, consistent with security needs, all 14 out of 15 staff stated they have been trained and received training in conducting cross gender and pat down searches of transgender and intersex residents in a professional and respectful manner, consistent with security needs. The auditor reviewed training records for staff. Along with the in-person search training, staff is provided refresher training every two years on searches of residents through PREA refresher training online. The evidence shows that the facility does not conduct cross gender strip searches or body cavity searches cross gender pat searches of residents which were verified by policy, PAQ, interviews and onsite observation. Residents can shower, change clothes and perform bodily functions without being viewed by non-medical staff of the opposite gender and staff announce their presence when entering a residents housing unit which was verified by policy, interviews and observation. Further, evidence shows that the facility prohibits staff from examining residents for the sole

	purpose of determining a resident's genital status which was verified by PAQ, policy, interviews, file review and onsite observation. Lastly, facility staff have received training on how to conduct cross gender pat down searches were verified through video, interviews, policy, and onsite observation. Based upon this analysis, the facility is substantially compliant with this standard and no corrective action is required.

115.316	**Residents with disabilities and residents who are limited English proficient**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. DYRS PREA Policy 2.13.IV.C.2.d 2. DSCYF Policy 118.II 10-6-2017 3. Pre-Audit Questionnaire (PAQ) 4. Roster of Residents Receiving Special Education Services 5. Statement from SHDC Pertaining to Disabled Residents 6. State of Delaware Executive Department Office of Management and Budget Contract NO. GSS19602-LINGUIST Interpretation & Translation Services-Foreign Languages Effective 7-1-2024 7. State of Delaware Executive Department Office of Management and Budget Contract NO. 24604 Sign Language Interpretation Services 8. How to Access and Purchase Contracted Translation Services 9. Quick Glance Interpretation & Translation Services 10. List of Translation Providers 11. SHDC Safety Guide Spanish 12. SHDC Resident Manual Spanish 13. PREA video with closed captions Interviews: 1. Agency Head 2. PREA Compliance Manager 3. Random Residents 4. Random Staff Site Review:

1. Intake
2. Posters and Audit Postings

Findings (by Provision):

115.316 (a)-1:

DYRS has reported in the pre-audit questionnaire (PAQ) that it has established procedures to provide disabled residents 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. Specifically in the agency PREA policy, there is specifics that ensure that disabled residents receive the same equal access to services and information pertaining to the prevention, detection, and response to sexual harassment and sexual abuse. Within PREA Policy 2.13.IV.C.2.d states each facility is to ensure that youth with language barriers or disabilities of any kind, are given the same information to prevent, detect and respond to sexual abuse and sexual harassment in a format supportive of the language barrier or disability.

In the PAQ, the agency provided the contract for interpretation and translation services from the State of Delaware Executive Department Office of Management and Budget Contract NO. GSS19602-LINGUIST Interpretation & Translation Services-Foreign Languages and Contract 24604 Sign Language Interpretation Services. The contract is a mandatory use contract that requires every state department and agency within the Executive Branch and Judicial Branch of the state government shall procure all material, equipment, and nonprofessional services through the statewide contract administered by Government Support Services. To locate the services needed, the document includes the Quick Glance Interpretation & Translation Services, and there was provide another list of Sign Language Services for residents that are hearing impaired.

Through the issue log the auditor requested a roster of students that received special education services and residents that were limited English proficient. There were several residents listed as receiving special education services at SHDC. During the interviews with targeted residents there was no apparent indication of a need for specialized vocabulary on the part of the auditor. There were no residents that had any speech impairment, blindness, overt intellectual disabilities, or hearing impaired. The resident's classifications were more related to learning disabilities, behavioral, and mental health. Residents stated that they understood PREA-related information and if they needed assistance, it would be provided by staff. Further, the SHDC provided a statement detailing the facilities ongoing assessments to address all residents visual and other health impairments.

During the interview with the agency head of DYRS relayed that there are procedures implemented to ensure that residents with disabilities and limited English proficiency receive information related to PREA. It was mentioned there was a contract for translation and interpretation services that included sign language for the hearing impaired. Also, it was stated the language and interpretation line was not used by SHDC in the prior 12 months.

During the onsite review, there were many large PREA posters created by the facility that included Child Abuse Hotline information for residents that may have limited vision. During the mock intake process, staff interviewed were aware of the interpretation and translation services that were available. Also, the facility did have a TTY phone in the intake area. Also, intake staff was able to identify ways to communicate with disabled residents during the admission process including the translation and interpretation services.

During interviews with targeted residents identified from the special education list, they confirmed receiving PREA related information that they were able to understand. The residents stated that they received the information from the PREA video and staff. The auditor inquired about extra assistance given by staff, and the residents stated that staff would help them if they needed help in understanding their rights concerning sexual abuse and sexual harassment.

The agency is substantially complaint with this provision and no corrective action is required.

115.316 (b):

According to the PAQ, DYRS confirmed it has established procedures to provide residents with limited English proficiency equal opportunity to participate in or benefit from all aspects of the agency’s efforts to prevent, detect, and respond to sexual abuse and sexual harassment. In DSCYF Policy 118.II, it is the policy of the Department that all limited English proficient (LEP) persons must have equal access to Department services, whether they are delivered by the Department or its contractors shall be entitled to language assistance at no cost to themselves. During the onsite audit, there were no residents identified as limited English proficient. It should be noted that Spanish is the second largest spoken language in the state of Delaware.

Meaningful access to all aspects of the agency efforts to prevent, detect, and respond to sexual abuse and sexual harassment to residents who are limited English proficient are meet through the availability of the contract for interpretation and translation services. In the PAQ, the facility provided the contract for interpretation and translation services from the State of Delaware Executive Department Office of Management and Budget Contract NO. GSS19602-LINGUIST Interpretation & Translation Services- Foreign Languages. The contract is a mandatory use contract that requires every state department and agency within the Executive Branch and Judicial Branch of the state government shall procure all material, equipment, and nonprofessional services through the statewide contract administered by Government Support Services. To locate the services needed, the document includes the Quick Glance Interpretation & Translation Services. Located in the PAQ was the instructions to access the services. The contract requires that the interpreters and translators are screened to ensure individuals providing services were effective, accurate, and impartial both receptively and expressively.

At the time of onsite audit, there were no limited English proficient residents to interview.

	During the onsite review, the auditors located PREA information in English and Spanish pertaining to the prevention, detection, and response to sexual harassment, sexual abuse, and retaliation for reporting. Also, there were audit postings throughout the building posted in both English and Spanish. The agency is substantially compliant with this provision and no corrective action is required. 115.316 (c): Review of DSCYF Policy 118.II does not explicitly prohibit the use of resident interpreters, resident readers, or other types of resident assistants. The policy does state that Department staff should utilize language assistance services in any situations where they are not able to communicate at a satisfactory level with an LEP person. Utilizing the interview protocols for random staff, it was found that 15 out of 15 random staff were aware that residents could not be utilized as translators or interpreters. There were no limited English proficient residents to interview nor documentation in PAQ to determine if resident interpreters, resident readers, or other types of resident assistants were utilized except in limited circumstances. According to random staff, there has not been any limited English proficient residents at SHDC within the last 12 months. According to the information taken from the PAQ, there were no instances in the past 12 months that indicated where resident interpreters, readers, or other types of resident assistants had been used. There was no documentation located by the auditor that there was an extended delay in obtaining an interpreter that could have compromised a resident’s safety, first-responder duties, or the investigation of a resident’s allegations. The facility is substantially compliant with this provision and no corrective action is required. The evidence demonstrates that the facility has taken steps to ensure that residents with disabilities and limited English proficiency have an equal opportunity to participate in or benefit from all aspects of the agency’s efforts to prevent, detect, and respond to sexual abuse and sexual harassment. There is no evidence of the utilization of resident interpreters, resident readers, or other types of resident assistants. It was verified by the agency’s policies, contracts, resident roster, interviews, and site reviews. Based upon this analysis, the facility is substantially compliant with this standard and no corrective action is required.

115.317	**Hiring and promotion decisions**
	Auditor Overall Determination: Meets Standard

Auditor Discussion

Documents:

1. DYRS PREA Policy 2.13.III
2. DYRS PREA Policy 2.13 Attachment F-DYRS Hiring and Promotion Decisions
3. DSCYF Policy 313
4. DSCYF 318.IV.E
5. DYRS Policy 2.2
6. Letter of Affirmation of NCIC 5 year Checks of Employees of SHDC
7. Volunteer Roster
8. Delaware Criminal Justice Information System (DELJIS)
9. Employee Files
10. Volunteer Documentation
11. Contractor Documentation
12. PREA Reference Check
13. Consent to Release Information for Prison Rape Elimination Act
14. Previous Institutions Worked- Prison Rape Elimination Act Compliance
15. Pre-Audit Questionnaire (PAQ)

Interviews:

1. Human Resources
2. Criminal Background Unit
3. Contractors and Volunteers

Findings (by Provision):

115.317 (a):

DYRS reported in the pre-audit questionnaire (PAQ) that the agency prohibits hiring or promoting anyone who may have contact with residents, and prohibits enlisting the services of any contractor who may have contact with residents who may have engaged attempted to engage, convicted of sexual abuse in prison, jail, lockup, community confinement facility, juvenile facility, other institutions, the community, which was facilitated by force or coercion, consent, or unable to consent or has been civilly or administratively adjudicated of the above actions.

In order to address the PREA standard 115.317, the agency has implemented two policies and a form. The documents provide a questionnaire for the employment candidates, volunteers, contractors, current employees (annually), and promoted employees to complete. The following items addressed on the forms are to prohibit the hiring, promoting, or contracting anyone who may have contact with residents who have engaged, attempted to engage, convicted of sexual abuse in prison, jail, lockup, community confinement facility, juvenile facility, other institutions, the community, which was facilitated by force or coercion, consent, or unable to consent or has been civilly or administratively adjudicated of the above actions.

- DYRS PREA Policy 2.13 attachment F-Prison Rape Elimination Act (PREA) Acknowledgement Form Hiring and Promotion is an affirmation completed by employment candidates, current employees (annually), employees at promotion, contractors, and volunteers. The form addresses both sexual abuse and sexual harassment.
- DYRS Policy 318.IV.E-G references that PREA requires pre-employment reference checks for covered employees to determine whether the candidate has engaged in the above stated behaviors. Additionally, the policy requires a service letter containing employment related information including the nature of the employee's separation from employment, and if there were any reasonably substantiated incidents involving violence, threat of violence, abuse, or neglect, by the person seeking employment toward any other person. Lastly, the policy requires a National Sex Offender Registry Check and Delaware Sex Offender Registry which would be disclosed as part of the criminal background check.
- In DSCYF Policy 313 Title 31, Chapter 3, Section 309 of the Delaware Code requires a check of SBI and FBI records and review of the Department's Child Protection Registry be conducted on employees of the Department hired after September 1,1989 who have regular direct access or unsupervised direct access to children and/or adolescents under the age of 18.

After reviewing list of new hires at SHDC and the list of staff completion of criminal background checks at SHDC, the practice of completing required criminal background checks and child registry checks were completed. There were 18 out of 18 criminal background checks completed and child abuse registry consulted.

Review of contractor and volunteer files and current employment files, the auditor located copies of the DYRS PREA Policy 2.13 attachment F-Prison Rape Elimination Act (PREA) Acknowledgement Form Hiring and Promotion.

Review of files of staff that were new hires it was confirmed during the hiring process, employment candidates complete DYRS PREA Policy 2.13 Attachment F-Hiring and Promotion which inquiries about past conduct. The employees affirmed that they have or have not been investigated for or engaged in sexual abuse or sexual harassment in confinement, community, and civilly or administratively adjudicated.

The agency is substantially compliant with this provision and no corrective action is required.

115.317(b):

According to the information provided on the PAQ, DYRS responded that the agency policy requires consideration of any incidents of sexual harassment in determining whether to hire, promote anyone, or to enlist the services of any contractor who may have contact with residents.

Considerations of incidents of sexual harassment would be captured in the DYRS

	PREA Policy 2.13 attachment F-Prison Rape Elimination Act (PREA) Acknowledgement Form Hiring and Promotion. Specifically, the form inquires about sexual harassment. It is an affirmation completed by employment candidates, current employees (annually), employees at promotion, contractors, and volunteers. According to the definition of staff in DYRS PREA Policy 2.13. III, contractors and volunteers are defined as employees. All prohibitions to hiring apply to contractors and volunteers which include DCYF Policy 318 and DCYF 313. Attachment F of DYRS PREA Policy 2.13 captures both volunteers' and contractors' affirmation that they have or have not been investigated for or engaged in sexual abuse or sexual harassment in confinement, community, and civilly or administratively adjudicated. Further during the interview with the human resource representative, it was confirmed that the agency does consider past conduct of sexual abuse and sexual harassment during the hiring process. The agency is substantially compliant with this provision and no corrective action is required. 115.317(c) In the PAQ, DYRS reports that agency policy requires that before it hires any new employees who may have contact with residents, it conducts criminal background record checks; consults any child abuse registry maintained by the State or locality in which the employee would work; and consistent with Federal, State, and local law, makes 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. DYRS has demonstrated the implementation of policy and documentation to ensure that criminal background checks are completed, child abuse registry consulted, and references are completed for prior institutional employment pertaining to sexual abuse and sexual harassment. • DSYCF Policy 313.III cites Title31, Chapter 3, Section 309 of the Delaware Code requires of SBI and FBI records and review of the Department's Child Protection Registry be conducted on employees of the Department hired after September 1,1989 who have regular direct access or unsupervised direct access to children and/or adolescents under the age of 18. • In DSYCF Policy 318.IV.E specifically address the mandates required by PREA. The policy states that PREA requires pre-employment reference checks for covered employees to determine whether the candidate (1) Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility or other institution; (2) Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; and/or (3) Has been adjudicated

in civil court or administratively adjudicated (substantiated) in employment related hearings. The policy is the general guidance for pre-employment checks. According to the policy the pre-employment checks must be considered in hiring decision making. Additionally, all information provided on the employment application, resume, reference and pre-employment check materials may be verified, including but not limited to, contacting current and former employers.

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

There were 18 out of 18 new hire criminal background checks completed and child abuse registry consulted.

SHDC does complete pre-employment reference checks, and they have recently implemented contacting prior institutional employment with a uniform questionnaire. The reference check (questionnaire) does inquire about conduct related to sexual abuse and sexual harassment.

The agency is substantially compliant with this provision and no corrective action is required.

115.317(d)-1-2

According to the DYRS Policy 2.13.III.a Definition the SHDC contractors are considered staff. The DYRS Policy 318.IV.E requires that criminal background checks are to be completed and child abuse registries consulted prior to enlisting the services of any contractor who may have contact with residents.

Inquiry was made by the auditor regarding the criminal background checks for contractors that were provided on the contractor/volunteer list for SHDC. The auditor was able to determine the extent of background checks and child registry checks. In the PAQ, there was a list providing the dates of completion of the criminal background checks and child registry consults for five out five contractors.

The auditor interviewed a contractor that recalled having to complete a criminal background check.

The criminal history unit confirmed the process of obtaining criminal background checks for contractors.

The agency is substantially compliant with this provision and no corrective action is required.

115.317(e)-1

According to the PAQ, agency policy requires that either criminal background records checks be conducted at least every five years of current employees and

	contractors or have another system in place to capture such information for current employees. DSYCF Policy 313.III cites Title31, Chapter 3, Section 309 of the Delaware Code requires SBI and FBI records and review of the Department's Child Protection Registry be conducted on employees of the Department hired after September 1,1989 who have regular direct access or unsupervised direct access to children and/or adolescents under the age of 18. Provided through the supplemental files of the OAS the PREA Coordinator provided a Letter of Affirmation for the 5-year employee background checks for SHDC. Provided to the auditor was the dates of criminal background checks and child abuse registry consult. DYRS employs the use of the Delaware Criminal Justice Information System (DELJIS). This system flags the department if any employee, contractor, or volunteer receives a criminal charge while employed with the agency. Only criminal charges that occur in Delaware are subject to be flagged by DELJIS. This practice was confirmed by the Criminal History Unit. The facility is substantially compliant with this provision and no corrective action is required.. 115.317(f)-1 According to the PAQ, DYRS shall also ask all applicants and employees who may have contact with residents directly about previous misconduct described in 115.317(a) in written applications or interviews for hiring or promotions and interviews or written self-evaluations as part of reviews of current employees. The auditor reviewed DYRS Policy 2.13-Attachment F-PREA Acknowledgement Form which is used to as a continuing affirmative duty to disclose the engagement of sexual abuse in a place of confinement, convicted of engaging; attempting to engage in sexual activity in the community; or civilly or administratively adjudicated of said behavior and investigated in sexual harassment. In the introduction of the form, it states the agency shall not hire, promote or contract with anyone who may have contact with youth who participated in above behaviors listed. All 20 files contained copies of the DYRS PREA Policy 2.13 Attachment F. It was also confirmed by PREA coordinator that DYRS Policy 2.13 – Attachment F-PREA Acknowledgement Form is completed by employees annually and upon promotion. 115.317(g)-1 In the PAQ, DYRS has confirmed that material omissions regarding such misconduct, or the provision of materially false information, shall be grounds for termination.

	DYRS has established two policies wherein material omissions regarding misconduct or false information shall be grounds for termination. Within DSCYF Policy 318.V.C states any false, misleading, or substantive omission of information provided by an applicant during any phase or by any means may be cause for rejection of the application, rescinding an offer, repeating all or part of the hiring process, or dismissal if employed by the State. Found in DYRS Policy 2.2.IV.B.1.a. maintains that employees have the responsibility to immediately disclose to their supervisor any criminal investigations, arrests, indictments, or convictions of themselves or any investigation of child/abuse or entry onto the Child Abuse Protection Registry subsequent to initial employment. Failure to immediately notify a supervisor of any of the above, including final disposition, could result in discipline up to and including termination. The agency is substantially compliant with this provision and no corrective action is required. 115.317(h)-1 According to the PAQ, unless prohibited by law, the agency shall 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. It was confirmed by human resources that with a service letter and a signed consent by a former employee, DYRS would provide information on substantiated allegations of sexual abuse or sexual harassment involving a former employee to a perspective employer. The evidence has shown that the agency has established policies and procedures that prohibit the hiring or promotion of employees or contractors who may have contact with residents who have engaged in sexual abuse in confinement, institution settings, community or civilly or administratively adjudicated for said behaviors. The agency through practice and policy has established forms. The auditor was able to determine the practice of consideration of sexual harassment verified by background checks, child registry checks, policy attachment and files. The prior institutional employment reference has been implemented and inquiries about misconduct as it relates to sexual abuse and sexual harassment. The agency completes criminal background checks and child abuse registry consult prior to hiring. The agency does complete background checks every 5 years or less, and DELJIS captures incidents of criminal conduct in Delaware. Imposed on employees is a continuing affirmative duty to disclose any misconduct including PREA standard 115.317(a). Any omissions or false statements are grounds for termination and is verified by policies. Lastly, a written consent from a former employee, the agency would provide information of a substantiated allegation of sexual harassment and sexual abuse verified by interview. Based on this analysis, the facility is substantially compliant with this standard and no corrective action is required.

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

Documents:

1. Email 6-13-2024 Stevenson House Camera Replacement Project
2. Pre-Audit Questionnaire (PAQ)

Interviews:

1. Director of DYRS
2. Superintendent

Site Review:

1. Facility
2. Cameras

Findings (by Provision):

115.318 (a)-1:

DYRS reported in the pre-audit questionnaire (PAQ) that the agency has not acquired a new facility or made substantial expansion or modification to existing facilities since August 20, 2012 or since the last PREA audit. Information obtained from the director of DYRS, it was stated that there has been no newly acquired facility or any substantial modifications to SHDC since the last PREA audit finalized on 8/10/2021.

The agency is substantially compliant with this provision and no corrective action is required.

115.318 (b)-1:

Since the last PREA audit there have been updates to the video monitoring system. The facility provided an email of the details of the Stevenson House Camera Replacement Project. There were 49 cameras replaced in June of 2024. Cameras were replaced in housing units, classrooms, sally port, library, medical, intake, canteen, cafeteria, lobby, central control, administration. The SHDC has a total of 98 cameras.

During the interview with the superintendent, it was identified that placement of cameras is considered when using technology to enhance residents’ protection from sexual abuse. After the review of the video monitoring system, it was determined the capability of capturing footage is up to 30 days which provides information to assist in the ability to prevent and detect sexual abuse. During the site review, the

	auditor was able to view all 98 cameras with enhanced capabilities. The agency is substantially compliant with this provision and no corrective action is required. Through site review, emails, and interviews, DYRS has demonstrated that the agency has not acquired a new facility. There have been no modifications since the last PREA audit at SHDC. The facility has replaced 49 cameras since the last PREA audit. Considerations were made to improve the prevention and detection of sexual abuse. Based on this analysis, the facility is substantially compliant with this standard and there is no corrective action required.

115.321	**Evidence protocol and forensic medical examinations**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. DYRS PREA Policy 2.13.IV.G.1 2. DYRS PREA Policy 2.13.IV.I.2 3. DYRS Policy 2.13.IV.E.4.a-b 4. State of Delaware Memorandum of Understanding for the Multidisciplinary Response to Child Abuse and Neglect 5/2022 pp 93-104 5. US Department of Justice's Office on Violence Against Women publication, "National Protocol for Sexual Assault Medical Forensic Examination, Adult/ Adolescents" 6. Affirmation of Compliance with Forensic Examinations Standards for Sexual Assaults-Bayhealth 7. Affirmation of Compliance with Investigative Standards for Sexual Assaults with Milford Police Department 8. Pre-Audit questionnaire (PAQ) Interviews: 1. Institutional Abuse (IA) 2. Delaware State Police Department (DSP) 3. PREA Coordinator Findings (by Provision):

	115.321 (a): In the pre-audit questionnaire (PAQ), DYRS responded that the agency is responsible for conducting administrative sexual abuse investigations including resident-on-resident sexual abuse or staff sexual misconduct. DYRS has established through memorandum of understanding and affirmation agreement to ensure Milford Police Department (MPD) follows uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions. DYRS PREA Policy 2.13.IV.G.1.a-c requires that all allegations of sexual abuse or sexual harassment are reported to the Child Abuse Hotline and screened for Institutional Abuse investigation. At SHDC, allegations of criminal behavior will be investigated jointly by Milford Police Department and Institutional Abuse (IA). The DYRS does not conduct criminal investigations. When conducting sexual abuse investigations, there is an existing memorandum of understanding which was contained in the PAQ. It is titled the State of Delaware Memorandum of Understanding for the Multidisciplinary Response to Child Abuse and Neglect. Within the document there is the Child Sexual Abuse Protocol. Found in the protocol there is a description and mention of PREA mandates. All police departments within the state of Delaware have signed this document. According to the IA PREA investigator, there were no sexual abuse allegations at SHDC referred to by the Child Abuse Hotline within the prior 12 months. This was further confirmed after the review of the information provided from the Child Abuse Hotline Call Center. During random staff interviews, all 15 staff stated the steps to obtain usable physical evidence would be to separate victim and abuser, secure area, and require that resident and perpetrator do not destroy evidence that could be obtained from forensic examination. There were 14 out of 15 random staff that were able to identify the facility's PREA investigator. The agency is substantially compliant with this provision and no corrective action is required. 115.321(b) DYRS responded in the PAQ that the protocol for investigations was developmentally appropriate for youth. State of Delaware Memorandum of Understanding for the Multidisciplinary Response to Child Abuse and Neglect was developed for youth and children. During the auditor's review, the protocols appear to be developmentally appropriate for youth. The document does not specifically cite as the framework the US Department of Justice's Office on Violence Against Women publication, "National Protocol for Sexual Assault Medical Forensic Examination, Adult/Adolescents." The US Department of Justice's Office document was not utilized to develop the protocols. The protocol was developed based on best practice. Comparison was made of both documents; it was found that there were commonalities between the protocols. Items covered in the US Department of Justice's Office on Violence Against Women publication, "National Protocol for Sexual Assault Medical Forensic Examination, Adult/Adolescents:

- Coordinated Team Approach
- Informed Consent
- Confidentiality
- Reporting to Law Enforcement
- Payment for the Examination Under VAWA
- Sexual Assault Forensic Examiners
- Facilities
- Equipment and Supplies
- Sexual Assault Evidence Collection
- Timing Considerations for Collecting Evidence
- Evidence Integrity
- Initial Contact
- Triage and Intake
- Documentation by Health Care Personnel
- Medical Forensic History
- Photography
- Exam and Evidence Collection Procedures
- Alcohol and Drug-Facilitated Sexual Assault
- STI Evaluation and Care
- Pregnancy Risk Evaluation and Care
- Discharge and Follow-up
- Examiner Court Appearances

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

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

The agency is substantially compliant with this provision and no corrective action is required.

115.321(c)

It was reported in the PAQ that SHDC offers all residents who experience sexual abuse access to forensic medical examinations. In DYRS PREA Policy 2.13.IV.I.2, states that resident victims of sexual abuse will be referred to Bayhealth Hospital in Milford, Delaware for medical interventions.

Existing is the Affirmation of Compliance with Forensic Examinations Standards for Sexual Assaults between the Bayhealth Hospital SANE coordinator, DYRS director, and PREA coordinator. The affirmation states that forensic examinations are made

	available without consideration of cost to the youth where evidentiary or medically appropriate. The affirmation assured those forensic medical examinations would be completed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) or other qualified medical practitioners. According to PREA coordinator, IA, and documentation provided in the PAQ, there were no forensic medical examinations sent to Bayhealth within the prior 12 months from SHDC. Interview with SANE Coordinator confirmed that there was an existing agreement with DYRS for forensic examinations The agency is substantially compliant with this provision and no corrective action is required. 115.321(d) Through a memorandum of agreement, Survivors of Abuse Recovery, Inc. (SOAR) and YRS have an agreement for SOAR to provide victim support services to individuals who have been a victim of sexual abuse. The services include support during forensic medical examination and emotional support during the investigative process, counseling while in custody, and counseling in the community. The agreement requires that qualified staff members provide advocacy services. DYRS Policy 2.13IV.E.4, referenced that youth shall be made aware of community agencies, addresses, and contact information of victim advocates that provide emotional support services related to sexual abuse. Interview of the 10 random youth, it was found the residents were not able to recall victim advocacy services. The auditor was unable to determine the use of victim advocacy services because there were no youth identified at the facility who reported sexual abuse during the onsite audit. The auditor was unable to determine if there were any referrals from SOAR within the prior 12 months from SHDC. There was an attempt by auditor by email correspondence with the agency, but there was no response to the email. According to PREA coordinator, referrals for victim advocacy can be requested by residents with prior victimization that occurred in either the community or in another facility. The PREA compliance manager confirmed SHDC has an existing MOA with SOAR to provide victim advocacy and emotional support to residents that have experienced sexual abuse. The facility is substantially compliant with this provision and no corrective action is required. 115.321(f) According to SHDC in the PAQ, if requested by the victim, a victim advocate, or qualified agency staff member, or qualified community-based organization staff member accompanies and supports the victim through the forensic medical examination process and investigatory interviews and provides emotional support, crisis intervention, information, and referrals.

SHDC reported in the PAQ that it makes attempts to make a victim advocate from a rape crisis center available to the victim, in person or by other means. Through a memorandum of agreement, Survivors of Abuse Recovery, Inc. (SOAR) and DYRS have an agreement for SOAR to provide victim support services to individuals who have been victims of sexual abuse. The services include support during forensic medical examinations and emotional support during the investigative process, and counseling while in custody.

The PREA compliance manager confirmed that if requested that a resident that experienced sexual abuse at SHDC would be provided a victim advocate and emotional support through SOAR.

Residents are made aware of the availability of victim advocacy and emotional support in the comprehensive PREA training and the SHDC safety guide.

In the affirmation between DYRS and Bayhealth Hospital there is reference that the hospital would make available to the victim, a victim advocate, qualified agency staff member, or a qualified community-based organization member with support through the forensic medical examination process, investigatory interviews, and assist in providing emotional support, crisis intervention, information, and referrals.

The agency is substantially compliant with this provision and no corrective action is required.

115.321(f)

DYRS confirmed in the PAQ that the agency has requested that the responsible agency follow the requirements set by the PREA mandates required 115.321(a)-(e). Milford Police Department (MPD) MPD conducts criminal investigations for allegations of sexual abuse at the SHDC. DYRS and the MPD implemented the Affirmation of Compliance with Investigative Standards for Sexual Assaults 4/2023. Additionally, there is the State of Delaware Memorandum of Understanding for the Multidisciplinary Response to Child Abuse and Neglect 5/2022. Both documents include the requirements mandated by PREA Standard 115.321(a)-(e).

The agency is substantially compliant with this provision and no corrective action is required.

It evident from policy, memorandums, documentation and interviews that the facility ensures evidence protocols are adhered to and forensic medical examinations are conducted. Within agency policy, DYRS is responsible for conducting administrative sexual abuse investigations in cases in which the Child Abuse Hotline screens an allegation of sexual abuse. When it is determined that the allegations meet the criminal threshold by IA, criminal sexual abuse allegations are conducted by the MPD in conjunction with IA. The State of Delaware Memorandum of Understanding for the Multidisciplinary Response to Child Abuse and Neglect 5/2022, the Affirmation of Compliance with Forensic Examinations Standards for Sexual Assaults 4/2023, and the Affirmation of Compliance with Investigative Standards for Sexual Assaults 4/2023 are developmentally appropriate protocols for

youth. The three protocols are in alignment with the US Department of Justice's Office on Violence Against Women publication, "National Protocol for Sexual Assault Medical Forensic Examination, Adult/Adolescents." DYRS provides forensic medical examinations utilizing the SANE/SAFE from Bayhealth Hospital. Residents are provided victim advocacy services from SOAR, a community-based victim advocacy agency.

Based on this analysis, the agency substantially meets compliance with this standard no corrective action is needed.

115.322 Policies to ensure referrals of allegations for investigations

Auditor Overall Determination: Meets Standard

Auditor Discussion

Documents:

1. DYRS PREA Policy 2.13 DYRS 2.13.IV.B.
2. DYRS PREA Policy 2.13 DYRS 2.13.IV.G. 1-3
3. DYRS PREA Policy 2.13 Attachment A: Sexual Incident Form
4. DYRS PREA Policy 2.13 Attachment B: Investigative Summary
5. DYRS PREA Policy 2.13 Attachment C: Substantiated Sexual Abuse or Sexual Harassment Form
6. DYRS PREA Policy 2.13 Attachment D: Notification of Investigation
7. Affirmation of Compliance with Investigative Standards for Sexual Assaults with Delaware State Police
8. DYRS Policy Reportable Events 2.12
9. Child Sexual Abuse Protocol Memorandum of Understanding
10. Policy 309 Removal of Employee from the Workplace

Interviews:

1. Agency head
2. Investigative staff

Findings (by Provision):

115.322 (a):

In the PAQ, the DYRS reported they ensure that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment. Although a policy is not required for this provision, the agency relies on DYRS PREA Policy 2.13.IV. B., that states all allegations of sexual abuse or sexual harassment will receive an administrative and criminal investigation. The policy details that all allegations of sexual abuse and sexual harassment that involve potentially criminal behavior will be referred to the Milford Police Department (MPD) by institutional abuse for joint investigation.

DYRS provided an Affirmation with MPD that requires they follow investigative protocol consistent with PREA at SHDC.

The facility reported in the PAQ there was one sexual abuse allegation reported in the past 12 months that resulted in an administrative investigation, but it was not investigated criminally. In the preceding 12 months, there was no sexual harassment allegations reported or investigated administratively or criminally.

During an interview, the agency head stated that they do ensure that administrative and criminal investigations are conducted. Initially, the Child Abuse Hotline is contacted, and if Institutional Abuse (IA) does not proceed with investigation, the facility PREA investigators complete the investigation. The facility PREA investigator is assigned from another DYRS operated facility. If IA investigates, a determination would be made to involve MPD if allegation is criminal in nature.

The facility is substantially compliant with this provision and no corrective action is required.

115.322 (b) 1-3:

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

DYRS PREA Policy 2.13.IV.G.1-3, references that all allegations of any sexual abuse or sexual harassment are reported to the Child Abuse Hotline and screened for institutional abuse investigation. Institutional abuse may complete a joint investigation with the Delaware State Police or Milford Police for allegations that involve potentially criminal behavior. Institutional abuse will investigate all matters involving staff actions that may not be potentially criminal behavior but still violates PREA. Any allegation that Institutional Abuse does not investigate will be administratively investigated by facility PREA investigators.

In the PAQ, the facility outlined in the Child Sexual Abuse Protocol (MOU), Mandates that reports of child abuse or neglect be made to the appropriate authorities. In the

PAQ, the agency reported the policy regarding referral of allegations of sexual abuse or sexual harassment for criminal investigation is published on the agency's website or made publicly available via other means. For public access, the agency publishes DYRS PREA Policy 2.13 on the agency's website https://kids.delaware.gov/policies/. The auditor reviewed the agency's website and determined that PREA Policy 2.13 is available on the website.

Additionally, the SHDC has an existing memorandum with he Milford Police Department (MPD).

The agency relies on DYRS Policy Reportable Events 2.12 as evidence that all referrals of allegations of sexual abuse or sexual harassment for criminal investigation is documented. The auditor requested the prior 36 months of investigations of allegations of sexual abuse and sexual harassment. A review of the records and tracking sheets confirms the agencies process with documenting referrals and allegations of sexual abuse and sexual harassment.

The auditor was able to determine that there was no criminal cases of sexual abuse or sexual harassment received during the audit period for SHDC.

During an interview, facility investigator stated that all criminal allegations of sexual abuse and sexual harassment would be referred to MPD. The auditor was able to interview a representative of MPD who would be responsible for conducting criminal investigations for allegations of sexual abuse and sexual harassment at SHDC. MPD reported they have the legal authority and did not have any sexual abuse or sexual harassment cases in the last 12 months that occurred at the facility.

The evidence shows that the agency has a policy that outlines the investigation process for reporting sexual abuse and sexual harassment. The agency's Child Sexual Abuse Protocol (MOU) does establish a reporting requirement to the appropriate law enforcement for all criminal offenses identified in the sexual abuse protocol and documenting that contact.

The facility is substantially compliant with this provision and no corrective action is required.

115.322 (c):

DYRS PREA Policy 2.13.IV.G.1, describes the responsibility for conducting criminal investigations for Institutional Abuse and Milford Police Department (MPD). The agency's policy is published on the agency's website that identifies the agency and MPD for conducting joint criminal investigations.

During an interview, facility investigator stated that all allegations of sexual abuse and sexual harassment that are deemed criminal are referred to MPD. The auditor was able to interview a representative of MPD who would be responsible for conducting criminal investigations for allegations of sexual abuse and sexual harassment at SHDC. It was reported they have not had any sexual abuse or sexual harassment cases in the last 12 months that occurred at the facility. The

representative from MPD was able to describe to the auditor the investigative process for allegations of sexual abuse at SHDC.

The facility is substantially compliant with this provision and corrective action is not required.

DYRS has a policy that requires allegations of sexual abuse or sexual harassment be referred for investigation to an agency with the legal authority to conduct criminal investigations. The information regarding referrals is published on the agency's website. It is verified through the PAQ, interviews, policy, and documentation review that administrative and criminal investigations are conducted. The evidence shows that SHDC does conduct administrative investigations, but it did not contact the Child Abuse Hotline in accordance with DYRS Policy 2.13 which is to initiate all PREA related investigations of sexual abuse and sexual harassment through the Child Abuse Hotline.

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

115.331 Employee training

Auditor Overall Determination: Exceeds Standard

Auditor Discussion

Documents:

1. DYRS Policy 2.13.IV.A
2. DSCYF Academy Staff Training PowerPoint Presentation
3. Stevenson House Detention Center PREA Refresher Training Roster
4. Stevenson House Detention Center PREA Refresher Assessment Scores for Staff
5. Copy of PREA Refresher Assessment
6. Staff Roster
7. Personnel Files
8. Pre-Audit Questionnaire (PAQ)

Interviews:

1. Random Staff
2. Medical Staff
3. PREA Coordinator

4. Training Administrator

Findings (by Provision):

115.331 (a)-1-11:

According to information provided on the Pre-audit questionnaire (PAQ), DYRS trains all employees who may have contact with residents on the agency's zero tolerance policy for sexual abuse and sexual harassment and all other training required under PREA standard 115.331(a)-1-11. Though not required, DYRS has implemented Policy 2.13.IV.C.1.a-d to address PREA training for all employees. The policy states that all department staff working with or monitoring programs/services of youth in secure care and community services must receive PREA training. Further, the policy details that the Center for Professional Development will provide training to all new DYRS employees during orientation. Review of new hires' personnel files substantiated the practice of the agency providing PREA training during orientation. All new hirers are provided PREA training during their orientation at the Center for Professional Development. All employees are to complete PREA refresher training every 2 years via the Delaware Learning Center's database. The years that that an employee does not receive PREA refresher training, refresher information must be provided on current sexual abuse and sexual harassment policies. This information is delivered via the agency's training database. DYRS staff are to renew this training every two years. Lastly, the training will include, but not limited to, complaint recipient responsibility, how to report and incident, coordinated responses duties, investigations, and how to access victim services.

Training material was provided in the Pre-Audit Questionnaire (PAQ). The initial PREA training is provided in person, and instruction is lead utilizing a PowerPoint presentation which is based on the Moss Group training materials for PREA. Located in the Academy Staff Training on slide 8, there is specific language that addresses the agency's Zero Tolerance Policy. The slide was titled Zero Tolerance Policy. Underneath, the slide read DYRS commits to full compliance with the Prison Rape Elimination Act (PREA). There are 2 statements that are bulleted. The first bullet states DYRS has a zero tolerance for any incidence of sexual abuse of youth in our care, and the last bullet details any type of forced or unwanted sexual activity, touching or sexual harassment between youth or any type of sexual activity or sexual harassment between staff and youth is criminal and prohibited. The following information was located in DSCYF Academy Staff Training PowerPoint Presentation.

- Agency's zero-tolerance policy for sexual abuse and sexual harassment-Slide 8
- Responsibilities of prevention, detection, reporting, and response policies and procedures-Slides 45-73
- Right of residents to be free from sexual abuse and sexual harassment-Slide 9Right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment-Slides 9, 10, 50, 54, 96
- Dynamics of sexual abuse and sexual harassment-Slides 5,26,34,36,37,40,

81

- Common reactions of juvenile victims of sexual abuse and sexual harassment-Slides 26,41-43
- How to detect and respond to signs of threatened and actual sexual abuse/ how to distinguish between consensual sexual contact and sexual abuse between residents-Slides 12-20
- How to avoid inappropriate relationships with residents-Slides 89-96
- How to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents-Slides 66-88
- How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities-Slides 50-53
- Relevant laws regarding the applicable age of consent-Slides 19-20 and Policy

Review of the PREA training refresher roster, the auditor was able to determine that there were only two out of 79 staff that had not received the PREA refresher training through the Center of Professional Development. This information is based on the PREA training roster dated 9/4/2024. The agency has implemented a monthly review of PREA training records to ensure that training is completed in a timely manner. The review of a sample of seven new hire files yielded that all seven new hirers completed PREA orientation training.

Utilizing the PREA protocols for random staff, the auditor found that all 15 random staff interviewed stated that they had received PREA training at orientation or during the implementation of PREA mandates at the facility. Also, they had confirmed that they had received PREA refresher training through the Delaware Learning Center Database.

The agency is substantially compliant with this provision and no corrective action is required.

115.331(b)-1-2

According to the PAQ, training is tailored to the unique needs and attributes and gender of the residents at the facility. DYRS provides services to both genders, and Ferris School is the only facility that is male specific. SHDC is a detention center that services both male and female residents. Historically, DYRS staff are trained and used at all the facilities that services both genders. During the interview with the training administrator, it was found there was no separate training for female and male facilities. Staff are provided with comprehensive training to work with both genders.

The agency is substantially compliant with this provision and no corrective action is required.

115.331(c)1-2

	In accordance with DYSR Policy 2.13.IV.A.1.b., employees are required to participate in PREA refresher trainings. Based on information obtained from facility staff, they received PREA refresher training. Based on the PAQ and the interview with the training administrator at the Center for Professional Development, the PREA refresher training is prompted online every 22 months. In 2024, as a part of the annual training modules DYRS implemented providing PREA policy information through the Delaware Learning Center database. Review of the PREA training refresher roster, the auditor was able to determine that there were only two staff that were scheduled out of 79 staff that had not received the PREA refresher training through the Center of Professional Development. The agency is substantially compliant with this provision and no corrective action is required. 115.331(d)-1 Reported in the PAQ, the agency confirmed that employees who may have contact with residents understand the training they have received through employee signature or electronic verification. The agency provided the roster of results from the PREA Refresher Assessment. Further, it was clarified by the training director that staff electronically sign once they complete the course. Staff have up to five times to take and pass the assessment. After five failed attempts, staff must take the test in person at the Center for Professional Development. Review of transcripts of new hirers provided evidence that staff receive comprehensive PREA training during orientation. The training meets all PREA standard requirements of 115.331(a). The agency is substantially compliant with this provision and no corrective action is required. The agency provides training on the agency's zero-tolerance policy for sexual abuse and sexual harassment. All employees who may have contact with residents are trained in accordance to PREA standard 115.331 (a)1-11. The agency provides PREA refresher training through the Delaware Learning Center's database. The PREA refresher roster has shown that almost all the staff scheduled for PREA refresher training have completed the requirement. The agency provided documentation on maintaining electronic signature and assessment results. Based upon this analysis, the facility exceeds compliance with this standard and corrective action is not required.

115.332	**Volunteer and contractor training**
	Auditor Overall Determination: Meets Standard

	Auditor Discussion
	Documents: 1. DYRS 2.13.III 2. DYRS 2.13.IV.A.1 3. Volunteer and Contractor Roster 4. PREA Acknowledgement Form for Hiring/Promotion 5. PREA Training Volunteer/Contractor Acknowledgement Form Interviews: 1. Volunteer 2. Contractor 3. Volunteer/Contract Coordinator Findings (by Provision): 115.332 (a): SHDC reported on the pre-audit questionnaire (PAQ) that all volunteers and contractors who have contact with residents have been trained on their responsibilities under the agency's policies and procedures regarding sexual abuse and sexual harassment prevention, detection, and response. According to DYRS 2.13.III, staff are defined as any Department employee, volunteer, contractor, official visitor, or other agency representative. Further in DYRS 2.13IV.A.1, all department staff working directly with or monitoring programs/services of youth in secure care and community services must receive PREA training. Volunteers and contractors are to be trained on the agency's zero tolerance policy for sexual abuse and sexual harassment. It was reported in the PAQ that there were five volunteers and five contractors. The volunteer/ contractor coordinator confirmed conducting the training of volunteers and contractors. The training includes an overview of the PREA Policy 2.13. The contractors and volunteers sign an acknowledgement form of participation and understanding. The practice was further confirm during the auditor's review of the training documentation included in the PAQ for both the volunteers and contractors. The facility is substantially complaint with this provision and no corrective action is required. 115.332(b) SHDC affirmed in the PAQ that the level and type of training provided to volunteers and contractors is based on the services they provide and level of contact they have with residents. Based on the information provided from the interview of the volunteer coordinator, the policy used for training, and interviews with the

	volunteers and contractors, it appears that volunteers are receiving PREA training that is based on the services that are provided and the level of contact with residents. Additionally, the volunteers are made aware of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment via the PREA Policy 2.13, and they are given a copy of the policy. During interviews with two contractors and a volunteer. It was made evident that the training included the agency's zero tolerance policy and their responsibilities regarding sexual and sexual harassment at SHDC. The facility is substantially complaint with this provision and no corrective action is required. 115.332 (c) DYRS maintains documentation confirming that volunteers and contractors understand the training that they have received, and the receipt of a copy of PREA Policy 2.13. Uploaded in the PAQ, the auditor located documentation of understanding from the volunteers and contractors. The PREA Training Volunteer/Contractor Acknowledgement Form is signed to show that the volunteer or contractor understands the agency's zero tolerance policy, the role as a mandatory reporter, and their reporting responsibilities in cases of sexual harassment or sexual abuse. The facility is substantially complaint with this provision and no corrective action is required. It is evident by interview and documentation that volunteers and contractors have received training on the agency's zero-tolerance policy, and the type of PREA training received is based on the services provided and the level of resident contact. The documentation for this training is maintained by the agency. Based on the analysis, the facility is substantially compliant with this standard and no corrective action is required. Recommendation: Annually provide PREA training to contractors and volunteers that is based on the services provided and level of contact they have with residents.

115.333	**Resident education**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents:

1. DYRS 2.13.IV.C.2.a-b.
2. DYRS PREA Policy 2.13.IV.C.2.c
3. Policy 2.13.IV.C.2.d
4. William Marion Stevenson's Detention Manuel for Residents p. 3
5. What is PREA?-Handout at Intake
6. SHDC What You Need to Know About Sexual Abuse/Assault and Harassment Pamphlet-English
7. SHDC What You Need to Know About Sexual Abuse/Assault and Harassment Pamphlet- Spanish
8. Residents PREA Orientation Acknowledgement Form
9. Residents PREA Comprehensive Acknowledgement Form
10. PREA Video with close caption capability
11. Pre-Audit Questionnaire (PAQ)
12. Pictures of PREA Related Postings
13. Resident Files

Interviews:

1. Intake Staff
2. Residents

Site Review:

1. Intake Process 10/17/2024
2. PREA Video
3. Review of PREA Related Posters

Findings (by Provision):

115.333 (a): 1-3

SHDC reported in the PAQ that residents receive information at time of intake about the zero-tolerance policy and how to report incidents or suspicions of sexual abuse or sexual harassment. According to DYRS Policy 2.13.IV.C.2.a-b, all youth in secure care shall receive PREA orientation and/or training. Specifically, the policy states that during the intake process, residents shall receive information explaining the zero- tolerance policy regarding sexual abuse and sexual harassment and how to report incidents or suspicions of sexual abuse or sexual harassment. Documented in the PAQ, SHDC provided 184 residents from 8/1/2023 to 8/31/2024 with PREA information at intake. Residents were provided information by a video in an age-appropriate fashion, and they were provided the handout "What is PREA?"

At intake, residents are provided with the handout and manual, and they view the PREA video. On page 3 of the manual, it specifies the following information:

- Agency's Zero-Tolerance Policy

- Definition of sexual abuse and sexual harassment
- Prevention/Intervention
- Reporting
- Victim Support Services

On the handout, residents were provided with the telephone number for the Child Abuse Hotline.

Review of 12 random resident files yielded that all are residents obtained training during orientation.

According to the intake staff, residents receive information about the agency's zero-tolerance policy and provided information on how to report incidents or suspicions of sexual abuse and sexual harassment during intake. All intakes including those from other facilities obtain information about the agency's zero-tolerance policy on sexual abuse and sexual harassment from the PREA intake orientation, resident manual, handout, and watching the PREA video.

There were 10 residents interviewed, and all residents stated that they had received information pertaining to the agency's zero-tolerance for sexual abuse and sexual harassment. The residents confirmed receiving PREA information during intake.

On the last day of the onsite audit, the auditors had an opportunity to observe a mock intake on 10/17/2024. The auditor was taken through the steps including given an opportunity to view a PREA video and answer any questions. Later, the auditor was given the handout, "What is PREA?"

There were no residents that were limited English proficient during the onsite audit. The facility does have a translation/language line service if necessary. During interviews with residents, the auditor was informed that additional assistance is provided for reading and comprehension by staff.

The agency substantially meets compliance in this provision and no corrective action is required.

115.333(b)

SHDC reported on the PAQ that out of the 184 residents that had taken the PREA orientation, there was 125 of those residents that participated in the PREA comprehensive training within 10 days. Due to the nature of juvenile detention, many residents are released shortly after being admitted. According to DYRS Policy 2.13.IV.A.2.a-b, all youth in secure care shall receive PREA orientation and/or training. The policy states that within 10 days of the intake the secure care program is responsible for implementing a more comprehensive PREA training. The comprehensive training is provided by the PREA compliance manager. During the comprehensive PREA training, the residents are provided the resident handbook "William Marion Stevenson's Detention Manuel for Residents."According to the PREA compliance manager, residents are taken to the resident phones and shown how to call the Child Abuse Hotline. In the PAQ, the auditor was provided with a form titled:

SHDC PREA Comprehensive Training Acknowledgement Form. The document was being utilized to document completion and understanding of the comprehensive PREA training. The auditor reviewed 12 random resident files. Out of the 12 resident files, there were 12 resident files that contained the completed Comprehensive PREA Acknowledgement forms.

During the interview with the intake staff, it was stated that the PREA compliance manager conducts the comprehensive PREA training. Further, the auditor inquired to the residents if they were informed about there right not to be sexually abused or sexually harassed, and all 10 residents affirmed that they were aware. The auditor questioned the residents if they were aware of how to report sexual abuse and sexual harassment, and the 10 residents said that they were aware. The 10 residents were also informed that they had a right not to be punished for reporting sexual abuse or sexual harassment. Residents were asked when they received the information. The residents stated that they learned during their PREA training. When the auditor reviewed the 12 Residents PREA Comprehensive Acknowledgement Forms, all forms were dated within the 10 days of intake.

The agency is substantially compliant with this provision and no corrective action is required.

115.33(c)

SHDC responded on the PAQ that residents who did not receive comprehensive PREA training within 10 days had been released from the facility. The auditor determined from the documentation submitted and the review of resident files that the facility practice conducting comprehensive PREA training within 10 days of intake.

DYRS PREA Policy 2.13.IV.C.2.c states that residents transferred to a different facility must immediately be taught about any difference in the policies and procedures at the new facility. During the mock intake, the auditor was informed that residents receive PREA orientation regardless of their status during admission to the facility. It does not matter if the resident was admitted to the facility in a prior instance or was transferred from another facility.

The agency is substantially compliant with this provision and no corrective action is required.

115.333(d)-1-5

According the PAQ, resident PREA education is available in formats accessible to all residents, including those who are limited English proficient. DYRS Policy 2.13.IV.C.2.d., ensures that youth with disabilities and language barriers are given the same information to prevent, detect, and respond to sexual abuse and sexual harassment in a format supportive of the disability or language barrier. Additionally, DSCYF Policy 118 ensures that individuals do not face discrimination and/or obstacles to receiving benefits or services for which they may be eligible.

Based on the documents provided in the PAQ, resident PREA education is available for limited English proficient residents. Spanish is the second language spoken in Delaware. The following items are available at SHDC in Spanish:

- William Marion Stevenson's Detention Manuel for Residents
- SHDC What You Need to Know About Sexual Abuse/Assault and Harassment Pamphlet- Spanish

There is an existing contract to provide interpretative and translation services for limited English proficient residents. For residents that are deaf, there are vendors on the state contract that can provide sign language services at no cost to the residents. Additionally, the facility has a Minicom IV for residents that are hearing impaired. SHDC has the capability to enlarge PREA training materials for residents that are visually impaired. Also, PREA training is available by video with close captioning.

There were residents at the facility that received special education services. During their interviews, they disclosed that assistance by staff was available if assistance in understanding information was needed.

The agency is substantially compliant with this provision and no corrective action is required.

115.333(e)-1

Confirmation of the agency-maintained documentation of resident participation in PREA education sessions was provided in the PAQ. Documentation of PREA orientation and comprehensive trainings participation were located in all 12 resident files.

The agency is substantially compliant with this provision and no corrective action is required.

115.333(f)-1

The agency ensures that key information about the agency's PREA policies is continuously and readily available or visible through posters, resident handbooks, or other written formats. SHDC does ensure that the agency's PREA policy is continuously and readily available. During the site review, the auditor observed that there were several PREA related posters throughout SHDC. The facility created PREA posters that were enlarged to a size that is comparable to walls in the facility. The posters were in both English and Spanish, and they included the Child Abuse Hotline number and the resident's rights to be free from sexual abuse and sexual harassment. Also, located were posters for the victim service agency, SOAR. The facility provided pictures in the PAQ. There were accessible PREA related pamphlets.

The agency is substantially compliant with this provision and no corrective action is required.

Evidence from policy, interviews, documentation and the site review shows that the SHDC provides information at the time of intake about the agency's zero tolerance and how to report incidents or suspicions of sexual abuse and sexual harassment. The facility has demonstrated comprehensive PREA training is provided within 10 days of intake. The DYRS PREA Policy 2.13 states that residents that are transferred from another facility are provided PREA training. The agency does provide PREA education in formats that are accessible to all residents including students that are limited English proficient, vision impaired, deaf, learning disabled, or other disabled.

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

115.334 Specialized training: Investigations

Auditor Overall Determination: Meets Standard

Auditor Discussion

Documents:

1. DYRS Policy 2.13.IV.C.3.a
2. Pre-Audit Questionnaire (PAQ)
3. 2 Moss Group Certificates PREA Juvenile Specialized Investigations Training
4. 3 National Institute of Corrections Certificates PREA: Investigating Sexual Abuse in Confinement Settings

Interviews:

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

Findings (by Provision):

115.334 (a)-1

DYRS reported that the agency policy requires that investigators are trained in conducting sexual abuse investigations in confinement settings. DYRS Policy 2.13.IV.C.3.a specifically states PREA investigators are required to complete

specialized training in conducting investigations in confinement settings. This training will include training on techniques for interviewing juvenile sexual abuse victims, proper use of Miranda and Gary warnings, how to collect evidence after sexual abuse incidents and the criteria and evidence needed to substantiate an allegation.

The agency has two institutional abuse investigators that are trained to conduct PREA investigations, and there are three facility staff that are trained to conduct PREA investigations.

During the interview with the Institutional Abuse PREA investigator, the investigator recalled several topics that were included in the Moss Group's virtual training. The training included interviewing juveniles, evidence preservation, and reporting writing.

The facility PREA investigators were virtually trained by the National Institute of Corrections. The facility investigators attended the training titled PREA: Investigating Sexual Abuse in Confinement Settings. During interviews, the facility investigators were able to determine the difference between an administrative investigation versus a criminal investigation. They also recalled the training on determining outcomes and victim notification.

The agency is substantially compliant with this provision and no corrective action is required.

115.334 (b)

According to the PAQ, specialized training shall include techniques for interviewing juvenile sexual abuse victims, proper use of Miranda and Garrity warnings, sexual abuse evidence collection in confinement settings, and the criteria and evidence required to substantiate a case for administrative action or prosecution referral. During the interviews with PREA investigative staff, it was disclosed that all five investigators had received specialized training in conducting sexual abuse investigations in confinement settings. There was a recall by both the IA PREA investigator and the facility PREA investigator of training pertaining to securing the crime scene, criteria for substantiating a case, collecting circumstantial evidence, and interviewing of witnesses and a the alleged victim.

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

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

The auditor has reviewed the curriculum for the 3-hour NIC course, and the training

delivered contained the same as above and it met the criteria required for the PREA mandate.

The agency is substantially compliant with this provision and no corrective action is required.

115.334(c):

DYRS stated that the agency maintains documentation showing that investigators have completed the required PREA training. In the PAQ the agency submitted 5 PREA investigators training certificates. The agency maintains the copies of the two certificates for the institutional abuse investigators and three certificates of the facility PREA investigators.

The agency is substantially compliant with this provision and no corrective action is required.

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

The agency is substantially compliant with this provision and no corrective action is required.

Based on interviews, documentation and policy, DYRS demonstrated utilizing investigators with appropriate PREA training when conducting investigations of sexual abuse and sexual harassment. The agency ensures through DYRS Policy 2.13.IV.C.3.a that PREA investigations are conducted by certified and trained investigators in conducting investigations in confinement. The Moss Group and NIC training includes subject matter in accordance with PREA provision 115.334(b). The agency maintains documentation of certificates for all five investigators.

Based on this analysis the agency substantially meets this standard, and no corrective action is required.

115.335 Specialized training: Medical and mental health care

Auditor Overall Determination: Meets Standard

Auditor Discussion

Documents:

1. DYRS PREA Policy 2.13.III.A
2. DYRS PREA Policy 2.13IV.A.1.
3. DYRS Policy 2.13IV.A.3.

4. Affirmation of Compliance with Forensic Examinations Standards for Sexual Assault 4/12/2023
5. Pre-Audit Questionnaire (PAQ)
6. NIC PREA 201 Certificates

Interviews:

1. Medical Staff
2. Mental Health Staff

Findings (by Provision):

115.335 (a): -1

According to the Pre-Audit Questionnaire (PAQ), the agency has a policy related to the training of medical and mental health practitioners who work regularly in its facilities. DYRS Policy 2.13.III.A includes the medical and mental health personnel as staff. The policy states that staff for the purpose of this policy, staff is defined as any Department employee, volunteer, contractor, official visitor, or other agency representative (exclude family, friends and other visitors). Further within Policy 2.13IV.A.1. it is quoted that all staff working directly with or monitoring programs/ services of youth in secure care and community services must receive PREA training. DYRS Policy 2.13IV.A.3 is specific to medical and mental health practitioners receiving specialized training. Cited in the policy is the specialized training requirements:

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

To comply with the PREA standard for medical and mental health specialized training, DYRS medical and mental health practitioners take the NIC PREA 201 training for medical and mental health practitioners. Documented on the PAQ, there were 17 medical practitioners. There are four behavioral health practitioners and 13 medical practitioners.

Review of employee rosters and training rosters, there were 17 medical and mental health practitioners. Of the 17 medical and mental health practitioners, there were 16 certificates for the specialized training received in the Pre-Audit Questionnaire (PAQ).

During the interview with medical and mental health practitioners, it was confirmed that staff is required to take the PREA 201 training to fulfill the requirements of

115.335(a).

The agency is substantially compliant with this provision and no corrective action is required.

115.335(b)

According to the PAQ, the agency medical staff at SHDC does not conduct forensic medical exams. It was further confirmed by the auditor that the medical staff at SHDC does not perform forensic medical examinations. Forensic examinations are performed at Bayhealth Hospital. In existence, there is an Affirmation of Compliance with Forensic Examinations Standards for Sexual Assault between DYRS and the Bayhealth Hospital in Milford, Delaware. During the interview, the medical practitioner stated that SHDC does not conduct forensic medical examinations.

The agency is substantially compliant with this provision and no corrective action is required.

115.335 (c)-1

Reported by the agency in the PAQ, the agency maintains documentation showing that medical and mental health practitioners have completed the required training. The agency maintains documentation of the specialized NIC PREA 201. Medical and mental Health practitioners' certificates were made available through the PAQ. In total, there were 16 out of 17 specialized training for medical and mental health practitioners' certificates made available through the PAQ.

The agency is substantially compliant with this provision and no corrective action is required.

115.33 (d)-1

DYRS Policy 2.13.III.A includes the medical and mental health personnel as staff. The policy states that staff for the purpose of this policy, staff is defined as any Department employee, volunteer, contractor, official visitor, or other agency representative (exclude family, friends and other visitors). Further within Policy 2.13IV.A.1. it is quoted that all staff working directly with or monitoring programs/ services of youth in secure care and community services must receive PREA training. There were 17 medical and mental health practitioners that worked regularly at SHDC. When reviewing certificates, there were 15 out of the 17 medical and mental health practitioners that received the training mandated for employees by PREA standard 115.331 and PREA standard 115.332.

The agency is substantially compliant with this provision and no corrective action is required.

Based on policy, interviews, and documentation, it is evident that the agency requires required specialized training for medical and mental health practitioners. DYRS PREA Policy 2.13 does have language that requires specialized PREA training for medical and mental health practitioners. Medical and mental health practitioners

are trained in the PREA specialized training for medical and mental health practitioners. There were 2 out of 17 medical and mental health staff in need of PREA refresher training. The agency does maintain documentation of completion of the required specialized training for medical and mental health practitioners and the required PREA training in accordance with PREA standard 115.331 and PREA standard 115.332.

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

115.341 Obtaining information from residents

Auditor Overall Determination: Meets Standard

Auditor Discussion

Documents:

1. DYRA PREA Policy 2.13.IV.D.1
2. PREA Risk Assessment and PREA Recommendation Decision Tree
3. 12 Resident Files
4. 12 Risk Assessments
5. Pre-Audit Questionnaire (PAQ)

Interviews:

1. Staff responsible for risk screening
2. Resident
3. PREA coordinator
4. PREA compliance manager

Site Review Observation:

1. Intake Areas including Medical and Mental Health Offices

Findings (by Provision):

115.341 (a):

In the PAQ, the agency reported that they have a policy that requires screening upon admission to a facility or transfer to another facility for risk of sexual abuse victimization or sexual abusiveness toward other residents within 72 hours and

	reassessed periodically throughout their confinement. Agency relies on PREA Policy 2.13 Prevention Section IV D.1. that outlines that it requires a formal PREA risk assessment is completed by facility clinical staff within 72 hours of a new admission or transfer from another facility and residents are reassessed every 6 months thereafter. The facility reported in the PAQ, 54 residents that entered the facility in the past 12 months whose length of stay was 72 hours, or more was screened for risk of sexual victimization and risk of sexually abusing others was completed within 72 hours of admission. At the time of the onsite audit there were 144 residents admitted to the facility. The auditors reviewed 12 resident PREA screenings and 12 resident files. In review of the randomly selected 12 resident PREA screenings, the auditor found that residents were screened were completed within 72 hours of admission to the facility. The PREA risk assessment form provides that the resident is being screened for victimization and abusiveness. During interviews with residents, all 10 residents recall being asked questions related to the PREA risk assessment by the mental health practitioner at intake within a few days of admittance to the facility. During interviews with staff that are responsible for risk screening, mental health staff complete risk screening of residents upon admission to the facility within 72 hours of the intake process. When asked how often residents' risk levels are assessed, staff stated risk levels are reassessed every six months. In the PAQ the facility reported the average length of stay was 27 days. At the time of the onsite audit, there were three residents that had been at the facility for nearly six months. The facility is substantially compliant with this provision and corrective action is not required. 115.341 (b): In the PAQ, the facility reported that a risk assessment is conducted using an objective screening instrument. SHDC utilizes a decision tree and risk assessment in all DYRS facilities. The facility provided a PREA risk assessment and decision tree for review. The auditor reviewed the PREA risk assessment and decision tree and was able to determine that the screening instrument was objective. The assessment had all the criteria mandated by PREA. The risk assessment screening instrument assist staff in ascertaining information that provides a resident's overall risk of sexual victimization or risk of abusiveness towards others. This assessment is conducted on the agency's resident database, FOCUS. The PREA risk assessment consists of a series of questions and information about the resident, and the PREA recommendation decision tree yields an outcome that could be used to inform staff of supervision needs for housing, bed, education and

	program placement. The facility is substantially compliant with this provision and no corrective action is required. 115.341 (c): Upon review of the PREA risk assessment, it was determined by the auditor that the assessment contained all eleven key components required by the PREA mandates. During an interview with staff responsible for conducting risk screening, when asked what the initial risk screening consider, staff indicated questions of age, education, history, physical attributes, sex, mental health, cognitive ability, emotional issues, and physical size. Based upon this analysis, the facility is substantially compliant with this provision and corrective action is not required. 115.341 (d): PREA Policy 2.13 Section IV D outlines that upon intake staff will ask the youth their gender identity for immediate safety and housing decisions. The PREA risk assessment is completed by facility clinical staff within 72 hours of a new admission or a transfer from another facility. During an interview with staff that conduct risk screening, when asked how information is ascertained, staff stated they obtain the information verbally and through mental health screening. It is noted that the mental health staff conduct risk assessment screening at intake. All the information is located in the FOCUS database. The evidence shows that information is ascertained from talking with the resident, file and focus database which is verified through the risk assessment, onsite observation of intake and staff interviews. The facility is substantially compliant with this provision and corrective action is not required. 115.341 (e): In the PAQ, the provision requires that an agency implement appropriate controls on the dissemination within the facility of the responses to questions in order to ensure that sensitive information is not exploited to the residents' detriment by staff or other residents. During an interview with the PREA coordinator and the PREA compliance manager, when asked the agency outlined who should have access to a resident's risk assessments within the facility in order to protect the resident's information from exploitation, staff indicated yes. One of the staff that is responsible for conducting risk screening disclosed that once a risk screening is conducted, an email recommendation is sent to administration. It was also determined that access to

	information in FOCUS was granted based on the staff person's position and information is disseminated regarding recommendations to the superintendent and assistant superintendent. The facility is substantially compliant with this provision and no corrective action is required. The evidence shows that the agency requires screening upon admission or transfer and periodic reassessments which were verified through PAQ, policy, resident files, resident interviews, and staff interviews. Additionally, all of the criteria on the PREA risk screening are included in the risk assessment screening instrument, which was verified by comparison of PREA mandated criteria. It was determined by interview and email correspondence that the agency has controlled the level of access that each staff has in the FOCUS database to control and protect sensitive information. The agency's risk assessment is conducted using an objective screening instrument which was verified through PAQ, risk assessment, and the PREA recommendation decision tree. Based upon this analysis, the facility is substantially compliant with this standard and no corrective action is required.

115.342	**Placement of residents**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. DYRS PREA Policy 2.13.IV.D 2. Division of Youth Rehabilitative Services Professional Practices Lesbian, Gay, Bisexual, Transgender, Questioning, and Intersex (LGBTQI) Policy 2.20. IV 3. 12 Resident Files 4. 12 PREA Risk Assessments 5. Housing Unit Logs 6. Pre-Audit Questionnaire (PAQ) 7. Resident List of Administrative Intervention Interviews: 1. PREA compliance manager 2. Staff responsible for risk screening 3. Superintendent 4. Medical and mental health staff

Site Review Observation:

1. Observation during onsite review of physical plant

Findings (by Provision):

115.342 (a):

Reported in the pre-audit questionnaire (PAQ), the facility reported that they use information from the risk screening to inform housing, bed, work, education, and program assignments with the goal of keeping all residents safe and free from sexual abuse.

The agency relies on PREA Policy 2.13.IV.D. that the PREA risk assessment is used to determine risk of sexual abuse victimization or sexual abusiveness toward other residents and will inform housing, bed, work, education, and program assignments for all residents.

There is also a reliance on LGBTQI Policy 2.20.IV.E. 1. that outlines that DYRS shall use information obtained in intake and referral documentation and the mental health assessment to make housing, bed, program, education and work assignments for youth with the goal of keeping all youth safe and free from sexual abuse and sexual assault.

During interviews with the PREA compliance manager, when asked how the facility uses information from the risk screening during intake to keep residents safe and free from sexual abuse, it was stated recommendations are provided from the medical department which assist in appropriate placement. During interviews with staff responsible for risk screening, when asked how the facility uses information from the risk screening during intake to keep residents safe and free from sexual abuse and sexual harassment, staff stated that the information relegates placement in the facility. A recommendation is provided from the results of the risk assessment.

The auditor was able to determine from email correspondence from medical that residents identified as having a PREA risk related factor are provided specific recommendations as it relates to housing, bed, work, education, and program assignments with the goal of keeping all residents safe and free from sexual abuse.

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

115.342 (b):

It was reported in the PAQ by the facility that there is a policy for residents at risk of sexual victimization that may only be placed in isolation as a last resort if less restrictive measures are inadequate to keep them and other residents safe, and only until an alternative means of keeping all resident’s safe can be arranged. The facility also affirmed that the policy also requires that residents at risk of sexual

	victimization who are placed in isolation have access to legally required educational programming, special education services, and daily large-muscle exercise. According to LGBTQI Policy 2.20.IV.E.1.c, outlines that LGBTQI residents may be isolated from others only as a last result and only until less restrictive means of keeping residents safe can be arranged. During any period of isolation residents shall not be denied daily large-muscle exercise, legally required programming, or special education services. In the PAQ, the facility reported that in the past 12 months there was no residents at risk of sexual victimization placed in isolation that would have been denied access to daily large-muscle exercise, legally required educational programming or special education services. During interviews with mental health and medical staff, when asked do residents in administrative intervention receive visits from medical and mental health care, staff stated yes by both medical and mental health practitioners at least once a day. When the superintendent was asked are residents only isolated from others as a last resort when less restrictive measures are inadequate to keep them and other residents safe, and only until an alternative means of keeping all residents safe can be arranged, staff stated yes. Further, it was stated that the status is reviewed every 24 hours by someone other than direct care staff. During the onsite review, the auditor observed the housing units. There was no specific housing unit that was for administrative intervention. At the time of the onsite review, there were residents on administrative intervention, but there were no residents that were at risk of sexual victimization or alleged to have suffered sexual abuse. The auditor reviewed the PREA risk assessment log and housing logbooks that confirmed that there were no residents placed on administrative intervention due to being victimized or abused during the onsite review. The housing logbooks provide a detailed tracking of the residents, date, time, activity observed, and staff assigned to the unit. Also, the shift summaries provide information pertaining to resident status as well. The facility also practices shift debriefings. The facility is substantially compliant with this provision and no corrective action is required. 115.342 (c): In the PAQ, facility reported they prohibit placing lesbian, gay, bisexual, transgender, or intersex residents in particular housing, bed, or other assignments solely on the basis of such identification or status. Also, the facility prohibits considering lesbian, gay, bisexual, transgender, or intersex identification or status as an indicator of likelihood of being sexually abusive. The agency relies on LGBTQI Policy 2.20.IV.E.1.d. states LGBTQI youth shall not be placed in particular housing, bed, or other assignments solely on the basis of such

identification or status, nor shall DYRS consider lesbian, gay, bisexual, transgender or intersex identification or status as an indicator of likelihood of being sexually abusive.

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

At the time of the onsite audit, the auditor reviewed resident files and housing placements for all residents. There were no residents placed in a housing assignment solely based off of their identification status. During the onsite review, the auditor did not identify any special housing units solely for LGBTQI residents.

The facility is substantially compliant with this provision and no corrective action is required.

115.342 (d):

In the PAQ, the SHDC reported they make housing and program assignments for transgender or intersex residents in a facility on a case-by-case basis whether a placement would ensure the resident's health and safety.

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

During an interview with the PREA compliance manager, when asked how the facility determines housing and program assignments for transgender or intersex residents, staff indicated they assign on a case-by-case basis.

Prior to the onsite review, the auditor reviewed the facility website and obtained information that the facility housed male and female residents. During the onsite review, the auditor observed male residents at the facility, and there were no female residents detained at the time. There were no residents identified as transgender or intersex during the onsite audit.

The facility is substantially compliant with this provision and no corrective action is required.

115.342 (e):

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

The agency relies on PREA Policy 2.13.IV.D.2 for placement and programming assignments for each transgender youth, intersex youth, youth assessed as high

	risk for being victimized or offending or in need of protective housing is reviewed by the facilities assessment team at least twice a month to review any threats to safety experienced by the resident. Agency LGBTQI Policy 2.20.IV.E.1.f. details the placement and programming assignments for each transgender or intersex youth shall be reassessed by the interdisciplinary team at least twice each year to review any threats to safety experienced by the youth. During an interview with the PREA compliance manager, when asked how often placement and programming assignments for each transgender or intersex resident are reassessed to review any threats to safety experienced by the resident, the staff indicated yes they would reassess every 6 months or as needed. During interview with staff that are responsible for risk screening, when asked how often are placement and programming assignments for each transgender or intersex resident reassessed to review any threats to safety experienced by the resident, staff confirmed they are reassessed every six months. During the onsite audit, the auditor reviewed 12 resident files and was able to determine there were no residents that identified as transgender or intersex. The facility is substantially compliant with this provision and no corrective action is required. 115.342 (f): In the PAQ, a transgender or intersex resident's own view with respect to his or her own safety shall be given serious consideration. Agency LGBTQI Policy 2.20.IV.E.1.g. references that a transgender or intersex youth's views with respect to his or her own safety shall be given serious consideration. During an interview with the PREA compliance manager, when asked are transgender or intersex residents own views with respect to his or her own safety given serious consideration when making placement and programming assignments, staff stated yes. During an interview with staff responsible for risk screening, when asked are transgender or intersex residents own views with respect to his or her own safety given serious consideration in placement and programming assignments, staff stated yes. Prior to onsite audit, the auditor reviewed 12 resident files and was able to determine there were no residents that identified as transgender or intersex. Additionally, the facility was asked to provide a list of residents that identified as LGBQTI. The facility is substantially compliant with this provision and no corrective action is required. 115.342 (g):

	It states in the PAQ that transgender and intersex residents shall be given the opportunity to shower separately from other residents. The agency policy LGBTQI Policy 2.20.IV.F. references that transgender and intersex youth shall be given the opportunity to shower and use the bathroom separately from other youth. During an interview with the PREA compliance manager, when asked are transgender or intersex residents given an opportunity to shower separately from other residents, staff stated yes, all residents can shower separately, because the facility has individual private showers. During an interview with staff responsible for risk screening, when asked are transgender or intersex residents given the opportunity to shower separately from other residents, staff stated yes. During the onsite review, the auditor observed the showers are separate and all residents shower separately. Only one resident may shower at any given time. The auditor was on the housing unit during showers, and residents take individual showers. The showers are locked and unlocked by staff. Prior to the onsite audit, the auditor reviewed 12 resident files and was able to determine there were no residents that identified as transgender or intersex. Also, the auditor asked the facility for a list of residents that identified as LGBQTI. The facility is substantially compliant with this provision and no corrective action is required. 115.342 (h): The facility reported in the PAQ that there were no residents isolated pursuant to paragraph b of this section in the past 12 months that required the facility to document a concern of a resident’s safety. During the onsite review, the auditor did observe any housing units for isolation. A review of 12 resident files and housing logbooks did not reveal that residents were placed in isolation as outlined in this provision for risk of sexual victimization. Rather residents were placed on Administrative Intervention due to behavioral issues. The facility is substantially compliant with this provision and no corrective action is required. 115.342 (i): Affirmed in the PAQ, every 30 days, the facility shall afford each resident described in paragraph h of this section to determine whether there is a continuing need for separation from the general population. Agency LGBTQI Policy 2.20.IV.E.I. details that every 30 days the facility shall afford each youth in isolation a review to determine whether there is a continuing need for separation from the general population. During an informal conversation with staff, it was stated that residents are not

	placed on isolation rather residents are placed on Administrative Intervention. Residents are still provided education and large muscle exercise. During the onsite review, the auditor did observe housing units. A review of 12 resident files did not reveal that residents were placed in isolation as outlined in this provision, and housing unit logs did not reveal that residents were placed in isolation as outlined in this provision. The facility is substantially compliant with this provision and no corrective action is required. The evidence shows that the facility has demonstrated how the information obtained from the risk assessment is used to inform them of housing, bed, education and program assignments that would keep residents safe and free from sexual abuse which was verified by risk assessment, policy and staff interviews. SHDC does place residents on Administrative Intervention, but not isolation. The residents would receive daily visits from medical and mental health care clinicians. There were no residents at risk for sexual victimization placed in isolation in the 12 months preceding the onsite audit which was verified through interview, observation, policy and documentation review. The facility does not have a special housing unit for LGBTQI residents or consider identification status as a likelihood of being sexually abusive this was verified by policy, interviews, and onsite observation. SHDC makes housing and program assignments for transgender and intersex residents on a case-by-case basis which is verified by PAQ, policy, interview, and onsite review. Each transgender or intersex resident shall be assessed at least twice monthly and twice each year, and it was confirmed through policy and interviews. Also, each transgender or intersex resident views are considered which is verified by policy and interviews. It is further evident that each transgender or intersex resident are given an opportunity to shower separate from other residents which is verified by policy, interviews, files and onsite observation. The facility does not isolate residents at SHDC, it was confirmed by observation and documentation review. Lastly, the facility did not have an incident where a resident was isolated at the facility as outlined in this provision that would prompt a 30-day review which was verified through interviews, observation, and documentation review. Based upon this analysis, the facility is substantially compliant with this standard and corrective action is not required.

115.351	**Resident reporting**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion

Documents:

1. DYRS PREA Policy 2.13.E.1-3
2. PREA Phone Instruction Cards (English and Spanish).
3. William Marion Stevenson's Detention Manuel for Residents
4. Title 10 Courts and Judicial Procedure
5. DYRS Prisoner Professional Practices Reportable Events 2.12 III.B.1, IV.B.3.b.
6. Agency Website www.kids.delaware.gov/yrs/prea
7. DSCYF PREA Academy Training Manual pp. 51-53.
8. Survivors of Abuse in Recovery (SOAR) Memorandum of Agreement
9. Pre-Audit Questionnaire

Interviews:

1. Random staff
2. Resident
3. PREA compliance manager
4. Just Detention International (JDI)
5. Child Abuse Hotline Administrator

Site Review Observations:

1. Observation during onsite review of physical plant postings.

Findings (by Provision):

115.351 (a):

According to the pre-audit questionnaire (PAQ), the DYRS responded that they provide multiple internal ways for residents to privately report sexual abuse and sexual harassment; retaliation by other residents or staff for reporting sexual abuse and sexual harassment and staff neglect or violation of responsibilities that may have contributed to such incidents.

In PREA Policy 2.13 DYRS PREA Policy 2.13.IV.E-1 states that residents can privately report sexual abuse and sexual harassment, retaliation by other residents or staff for reporting sexual abuse and sexual harassment and cases where sexual abuse, harassment or retaliation might have happened because staff were neglectful or failed their responsibilities by verbally reporting to staff, by filing an emergency PREA grievance or by calling the Child Abuse Hotline. The policy states that staff shall accept any report of sexual abuse and sexual harassment made verbally, in writing, anonymously and from third parties.

During the onsite review, the auditor did observe posting with the outside victim advocate number and the PREA hotline number and information on how to report that included calling the hotline 7735. The auditor called the hotline number and was able to confirm that all phones were operational in all the housing units. There

were very large signs containing this information throughout the facility in both English and Spanish.

During interviews with random staff, all 15 staff interviewed confirmed that residents have multiple ways to report sexual abuse, sexual harassment, retaliation, and neglect by calling the hotline, reporting to staff, or writing a grievance.

During interviews with residents, when asked about the multiple ways they can make a report, 8 out of 10 stated they could call the PREA hotline, 3 out of 10 stated they could write a grievance, 2 out of 10 stated they could tell a family member guardian or someone they trust, 5 out of 10 stated they could tell a staff member. All 10 residents were able to identify a means to report.

The facility is substantially compliant with this provision and no corrective action is required.

115.351 (b):

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

The agency relies on PREA Policy 2.13, which states that a resident can make a complaint about sexual abuse and sexual harassment verbally to staff, filing an emergency PREA grievance, or calling the child abuse hotline. The child abuse hotline is a designated 24-hour, seven days a week resource for residents to report abuse. There are large postings throughout the building detailing information, and on each phone in the housing units there are labels with the Child Abuse Hotline information. The agency relies on Title 10 courts and judicial procedure 1007 that outlines that the facility does not detain residents for immigration purposes.

In a memorandum of agreement, Survivors of Abuse in Recovery (SOAR) has partnered with the DYRS to provide survivors of sexual abuse with emotional support services and advocates for support during a forensic medical examination. The facility did provide information posted and in written format that would establish residents knew of the way in which they could contact SOAR, a third-party victim advocate. During interviews with residents, there were 3 out of 10 residents that were familiar with SOARS.

During Interviews, the PREA compliance manager stated residents have access to contact SOAR or the Child Abuse Hotline to make a report. DYRS has been making efforts to ensure that reports from the Child Abuse Hotline are being reported back to the agency whether allegations of abuse are screened in or screened out. During an interview with the Child Abuse Hotline administrator, it was determined that the operators' protocols are not necessarily aligned with the PREA mandates.

The auditor was able to confirm that SOARS has a memorandum of agreement with

the facility to provide victim advocacy and emotional support. The auditor was able to communicate via email with Just Detention International (JDI) Operations Director regarding any reports received from the facility. Just Detention International (JDI) Operations Director reported that they have not received any reports from SHDC.

During interviews the auditor asked all of the residents is there someone who does not work at this facility you could report to about sexual abuse or sexual harassment, 9 out of 10 stated they could call a family member, 1 out of 10 stated they could report to their YAP worker.

During the onsite review, the auditor did observe posting with the SOAR outside victim advocate number and the PREA hotline number and information on how to report that included calling the hotline 1-800-292-9582 or 7735 #4. The auditor tested the hotline number and was able to contact the Child Abuse Hotline.

The facility is substantially compliant with this provision and no corrective action is required.

115.351 (c):

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

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

During interviews with random staff, all 15 staff affirmed if a resident alleges sexual abuse and sexual harassment they can do so verbally, in writing anonymously and through third parties. When asked do you document verbal reports, all 15 stated yes. When questioned how long it takes to document after a resident makes a verbal report, all 15 staff stated immediately.

During interviews with residents, when asked can you make a report of sexual abuse or sexual harassment either in person or in writing, all 10 residents confirmed that they knew they could make a report of sexual abuse or sexual harassment in person or in writing.

The facility is substantially compliant with this provision and no corrective action is required.

115.351 (d):

According to the information provided on the PAQ, the agency reported that they provide residents with access to tools to make written reports of sexual abuse or sexual harassment, retaliation by other residents or staff for reporting sexual abuse and sexual harassment, and staff neglect or violation of responsibilities that may

have contributed to such incidents.

During an interview, the PREA compliance manager stated that residents have access to grievance forms and a secured grievance box to help them make written reports of sexual abuse and sexual harassment and/or staff neglect or violation of responsibilities that may have contributed to such incidents.

During the onsite review, the auditor located the grievance forms and secured grievance boxes on the housing units.

The facility is substantially compliant with this provision and no corrective action is required.

115.351 (e):

In the PAQ, the DYRS reported that they have established and trained staff on the procedures to privately report sexual abuse and sexual harassment of residents.

The agency relies on DYRS PREA Policy 2.13.IV.E.3 that states staff can privately report sexual abuse and sexual harassment of residents through their chain of command, facility administrator, PREA Coordinator, child abuse hotline and submitting an anonymous administrative report.

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

During Interviews with random staff, 13 out of 15 staff reported that they can privately report through the PREA hotline, 2 out of 15 staff reported they can tell a supervisor, 1 out of 15 stated they can write a email and 2 out of 15 stated they can by administrative report.

The evidence shows that the facility has provided multiple ways for a resident to report sexual abuse, sexual harassment, retaliation, and staff neglect or which was verified through policy, resident interviews, staff interviews, PREA phone and posting in the facility. DYRS has proven that the facility has provided at least one way for a resident to report sexual abuse to a public or private entity or office that is not part of the agency which was verified through interviews, memorandum, policy, and postings in the facility. DYRS does not provide information for consulate officials or relevant officials with Homeland Security because the court places a child in secure detention pending adjudication but not for civil immigration purposes. The agency has a policy that mandate that staff accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously and from third parties. Interviews with staff and residents are consistent with the requirements of the provision and the residents confirmed they knew they could make a report in person

	or in writing. The evidence shows that the agency has an established procedure for staff to privately report sexual abuse and sexual harassment of residents through calling PREA hotline, making an anonymous administrative report, talking with a supervisor, administrator or PREA coordinator which was verified through interviews, training documentation, postings, and agency website. Lastly, the facility provides residents with access to make written reports through staff, Child Abuse Hotline, and grievance form which was verified through site review, interviews, posting in the housing unit, and grievance forms. Based upon this analysis, the facility is substantially compliant with this standard and no corrective action is required. Recommendations: Add Child Abuse Hotline Information and SOARS contact information to the Resident Manuel for external reporting.

115.352	**Exhaustion of administrative remedies**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. DYRS PREA Policy 2.13 Section IV. E. 1. 2. William Marion Stevenson's Detention Manuel for Residents 3. Stevenson House Detention Center Resident Grievance/Complaint Form Interviews: 1. Grievance coordinator Findings (by Provision): 115.352 (a-g): In the PAQ, the agency stated that they are exempt from this standard as they do not have an administrative procedure that addresses resident grievances regarding sexual abuse. All allegations of sexual abuse are called in to the Child Abuse Hotline. All staff are mandatory reporters of sexual abuse to the hotline. Review of DYRS PREA Policy 2.13 outlines that residents can privately report sexual abuse and sexual harassment, retaliation by other residents or staff for reporting sexual abuse or sexual harassment and cases where sexual abuse, harassment or

retaliation might have happened because staff were neglectful or failed their responsibilities verbally to staff, by filing an emergency PREA grievance or by calling the Child Abuse Hotline. The policy states that staff must comply with child abuse reporting laws and will report any incident of sexual abuse and sexual harassment to the Child Abuse Hotline.

The resident manual does not outline a procedure for filing a PREA grievance or complaint. The auditor was able to review 324 Stevenson House Detention Center Resident Grievance/Complaint Forms, and there was one grievance alleging sexual abuse. The grievance was processed internally, but it was not reported to the Child Abuse Hotline as per agency policy.

The grievance coordinator confirmed there is a process for residents to file a grievance pertaining to sexual harassment, sexual abuse, retaliation for reporting, and the staff neglect or violation of responsibilities that may have contributed to such incidents. Any grievance that involves imminent sexual abuse will be processed immediately and go directly to Child Abuse Hotline. Staff can help a resident make a complaint by calling the Child Abuse hotline. Residents can also submit a grievance related to sexual abuse to a third party, any staff or family members.

The facility is not substantially compliant with this provision and corrective action is required at this time.

The evidence shows that grievances that are related to sexual abuse or sexual harassment are not referred to the Child Abuse Hotline as outlined in the agency policy.

The facility is not substantially compliant with this standard and corrective action is required.

Corrective Action:

1. Process all grievances involving any incident of sexual abuse and sexual harassment in accordance to DYRS PREA Policy 2.13.IV.E.1.
2. Provide auditor with all grievance complaints for the next 60 days with attached outcomes.
3. Train all staff responsible for processing grievances on DYRS PREA Policy 2.13.IV. E. 1.
4. Provide auditor with documentation that shows staff responsible for grievances have been trained on this process.
5. Revise the resident manual to include grievances are accepted for sexual abuse and sexual harassment complaints in accordance with DYRS PREA Policy 2.13.IV. E. 1.

Completed Corrective Action:

In response to the auditor’s findings under PREA standard 115.352, Stevenson

	House Detention Center (SHDC) has provided the auditor with the following: • Copies of 50 grievances including the signed outcomes being processed in accordance with DYRS PREA Policy 2.13. • Copy of signed roster of participation in PREA Policy 2.13 and Grievance Procedures training for staff responsible for grievances. Staff included YCS and FS supervisors. • Copy of revised resident manual informing residents that grievances are accepted for sexual abuse and sexual harassment complaints in accordance with the DYRS PREA Policy 2.13. Documentation of the grievances, trainings, and resident manual was uploaded to supplemental files of OAS on 3/17/2025. The auditor has determined that the facility is substantially compliant with this PREA standard, and no corrective action is required at this time.

115.353	**Resident access to outside confidential support services and legal representation**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. DYRS PREA Policy 2.13.IV.E-4-5 pp. 6-7 2. DYRS Mail, Telephone and Visitation Policy 5.24 3. PREA SOAR PowerPoint 4. SHDC 505 Youth Rights 5. SHDC Visitation Policy 807 6. Title 10 Courts and Judicial Procedure. 7. SHDC Safety Guide 8. Memorandum of Agreement Between DYRS and Survivors of Abuse in Recovery, Inc. (3/29/23). Interviews: 1. Residents 2. Superintendent 3. PREA compliance manager 4. Survivors of Abuse in Recovery (SOAR) Director

Site Review Observation:

1. Mock Intake

Findings (by Provision):

115.353 (a):

In the PAQ, the facility reported that they provide residents with access to outside victim advocates for emotional support services related to sexual abuse including making available addresses, telephone numbers including toll free hotline numbers for state, local, or national victim advocacy or rape crisis organizations. The facility confirmed that residents have access for reasonable communication to these organizations in as confidential manner as possible. The agency reported they do not provide information for immigrant services because it prohibits detention of persons for civil immigration purposes.

The facility relies on DYRS PREA Policy 2.13.IV.E.4-5. that outlines that all youth shall be made aware of community agencies, address and contact numbers of mental health practitioners that provide emotional support services related to sexual abuse. The policy states that the agency shall maintain a memorandum of agreement with one or more such agencies to ensure a statewide service agreement and communication between resident and these agencies will be in as confidential manner as possible. The agency relies on Title 10 courts and judicial procedure 1007 that outlines that the facility does not detain residents for immigration purposes.

Information pertaining to the victim advocacy and emotional support services are given during resident PREA orientation. Residents are given the SHDC Safety Guide that includes information about Survivors of Abuse in Recovery (SOAR), Brandywine Counseling and Community Services 302-656-2348 http://www.brandywinecounselin.org/, Delaware Guidance Services http://delawarguidance.org/, Delaware Renaissance http:/www.delren.org/, AIDS Delaware 302-652-6776 http://aidsdelaware.org/ for victim support. Also, the residents view PowerPoint Training on Survivors of Abuse in Recovery (SOAR) that includes the contact information, confidentiality, and mandatory reporting. provides that residents can call Survivors of Abuse in Recovery (SOAR) 302-655-3953 with a website address http://soarinc.com/.

During the site review, the auditors did observe SOAR victim advocate postings and the Resident safety guide for victim advocacy for rape crisis organizations on the housing units.

During interviews, 2 out of 10 residents stated they knew of an agency and could provide the name of the agency. The residents were unable to give any information about obtaining contact information. There were postings throughout the facility with the information.

Post onsite auditor tested the SOAR telephone number at (302)-655-3953 and was

taken through a series of prompts to leave a message on an intake line. The auditor confirmed via information provided in the PAQ that there is a memorandum of agreement with the DYRS to provide victim advocate for emotional support. During the mock intake, the auditor was able to observe that residents are provided the SHDC Safety Guide English that includes the SOAR contact information.

The facility is substantially compliant with this provision and corrective action is not required.

115.353 (b):

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

During PREA orientation, residents are shown the PowerPoint presentation on SOAR that details pertaining to privacy and confidentiality.

During interviews none of the residents were able to recall the information from the SOAR PowerPoint. Specifically, the information that conversations with outside support services would be monitored, the mandatory reporting rules regarding privacy and confidentiality, disclosures of sexual abuse made to outside victim advocates including any limits to confidentiality.

The facility is not substantially compliant with this provision and corrective action is required.

115.353 (c):

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

Found in the PAQ was the Memorandum of agreement between the Division of Youth Rehabilitative Services and Survivors of Abuse in Recovery, Inc (SOAR). The Memorandum of agreement outlines that SOAR will provide victims of sexual abuse advocates for support during forensic examinations, emotional support and counseling.

The facility is substantially compliant with this provision and no corrective action is required.

115.353 (d):

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

access to parents or legal guardians.

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

Further, the policy outlines that attorney's, clergy, government officials, legislators, media representatives and family may be approved by the superintendent on a case-by-case basis and will not count against the youth's normal visiting schedule. An area is to be set aside for attorney/client interviews. The auditor observed a special area designated for those types of visits within existing visiting area.

The policy allows residents to send and receive unlimited mail. All residents can send sealed correspondences to courts, counsel, officials of the confining authority and administrator of grievance systems or representatives. The facility is now utilizing the mail service Pigeonly at the facility to safeguard staff and residents. Legal correspondence is never opened by staff. Letters incoming and outgoing are not read by staff except if there is clear evidence to justify such action. If the mail is read the resident is present when the letter is opened. Outgoing mail will be submitted unsealed to staff, inspected for contraband before it is processed to be mailed.

During interviews, the PREA compliance manager. stated residents have access to legal representation through the courts. Residents are given access to family visitation.

During the interview, the superintendent stated residents are free to access their attorney upon request via Zoom or phone with the case manager on a non-recorded line. Schedules for parents are at least once a week in person or by telephone on the housing unit.

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

The facility is substantially compliant with this provision and no corrective action is required.

The evidence shows that the agency has a policy that establishes that residents will be provided access to outside victim advocates for emotional support services related to sexual abuse and make available agency contact information. The auditor did observe information that would provide residents with a victim advocate for emotional support. The residents did not retain or recall information about SOAR. The SHDC Safety Guide provided information to the residents about SOAR and other outside victim advocates for emotional support related to sexual abuse. The

	agency does not provide information for immigrant services because the court places a child in secure detention pending adjudication but not for civil immigration purposes. The agency has demonstrated that it has entered into a memorandum of agreement on 3/29/23 that outlines SOAR will provide victims of sexual abuse advocates for support during forensic examinations, emotional support and counseling. The evidence shows that agency policy provides that residents can make confidential calls and visits with their attorney and have contact with a parent through phone calls and visits. Facility administration stated that residents are allowed access to their attorney virtually via zoom, teams, facetime and telephone and parents through phone calls, zoom visits, in person visits, and written correspondence. The residents further confirmed that they were allowed access to contact their attorney privately and visit with their parents through a zoom and onsite visits. Based upon this analysis, the facility is not substantially compliant with this standard and corrective action is required. Corrective Action: Educate all residents on the services provided by Survivors of Abuse in Recovery (SOAR) victim advocate for emotional support related to sexual abuse, contact information for the agency telephone, mailing address and inform residents of the mandatory reporting and limits to confidentiality. Document that all residents have received education on SOAR. Provide contact information for SOAR and Child Abuse Hotline in resident manual. **Completed Corrective Action:** In response to the auditor's findings under PREA standard 115.353, Stevenson House Detention Center (SHDC) has provided the auditor with the following: • Signed roster of participation by all residents receiving PREA Refresher/ SOAR Training on 2/27/2025 • Revised resident manual with the addition of information for SOAR and the Child Abuse Hotline number. Documentation of signed roster of resident participation in PREA/SOAR training and the revised resident manual was uploaded to supplemental files of OAS on 3/17/ 2025. The auditor has determined that the facility is substantially compliant with this PREA standard, and no corrective action is required at this time.

115.354	**Third-party reporting**

Auditor Overall Determination: Meets Standard

Auditor Discussion

Documents:

1. DYRS PREA Policy 2.13.IV.E-1, 6
2. DYRS PREA Policy 2.13.IV.F-1
3. Child Abuse Hotline
4. Department of Services for Children, Youth and Their Families (DSCYF) Public Website https://kids.delaware.gov/yrs/prea.shtml
5. SHDC Resident Safety Guide
6. PREA Contacts: https://kids.delaware.gov/youth-rehabilitative-services/prea--contacts/

Findings (by Provision):

115.354 (a):

SHDC indicated in the pre-audit questionnaire (PAQ) that they provide a method to receive third-party reports of sexual abuse or sexual harassment. DYRA PREA Policy 2.13. IV. E.1 and DYRS PREA Policy 2.13.IV.F.1 details that staff can privately report sexual abuse and sexual harassment of residents through their chain of command, facility administrator, PREA coordinator, Child Abuse Hotline and submitting an anonymous administrative report.

Staff can accept any report of sexual abuse and sexual harassment made verbally, in writing, anonymously and from third parties. The agency policy DYRS PREA Policy PREA 2.13. IV. E.1. establishes a method for third-party reporting of sexual abuse and sexual harassment by calling the Child Abuse Hotline.

The agency's website http://kids.delaware.gov/yrs/prea) provides a link for reporting and receiving third-party reports of sexual abuse or sexual harassment by calling the Delaware Child Abuse hotline (800-292-9582) or contacting a local law enforcement agency. Additionally, the website has a family services reporter portal that allows third parties to make reports electronically. The website also provides information on applicable PREA statutes and policies, agency contact information, Survivors of Abuse and Recovery, Inc. (SOAR), a victim advocate agency, and facility PREA audit reports.

The agency provided a SHDC Resident Safety Guide that outlines how to report sexual abuse and sexual harassment by calling the Child Abuse Hotline (800)-292-9582, completing an emergency grievance form, and facility staff.

The facility is substantially compliant with this provision and no corrective action is required.

The evidence shows the agency and facility provide a method of receiving third-party reports of resident sexual abuse or sexual harassment. This information was

	verified through review of the agency policy, resident safety guide and website information. Based on the review of the policy, and the agency website, staff and the public can make a third-party report of sexual abuse or sexual harassment by calling the child abuse hotline, reporting to a local law enforcement agency, submitting a report electronically, contacting the agency PREA coordinator or facility PREA compliance manager. Based upon this analysis, the facility is substantially compliant with this standard and no corrective action is required.

115.361	Staff and agency reporting duties
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. DYRS PREA Policy 2.13.IV. F.1. 2. DYRS PREA Policy 2.13.IV. F.2. 3. DYRS PREA Policy 2.13.IV. F.3. 4. DYRS 2.2.IV.A.21 5. DYRS 2.2.IV.A.22 6. DYRS 2.2.IV.A.25 7. Pre-Audit Questionnaire (PAQ) 8. DSCYF Academy Training PowerPoint 9. Investigative Files 10. 12 Resident Medical Files Interviews: 1. Superintendent 2. PREA Compliance Manager 3. Medical and Mental Health Practitioners 4. 15 Random staff 5. Milford Police Department Findings (by Provision): 115.361 (a): DYRS reported in the pre-audit questionnaire (PAQ) the agency requires 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 a part of the agency.

	The agency cites DYRS PREA Policy 2.13.IV. F.1., that outlines all staff must comply with child abuse reporting laws and will report any incidents of sexual abuse and sexual harassment to the Child Abuse Hotline. In the PAQ, the agency reported they require all staff to report immediately any retaliation against residents or staff who reported such an incident. The agency relies on DYRS 2.2.IV.A.21 and DYRS PREA Policy 2.13.IV.F.2., that outlines staff will immediately report to facility administration any retaliation against a resident or staff who reported sexual abuse or sexual harassment. According to the PAQ, the DYRS reported they require all staff to report immediately and according to agency policy any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. The agency relies on DYRS 2.2.IV.A.22, and DYRS PREA Policy 2.13.IV.F.3. which outlines that staff will immediately report any staff neglect or violation of responsibilities that may have contributed to an incident of retaliation. DSCYF Academy Training outlines that staff must report all knowledge, suspicion, or information regarding sexual abuse or sexual harassment, retaliation against residents or staff who report such incidents and staff neglect or violation of responsibilities that may have contributed to abuse or retaliation. The training does not provide that staff immediately report. During interviews, 15 Random staff reported that they were aware of the agencies requirement to report regarding any incident of sexual abuse or sexual harassment that occurred in the facility including retaliation against residents or staff who reported sexual abuse or sexual harassment. Additionally, 15 random staff knew the agency's policy or procedure for reporting any information related to a resident's allegation of sexual abuse. The facility is substantially compliant with this provision and corrective action is not required. 115.361 (b): In the PAQ, the agency reported that they require all staff to comply with any applicable mandatory child abuse reporting laws. The agency references DYRS PREA Policy 2.13.IV.F.1., specifies that staff must comply with child abuse reporting laws and will report any incidents of sexual abuse and sexual harassment to the Child Abuse Hotline. DSCYF Academy Training outlines that all YRS staff are mandatory reporters and required to report any allegations and instances of sexual abuse and sexual harassment to the Child Abuse Hotline (800)-292-9582. During interviews, 15 Random staff interviewed knew they were required to comply with mandatory reporting of sexual abuse and noted they would call the hotline.

	During the investigative file review, the auditor determined that an allegation of sexual abuse was not reported to the Child Abuse Hotline. The allegation was administratively investigated by the PREA facility investigator, but prior to Institutional Abuse(IA) determination to screen the allegation in or out to SHDC. The facility is not substantially compliant with this provision and corrective action is required. 115.361 (c): In the PAQ, the agency reported that policy prohibits staff from revealing any information related to sexual abuse report to anyone other than to the extent necessary to make treatment, investigation, and other security and management decisions. Agency relies on DYRS 2.2.IV.A.25 that details that staff will not reveal any information related to sexual abuse report to anyone other than to the extent necessary to make treatment, investigation and other security and management decisions. During interviews all 15 staff were aware of the agency's policy for revealing information related to a resident sexual abuse incident. The facility is substantially compliant with this provision and no corrective action is required. 115.361 (d): According to the PAQ, medical and mental health practitioners shall be required to report sexual abuse to designated supervisors and officials and to the designated state and local services agency where required by mandatory reporting laws. Additionally, practitioners shall be required to inform residents at the initiation of services of their duty to report and the limitations of confidentiality. During interviews with medical and mental health practitioners, they stated they are mandatory reporters, and they would report sexual abuse to their supervisors and facility administrators. Additionally, they would report to the Child Abuse Hotline. When medical and mental health staff were asked at the initiation of services to a resident, do you disclose the limitations of confidentiality and your duty to report, all medical/mental health practitioners responded that they do disclose the limitations as well as their duty to report. The auditor reviewed 12 resident medical files and was able to confirm that residents were informed of medical and mental health limits on confidentiality and duty to report. The facility is substantially compliant with this provision and no corrective action is required. 115.361 (e):

	According to the PAQ, receipt of any allegation of sexual abuse the agency head or designee shall promptly report the allegation to the appropriate agency office, alleged victim's guardian unless there is official documentation that the guardians should not be notified. If resident's guardian of the child welfare system, the report shall be made to the allege victim's caseworker, and if the juvenile court retains jurisdiction over the alleged victim, the facility head or designee shall report the allegation to the juvenile's attorney or legal representation within 14 days of receiving the allegation. During an interview, the PREA compliance manager stated he would immediately report it to the agency head, and notification of allegations would be made to the courts that would inform the juvenile's attorney or other legal representation. The superintendent stated that upon a receipt of an allegation of sexual abuse there would be immediately called to the Child Abuse Hotline. Also, if a juvenile court retains jurisdiction over the victim the superintendent would report allegation to the case manager. The facility reported there was one allegation of sexual abuse during the last 12 months, and there were no allegations of sexual harassment in the last 12 months. During an interview, Milford Police Department (MPD) reported that there were no criminal cases of sexual abuse or sexual harassment reported to the department. The facility is substantially compliant with this provision and no corrective action is required. 115.361 (f): The PAQ requires the facility shall report all allegations of sexual abuse and sexual harassment including third party reporting and anonymous reports to the facility's designated investigators. During an interview, when asked are all allegations of sexual abuse and sexual harassment including those from third-party and anonymous reported directly to designated facility investigators, the superintendent stated yes, we report to both Institutional Abuse (IA) investigators and the facility PREA investigators. The facility reported there was one allegation of sexual abuse and no reports of sexual harassment during the last 12 months. During an interview, the Milford Police Department (MPD) reported that there were no criminal cases of sexual abuse or sexual harassment reported to the department in the prior 12 months. The auditor was able to review past three years of investigations involving sexual abuse or sexual harassment. In review, there was one allegation of sexual abuse reported to the facility PREA investigator in the 12 months preceding the onsite audit. The allegation was not screened by IA, because the allegation was not called into the Child Abuse Hotline. The facility is not substantially compliant with this provision and corrective action is required.

Evidence shows that the agency requires all staff to comply with any applicable mandatory child abuse reporting laws which was verified through policy, staff interviews and academy training, but the facility practice is not in alignment with the agency policy. The facility's practice of compliance with the applicable mandatory child reporting laws is not evident. The facility did not report the allegation of sexual abuse to the Child Abuse Hotline. The agency prohibits staff from revealing any information related to sexual abuse report to anyone other than to the extent necessary to make treatment, investigation and other security and management decisions which was verified through policy and staff interviews. All staff are required to report an incident of sexual abuse or sexual harassment, any retaliation against residents or staff and any staff neglect or violation of responsibilities that may have contributed to an incident of retaliation which was verified through policy, staff interviews and academy training. Medical and mental health practitioners are required to report sexual abuse to designated supervisors as well as state or local services agency required by mandatory reporting laws which were verified through staff interviews and documentation obtained from the Child Abuse Hotline. Allegations of sexual abuse are not reported to the Child Abuse Hotline in accordance with agency policy which was verified through staff interviews, policy and investigative files. Allegations of sexual abuse are not reported to both IA investigators and the PREA facility investigators which was verified through staff interviews and investigative files.

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

Corrective Action:

The facility shall monitor all allegations of sexual abuse and sexual harassment during the corrective action period. Provide auditor with the investigative summary/file for all incidents of sexual abuse and sexual harassment.

The facility shall complete a mock scenario training of a substantiated sexual abuse allegation and a substantiated sexual harassment allegation with the PREA coordinator, PREA compliance manager, superintendent, all facility PREA investigators, and YCS supervisors. Provide the auditor with the completed investigative summary/files. Each scenario should start with first responder duties to the sexual abuse incident review. There should be an emphasis on contacting the Child Abuse Hotline for every allegation of sexual abuse and sexual harassment. Provide a curriculum and a roster of attendance for the mock scenario training.

Completed Corrective Action:

In response to the auditor's findings under PREA standard 115.361, Stevenson House Detention Center (SHDC) has provided the auditor with the following:

- Five investigative summaries/files of allegations of sexual harassment and sexual abuse that occurred since the onsite PREA audit of the facility.
- Copy of scenario-based trainings of a substantiated sexual abuse allegation

and a substantiated sexual harassment allegation.

- The facility provided a roster of signed participants of attendance for the mock scenario training. The following staff participated in scenario-based training the PREA coordinator (professional standards manager), PREA compliance manager, superintendent, all facility PREA investigators, YCS supervisors, retaliation monitor, social services administrator, FCT supervisor and medical practitioner. Included was the supporting documentation of each scenario.

Documentation of the investigative summaries/files, scenario-based training, and roster of participation were uploaded to supplemental files of OAS on 3/17/2025 and 3/18/2025.

The auditor has determined that the facility is substantially compliant with this PREA standard, and no corrective action is required at this time.

115.362	Agency protection duties
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. DYRS PREA Policy 2.13.IV.F.5 2. Pre-Audit Questionnaire (PAQ) 3. Investigative Files Interviews: 1. Agency head 2. Superintendent 3. Random staff Findings (by Provision):

	115.362 (a) 1-4: According to information provided on pre-audit questionnaire (PAQ), DYRS reported that when they learn that a resident is subject to a substantial risk of imminent sexual abuse, the facility takes immediate action to protect the resident and implement appropriate protective measures without unreasonable delay. The agency relies on DYRS PREA Policy 2.13.IV.F.5, that specifies upon receiving information that a resident is subject to a substantial risk of imminent sexual abuse, immediate action will be taken to protect the resident. In the prior 12 months, the facility reported there were no instances in which the facility determined that a resident was subject to a substantial risk of imminent sexual abuse. The agency head stated immediate action would be taken to isolate the resident from substantial risk of imminent sexual abuse. Further, the superintendent responded in the instance of substantial risk of imminent sexual abuse the resident would be moved immediately to another DYRS operated facility. Additionally, it was stated immediate action would be taken and all things including PREA is considered. If a resident was in substantial risk of imminent sexual abuse all 15 random staff interviewed reported they would separate, isolate, or remove the victim and notify a supervisor. In the PAQ, the facility reported that for the past 12 months there were no residents determined to be at substantial risk of imminent sexual abuse. The average amount of time and longest time that passed before responding was not applicable as there were no residents determined to be at substantial risk of imminent sexual abuse. The auditor reviewed investigative files and incident reports, and there were no reports in which the SHDC had to take immediate action for a resident subject to a substantial risk of imminent sexual abuse. The evidence shows that the agency when they learn that a resident is subject to a substantial risk of imminent sexual abuse, they would take immediate action. This was verified through the policy, interviews, investigative files, and incident reports. Based upon this analysis, the facility is substantially compliant with this standard and no corrective action is required.

115.363	**Reporting to other confinement facilities**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion

Documents:

1. DYRS PREA Policy 2.13.IV.F.6.a-b
2. DYRS PREA Policy 2.13.IV.G.1
3. Pre-Audit Questionnaire (PAQ)
4. Investigative File
5. Pre-Audit Questionnaire (PAQ)

Interviews:

1. Agency head
2. Superintendent

Findings (by Provision):

115.363 (a):

DYRS reported in the pre-audit questionnaire (PAQ) the agency has a policy requiring that, upon receiving an allegation that a resident was sexually abused while confined at another facility, the head of the facility must notify the head of the facility or appropriate office of the agency or facility where sexual abuse is alleged to have occurred.

The agency references DYRS PREA Policy 2.13.IV.F.6.a-b that cites upon receiving an allegation that a youth was sexually abused while confined to another facility, the administrator of the facility that received the allegation shall notify the administrator of the facility or appropriate office of the agency where the alleged abuse occurred and shall notify the appropriate investigative agency.

According to information in the PAQ, the DYRS reported that in the last 12 months there were no allegations received by the facility that a resident was abused while confined at another facility that would prompt a facility response.

The agency is substantially compliant with this provision and no corrective action is required.

115.363 (b):

In the PAQ, the DYRS reported that their policy requires that the facility head provides such notification as soon as possible, but no later than 72 hours after receiving the allegation.

The agency relies on, DYRS PREA Policy 2.13.IV.F.6.a that specifically states such notification shall be provided as soon as possible but no later than 72 hours from receiving the allegation.

Reviewing investigative files, the auditor found no evidence of SHDC receiving a report of sexual abuse from another facility.

	The facility is substantially compliant with this provision and no corrective action is required. 115.363 (c): In the PAQ, the SHDC reported that the facility documents that it has provided such notification within 72 hours of receiving the allegation. The agency relies on DYRS PREA Policy 2.13.IV.F.6.b, that states the facility administrator shall document that notification to both the other agency administrator and the investigative agency has been made. Documentation must also show that DYRS director and the Division's PREA coordinator have been notified. Review of investigative files the auditor did not find investigative records of an allegation being reported from another facility. The facility is substantially compliant with this provision and no corrective action is required. 115.363 (d): In the PAQ, the facility reported that agency policy requires that allegations received from other agencies or facilities are investigated in accordance with the PREA standards. The facility reported in the last 12 months, they did not receive any allegations of sexual abuse from other facilities. Stated in DYRS PREA Policy 2.13.IV.G.1 all allegations of sexual abuse or sexual harassment are reported to the Child Abuse Hotline and screened for Institutional Abuse investigation. During an interview, the Agency head stated that allegations of sexual abuse are to be reported to the Child Abuse Hotline. The superintendent stated that if an allegation was received from another facility, the Child Abuse Hotline would be notified. Additionally, the auditor was informed there were no allegations reported from another facility. It is evident that DYRS has a policy that outlines the actions to be taken by the facility administrator upon receiving an allegation that a resident was sexually abused while confined at another facility including notifying the head of the facility and investigative agency. SHDC has not received any allegations to provide notification that would prompt the facility to document a notification within 72 hours. The agency policy outlines that documentation of the notification would occur within 72 hours of receiving the allegation that was verified through policy, staff interviews and investigative files. Additionally, DYRS policy does require that all allegations of sexual abuse are reported to the Child Abuse Hotline for investigation. Information from the PAQ reveals the facility has not received any allegations of sexual abuse from another facility for investigation. Based upon this analysis, the facility is substantially compliant with this standard

	and no corrective action is required.

115.364	Staff first responder duties
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. DYRS PREA Policy 2.13.IV.F.7. 2. PREA First Responder Wallet Cards 3. DSCYF Staff First Responder Checklist Duties 4. Stevenson House Detention Center Coordinated Response 5. DSCYF Academy Staff Training (pp. 56-63) 6. Pre-Audit Questionnaire (PAQ) Interviews: 1. Random Staff Findings (by Provision): 115.364 (a): DYRS reported in the pre-audit questionnaire (PAQ) reports that the agency has a first responder policy for allegations of sexual abuse, DYRS PREA Policy 2.13.IV.F.7. outlines that upon learning of an allegation that a resident was sexually abused, the first staff member to respond to the report must separate the alleged victim and abuser, preserve and protect any crime scene until appropriate steps can be taken to collect evidence and if the abuse occurred within a time period that still allows for the collection of physical evidence, they will ensure that the alleged victim and or alleged abuser does not take any actions that could destroy physical evidence. The policy requires that the facility follow the coordinated facility response plan and utilize the first responder cards and the coordinated response flowcharts. The same information is found on the First Responder Checklist. It requests that the alleged victim not take any action that could destroy physical evidence, including washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating. In addition, ensure that the alleged abuser does not take any action that could destroy physical evidence, including washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating.

	The First Responder Cards outlines four steps to be taken by line staff upon learning of an allegation that a juvenile was sexually abused (do not shower, eat, drink, brush their teeth, use the rest room, or change clothes). The First Responder card also requires the alleged perpetrator not to shower, eat, drink, brush their teeth, use the restroom, or change clothes. The first responder is to notify supervisor, mental health, and medical staff for all sexual abuse, ask the alleged victim if they would like to speak with a victim advocate, and complete an administrative report before the end of shift. During PREA Orientation Training and PREA Refresher training, staff is afforded training in person and online utilizing the DSCYF Academy staff training for prevention, detection and response to sexual abuse in detention. The training outlines the duties of a first responders as follows, separate the victim and perpetrator as quickly as possible, ask the victim are you injured, do you need medical attention, do you believe that you or someone else is in immediate danger, alert your administrator, ensure victim is escorted to medical, ensure perpetrator is in a secure room. preserve evidence by not changing clothes, washing face, body, hair, brushing teeth, urinating or defecating, eating, drinking or smoking. In the PAQ, the agency reported there was one sexual abuse allegation of a resident within the last 12 months. The allegation was conducted administratively. During an interview, Milford Police Department (MPD) reported that there were no criminal cases of sexual abuse or sexual harassment reported to the department within the preceding 12 months. The allegation of sexual abuse did not require the collection of physical evidence, protection of the crime scene, or to request the victim or abuser not to destroy evidence. At the time of the onsite audit, there were no residents who reported a sexual abuse at SHDC to interview. The facility is substantially compliant with this provision and corrective action is not required. 115.364 (b): In the PAQ, the agency reports their policy requires that if the first staff responder is not a security staff member, that responder shall be required to request that the alleged victim not take any actions that could destroy physical evidence. The agency refers to DYRS PREA Policy 2.13.IV. F.7. that requires upon learning of an allegation that a resident was sexually abused, the first staff member to respond to the report must separate the alleged victim and abuser, preserve and protect any crime scene until appropriate steps are taken to collect evidence and if the abuse occurred within a time period that still allows for the collection of physical evidence, they will ensure that the alleged victim and or alleged abuser does not take any actions that could destroy physical evidence. The policy requires that each facility will follow the coordinated facility response plan and utilize the first responder cards

	and the coordinated response. The DSCYF Academy staff training references that any staff member can be a first responder. Also, it was referenced in the PAQ by DYRS. Further the staff training for prevention, detection and response to sexual abuse in detention explains that first responders are to separate the victim and perpetrator as quickly as possible, ask the victim are you injured, do you need medical attention, do you believe that you or someone else is in immediate danger, alert your administrator, ensure victim is escorted to medical, ensure perpetrator is in a secure room, preserve evidence by not changing clothes, washing face, body, hair, brushing teeth, urinating or defecating, eating, drinking or smoking. The First Responder cards give steps to be taken if the first responder is not a security employee. Non-security employees shall request that the alleged victim not take any actions that could destroy physical evidence and notify a security employee. A review of facility investigation records in the past 12 months revealed that there was one sexual abuse allegation, but a non-security first responder did not have to take any actions to prevent the destroying of physical evidence or notifying a security employee/supervisor. During interviews, all 15 random staff indicated that they would secure area, separate victim and abuser, notify supervisor, call hotline, write a report, not allow resident to wash, eat or anything that would destroy physical evidence. The agency is substantially compliant with the provision and no corrective action is required. Evidence shows that the agency does have a first responder policy and relies on the DSCYF academy staff training and PREA refresher training for prevention, detection, and response to sexual abuse in detention. Additionally, the agency's first responder cards as evidence to support non-security first responder action for an allegation of sexual abuse. Based on the first responder checklist, policy, and interviews. The facility is substantially compliant with this provision and corrective action is not required. Evidence shows that the agency does have a first responder policy. The facility relies on the policy, first Responder checklist, cards and DSCYF academy training for prevention, detection, and response to sexual abuse in detention as evidence to support first responder action for an allegation of sexual abuse. Both the first responder cards and the first responder checklist outline all the requirements of the standard. Based upon this analysis, the facility is substantially compliant with this standard and no corrective action is required.

115.365	Coordinated response
	Auditor Overall Determination: Meets Standard
	Auditor Discussion

Documents:

1. PREA First Responders Cards
2. DSCYF Staff First Responder Duties Wallet Card
3. Stevenson House Detention Center Facilities Coordinated Response
4. Pre-Audit Questionnaire (PAQ)

Interviews:

1. Superintendent

Findings (by Provision):

115.365 (a):

SHDC reported in the pre-audit questionnaire (PAQ), the facility developed a written institutional plan to coordinate actions taken in response to an incident of sexual abuse among staff first responders, medical and mental health practitioners, investigators, and facility leadership.

The facility provided the Stevenson House Coordinated Response Flowchart, the First Responder Checklist and the First Responder Card as the documents utilized in the written institutional plan to coordinate actions taken in response to an incident of sexual abuse among staff first responders, medical and mental health unit, investigators, and facility leadership.

For the coordinated response flowchart, there are four separate flowcharts that outline immediate responses from staff. The charts are:

- SHDC Staff Sexual Misconduct Allegation Scenario: Immediate Response
- SHDC Staff Sexual Misconduct Allegation Scenario: Investigation
- SHDC Youth on Youth Sexual Assault Allegation Scenario: Immediate Response
- SHDC Youth on Youth Allegation Scenario: Investigation

The charts provide guidance from the first responder immediate response to the investigation process including notifications.

The First responder checklist prioritizes that the alleged victim not take any action that could destroy physical evidence, including washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating. In addition, ensure that the alleged abuser does not take any action that could destroy physical evidence,

	including washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating. The First Responder Card outlines four steps to be taken by line staff upon learning of an allegation that a juvenile was sexually abused that include do not shower, eat, drink, brush their teeth, use the rest room, or change clothe. Also, the First Responder Card also requires the alleged perpetrator not to shower, eat, drink, brush their teeth, use the restroom, or change clothes. Lastly, the first responder is to notify supervisors, mental health, and medical staff for all sexual abuse, ask the alleged victim if they would like to speak with a victim advocate, and complete an administrative report before the end of shift. During the interview, the superintendent stated that all would be involved in coordination in response to an allegation of sexual abuse. Any administrative investigation conducted by facility level PREA investigators would be cross investigated by one of the other DYRS operated facilities. The facility is substantially compliant with this provision and no corrective action is required. The evidence shows that the agency has a written institutional plan to coordinate a response to incidents of sexual abuse among staff first responders, medical and mental health, investigators and facility leadership which was verified through the DYRS immediate response flowcharts, checklist, cards, and the interview with the superintendent. Based upon this analysis, the facility is substantially compliant with this standard and no corrective action is required.

115.366	**Preservation of ability to protect residents from contact with abusers**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. DSCYF 309 Removal of Employees from the Workplace 2. Dsc309-removal-of-employees-from-the-workplace.pdf (delaware.gov) 3. AFSCME Local 3384 and DSCYF MOA (4/30/21) 4. AFSCME Local 2004 and DSCYF MOA (4/30/21) 5. Pre-Audit Questionnaire (PAQ) Interviews:

1. Agency head

Findings (by Provision):

115.366 (a):

DYRS reported in the pre-audit questionnaire (PAQ), the agency has entered into or renewed any collective bargaining agreement or other agreement since August 20, 2012, or since the last PREA audit, whichever is later. The agency has renewed AFSCME Local 3384 and DSCYF MOA (4/30/21) and AFSCME Local 2004 and DSCYF MOA (4/30/21).

DSCYF Policy 309, establishes the right to remove employees from the workplace when they pose a risk to the safety of residents for allegations of sexual abuse. An administrative investigation would be completed within 14 days of removal from the workplace and if findings indicate termination is warranted the employee may be suspended without pay pending termination.

A review of the Union and DSCYF memorandum of agreements does not prohibit the agency from removing alleged staff sexual abusers from contact with any resident pending the outcome of an investigation or to an extent discipline is warranted.

During an interview, when asked has the agency entered into or renewed any collective bargaining agreements or other agreements since August 20, 2012, the agency head reported yes, and Department policy 309 still permits them to release staff from duty for allegations of sexual abuse.

The agency is substantially compliant with this provision and no corrective action is required.

The evidence shows that the agency has not entered into a collective bargaining agreement that limits the agency's ability to remove an employee from duty which is verified through the agency policy, memorandums, and interviews with staff.

The agency is substantially compliant with this standard and no corrective action is required.

115.367	Agency protection against retaliation
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents:

1. DYRS PREA Policy 2.13.IV.F.9
2. Pre-Audit Questionnaire (PAQ)

Interviews:

1. Agency head
2. Superintendent
3. Designated Staff Member Charged with Monitoring Retaliation

Findings (by Provision):

115.367 (a) 1-2:

In the pre-audit questionnaire (PAQ), DYRS reported they have a policy to protect all residents and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other residents or staff.

DYRS PREA Policy 2.13.IV.F.9 establishes that all resident and staff who report sexual abuse or sexual harassment or cooperate with the investigations of sexual abuse or sexual harassment are protected from retaliation by other residents or staff.

In the PAQ, the agency reported that they have designated a youth care specialist 3 that monitors possible retaliation. It was determined that the duty was recently assigned.

During interviews with the staff that monitor for retaliation, the role is to uphold fair treatment. Also, described there would be no difference in the protections from retaliation afforded to residents or staff. Stated that there would be a review of point sheets to determine unfair treatment of residents. Additionally, there would be no limits to the length of time of observing retaliation.

The facility is substantially compliant with this provision and no corrective action is required.

115.367 (b):

DYRS PREA Policy 2.13.IV.F.9.a-b, all residents and staff who report sexual abuse or sexual harassment or cooperate with the investigation of sexual abuse or sexual harassment are protected from retaliation by other residents or staff. Retaliation from youth or staff will result in disciplinary action and subject to the full progression of sanction and or referral for criminal prosecution. Retaliation will be monitored for 90 days or longer if needed.

During an interview, the agency head stated that residents and staff can be protected from retaliation by moving from the housing unit or to another DYRS operated facility. During an interview, the superintendent stated the measures to protect residents and staff from retaliation is to monitor retaliation.

	At the time of onsite audit, there were no residents that were isolated for risk of victimization or who alleged sexual abuse that the auditor was able to interview. The facility is substantially compliant with this provision and no corrective action is required. 115.367(c): SHDC reported in the PAQ that facility monitors the conduct or treatment of residents or staff who reported sexual abuse and of residents who were reported to have suffered sexual abuse to see if there are any changes that may suggest possible retaliation by residents or staff for 90 days or longer if needed. The facility reported there have been no incidents of retaliation in the past 12 months. Based on DYRS PREA Policy 2.13.IV.F.9, residents can privately report sexual abuse and sexual harassment and retaliation by other residents or staff for reporting sexual abuse or sexual harassment. Retaliation from youth or staff will result in disciplinary action and subject to the full progression of sanction and or referral for criminal prosecution. Retaliation will be monitored for 90 days or longer if needed. During an interview, the superintendent stated the facility conducts retaliation monitoring and can move residents or staff. Further, it was stated by the retaliation monitor that monitoring would continue for 90 days or longer if necessary. The facility is substantially compliant with this provision and no corrective action is required. 115.367 (d): According to the PAQ, monitoring of residents shall include periodic status checks. The monitoring would consist of upholding fair treatment. The retaliation monitor detailed there would be a review of point sheets utilized for the behavior modification program. Also, they would monitor the residents over a 90-day period and longer, if necessary, until the resident leaves SHDC. The facility is substantially compliant with this provision and no corrective action is required. 115.367 (e): Written in the PAQ, if any other individual who cooperates with an investigation expresses fear of retaliation, the agency shall take appropriate measures to protect that individual against retaliation. DYRS PREA Policy 2.13.IV.F.9 establishes that retaliation from youth or staff will result in disciplinary action and subject to full progression of sanctions and or referral for criminal prosecution. The agency reported in the PAQ that there has not been any incident of retaliation in the past 12 months. During interviews, the agency head stated they would move staff or resident to another DYRS operated facility to protect them from retaliation. The superintendent

confirmed the same protocol.

The facility is substantially compliant with this provision and no corrective action is required.

The evidence shows that the agency has outlined a policy to protect residents and staff from retaliation and has designated a staff member to monitor for possible retaliation which was verified through the agency policy and interview. The facility employs multiple measures for residents and staff that fear retaliation for reporting sexual abuse or sexual harassment. The facility has designated a staff to monitor retaliation. SHDC has a process to take appropriate measures to protect an individual that fears retaliation which was verified through the PAQ, policy, and staff interviews.

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

115.368 Post-allegation protective custody

Auditor Overall Determination: Meets Standard

Auditor Discussion

Documents:

1. DYRS PREA Policy 2.13.IV.D.2.
2. DYRS Policy LGBTQI 2.20.IV.E.1.c.
3. SHDC-501 Legal, Programmatic Rights/Program Access
4. SHDC-601 Disciplinary Procedures
5. 12 Resident Files
6. Housing unit record logs

Interviews:

1. Superintendent
2. Medical and mental health staff

Site Review Observations:

1. Site review of facility housing units

Findings (by Provision):

115.368 (a) 1-7:

	In the PAQ, the DYRS reported residents who allege to have suffered sexual abuse may only be placed in isolation as a last resort if less restrictive measures are inadequate to keep them and other residents safe, and only until an alternative means of keeping all resident's safe can be arranged. DYRS PREA Policy 2.13.IV.D.2, establishes that placement and programming assignments for each transgender youth, intersex youth, youth assessed as high risk for being victimized or offending or in need of protective housing is reviewed by the facility's assessment team at least twice a month to review any threats to safety experienced by the resident. DYRS Policy LGBTQI 2.12.IV.E.1.c. establishes that LGBTQI youth may be isolated from others only as a last resort when less restrictive measures are inadequate to keep them and other youth safe, and then only until alternative means of keeping all youth safe can be arranged. During any period of isolation, DYRS staff shall not deny youth daily large-muscle exercise and any legally required educational programming or special education services. Youth in isolation shall receive daily visits from medical staff or behavioral health services clinician or provider. Youth shall also have access to other programs and work opportunities to the extent possible. In the PAQ, the agency reported that they have a policy that requires that residents who are placed in isolation because they allege to have suffered sexual abuse have access to legally required educational programming, special education services, and daily large muscle exercise. In SHDC-501 maintains residents are afforded rights that are consistent with the requirement of assuring that a resident has access to educational programming, special education services, and daily large muscle exercise. Within SHDC-601, there is language that describes involuntary confinement and having the rights listed above, but the policy is for discipline not for instances of allegations of sexual abuse. In the PAQ the facility reported in the prior 12 months, there were no residents to have suffered sexual abuse or risk of sexual victimization placed in isolation, who have been denied daily access to large muscle exercises and/or legally required education or special education. During an interview, the superintendent stated that there were no residents alleged to have suffered sexual abuse placed in isolation during the last 12 months. Mental health staff indicated that medical and mental health practitioners would check on residents in administrative intervention daily. Review of a list of residents that were at risk of victimization, the auditor was able to confirm that those residents were not confined in isolation at SHDC for allegations of sexual abuse or the risk of victimization. During interviews with medical and mental health practitioners, there were no residents identified as being in isolation due to allegations of sexual abuse or at risk of victimization. During the onsite audit, there were no residents that alleged sexual abuse or at risk

	of victimization being held in isolation for the audit or to interview. The facility is substantially compliant with this provision and no corrective action is required. SHDC has a policy to isolate residents who allege to have suffered sexual abuse as a last resort until a less restrictive alternative means is arranged for safety. This was verified through interview, observation, policy and documentation review. Residents in isolation would receive daily visits from medical and mental health care clinicians. According to policy, residents would receive required educational programming, special education programming, and large muscle exercises. The facility is substantially compliant with this standard and no corrective action is required.

115.371	**Criminal and administrative agency investigations**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. DYRS Policy 2.13.IV.G.1 2. DYRS Policy 2.13IV.G.1.a 3. DYRS Policy 2.13.IV.J.9 4. DYRS Policy 2.13.IV.J.10 5. Affirmation of Compliance with Investigative Standards for Sexual Assaults with Milford Police Department 6. State of Delaware Memorandum of Understanding for the Multidisciplinary Response to Child Abuse and Neglect 2022 7. 2 Moss Group Certificates PREA Juvenile Specialized Investigations Training 8. 3 National Institute of Corrections Certificates PREA: Investigating Sexual Abuse in Confinement Settings 9. Notification of Investigation Status Form 10. Sexual Abuse Review of Substantiated and Unsubstantiated Outcomes Form 11. Non-Critical Reportable Event Form 12. PAQ Pre-Audit Questionnaire 13. Investigative Files Interviews: 1. Milford Police Department (DSP) 2. Institutional Abuse (IA) PREA Investigator

3. Facility PREA Investigator
4. PREA coordinator
5. PREA compliance manager
6. Superintendent

Findings (by Provision):

115.371 (a):

According to information provided on the pre-audit questionnaire (PAQ), DYRS has a policy related to criminal and administrative agency investigations. Within DYRS Policy 2.13.IV.G.1, there is a section that addresses investigations in secure care. The policy details that all matters that involve the allegation of any sexual contact as in this policy will be reported to the Child Abuse Hotline. Further, the policy mentions that for matters that could result in criminal action, Institutional Abuse (IA) will conduct a joint investigation with the Milford Police Department.

Based on information obtained from the investigative files of sexual abuse and sexual harassment, there was one allegation of sexual abuse and no allegations of sexual harassment in the preceding 12 months. The auditor was provided with investigative files from 2022, 2023, and 2024. The auditor reviewed the Non-Critical Reportable Event Forms, and there were no allegations of incidents that were found to initiate an investigation of sexual abuse or sexual harassment of residents at the SHDC. There was one grievance that prompted the investigation of an allegation of sexual abuse.

Based on the information provided in the alleged sexual abuse investigative file, the incident was not reported to the Child Abuse Hotline. Once the facility was made aware of the allegation through a grievance within 24 hours an investigation was promptly conducted. The investigation included interviewing both residents and staff. Additionally, there was viewing and collection of video footage. Review of the investigative summary, the allegation of sexual abuse was investigated objectively.

According to IA PREA investigators, facility PREA investigators, and DSP, all investigations including third-party reports and anonymous reports are investigated immediately upon receipt of complaint of sexual abuse and sexual harassment are conducted. It was also detailed the steps in conducting administrative and criminal investigations of allegations of sexual abuse and sexual harassment. The investigators also stated that anonymous and third-party reports of sexual abuse are handled the same as all other allegations of sexual abuse and sexual harassment.

The agency is substantially compliant with this provision and no corrective action is required.

115.371(b)

According to the PAQ, where sexual abuse is alleged the agency shall use investigators who have received special training in sexual abuse investigations

	involving victims in accordance for PREA standard 115.334. In the PAQ, the agency provided two investigators' certificates through the PAQ for the Internal Abuse (IA) PREA investigators. The training taken was the Moss Group virtual course PREA Juvenile Specialized Investigation Training. The facility also provided three investigator's certificates for the facility PREA investigators. Previously, the agency had facility PREA investigators view the training provided by NIC. The training was through the virtual training provided by the National Institute of Corrections. It was determined from the review of the investigative file of the sexual abuse allegation at SHDC was completed by a certified PREA investigator. The agency is substantially compliant with this provision and no corrective action is required. 115.371(c) According to the PAQ, investigators shall 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 and shall review prior complaints and reports of sexual abuse involving the suspected perpetrator. Review of the investigative file of alleged sexual abuse, the file contained an investigative summary, interviews, and reference to the reviewing and retention of the video footage. According to the PREA investigators, all investigations are to begin with a call to the Child Abuse Hotline. Once received by the hotline, there is a determination of whether the investigation would be conducted by either Institutional Abuse or the facility PREA investigators. The facility PREA investigator stated the first steps in initiating an investigation would be to begin interviewing the victim, witnesses, and perpetrator. Also, the collection of any circumstantial evidence including footage as well as review prior reports of sexual abuse by perpetrator. In incidents in which the Child Abuse Hotline assigns an Institutional Abuse (IA) PREA investigator, the process is the same unless the Child Abuse Hotline determines that a criminal offense has occurred. The IA PREA investigator stated that they would meet with facility staff and conduct interviews. In the case of a criminal offense, there is a joint investigation with Milford Police Department(MPD) and Institutional Abuse (IA). The role of IA in criminal cases of sexual abuse and sexual harassment is supportive and as a liaison between the facility and MPD. The agency is substantially compliant with this provision and no corrective action is

	required. 115.371(d)-1 According to the information provided by the PAQ, DYRS reported that it does not terminate an investigation solely because the source of the allegation recants the allegation. In the Affirmation of Compliance with Investigative Standards for Sexual Assault with Milford Police Department, it affirms MPD will not terminate an investigation solely because the source of the allegation recants the allegation. According to interviews with IA, MPD, and the facility PREA investigator, an investigation continues and does not terminate if the source of the allegation recants. The agency is substantially compliant with this provision and no corrective action required. 115.371(e) According to the PAQ, when the quality of evidence appears to support criminal prosecution, the agency shall conduct compelled interviews only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution. According to the IA PREA investigator and Milford Police Department, there has been no sexual abuse investigation that rose to criminal threshold. Investigations that meet the criminal threshold are jointly investigated by MPD and IA. In the case of compelled interviews, confirmation was made by IA PREA investigator and MPD that the responsibility of consultation with the prosecutor prior to conducting a compelled interview would be done by MPD. The agency is substantially compliant with this provision and no corrective action is required. 115.371(f) According to the PAQ, the credibility of an alleged victim, suspect, or witness shall be assessed on an individual basis and shall not be determined by the person's status as resident or staff. No agency shall require a resident who alleges sexual abuse to submit to a polygraph examination or other truth-telling device as a condition for proceeding with the investigation of such an allegation. According to the interviews of MPD, IA, and the facility PREA investigators, assessment of the credibility of an alleged victim, witness, or suspect is based on the evidence and an individual basis. It is not based on the individual's status as a resident or staff member. Further, it was confirmed from the IA investigator and facility PREA investigator that

	the agency does not require a resident that alleges sexual abuse to submit to a polygraph examination or other truth telling device as a condition to proceed with an investigation. Additionally, these prohibitions of polygraph and truth telling device are also contained in the Affirmation of Compliance with Investigative Standards for Sexual Assault with Milford Police Department. During the onsite audit, there were no residents who had reported sexual abuse at SHDC to further confirm. The agency is substantially compliant with this provision and no corrective action is required. 115.371(g) According to the PAQ, administrative investigations shall include an effort to determine whether staff actions or failures to act contributed to the abuse and shall be documented in written reports that include a description of the physical and testimonial evidence and the reasoning behind credibility assessments and investigative facts and findings. During the auditor's inquiry regarding documents contained in investigation files, the facility PREA investigator stated the investigations are documented in written reports. Further review of investigative files, the auditor located investigative summary, reference to footage of video, interviews, and a narrative with findings and recommendations. Due to the lack of unsubstantiated and substantiated sexual abuse and sexual harassment allegations, the auditor was unable to determine if administrative investigations would include an effort to determine whether staff actions or failures to act contributed to the abuse. The agency is substantially compliant with this provision and no corrective action is required. 115.371(h) According to the PAQ, criminal investigations shall be documented in a written report that contains a thorough description of physical, testimonial, and documentary evidence and attaches copies of all documentary evidence where feasible. DYRS has not reported or provided documentation of any criminal investigations, because there has been no investigations of sexual abuse that have met the threshold. The interview with MPD yielded that criminal investigations would be documented in a report, and there were no criminal investigations of sexual abuse at SHDC. To obtain a portion of the documented report, the agency would have to obtain a FOYA, and forensic examination evidence would be turned over to the Delaware State Police for processing. The results of the forensic examination evidence would be returned to MPD.

	Within the Affirmation of Compliance with Investigative Standards for Sexual Assault, it affirms MPD would be responsible for documenting reports. The reports are to contain thorough description of physical, testimonial, and documentary evidence and include copies of all documentary evidence where feasible. The agency is substantially compliant with this provision and no corrective action is required. 115.71(i)-1 In the PAQ, it states that substantiated allegations of conduct that appears to be criminal shall be referred for prosecution. Cited in DYRS Policy 2.13IV.G.1.a, Institutional Abuse may complete a joint investigation with Milford Police Department for allegations that involve potentially criminal behavior. In both the interview with MPD and the IA investigator, the auditor determined that substantiated allegations of conduct that appear to be criminal are referred for prosecution. According to MPD, there were no substantiated allegations of conduct that appeared to be criminal that was referred to for prosecution from SHDC within the last 12 months. Once MPD has probable cause, the department confers with the Attorney General's Office for approval for prosecution. The agency is substantially compliant with this provision and no corrective action is required. 115.371(j)-1 DYRS reported in the PAQ that the agency retains all written reports pertaining to the administrative or criminal investigation of alleged sexual abuse or sexual harassment for as long as the alleged abuser is incarcerated or employed by the agency, plus five years. Documentation pertaining to sexual abuse and sexual harassment are maintained at the main campus of DSCYF which is 70 miles way from SHDC. The facility provided pictures of the secured files, and the auditor has prior knowledge from the recent onsite audits completed within the prior 12 months. The files are secured in the management analyst's office, and the auditor observed the 2-lock system. The keyless access cabinet contained past years of written reports of sexual harassment and sexual abuse. In DYRS Policy 2.13.IV.J.9 is the agency's retention policy that PREA data shall be retained for no less than 10 years after the date of its initial collection unless Federal, State, or local law requires otherwise. The agency is substantially compliant with this provision and no corrective action is required. 115.371(k)-1 The PAQ states the departure of the alleged abuser or victim from the employment or control or the facility or agency shall not provide a basis for terminating an

investigation.

According to interviews with both IA investigator, facility PREA investigator, and MPD, the departure of an alleged abuser or victim from employment or control of the facility or agency does not provide a basis for terminating an investigation. The auditor was unable to confirm practice due to the lack of allegations of sexual abuse files.

The agency is substantially compliant with this provision and no corrective action is required.

115.371(l)-1

Auditor is not required to audit this provision.

The agency is substantially compliant with this provision and no corrective action is required.

115.371(m)

According to the PAQ, when outside agencies investigate sexual abuse, the facility shall cooperate with the outside investigators and shall endeavor to remain informed about the progress of the investigation. Further, the cooperation is outlined in the agreement between DYRS and MPD.

The auditor confirmed through interviews with the superintendent, PREA compliance manager, and the PREA coordinator that MPD would provide information pertaining to a sexual abuse investigation at SHDC to the IA PREA investigators.

The agency is substantially compliant with this provision and no corrective action is required.

The evidence provided shows that the agency has a policy related to criminal and administrative agency investigations. The investigation was conducted promptly, thoroughly, and objectively based on investigative files. It should be noted that the investigation was thorough except for not notifying the Child Abuse Hotline before proceeding with the investigation. The auditor was able to determine the practice of certified PREA investigators conducting investigations of sexual abuse and sexual harassment and it was verified by reviewing investigative files. The auditor was able to determine the practice of documenting interviews, collecting direct or circumstantial evidence, video footage, and review of prior reports and complaints. Interviews of investigators have confirmed that investigations are not terminated due to the source of the allegation being recanted, and credibility is assessed on an individual basis. Also, investigations are not terminated due to the departure of an alleged abuser or victim from employment or release from the facility. The auditor relied on interviews to determine if the facility reports if staff actions or failures contributed to sexual abuse. The prior site review at the DSCYF Campus and pictures confirmed the practice of maintaining written reports in accordance to115.371(j). MPD, IA and facility PREA investigators confirmed investigations of sexual abuse and sexual harassment are conducted jointly, and information would

	be shared with IA of the progress of the investigation. Based on this analysis, the agency is substantially compliant with this standard and no corrective action is required.

115.372	Evidentiary standard for administrative investigations
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. State of Delaware Memorandum of Understanding for the Multidisciplinary Response to Child Abuse and Neglect: Child Abuse Protocol p.35 2. Pre-Audit Questionnaire (PAQ) 3. DYRS PREA Policy 2.13IV.G.2 4. Investigative Files Interviews: 1. Institutional Abuse (IA) PREA investigator 2. Facility PREA investigator Findings (by Provision): 115.372 (a)-1: According to the pre-audit questionnaire (PAQ), DYRS imposes a standard of a preponderance of the evidence or a lower standard of proof for determining whether allegations of sexual abuse or sexual harassment are substantiated. Reviewed in the State of Delaware Memorandum of Understanding for the Multidisciplinary Response to Child Abuse and Neglect: Child Abuse Protocol p.35, DFS Institutional Abuse (IA) PREA Investigator will make a finding within 45 days once it has established that a preponderance of the evidence exists. Within the DYRS PREA Policy 2.13IV.G.2, its stated for administrative investigations into sexual abuse or sexual harassment, the allegations will be substantiated if most of the evidence supports them. During onsite audit interviews, the IA PREA investigator stated that evidentiary standard utilized to substantiate allegations of sexual abuse and sexual harassment is the preponderance of the evidence. Further confirmed by two of the facility PREA investigators, the evidentiary standard applied to substantiate allegations of sexual abuse and sexual harassment is the preponderance of the evidence.

Within the last 12 months, there was one allegation of sexual abuse investigation at SHDC documented on the Pre-Audit Questionnaire (PAQ). Based on the review of the investigative file, the PREA investigator applied the evidentiary standard of preponderance of the evidence.

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

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

115.373 Reporting to residents

Auditor Overall Determination: Meets Standard

Auditor Discussion

Documents:

1. DYRS Policy 2.13.IV.G.4
2. DYRS Policy 2.13 Attachment D Notification of Investigation
3. Pre-Audit Questionnaire (PAQ)
4. Investigative Files

Interviews:

1. Facility PREA investigator
2. Superintendent
3. Milford Police Department

Findings (by Provision):

115.373 (a):

DYRS affirms that the agency has a policy requiring that any resident who makes an allegation that he or she suffered sexual abuse in an agency facility is informed verbally or in writing as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded following an investigation by the agency. DYRS Policy 2.13.IV.G.4 requires, "Upon completion of an investigation, the resident will be informed whether the allegation was substantiated, unsubstantiated or unfounded. This notification is made using the Notification of Investigation form that is attached to this policy." The referenced Attachment D-Notification of Investigation is in the Pre-audit questionnaire (PAQ).

Within the preceding 12 months, there was one allegation of sexual abuse. Located in the investigative file for this allegation was a copy of the Notification of Investigation. The form included the findings, notations, and the signature of the facility PREA investigator. Sexual abuse investigation files were requested by the auditor for the prior 36 months, and located in the two files were the Notifications of Investigations.

According to the superintendent, residents are notified of the outcomes of allegations of sexual abuse.

The agency is substantially compliant with this provision and no corrective action is required.

115.373(b):

On the PAQ, there is no request for relevant information from the external investigative entity in order to inform the resident of the outcome of the sexual abuse investigation. Further the agency responded that the facility will always complete an administrative investigation and use the facility's findings to inform a resident. According to the PAQ, there were no investigations of allegations of sexual abuse conducted by an outside entity within the last 12 months. During an interview with the Milford Police Department, there were no allegations of sexual abuse investigated at SHDC in the last 12 months.

During the onsite PREA audit, there were no residents that had reported sexual abuse to interview.

The facility is substantially compliant with this provision and no corrective action is required.

115.373(c-d):

According to DYRS Policy 2.13.IV.G.4.a-b, youth are provided notification of outcome of investigation if the alleged abuse was by a staff member unless unfounded, no longer staffed on unit, no longer employed, or indicted/convicted on a charge of sexual abuse. If the alleged abuse was another youth, the youth would be informed when the facility is informed that the alleged abuser has been indicted or convicted on a charge of sexual abuse within the facility. There was one unfounded allegation of sexual abuse within the last 12 months at SHDC. The resident was provided the Notification of Investigations. Due to the outcome of unfounded, this information was not applicable.

During the onsite PREA audit, there were no residents that had reported sexual abuse to interview.

The facility is substantially compliant with this provision and no corrective action is required.

115.373(e)

DYRS Policy 2.13.IV.G.4 requires documentation of notification of outcome for sexual abuse investigations. Additionally, the DYRS Policy 2.13 Attachment D Notification of Investigation is the specific document identified in the policy to be utilized. There was one unfounded allegation of sexual abuse within the last 12 months. In the investigative file, the auditor located a copy of the Notification of Investigation.

The facility is substantially compliant with this provision and no corrective action is required.

Based on the analysis of DYRS Policy 2.13.IV.G.4 and DYRS Policy 2.13 Attachment D Notification of Investigation and interviews with the superintendent and the local police department, it is evident that the agency notifies residents of the outcomes of sexual abuse investigations. The agency maintains documentation of the outcomes of investigations.

The agency is substantially compliant with this standard and no corrective action is required.

115.376 Disciplinary sanctions for staff

Auditor Overall Determination: Meets Standard

Auditor Discussion

Documents:

1. DYRS PREA Policy 2.13.IV.H.1.
2. Delaware Children's Department Policy 309 Removal of Employee from the Workplace
3. Delaware Children's Department Policy 313 Initial Background Checks and Subsequent Arrest
4. Resignation and Termination List
5. Discipline Correspondence
6. Investigative Files
7. Pre-Audit Questionnaire (PAQ)

Interviews:

1. Investigative staff

Findings (by Provision):

115.376 (a):

According to the pre-audit questionnaire (PAQ), SHDC reports that staff is subject to

	disciplinary sanctions up to and including termination for violating the agency sexual abuse and sexual harassment policies. The facility references several policies in upholding the ability to sanction staff up to an including termination for violating the agency sexual abuse and sexual harassment policies. SHDC relies on DYRS PREA Policy 2.13.IV.H.1. that states all staff is subject to disciplinary sanctions up to and including termination for violating the agency sexual abuse and sexual harassment policies. Also, provided in the PAQ was the Agency Policy 309 Delaware Children's Department Policy Removal of Employee from the Workplace. The policy establishes guidelines for removal of an employee from the workplace when it is determined that their continued presence jeopardizes safety, security, or public confidence in the department. The policy includes behaviors that lead to physical or sexual abuse against a child and harassment. Lastly, agency Policy 313 Delaware Children's Department Policy Initial Background Checks and Subsequent Arrest and/or Allegations of Child abuse/Neglect provides that each employee shall have an affirmative duty to immediately inform their supervisor/manager of any criminal convictions, arrest, or indictment of any investigation of child abuse/neglect. Failure to immediately notify their supervisor/manager could result in discipline up to and including termination. The facility is substantially compliant with this provision and no corrective action is required. 115.376 (b): According to information provided on the PAQ, the facility reported in the last 12 months there was one staff at the facility that violated, resigned or have been terminated for violating the agency sexual abuse or sexual harassment policies. The violation was for staff on staff misconduct. The auditor reviewed termination and resignation list with PREA compliance manager and discussed each former staff person's explanation for resigning or being terminated. There were no instances in which a former staff member was terminated due to sexual abuse or sexual harassment. The auditor determined from reviewing investigative files that there was one allegation of sexual abuse and no allegations of sexual harassment during the last 12 months. There were no staff on resident violation, resignation or was termination for violating the agency sexual abuse or sexual harassment policy. During an interview, Milford Police Department (MPD) reported that there were no criminal cases of sexual abuse or sexual harassment reported to the department. The facility is substantially compliant with this provision and no corrective action is required.

	115.376 (c): In the PAQ, SHDC reported that sanctions for violations of agency policies relating to sexual abuse or sexual harassment are commensurate with the nature and circumstances of the acts committed, the staff member's disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories. The facility reported the last 12 months there was one staff on staff violation for violating the agency's sexual abuse or sexual harassment policy. The facility references DYRS PREA Policy 2.13.IV.H.1. states staff shall be subject to disciplinary sanctions up to including termination for violating agency sexual abuse and sexual harassment policies. Human resources will be consulted as applicable. PREA compliance manager reported there was one allegation of sexual abuse involving a resident and no sexual harassment allegations during the last 12 months, and there was one staff that was disciplined for misconduct against another staff. During an interview, MPD reported that there were no criminal cases of sexual abuse or sexual harassment reported to the department for sexual abuse against a resident. The facility is substantially compliant with this provision and no corrective action is required. 115.376 (d): In the PAQ, the facility reported all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, are reported to law enforcement agencies, unless the activity was clearly not criminal, and to any relevant licensing bodies. The facility reported the last 12 months there had been no staff terminations or resignations for violating the agency's sexual abuse or sexual harassment policy. SHDC refers to PREA Policy 2.13 Section IV, H.1, states that staff shall be subject to disciplinary sanctions up to including termination for violating agency sexual abuse and sexual harassment policies. Human resources will be consulted as applicable. Facility staff reported there was one allegations of sexual abuse and no allegations of sexual harassment during the last 12 months. During an interview, MPD reported that there were no criminal cases of sexual abuse or sexual harassment reported to the department. Review of the resignation and termination list, there were no former staff identified as being terminated for violating the agency's sexual abuse and sexual harassment policy. There was an incident provided in the PAQ of a staff on staff misconduct violation that constituted a suspension. The facility is substantially compliant with this provision and no corrective action is required.

	The evidence shows that agency policy provides that staff is subject to disciplinary sanctions up to and including termination for violating the agency sexual abuse and sexual harassment policies which was verified though the PAQ, policy, and discipline correspondence. Staff is subject to disciplinary sanctions up to and including termination. Within the prior 12 months, there was one staff on staff violation for misconduct which was verified through the PAQ and the discipline correspondence. SHDC has demonstrated that termination shall be the presumptive disciplinary sanction for staff who have engaged in sexual abuse that was verified through policy. It is evident that there were no incidents that warranted notification to law enforcement agencies verified through policy and investigative files. Based on this analysis, The facility is substantially compliant with this standard and no corrective action is required.

115.377	**Corrective action for contractors and volunteers**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. DYRS PREA Policy 2.13.III.A.IV. F.1. 2. State of Delaware Memorandum of Understanding for Multidisciplinary Response 3. Delaware Children's Department Policy 313 Initial Background Checks and Subsequent Arrest 4. Department of Services for Children, Youth and Their Families Policy 305 Standards of Conduct Employees, Volunteers and Interns 5. Removal of Employees from the Workplace Policy 309 (Revised 11/1/2021) 6. Investigative Files 7. Pre-Audit Questionnaire (PAQ) Interviews: 1. Superintendent 2. Milford Police Department Findings (by Provision): 115.377 (a):

	DYRS reported the pre-audit questionnaire (PAQ) states DYRS policy requires that any contractor or volunteer who engages in sexual abuse be reported to law enforcement agencies, unless the activity was not criminal to relevant licensing bodies and be prohibited from contact with residents. In the past 12 months the facility reported that there had been no volunteers or contractors reported to law enforcement or licensing bodies for engaging in sexual abuse of residents. The agency relies on DYRS PREA Policy 2.13.III.A.IV. F.1.that cites volunteers and contractors are defined as departmental employees. Staff must comply with child abuse reporting laws and will report any incidents of sexual abuse and sexual harassment to Child Abuse Hotline. The facility relies on Policy 309 Removal of Employee from Workplace Section II, which outlines that the allegations of sexual abuse against a resident may lead to immediate removal of the employee from the workplace. As written, the policy does not include the immediate removal for allegations of sexual harassment by a contractor or volunteer. Note that volunteers and contractors are identified as employees in DYR PREA Policy 2.13. The facility provided the State of Delaware Memorandum of Understanding for a Multidisciplinary Response that outlines DFS must make an immediate report to the appropriate law enforcement jurisdiction and the Department of Justice for all civil offenses identified in the Sexual Abuse Protocol, DFS is required to report all persons, agencies, organizations and entities to DOJ for investigation if they fail to make mandatory reports of child abuse or neglect. Reported in the PAQ, there was one allegation of sexual abuse and no allegations of sexual harassment during the last 12 months. During an interview, Milford Police Department reported that there were no criminal cases of sexual abuse or sexual harassment reported to the department. The facility is substantially compliant with this provision and no corrective action is required. 115.377 (b): SHDC reported the facility takes appropriate remedial measures and considers whether to prohibit further contact with residents in the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer. The facility refers to Policy 309 Removal of Employee from Workplace Section II which outlines that allegations of sexual abuse against a resident may lead to immediate removal of the employee from the workplace. As written, the policy does not include the immediate removal for allegations of sexual harassment by a contractor or volunteer, but the agency’s PREA policy identifies contractors and volunteers as employees. In the PAQ, the facility reported there was one allegation of sexual abuse and no

	allegations of sexual harassment during the last 12 months. During an interview, MPD reported that there were no criminal cases of sexual abuse or sexual harassment reported to the department. During an interview with the superintendent, when asked in the case of any violation of agency sexual abuse and sexual harassment policy by a contractor or volunteer does your facility take remedial measures and prohibit further contact with residents, staff confirmed SHDC would take remedial measures and prohibit further contact by a contractor or volunteer. The auditor reviewed the past three years of investigative files for allegations of sexual abuse and sexual harassment. No volunteer or contractor was found to have violated the agency's sexual abuse or sexual harassment policy that would have warranted remedial action to prohibit contact with residents. The facility is substantially compliant with this provision and no corrective action is required. The evidence shows that contractors and volunteers are subject to reporting to law enforcement for engaging in sexual abuse, prohibited from contact with residents. The facility would take remedial measures to prohibit further contact of volunteers and contractors from contact with residents for violation of agency sexual abuse or sexual harassment policies. These practices were further verified by policy, interviews, and investigative files. Based upon this analysis, the facility is substantially compliant with this standard and no corrective action is required.

115.378	**Interventions and disciplinary sanctions for residents**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. DYRS PREA Policy 2.13.IV.H.2 2. DYRS LGBTQI Policy 2.20.IV.E.1.c 3. SHDC-801 Stevenson House Services and Programs 4. CBT Discipline Matrix 5. Stevenson House Resident Manual English and Spanish. 6. Housing Unit Logs 7. Investigative Files 8. 12 Resident Files 9. Pre-Audit Questionnaire (PAQ)

10. DYRS PREA Academy Training

Interviews:

1. Superintendent
2. Medical and mental health staff
3. Discipline staff
4. Milford Police Department

Onsite Review Observations:

1. Observations during onsite review.

Findings (by Provision):

115.378 (a):

DYRS reported in the pre-audit questionnaire (PAQ) that residents are subject to disciplinary sanctions only pursuant to a formal disciplinary process following an administrative finding or criminal finding of guilt that the resident engaged in resident-on-resident sexual abuse.

SHDC reported in the past 12 months there was no administrative finding or criminal finding of guilt for resident-on-resident sexual abuse that occurred at the facility.

The facility refers to PREA Policy 2.13.IV.H.2 that details that residents are subject to disciplinary sanctions if after an investigation there is an administrative finding or criminal findings that he or she sexually abused another resident or if a resident had sexual contact with a staff member and there the finding indicates the staff did not consent.

During the review of the CBT Discipline Matrix, the auditor located the sanction for a false PREA allegation and the sanction for sexual assault.

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

The facility is substantially compliant with this provision and no corrective action is required.

115.378 (b):

In the PAQ, the SHDC reported that if a disciplinary sanction for resident-on-resident sexual abuse results in isolation of a resident, policy requires that residents in isolation have daily access to large-muscle exercise, legally required educational programming, and special education services, shall receive daily visits from medical

or mental health care clinician, and have access to other programs and work opportunities.

In the PAQ, the facility reported there were no residents placed in isolation as a disciplinary sanction for resident-on-resident sexual abuse that were denied access to large-muscle exercise, legally required programs, special education services, other programs, or work opportunities.

Agency Policy LGBTQI 2.20 Section IV, E, 1, c, outlines that during a period of isolation DYRS staff shall not deny youth daily large-muscle exercise, legally required programming, or special education services. Youth in isolation shall receive daily visits from medical staff or behavioral health services clinician provider. The facility reported there are no work programs at the facility.

During an interview with the superintendent, when asked what disciplinary sanctions residents are subject to following an administrative or criminal finding that a resident engaged in resident-on-resident sexual abuse, it was reported that residents would be possibly sanctioned with CBT sanctions, administrative intervention, and criminal charges.

During the onsite review, the auditor went into all areas of the facility. The auditor reviewed the housing unit logs. The housing logs provide a detailed tracking of the residents, date, time, activity observed, and staff assigned to each housing unit. A review of housing logs and informal conversation with staff and residents did not reveal that a resident was placed in isolation for resident-on-resident sexual abuse. A review of resident files did not indicate that residents were placed in isolation for resident-on-resident sexual abuse. When the auditor inquired, residents were placed on administrative intervention for a behavioral issue.

The facility is substantially compliant with this provision and no corrective action is required.

115.378 (c):

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

During an interview with the superintendent, when asked is a mental disability or mental illness considered when determining sanctions, it was confirmed that mental disability or mental illness are considered when determining sanctions.

A review of investigative files reveals there were no allegations, administrative findings or criminal findings of guilt of resident-on-resident sexual abuse at SHDC in the prior 12 months.

The facility is substantially compliant with this provision and no corrective action is required.

115.378 (d):

	According to the PAQ, SHDC reported that they offer therapy, counseling, or other interventions designed to address and correct the underlying reasons or motivations for abuse, they do not require the offending resident to participate in such interventions as a condition of access to any rewards-based behavior management system or other behavior-based incentives, access to general programs and education is not conditional on participation. During interviews with medical and mental health staff, when asked if the facility offers therapy, counseling or other interventions designed to address and correct underlying reasons or motivations for sexual abuse, does the facility offer to offending resident, staff reported that services would be offered to both alleged victim and alleged abuser. stated they would offer services. Also, the services would not be a part of a rewards-based behavior management system, programming or education. Investigative files consisted of one allegation of sexual abuse and no allegations of sexual harassment during the last 12 months. During an interview, Milford Police Department (MPD) reported that there were no criminal cases of sexual abuse or sexual harassment reported to the department in the prior 12 months. A review of investigative files confirms there was one sexual abuse allegations at the facility during the 12 months preceding the onsite audit. The facility is substantially compliant with this provision and no corrective action is required. 115.378 (e): In the PAQ, the facility reports that the agency disciplines residents for sexual conduct with staff only upon finding that the staff member did not consent to such contact. The facility relies on DYRS PREA Policy 2.13.IV.H.2, which outlines residents are subject to disciplinary sanctions if after an investigation there is an administrative finding or criminal findings a resident had sexual contact with a staff member and there the finding indicates the staff did not consent. As outlined in the Stevenson House Detention Center Resident Manual, the facility uses Cognitive Behavioral Training (CBT). The goal of the program is to change inappropriate behavior. It was reported there was one allegations of sexual abuse and no allegations of sexual harassment during the last 12 months. During an interview, MPD reported that there were no criminal cases of sexual abuse or sexual harassment reported to the department. A review of investigative information and the PAQ confirms there were no administrative findings or criminal findings that a resident had sexual contact with a staff member and the finding indicates the staff did not consent at the facility during the 12 months preceding the onsite audit. Based upon this analysis, the facility is substantially compliant with this provision

and no corrective action is required.

115.378 (f):

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

Agency relies on the Cognitive Behavioral Therapy Discipline Matrix. As outlined in the Stevenson House Detention Center Resident Manual, there is zero tolerance of sexual abuse, assault and harassment in the facility. The facility uses Cognitive Behavioral Training, or CBT. The goal of the program is to change inappropriate behavior. The matrix lists false PREA allegations as a behavior that would warrant discipline of being placed on administrative intervention. The matrix does not describe discipline for good faith reports, but for only bad faith reports. Although a policy is not required as written, the DYRS PREA policy does not specifically outline that prohibits disciplinary action for a report of sexual abuse made in "good faith" based upon a reasonable belief that the alleged conduct occurred, even if an investigation does not establish evidence sufficient to substantiate the allegation.

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

A review of investigative information and grievances confirms there was no disciplinary action for a report of sexual abuse made in good faith.

The facility is substantially compliant with this provision and no corrective action is required.

115.378 (g):

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

Agency relies on PREA Policy 2.13 Section II, that provides DYRS has a zero tolerance for any incidence of sexual activity with youth in secure care. DYRS commits to full compliance with the Prison Rape Elimination Act.

A review of investigative files confirms there was no reported sexual activity between residents at the facility during the 12 months preceding the onsite audit.

The facility is substantially compliant with this provision and no corrective action is required.

The evidence shows that residents are placed on administrative intervention on the housing unit. Residents that are placed on a close observation or administrative intervention receive daily visits from medical or mental health practitioners,

	residents are provided education and daily access to large-muscle exercise which was verified through interview, observation, policy and documentation review. Also, resident's disability and mental health is considered when determining sanctions which was verified through interviews, and investigation information. The facility offers therapy without conditions of access to the alleged abuser, which was verified through PAQ and staff interviews. Additionally, the agency disciplines residents for sexual conduct with staff upon finding that the staff did not consent, which was verified by PAQ and policy. The agency demonstrated that it prohibits disciplinary action for a report of sexual abuse made in good faith, which was verified by PAQ, and the CBT Matrix. The evidence shows that there were no administrative or criminal findings of guilt for resident-on-resident sexual abuse in the 12 months preceding the onsite audit, which was verified through PAQ, investigative files, policy and the CBT Discipline Matrix. Lastly, the evidence shows that the agency prohibits all sexual activity between residents which was verified by PAQ, policy, resident handbook, and Investigation records. The facility is substantially compliant with this provision and no corrective action is required. Based upon this analysis, the facility is substantially compliant with this standard and no corrective action is required.

115.381	**Medical and mental health screenings; history of sexual abuse**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. DYRS PREA Policy 2.13.IV.I.1. 2. 12 Resident Files 3. 12 PREA Risk Assessment 4. Pre-Audit Questionnaire (PAQ) 5. Authorization for Release of Information 6. Email Correspondence- Consent of 18 Year Olds Interviews: 1. Staff Responsible for Risk Screening 2. Medical and Mental Health Staff Onsite Review:

1. Review of Mental Health and Medical Records

Findings (by Provision):

115.381 (a):

In the pre-audit questionnaire (PAQ), SHDC reported that all residents at this facility who have disclosed any prior sexual victimization during a screening are offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening.

In the PAQ, the facility reported that in the past 12 months, all residents who disclosed prior victimization during a screening would be offered a follow-up meeting with a medical or mental health practitioner and medical and mental health staff maintain secondary materials documenting compliance.

During the onsite review, the auditor requested to review 12 medical and mental health resident files. These files were separate from the files requested through the OAS. In the secondary files, the auditor located notations of follow-up meetings with residents who disclosed prior sexual victimization as well as other noteworthy conditions and concerns. Follow-ups occurred well within the 14-day PREA mandate.

The facility references PREA Policy 2.13.IV.I.1. that outlines if the PREA assessment indicates that a resident has experienced sexual victimization or has been sexually abusive, whether it happened in an institutional setting or not, the resident will be offered a follow-up meeting with a medical or mental health practitioner as soon as possible, but within 14 days of the assessment.

Staff that conducts risk screenings are mental health staff and as a backup medical staff assists. The facility has 24 hour medical.

During an interview with the staff responsible for risk screenings, it was confirmed that the facility offers follow-up meetings with medical and mental health practitioners to residents that disclose prior victimization of sexual abuse.

According to a resident who experienced prior victimization, they confirmed that they were asked if they wanted to meet with a medical or mental health practitioner concerning the prior victimization.

The auditor reviewed 12 medical and mental file records and 12 PREA risk screenings. A review of the record shows that the resident was offered follow-up.

The facility is substantially compliant with this provision and no corrective action is required.

115.381 (b):

In the PAQ, the agency reported that all residents who have ever previously perpetrated sexual abuse are offered a follow-up meeting with a mental health practitioner within 14 days of the intake screening.

In the PAQ, the facility reported that in the past 12 months, all residents who would disclose they previously perpetuated sexual abuse during screening are offered a follow-up meeting with a mental health practitioner. Mental health staff maintain secondary materials documenting compliance.

The auditor reviewed 12 medical and mental health file records and 12 PREA risk screenings. A review of the record shows that there was one resident who previously perpetrated sexual abuse and the resident was offered a follow-up meeting.

It is noted that staff that conduct risk screening are also mental health staff. When asked if the screening indicates that a resident previously perpetuated sexual abuse, do you offer a follow-up meeting, staff confirmed that they would offer a follow up meeting within the 14 days of the PREA risk assessment.

The facility is substantially compliant with this provision and no corrective action is required.

115.381 (c):

It was reported in the PAQ, SHDC reported that information related to sexual victimization or abusiveness that occurred in an institutional setting is not strictly limited to medical and mental health practitioners, information shared with other staff is strictly limited to informing security and management decisions, including treatment plans, housing, bed, work, education, and program assignments, or as otherwise required by federal, state, or local law.

During informal conversation, it was detailed that PREA risk assessments are completed in the agency’s database, FOCUS. The assessment is separate from other files. Access to the actual risk assessment is limited to medical and mental health practitioners. A review of the PREA risk assessment notification shows that recommendations informing security and management decisions, including treatment plans, housing, bed, work, education, and program assignments are only provided to the superintendent, assistant superintendent and program manager.

The facility is substantially compliant with this provision and no corrective action is required.

115.381 (d):

In the PAQ, SHDC reported that the medical and mental health practitioners obtain informed consent from residents before reporting information about prior sexual victimization that did not occur in an institutional setting, unless the resident is under the age of 18.

During an interview with medical and mental health staff, when asked, do you obtain informed consent from residents before reporting about prior sexual victimization that did not occur in an institutional setting, it was stated that they are mandatory reporters. Residents over 18 would obtain verbal consent.

According to the email correspondence provided in the PAQ, there were no residents

	that were 18 that disclosed prior victimization within the last year. Also, provided in the PAQ is a consent that is completed by all residents and guardians that was in all 12 medical and mental health files. A review of file documentation, medical and mental health staff obtained informed and verbal consent for all residents which was verified through the PAQ, staff interviews and documentation review. The facility is substantially compliant with this provision and no corrective action is required. The evidence SHDC requires that a follow-up meeting is offered to residents that disclose prior victimization, and the facility would conduct the follow-up within 14 days of the intake process, which was verified through PAQ, policy, interview, and documentation review. Additionally, SHDC requires that a follow-up meeting is offered within 14 days to residents that disclose they previously perpetuated sexual abuse, which was verified through PAQ, interview and documentation review. SHDC has controlled the level of access that each member of staff has to the FOCUS database to control and protect sensitive information. In addition, information related to sexual victimization or abusiveness is limited and strictly controlled which was verified by PAQ, documentation review, and informal conversation. Lastly, evidence shows that medical and mental health staff do obtain informed consent for residents over the age of 18, they are informed of the role of mandatory reporters. Based upon this analysis, the facility is substantially compliant with this standard and no corrective action is required.

115.382	Access to emergency medical and mental health services
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. DYRS PREA Policy 2.13.IV.I.2. 2. DYRS Medical Emergencies Policy 7.3 3. Department of Services for Children, Youth and Their Families Affirmation of Compliance with Forensic Examinations Standards for Sexual Assaults with Bayhealth Hospital 4. Memorandum of Agreement Between the Division of Youth Rehabilitative Services and Survivors of Abuse in Recovery, Inc. 5. 12 Resident Files

Interviews:

1. Medical and mental health staff
2. SANE/SAFE Bayhealth

Findings (by Provision):

115.382 (a-b):

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

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

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

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

It should be noted that SHDC has 24 hour medical.

The auditors interviewed the SANE/SAFE examiner at Bayhealth. It was stated there were 10 SANE/SAFE examiners that were available or on call. If there was not one available, anyone under the age of 18 would be referred to AI Dupont, and anyone over the age 18 would go to Christiana Care Hospital.

The medical and mental health practitioners at SHDC confirmed that resident victims of sexual abuse receive timely and unimpeded access to emergency medical treatment and crisis intervention services. It was also confirmed that the nature and scope of these services determined according to your professional judgement.

PREA Policy 2.13 outlines that resident victims of sexual abuse will be referred Bayhealth Hospital, Sussex for medical interventions. The agency has an affirmation of compliance with forensic examinations standards for sexual assaults with

	Bayhealth Hospital that provides forensic examinations, victims advocate through investigatory interviews, emotional support, crisis intervention and referrals. The agency also has a Memorandum of Agreement between the Division of Youth Rehabilitative Services and Survivors of Abuse in Recovery, Inc. (SOAR) that DYRS youth that have been victims of sexual abuse be provided advocates during forensic examinations, emotional support and counseling services related to their victimization. The facility is substantially compliant with this provision and no corrective action is required. 115.382 (c): In the PAQ, the agency reported that resident victims of sexual abuse while incarcerated are offered timely information about access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate. The facility provided Department of Services for Children, Youth and Their Families Affirmation of Compliance with Forensic Examinations Standards for Sexual Assaults that outlines that Bayhealth Hospital employs forensic examination protocols in regards to sexual assaults of children in Delaware that are appropriate for youth, forensic exams are made available without cost to the youth, hospital attempts to make available to the victim a victim advocate from a rape crisis center, qualified agency staff member, qualified community based organization staff member with support through SANE process, investigative interviews, emotional support, crisis intervention, information and referrals. During an interview with medical and mental health staff, when asked are victims of sexual abuse while incarcerated were offered timely information about access to emergency contraception and sexually transmitted infections prophylaxis, staff stated yes. The facility is substantially compliant with this provision and no corrective action is required. 115.382 (d): In the PAQ, the DYRS reported that treatment services are provided to every victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. The facility provided Department of Services for Children, Youth and Their Families Affirmation of Compliance with Forensic Examinations Standards with for Sexual Assaults with Bayhealth Hospital that outlines forensic exams are made available without cost to the youth where evidentiary or medically appropriate. The facility is substantially compliant with this provision and no corrective action is required.

	The evidence shows that resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services, and it was verified through PAQ, policy, documentation review and interviews. Resident victims of sexual abuse while incarcerated are offered timely information about access to emergency contraception and sexually transmitted infections prophylaxis which was verified by PAQ, MOU, and interviews. Lastly, treatment services are provided to every victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation which was verified through PAQ and MOU. Based upon this analysis, the facility is substantially compliant with this standard and no corrective action is required.

115.383	Ongoing medical and mental health care for sexual abuse victims and abusers
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. DYRS PREA Policy 2.13.IV.I. 2. Department of Services for Children, Youth and Their Families Affirmation of Compliance with Forensic Examinations Standards for Sexual Assaults with Bayhealth Hospital 3. Memorandum of Agreement Between the Division of Youth Rehabilitative Services and Survivors of Abuse in Recovery, Inc. (SOARS) 4. Stevenson House Detention Center Resident Manual English and Spanish 5. 12 Resident files 6. 12 Risk assessments Interviews: 1. Medical and mental health staff 2. SANE/SAFE Bayhealth Hospital Sussex County Findings (by Provision): 115.383 (a): In the pre-audit questionnaire (PAQ), the SHDC reported they offer medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility.

SHDC references PREA Policy 2.13.IV.I.3, that states resident victims will be referred to Bayhealth, Sussex County for medical interventions. Non- emergency medical and mental health care are offered to all residents who are victims of sexual abuse in any juvenile facility.

The Agency provided the Department of Services for Children, Youth and Their Families Affirmation of Compliance with Forensic Examinations Standards for Sexual Assaults that outlines that Bayhealth Hospital provides forensic examinations, victims advocate through investigatory interviews, emotional support, crisis intervention and referrals.

Review of the facilities coordinated response plan outlines that once facility staff receive an allegation, they would notify a supervisor, the victim would be taken to the medical unit before being transported to Bayhealth Hospital for examination and services.

During interviews with medical staff, when asked what evaluation and treatment of residents who have been victimized entail, staff stated the provider would be included in the assessment of the alleged victim and there would be medical and mental health evaluations.

The auditors interviewed a sexual assault forensic nurse examiner (SANE) at Bayhealth Hospital regarding the services that would be provided for victims from SHDC. The forensic nurse stated they do provide SANE/SAFE exams and have a victim advocate available, counseling services are offered by the hospital, there ten SANE examiners available at the hospital or on call. If there is no forensic examiner available the hospital would refer anyone under 18 to AI Dupont Hospital, and over 18 they would refer to Christiania Care Hospital.

The facility is substantially compliant with this provision and no corrective action is required.

115.383 (b):

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

PREA Policy 2.13.IV.I.3 states that resident victims will be referred to Bayhealth Hospital, Sussex County for medical interventions. Non- emergency medical and mental health care are offered to all residents who are victims of sexual abuse in any juvenile facility.

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

The agency has a Memorandum of Agreement between the Division of Youth Rehabilitative Services and Survivors of Abuse in Recovery, Inc. (SOAR) that DYRS

youth that have been victims of sexual abuse be provided advocates for support during a forensic medical examination and emotional support services related to their victimization.

The auditors interviewed a sexual assault forensic nurse examiner (SANE) at Bayhealth Hospital regarding the services that would be provided for victims from SHDC. The forensic nurse stated they do provide SANE/SAFE exams and have a victim advocate available, counseling services are offered by the hospital, there ten SANE examiners available at the hospital or on call. If there is no forensic examiner available the hospital would refer anyone under 18 to AI Dupont Hospital, and over 18 they would refer to Christiania Care Hospital.

The facility is substantially compliant with this provision and no corrective action is required.

115.383 (c):

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

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

During interviews with medical and mental health staff, when asked are medical and mental health services consistent with community level of care, medical staff stated yes. Further, it was stated that the level of care is probably better than the care received in the community.

A review of the risk assessments confirms that mental health staff see every resident within 72 hours of admission.

The facility is substantially compliant with this provision and no corrective action is required.

115.383 (d-e):

In the PAQ, the SHDC reported that the facility offers pregnancy test to female victims of sexual abusive vaginal penetration while incarcerated.

The facility relies on PREA Policy 2.13.IV.I.3, that resident victims will be referred to Bayhealth, Sussex County for medical interventions. Non-emergency medical and mental health care are offered to all residents who are victims of sexual abuse in any juvenile facility.

Department of Services for Children, Youth and Their Families Affirmation of Compliance with Forensic Examinations Standards for Sexual Assaults outlines that Bayhealth Hospital provides forensic examinations, victim advocates through investigative interviews, emotional support, crisis intervention and referrals.

The auditors interviewed a sexual assault forensic nurse examiner (SANE) at

Bayhealth Hospital regarding the services that would be provided for victims from SHDC. The forensic nurse stated they do provide SANE/SAFE exams and have a victim advocate available, counseling services are offered by the hospital, there are 10 SANE examiners available at the hospital or on call. If there is no forensic examiner available the hospital would refer anyone under 18 to AI Dupont Hospital, and over 18 they would refer to Christiania Care Hospital. The facility ensures that residents obtain pregnancy testing, and it can be verified by PAQ, policy, and interviews and no corrective action is required.

The facility is substantially compliant with this provision and no corrective action is required.

115.383 (f):

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

The auditors interviewed a sexual assault forensic nurse examiner (SANE) at Bayhealth Hospital regarding the services that would be provided for victims from SHDC. The forensic nurse stated they do provide SANE/SAFE exams and have a victim advocate available, counseling services are offered by the hospital, there are 10 SANE examiners available at the hospital or on call. If there is no forensic examiner available the hospital would refer anyone under 18 to AI Dupont Hospital, and over 18 they would refer to Christiania Care Hospital. The facility ensures that residents obtain pregnancy testing, and it can be verified by PAQ, policy, and interviews and no corrective action is required.

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

The hospital would provide medications depending on the timeline to prevent sexually transmitted infections prophylaxis.

The facility reported that there were no sexual abuse allegations at the facility during the last 12 months preceding the onsite audit that would require a SANE examination. A review of investigative information confirms there were no sexual abuse allegations at the facility during the 12 months preceding the onsite audit that warranted tests for sexually transmitted infections.

The facility is substantially compliant with this provision and no corrective action is required.

115.383 (g):

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

	Department of Services for Children, Youth and Their Families Affirmation of Compliance with Forensic Examinations Standards for Sexual Assaults outlines that Bayhealth Hospital provides forensic examinations, victims advocate through investigative interviews, emotional support, crisis intervention and referrals. Within the affirmation there is language stating that the forensic examinations are made available without consideration of cost to the youth where evidentiary or medically appropriate. A review of investigative information confirms there were no sexual abuse allegations that required a forensic examination at SHDC within the prior 12 months. The facility is substantially compliant with this provision and no corrective action is required. 115.383 (h): According to the PAQ, SHDC reported that the facility attempts to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history and offers treatment when deemed appropriate by mental health practitioners. The facility relies on PREA Policy 2.13 Section IV, I-4, a mental health evaluation will be completed of all known resident on resident abusers within 60 days of finding out about the history of abuse. During interviews with mental health staff, when asked, do you conduct a mental health evaluation of all known resident-on-resident abusers and offer treatment if appropriate. Mental health staff stated yes, and it would be scheduled immediately. The auditors reviewed 12 resident files and 12 risk assessments, and there were no residents identified with a resident-on-resident abuse history in the prior 12 months. The facility is substantially compliant with this provision and no corrective action is required. The evidence shows that medical and mental health services evaluation and treatment is offered for residents that have been victimized by sexual abuse, and it was verified through policy, interviews, Bayhealth SAFE/SANE Coordinator and documentation review. The facility provides evaluation and treatment for victims including follow-up services, treatment plans, and when necessary, referrals for continued care following their transfer to another facility or release from custody which was verified though policy, MOA, and interviews. SHDC provides victims with medical and mental health services consistent with the community level of care which was verified though policy, documentation review, and interviews. Residents are provided with access to tests for sexually transmitted infections, and it was verified by the PAQ, policy, documentation review and interviews. Based upon this analysis, the facility is substantially compliant with this standard

	and no corrective action is required.

115.386	Sexual abuse incident reviews
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. DYRS PREA Policy 2.13.IV.J.1.a.-f 2. Sexual Abuse Incident Review of Substantiated or Un-substantiated Outcomes Form 3. Investigative Files 4. Mock Incident Review 6/13/2024 5. PREA Sexual Abuse Review Team List 6. Pre-Audit Questionnaire (PAQ) Interviews: 1. Superintendent 2. PREA Compliance Manager 3. Incident Review Team Member Findings (by Provision): 115.386 (a)-1-2: According to the information provided on the pre-audit questionnaire (PAQ), SHDC reported that the facility conducts a sexual abuse incident review at the conclusion of every criminal or administrative sexual abuse investigation, unless the allegation has been determined to be unfounded. The auditor requested investigative files for the prior three years in order to determine if the facility had any substantiated or unsubstantiated allegations of sexual abuse that warranted a sexual abuse incident review. There were no incidents that required such a review. Cited in the DYRS Policy 2.13.IV.J.1.a.-f, the facility will conduct a sexual abuse incident review within the 30 days of the investigation with the extension of 45 days. The purpose of the review is defined, and the list of positions required for the review. The purpose of the review is to consider whether the allegations or investigation indicated a need for the change policy, motivating factors, examination of the area of allegation, adequacy of staffing, and changes in monitoring technology.

	The agency utilizes the Sexual Abuse Incident Review of Substantiated or Unsubstantiated Investigations to collect information from the sexual abuse incident review meetings. Since there were no sexual abuse investigations in the past 12 months to corroborate the practice of utilizing a sexual abuse review team, the facility had a mock incident review on 6-4-2024. In the PAQ, the SHDC provided a copy of the incident review form and a list of the members of the review team. All participants listed were in accordance with the PREA standards. SHDC conducts a sexual abuse incident review at the conclusion of every criminal or administrative sexual abuse investigation unless the allegation has been determined to be unfounded, and it was verified by policy and mock incident review. The facility is substantially compliant with this provision and no corrective action is required. 115.386(b)-1 SHDC reported in the PAQ that ordinarily the facility conducts a sexual abuse incident review within 30 days of the conclusion of the criminal investigation or administrative sexual abuse investigation. Due to lack of sexual abuse allegations, there were no sexual abuse investigative files for the auditor to review to determine the practice of completing an incident review within 30 days of the closing of an investigation. The facility did provide a mock sexual abuse incident review. According to DYRS Policy 2.13.IV.J.1.a., it states that the facility will conduct a sexual abuse incident review within 30 days of completion of the investigation or when directed if the official investigation extends beyond 45 days. All extensions must be approved by the division director. The facility is substantially with this provision and no corrective action is required. 115.386(c)-1 SHDC affirmed in the PAQ that the sexual abuse incident review team includes upper-level management. Within DYRS PREA Policy 2.13.IV.J.1.d, listed the required participants which included upper-level management officials and allows for input from line supervisors, investigators, and medical or mental health practitioners. The policy is in alignment with the requirements of the provision. For the mock incident review, the participants included: • Superintendent • Assistant Superintendent • PREA compliance manager • 2 Registered nurses • Psychologist • Case Manager • Program managers (PREA compliance manager) • 3 Supervisors • PREA Investigator

- Retaliation Monitor

The facility is substantially compliant with this provision and no corrective action is required.

115.386(d)-1

The report of the sexual review team is documented on the Sexual Abuse Incident Review of Substantiated and Unsubstantiated Outcomes form. The form includes the following information:

- Reportable Incident Date
- Facility
- PREA Type: Resident on Staff or Resident on Resident
- Type of Sexual Violence
- Incident Description
- Substantiated or Unsubstantiated
- Review Team Members
- As a result of the allegation, is there a need for policy or practice change that would better prevent, detect, or respond to sexual abuse? If yes, what needs to be changed?
- Was the incident motivated by any of the below (check all that apply)
- Were there any physical barriers where the alleged incident occurred that would enable abuse? If yes note under (6) Recommendations
- What was the staffing level at the time of the incident? Was the staffing level adequate? If no, explain:
- Was monitoring technology adequate for that area? If it was not adequate, what is needed? (explain)
- Findings of Team
- Final Recommendation
- Facility Head Comments
- Facility Head Signature and Date

The completed form is to be copied to the agency head, PREA coordinator, PREA compliance manager, and the management analyst- Office of the Director

The form contains all required information required by 115.386(d) which includes the consideration for policy or practice to better prevent, detect, or respond to sexual abuse.

The document considers if the allegation was motivated by race, ethnicity, gender identity, LGBQTI, status or perceived status, gang affiliation, or other group dynamics. The review team examines the area to assess if there were any physical barriers, and they assess the staffing levels. The team also reviews the monitoring equipment.

In accordance with DYRS Policy 2.13.IV.J.1.e, the team completes the report and submits it to the deputy director, PREA coordinator, PREA compliance manager, and

	the division management analyst. During the interviews with the superintendent, it was stated that information from the sexual abuse incident review gives the facility an opportunity to review policy and procedures and if necessary, address anything that requires change. It was also confirmed that the motivating factors are considered during the incident review. Further the PREA compliance manager confirmed that there is consideration for motivating factors in during the incident review. Since there have been no substantiated or unsubstantiated allegations of sexual abuse, the PREA compliance manager was unable to conclude if there were any trends in allegations. The incident review member collaborated with the information provided by both the superintendent and the PREA compliance manager. The member of the incident review team added that there would be a review of the area where the incident occurred to check for any barriers. Also, there would be a look at supervision levels and the adequacy of monitoring technology. The facility is substantially complaint with this provision and no corrective action is required. 115.386(e)-1 In the PAQ, SHDC confirmed that the facility implements the recommendations for improvement or documents its reasons for not doing so. In accordance with DYRS PREA Policy 2.13, SHDC would complete a final report of findings from the sexual abuse incident review. Within DYRS Policy 2.13.IV.J.1.f states the facility shall implement the recommendations for improvement or shall document its reasons for not doing so, in the submitted form. Located on the Sexual Abuse Incident Review of Substantiated or Unsubstantiated Outcomes, there is a section on the form with final recommendations. The evidence shows that SHDC conducts a sexual abuse incident review within 30 days at the conclusion of every criminal or administrative sexual abuse investigation unless unfounded verified by policy and documentation. A sexual abuse incident team conducts the review utilizing the Sexual Abuse Incident Review of Substantiated and Unsubstantiated Outcomes to document the review. The form list variables to consider when reviewing allegations of sexual abuse which were verified by policy, interview and documentation. The facility's sexual abuse team includes all PREA mandated participants verified by policy and documentation. Lastly, the facility considers recommendations to implement or documents its reasons for not doing so verified by documentation. Based on this analysis, the facility is substantially compliant with this standard and there are no corrective actions required.

115.387	Data collection
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. DYRS Policy 2.13.IV.J.1-10 2. DYRS Policy 2.13 Attachment A 3. DYSR Policy 2.13 Attachment B 4. DYRS Policy 2.13 Attachment C 5. DYRS Policy 2.13 Attachment D 6. DYRS Policy 2.13 Attachment E 7. DYRS Policy 2.13.IV.C.1.c 8. Stevenson House Detention Center PREA Tracking 9. 2021-2023 PREA Aggregated Data both DYRS Operated and Contracted Facilities 10. Survey of Sexual Violence for 2022 11. Delaware Division of Youth Rehabilitative Services Prison Rape Elimination Act 2023 Annual Report 12. Pre-Audit Questionnaire (PAQ) 13. DSCYF Operating Guidelines 11/01/2022 Interviews: 1. Management Data Analyst Findings (by Provision): 115.387 (a)-1: SHDC reported on the pre-audit questionnaire (PAQ) that the agency collects accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set definitions. DYRS Policy 2.13.IV.J.2-4 requires data collection utilizing a standardized instrument. Provided in the (PAQ) are the 6 attachments to the policy which are forms used to collect the required sexual abuse and sexual harassment information. • DYRS Policy 2.13 Attachment A- Sexual Incident Form • DYSR Policy 2.13 Attachment B-Investigative Summary Template

- DYRS Policy 2.13 Attachment C- I. Substantiated Sexual Abuse or Sexual Harassment Incident Form: I. Victim Information; II. Perpetrator Information- Youth Perpetrator; III. Perpetrator Information- Adult Perpetrator
- DYRS Policy 2.13 Attachment D-Notification of Investigation
- DYRS Policy 2.13 Attachment E- Sexual Abuse Incident Review of Substantiated or Unsubstantiated Investigations

There was one allegations of sexual abuse and no allegations of sexual harassment at SHDC. The required forms were completed. There was an issue with one of the forms, but it was corrected during the onsite. During a prior review of the other DYRS facilities investigative files, the auditor was able to determine that investigative files are maintained in the management analyst double-locked files. It was also found that DYRS collects accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions. Uploaded to the PAQ was the Survey of Sexual Violence 2022 and the 2023 PREA Annual Report.

The agency is substantially compliant with this provision and no corrective action is required.

115.387(b)

According to DYRS PREA Policy 2.13.IV.J.7-8, the management analyst will provide a quarterly report to the deputy director to ensure outcome information is accurate and current. Further in the policy, an annual report shall be made available to the public. Additionally, the facility aggregates the incident-based sexual abuse data in preparation for the submission of the Survey of Sexual Violence conducted by the U.S. Department of Justice. Provided in the PAQ was the Survey of Sexual Violence 2022 and the 2023 PREA Annual Report.

The agency is substantially compliant with this provision and no corrective action is required.

115.387(c)-1

According to the information provided on the PAQ, the standardized instrument includes, at the minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence (SSV) conducted by the Department of Justice. The auditor determined that the 6 attachments to the DYRS PREA Policy 2.13 are in alignment with the information necessary to complete the most recent version of the Survey of Sexual Violence (SSV) conducted by the Department of Justice.

The agency is substantially compliant with this provision and no corrective action is required.

115.387(d)

Reported on the PAQ, the agency affirms the agency maintains, reviews, and

	collects data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews. Within DYRS Policy 2.13.IV.J.5-9 it states that the administrators are responsible for providing the internal investigation outcome for data collection. The Professional Standards Unit will be responsible for reporting Institutional Abuse and/or criminal investigation outcomes for data collection. All PREA data shall be securely stored by the management analyst using a double lock system. Review of the CY 2024 SHDC PREA Tracking, it was determined that the agency utilizes incident-based documents, reports, investigative files, and sexual abuse incident reviews. The agency is substantially compliant with this provision and no corrective action is required. 115.387(e)-1 In the PAQ, it was indicated that the agency obtains incident-based and aggregated data from every private facility with which it contracts for the confinement of residents. Cited in the DSCYF Operating Guidelines 11/01/2022 V.B., V.D., IX, service providers are required to adopt and comply with all applicable PREA standards and any DSCYF policies or standards related to PREA. Additionally, the guidelines outline documentation and reporting requirements. Uploaded in the PAQ was a copy of the 2021-2023 PREA Aggregated Data containing all incidents of sexual abuse and sexual harassment reported to DYRS from both Delaware state operated facilities and DYRS contracts for confinement of its residents. The agency is substantially compliant with this provision and no corrective action is required. 115.387(f) Located on the agency’s website is a copy of the report Survey of Sexual Violence for 2022. The report was submitted prior to June 30, 2023, by DYRS. The agency is substantially compliant with this provision and no corrective action is required. The evidence shows that the agency collects accurate, uniform data for every allegation of sexual abuse at facilities under direct control and DYRS contracts for confinement of its residents. The agency utilizes standardized instruments to collect data. The agency has demonstrated it annually aggregates the incidence based sexual abuse data. The data contains the minimum of the information to complete the Survey of Sexual Violence. The agency collects information from incident-based documents, reports, investigation files, and sexual abuse incident reviews. The agency collects information from facilities that contract with DYRS for the placement of residents. Based upon this analysis, the agency is substantially compliant with this standard and no corrective action is required.

115.388	Data review for corrective action
	Auditor Overall Determination: Meets Standard
	Auditor Discussion

Documents:

1. DYRS Policy 2.13.IV.J.8
2. https://kids.delaware.gov/yrs/prea-reports.shtml
3. DYRS Annual Report CY-2023 Delaware Division of Youth Rehabilitative Services Prison Rape Elimination Act 2023
4. Compliance manager meeting 8/28/2024- Virtual Meeting
5. Pre-Audit Questionnaire (PAQ)

Interviews:

1. Director
2. PREA Coordinator

Findings (by Provision):

115.388 (a):

DYRS Policy 2.13.IV.J.8 requires that an annual report shall be readily available to the public through the agency's website. All information must receive prior approval by the Division Director before website posting and will be redacted of personal identifiers before website posting. The annual report shall include the following:

- Any findings and corrective actions for all allegations identified by facility.
- A comparison of the current year's data and corrective actions with those from prior years
- An assessment of the Division's progress in addressing sexual abuse.

The Division may redact specific material from reports when a publication would present a clear and specific threat to the safety and security of a facility but must indicate the nature of the material redacted.
Review of Compliance Manager Meeting Minutes lead by the PREA coordinator revealed there is time devoted by DYRS to discuss information obtained from the data collected. During the meeting, there was an opportunity to discuss prior audit findings, accessible PREA information, and PREA training.

During the inquiry of the director of the agency, the auditor asked how the agency utilizes incident-based sexual abuse data to assess and improve sexual abuse

prevention, detection, response policies, practices, and training. The director informed the auditor that all information is reviewed quarterly, and the reviews produce ideas for training and to update policies. The PREA coordinator further confirmed the use of data collected to assess and improve effectiveness of its sexual abuse prevention, detection, and response policies and training. Both data and documents related to PREA are maintained with the management analyst under a 2-lock system. It was also established that the agency's annual report was generated and placed on the agency's website.

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

115.388(b)

According to the information provided on the Pre-audit questionnaire (PAQ), SHDC reported that the annual report includes a comparison of the current year's data and corrective actions with those of prior years and it provides an assessment of the agency's progress in addressing sexual abuse. The DYRS Annual Report CY-2023 summarizes and compares the aggregated information of sexual harassment and sexual abuse received from both DYRS operated facilities and contracted facilities. Included in the report is the data analysis which details corrective actions. Found within the report is an assessment of the agency's progress in addressing sexual abuse. Also, there is a comparison of data from prior years.

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

115.388(c)

The DYRS Annual Report CY-2023 can be located on the agency's website https://kids.delaware.gov/yrs/prea-reports.shtml, and the report is signed by the director of DYRS. During the interview, the director of DYRS confirmed that the annual report is approved by the agency head prior to publishing on the website.

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

115.388(d)-1-2

There were no redactions in the DYRS Annual Report CY-2023. The PREA coordinator stated that redactions would include personal information. The auditor determined that the report contained analysis of incident-based and aggregated information, and there was no personal information disclosed.

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

Review of the annual report, the agency policy, and interviews the auditor has

	determined that the agency reviews collected data and aggregated information to assess and improve the effectiveness of its sexual abuse prevention, detection, response policies, and training. This information is developed into a report titled the DYRS Annual Report CY-2023.The report is approved by the director and made public annually on the agency website. Lastly, the personal identifiers are redacted in the annual report. Based upon this analysis, the facility is substantially compliant with this standard and no corrective action is required.

115.389 Data storage, publication, and destruction

Auditor Overall Determination: Meets Standard

Auditor Discussion

Documents:

1. DYRS Policy 2.13.IV.J.9-10
2. DYRS Policy 2.13.IV.J.8
3. The DYRS Annual Report CY-2023
4. DSCYF/DYRS Electronic Double Lock System
5. Pictures of Management analyst's Office- Double Lock System
6. https://kids.delaware.gov/yrs/prea-reports.shtml

Interviews:

1. Management analyst
2. PREA coordinator

Findings (by provision):

115.389(a)

Cited within DYRS Policy 2.13.IV.J.9-10, All PREA data shall be securely stored by the management analyst using a double lock system. It was further confirmed by the management analyst that incident-based and aggregated data is secured in a double-lock system. DYRS has a double lock electronic method of maintaining all incident-based and aggregate data which includes incoming sexual abuse and sexual harassment investigative files. According to the information provided on the DSCYF/DYRS Electronic Double Lock System Information Sheet, electronic access of incident-based and aggregate data is limited to the agency PREA coordinator and the management analyst. All remaining investigative files are archived in the upgraded keyless lock system. In the case of PREA risk assessments, those files are

	maintained with the mental health department, and they are maintained electronically based on role-based access. The double lock system is in the agency office which is 70 miles away from the facility. The facility provided a copy of pictures of the double lock system, and the auditor virtually observed the management analyst when demonstrating the double lock system. The auditor site reviewed the location of these files during the recent PREA audit of Ferris School. Documents were secured in a double lock system which included the upgraded keyless locked file cabinet. Based on the analysis, the agency substantially meets compliance with this provision. 115.389(b) DYRS Policy 2.13.IV.J.8 mandates, "An annual report shall be made readily available to the public through the agency website. All information must receive prior approval by the Division Director and will be redacted of personal identifiers before website posting." The DYRS Annual Report CY-2023 is located on the DYRS website https://kids.delaware.gov/yrs/prea-reports.shtml. This report contains incident-based and aggregate data for both the DYRS operated and contracted facilities. Based on the analysis, the agency substantially meets compliance with this provision. 115.389(c) DYRS Policy 2.13.IV.J.8.d states, "The division may redact specific material from the reports when a publication would present a clear and specific threat to the safety and security of a facility but must indicate the nature of the material redacted." Interview with the PREA coordinator confirmed the practice of redacting personal identifiers in the DYRS Annual Report. During the auditors review of the DYRS Annual Report CY-2023, there were no personal identifiers located. Information contained in report was statistical information without narrative or specifics of allegations of sexual abuse or sexual harassment incidents. Based on the analysis, the agency substantially meets compliance with this provision. 115.389(d) DYRS Policy 2.13.IV.J.10 requires, "PREA data shall be retained for no less than 10 years after the date of its initial collection unless Federal, State, or local law requires otherwise. During the onsite review, the auditor located incident-based and aggregate data that was beyond 10 years in the double lock system in the management analyst's office. It is evident that the agency practices maintaining PREA required incident-based and aggregate data. During the recent Ferris School's site review of the management analyst office, there were incident-based and aggregate data that spanned beyond 10 years. Based on the analysis, the agency substantially meets compliance with this

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

115.401	**Frequency and scope of audits**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. Final PREA Audit Reports for the Residential Cottages 2. Final PREA Audit Reports for the New Castle County Juvenile Detention Center 3. Final PREA Audit Reports for the Stevenson House Detention Center 4. Final PREA Reports for Ferris School 5. Facility Files including Resident, Staff, and Medical 6. Resident Grievances 7. Shift Summaries 8. Pre-Audit Questionnaire (PAQ) 9. OAS Supplemental Files Onsite Review: 1. Stevenson House Detention Center 2. Agency Website: https://kids.delaware.gov/yrs/prea-reports.shtml Findings (by Provision): 115.401 (a-m): All four of the division operated facilities final PREA reports were located on the DYRS agency website. The mandated reports are located at https://kids.delaware.gov/yrs/prea-reports.shtml. Contained on the website are the past four audit cycles of PREA final reports for all four agency operated facilities. There was one exception due to the Covid-19 Pandemic. There was a postponement of the Residential Cottages. The onsite audit was rescheduled for December 2020, and the final PREA report was completed on July 27, 2021. Information provided on the DYRS website https://kids.delaware.gov/yrs/prea-reports.shtml, provides evidence of all four division operated facilities PREA final reports

	being published for public review. Stevenson House Detention Center granted auditor full access to all areas of the facility. Additionally, the auditor was able to observe daily operations, camera footage, logs, shift summaries, and staff/resident files. Both PREA coordinator and PREA compliance manager uploaded all documents requested by auditor via the issue log. Based on this analysis, the facility is substantially compliant with this standard and no corrective action is required.

115.403	**Audit contents and findings**
	Auditor Overall Determination: Exceeds Standard
	Auditor Discussion
	Documents: 1. DYRS Final Audit Reports for Division Operated Facilities 2. DSCYF agency's website https://kids.delaware.gov/yrs/prea-reports.shtml Findings (by Provision): 115.403 (f): Located on the DSCYF agency's website https://kids.delaware.gov/yrs/prea-reports.shtml are all past and present division operated facilities final PREA reports. The PREA final reports published include all cycles and years for the following facilities: **Present** Ferris School for Boys New Castle County Detention Center Residential Cottages Stevenson House Detention Center **Past**

	People Place Chris Stumfels Youth Center The evidence shows that DYRS archives both past and present PREA final reports for division operated facilities on the agency’s website https://kids.delaware.gov/yrs/-prea-reports.shtml. Based upon this analysis, the agency substantially exceeds compliance with this standard and no corrective action is required.

Appendix: Provision Findings		
115.311 (a)	**Zero tolerance of sexual abuse and sexual harassment; PREA coordinator**	
	Does the agency have a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment?	yes
	Does the written policy outline the agency's approach to preventing, detecting, and responding to sexual abuse and sexual harassment?	yes
115.311 (b)	**Zero tolerance of sexual abuse and sexual harassment; PREA coordinator**	
	Has the agency employed or designated an agency-wide PREA Coordinator?	yes
	Is the PREA Coordinator position in the upper-level of the agency hierarchy?	yes
	Does the PREA Coordinator have sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards in all of its facilities?	yes
115.311 (c)	**Zero tolerance of sexual abuse and sexual harassment; PREA coordinator**	
	If this agency operates more than one facility, has each facility designated a PREA compliance manager? (N/A if agency operates only one facility.)	yes
	Does the PREA compliance manager have sufficient time and authority to coordinate the facility's efforts to comply with the PREA standards? (N/A if agency operates only one facility.)	yes
115.312 (a)	**Contracting with other entities for the confinement of residents**	
	If this agency is public and it contracts for the confinement of its residents with private agencies or other entities including other government agencies, has the agency included the entity's obligation to adopt and comply with the PREA standards in any new contract or contract renewal signed on or after August 20, 2012? (N/A if the agency does not contract with private agencies or other entities for the confinement of residents.)	yes
115.312 (b)	**Contracting with other entities for the confinement of residents**	

	Does any new contract or contract renewal signed on or after August 20, 2012 provide for agency contract monitoring to ensure that the contractor is complying with the PREA standards? (N/A if the agency does not contract with private agencies or other entities for the confinement of residents OR the response to 115.312(a)-1 is "NO".)	yes
115.313 (a)	**Supervision and monitoring**	
	Does the agency ensure that each facility has developed a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse?	yes
	Does the agency ensure that each facility has implemented a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse?	yes
	Does the agency ensure that each facility has documented a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse?	yes
	Does the agency ensure that each facility’s staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: The prevalence of substantiated and unsubstantiated incidents of sexual abuse?	yes
	Does the agency ensure that each facility’s staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Generally accepted juvenile detention and correctional/secure residential practices?	yes
	Does the agency ensure that each facility’s staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any judicial findings of inadequacy?	yes
	Does the agency ensure that each facility’s staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any findings of inadequacy from Federal investigative agencies?	yes
	Does the agency ensure that each facility’s staffing plan takes into consideration the 11 criteria below in calculating adequate	yes

	staffing levels and determining the need for video monitoring: Any findings of inadequacy from internal or external oversight bodies?	
	Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: All components of the facility's physical plant (including "blind-spots" or areas where staff or residents may be isolated)?	yes
	Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: The composition of the resident population?	yes
	Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: The number and placement of supervisory staff?	yes
	Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Institution programs occurring on a particular shift?	yes
	Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any applicable State or local laws, regulations, or standards?	yes
	Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any other relevant factors?	yes
115.313 (b)	**Supervision and monitoring**	
	Does the agency comply with the staffing plan except during limited and discrete exigent circumstances?	yes
	In circumstances where the staffing plan is not complied with, does the facility fully document all deviations from the plan? (N/A if no deviations from staffing plan.)	na
115.313 (c)	**Supervision and monitoring**	
	Does the facility maintain staff ratios of a minimum of 1:8 during resident waking hours, except during limited and discrete exigent circumstances? (N/A only until October 1, 2017.)	yes

	Does the facility maintain staff ratios of a minimum of 1:16 during resident sleeping hours, except during limited and discrete exigent circumstances? (N/A only until October 1, 2017.)	yes
	Does the facility fully document any limited and discrete exigent circumstances during which the facility did not maintain staff ratios? (N/A only until October 1, 2017.)	yes
	Does the facility ensure only security staff are included when calculating these ratios? (N/A only until October 1, 2017.)	yes
	Is the facility obligated by law, regulation, or judicial consent decree to maintain the staffing ratios set forth in this paragraph?	yes
115.313 (d)	**Supervision and monitoring**	
	In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: The staffing plan established pursuant to paragraph (a) of this section?	yes
	In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: Prevailing staffing patterns?	yes
	In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: The facility's deployment of video monitoring systems and other monitoring technologies?	yes
	In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: The resources the facility has available to commit to ensure adherence to the staffing plan?	yes
115.313 (e)	**Supervision and monitoring**	
	Has the facility implemented a policy and practice of having intermediate-level or higher-level supervisors conduct and document unannounced rounds to identify and deter staff sexual abuse and sexual harassment? (N/A for non-secure facilities)	yes
	Is this policy and practice implemented for night shifts as well as day shifts? (N/A for non-secure facilities)	yes
	Does the facility have a policy prohibiting staff from alerting other staff members that these supervisory rounds are occurring, unless such announcement is related to the legitimate operational	yes

	functions of the facility? (N/A for non-secure facilities)	
115.315 (a)	**Limits to cross-gender viewing and searches**	
	Does the facility always refrain from conducting any cross-gender strip or cross-gender visual body cavity searches, except in exigent circumstances or by medical practitioners?	yes
115.315 (b)	**Limits to cross-gender viewing and searches**	
	Does the facility always refrain from conducting cross-gender pat-down searches in non-exigent circumstances?	yes
115.315 (c)	**Limits to cross-gender viewing and searches**	
	Does the facility document and justify all cross-gender strip searches and cross-gender visual body cavity searches?	yes
	Does the facility document all cross-gender pat-down searches?	yes
115.315 (d)	**Limits to cross-gender viewing and searches**	
	Does the facility implement policies and procedures that enable residents to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks?	yes
	Does the facility require staff of the opposite gender to announce their presence when entering a resident housing unit?	yes
	In facilities (such as group homes) that do not contain discrete housing units, does the facility require staff of the opposite gender to announce their presence when entering an area where residents are likely to be showering, performing bodily functions, or changing clothing? (N/A for facilities with discrete housing units)	yes
115.315 (e)	**Limits to cross-gender viewing and searches**	
	Does the facility always refrain from searching or physically examining transgender or intersex residents for the sole purpose of determining the resident’s genital status?	yes
	If a resident’s genital status is unknown, does the facility	yes

	determine genital status during conversations with the resident, by reviewing medical records, or, if necessary, by learning that information as part of a broader medical examination conducted in private by a medical practitioner?	
115.315 (f)	**Limits to cross-gender viewing and searches**	
	Does the facility/agency train security staff in how to conduct cross-gender pat down searches in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs?	yes
	Does the facility/agency train security staff in how to conduct searches of transgender and intersex residents in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs?	yes
115.316 (a)	**Residents with disabilities and residents who are limited English proficient**	
	Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who are deaf or hard of hearing?	yes
	Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who are blind or have low vision?	yes
	Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have intellectual disabilities?	yes
	Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have psychiatric disabilities?	yes
	Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including:	yes

	Residents who have speech disabilities?	
	Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency’s efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Other? (if "other," please explain in overall determination notes.)	yes
	Do such steps include, when necessary, ensuring effective communication with residents who are deaf or hard of hearing?	yes
	Do such steps include, when necessary, providing access to interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary?	yes
	Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Have intellectual disabilities?	yes
	Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Have limited reading skills?	yes
	Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Who are blind or have low vision?	yes
115.316 (b)	**Residents with disabilities and residents who are limited English proficient**	
	Does the agency take reasonable steps to ensure meaningful access to all aspects of the agency’s efforts to prevent, detect, and respond to sexual abuse and sexual harassment to residents who are limited English proficient?	yes
	Do these steps include providing interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary?	yes
115.316 (c)	**Residents with disabilities and residents who are limited English proficient**	
	Does the agency always refrain from relying on resident interpreters, resident readers, or other types of resident assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the resident’s	yes

	safety, the performance of first-response duties under §115.364, or the investigation of the resident’s allegations?	
115.317 (a)	**Hiring and promotion decisions**	
	Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997)?	yes
	Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse?	yes
	Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has been civilly or administratively adjudicated to have engaged in the activity described in the bullet immediately above?	yes
	Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997)?	yes
	Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse?	yes
	Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has been civilly or administratively adjudicated to have engaged in the activity described in the two bullets immediately above?	yes
115.317 (b)	**Hiring and promotion decisions**	
	Does the agency consider any incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any contractor, who may have contact with residents?	yes
115.317	**Hiring and promotion decisions**	

(c)		
	Before hiring new employees who may have contact with residents, does the agency: Perform a criminal background records check?	yes
	Before hiring new employees who may have contact with residents, does the agency: Consult any child abuse registry maintained by the State or locality in which the employee would work?	yes
	Before hiring new employees who may have contact with residents, does the agency: Consistent with Federal, State, and local law, make its best efforts to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse?	yes
115.317 (d)	**Hiring and promotion decisions**	
	Does the agency perform a criminal background records check before enlisting the services of any contractor who may have contact with residents?	yes
	Does the agency consult applicable child abuse registries before enlisting the services of any contractor who may have contact with residents?	yes
115.317 (e)	**Hiring and promotion decisions**	
	Does the agency either conduct criminal background records checks at least every five years of current employees and contractors who may have contact with residents or have in place a system for otherwise capturing such information for current employees?	yes
115.317 (f)	**Hiring and promotion decisions**	
	Does the agency ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in written applications or interviews for hiring or promotions?	yes
	Does the agency ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in any interviews or written self-evaluations conducted as part of reviews of current	yes

	employees?	
	Does the agency impose upon employees a continuing affirmative duty to disclose any such misconduct?	yes
115.317 (g)	**Hiring and promotion decisions**	
	Does the agency consider material omissions regarding such misconduct, or the provision of materially false information, grounds for termination?	yes
115.317 (h)	**Hiring and promotion decisions**	
	Unless prohibited by law, does the agency provide information on substantiated allegations of sexual abuse or sexual harassment involving a former employee upon receiving a request from an institutional employer for whom such employee has applied to work? (N/A if providing information on substantiated allegations of sexual abuse or sexual harassment involving a former employee is prohibited by law.)	yes
115.318 (a)	**Upgrades to facilities and technologies**	
	If the agency designed or acquired any new facility or planned any substantial expansion or modification of existing facilities, did the agency consider the effect of the design, acquisition, expansion, or modification upon the agency's ability to protect residents from sexual abuse? (N/A if agency/facility has not acquired a new facility or made a substantial expansion to existing facilities since August 20, 2012, or since the last PREA audit, whichever is later.)	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 responsible for investigating allegations of sexual abuse.)	yes
115.321 (h)	**Evidence protocol and forensic medical examinations**	
	If the agency uses a qualified agency staff member or a qualified community-based staff member for the purposes of this section, has the individual been screened for appropriateness to serve in this role and received education concerning sexual assault and forensic examination issues in general? (Check N/A if agency attempts to make a victim advocate from a rape crisis center available to victims per 115.321(d) above.)	yes
115.322 (a)	**Policies to ensure referrals of allegations for investigations**	
	Does the agency ensure an administrative or criminal investigation is completed for all allegations of sexual abuse?	yes
	Does the agency ensure an administrative or criminal investigation is completed for all allegations of sexual harassment?	yes

115.322 (b)	**Policies to ensure referrals of allegations for investigations**	
	Does the agency have a policy in place to ensure that allegations of sexual abuse or sexual harassment are referred for investigation to an agency with the legal authority to conduct criminal investigations, unless the allegation does not involve potentially criminal behavior?	yes
	Has the agency published such policy on its website or, if it does not have one, made the policy available through other means?	yes
	Does the agency document all such referrals?	yes
115.322 (c)	**Policies to ensure referrals of allegations for investigations**	
	If a separate entity is responsible for conducting criminal investigations, does such publication describe the responsibilities of both the agency and the investigating entity? (N/A if the agency/facility is responsible for criminal investigations. See 115.321(a))	yes
115.331 (a)	**Employee training**	
	Does the agency train all employees who may have contact with residents on: Its zero-tolerance policy for sexual abuse and sexual harassment?	yes
	Does the agency train all employees who may have contact with residents on: How to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures?	yes
	Does the agency train all employees who may have contact with residents on: Residents' right to be free from sexual abuse and sexual harassment	yes
	Does the agency train all employees who may have contact with residents on: The right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment?	yes
	Does the agency train all employees who may have contact with residents on: The dynamics of sexual abuse and sexual harassment in juvenile facilities?	yes
	Does the agency train all employees who may have contact with residents on: The common reactions of juvenile victims of sexual abuse and sexual harassment?	yes

	Does the agency train all employees who may have contact with residents on: How to detect and respond to signs of threatened and actual sexual abuse and how to distinguish between consensual sexual contact and sexual abuse between residents?	yes
	Does the agency train all employees who may have contact with residents on: How to avoid inappropriate relationships with residents?	yes
	Does the agency train all employees who may have contact with residents on: How to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents?	yes
	Does the agency train all employees who may have contact with residents on: How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities?	yes
	Does the agency train all employees who may have contact with residents on: Relevant laws regarding the applicable age of consent?	yes
115.331 (b)	**Employee training**	
	Is such training tailored to the unique needs and attributes of residents of juvenile facilities?	yes
	Is such training tailored to the gender of the residents at the employee's facility?	yes
	Have employees received additional training if reassigned from a facility that houses only male residents to a facility that houses only female residents, or vice versa?	no
115.331 (c)	**Employee training**	
	Have all current employees who may have contact with residents received such training?	yes
	Does the agency provide each employee with refresher training every two years to ensure that all employees know the agency's current sexual abuse and sexual harassment policies and procedures?	yes
	In years in which an employee does not receive refresher training, does the agency provide refresher information on current sexual abuse and sexual harassment policies?	yes

115.331 (d)	**Employee training**	
	Does the agency document, through employee signature or electronic verification, that employees understand the training they have received?	yes
115.332 (a)	**Volunteer and contractor training**	
	Has the agency ensured that all volunteers and contractors who have contact with residents have been trained on their responsibilities under the agency’s sexual abuse and sexual harassment prevention, detection, and response policies and procedures?	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	yes

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

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

115.335 (a)	Specialized training: Medical and mental health care	
	Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to detect and assess signs of sexual abuse and sexual harassment? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)	yes
	Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to preserve physical evidence of sexual abuse? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)	yes
	Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to respond effectively and professionally to juvenile victims of sexual abuse and sexual harassment? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)	yes
	Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How and to whom to report allegations or suspicions of sexual abuse and sexual harassment? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)	yes

115.335 (b)	Specialized training: Medical and mental health care	
	If medical staff employed by the agency conduct forensic examinations, do such medical staff receive appropriate training to conduct such examinations? (N/A if agency medical staff at the facility do not conduct forensic exams or the agency does not employ medical staff.)	na

115.335 (c)	Specialized training: Medical and mental health care	
	Does the agency maintain documentation that medical and mental health practitioners have received the training referenced in this standard either from the agency or elsewhere? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)	yes

115.335 (d)	Specialized training: Medical and mental health care	
	Do medical and mental health care practitioners employed by the agency also receive training mandated for employees by §115.331? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)	yes
	Do medical and mental health care practitioners contracted by and volunteering for the agency also receive training mandated for contractors and volunteers by §115.332? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners contracted by or volunteering for the agency.)	yes
115.341 (a)	**Obtaining information from residents**	
	Within 72 hours of the resident's arrival at the facility, does the agency obtain and use information about each resident's personal history and behavior to reduce risk of sexual abuse by or upon a resident?	yes
	Does the agency also obtain this information periodically throughout a resident's confinement?	yes
115.341 (b)	**Obtaining information from residents**	
	Are all PREA screening assessments conducted using an objective screening instrument?	yes
115.341 (c)	**Obtaining information from residents**	
	During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Prior sexual victimization or abusiveness?	yes
	During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Any gender nonconforming appearance or manner or identification as lesbian, gay, bisexual, transgender, or intersex, and whether the resident may therefore be vulnerable to sexual abuse?	yes
	During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Current charges and offense history?	yes
	During these PREA screening assessments, at a minimum, does	yes

	the agency attempt to ascertain information about: Age?	
	During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Level of emotional and cognitive development?	yes
	During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Physical size and stature?	yes
	During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Mental illness or mental disabilities?	yes
	During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Intellectual or developmental disabilities?	yes
	During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Physical disabilities?	yes
	During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: The resident's own perception of vulnerability?	yes
	During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Any other specific information about individual residents that may indicate heightened needs for supervision, additional safety precautions, or separation from certain other residents?	yes
115.341 (d)	**Obtaining information from residents**	
	Is this information ascertained: Through conversations with the resident during the intake process and medical mental health screenings?	yes
	Is this information ascertained: During classification assessments?	yes
	Is this information ascertained: By reviewing court records, case files, facility behavioral records, and other relevant documentation from the resident's files?	yes
115.341 (e)	**Obtaining information from residents**	
	Has the agency implemented appropriate controls on the dissemination within the facility of responses to questions asked	yes

	pursuant to this standard in order to ensure that sensitive information is not exploited to the resident's detriment by staff or other residents?	
115.342 (a)	**Placement of residents**	
	Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Housing Assignments?	yes
	Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Bed assignments?	yes
	Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Work Assignments?	yes
	Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Education Assignments?	yes
	Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Program Assignments?	yes
115.342 (b)	**Placement of residents**	
	Are residents isolated from others only as a last resort when less restrictive measures are inadequate to keep them and other residents safe, and then only until an alternative means of keeping all residents safe can be arranged?	yes
	During any period of isolation, does the agency always refrain from denying residents daily large-muscle exercise?	yes
	During any period of isolation, does the agency always refrain from denying residents any legally required educational programming or special education services?	yes
	Do residents in isolation receive daily visits from a medical or mental health care clinician?	yes
	Do residents also have access to other programs and work opportunities to the extent possible?	yes

115.342 (c)	**Placement of residents**	
	Does the agency always refrain from placing: Lesbian, gay, and bisexual residents in particular housing, bed, or other assignments solely on the basis of such identification or status?	yes
	Does the agency always refrain from placing: Transgender residents in particular housing, bed, or other assignments solely on the basis of such identification or status?	yes
	Does the agency always refrain from placing: Intersex residents in particular housing, bed, or other assignments solely on the basis of such identification or status?	yes
	Does the agency always refrain from considering lesbian, gay, bisexual, transgender, or intersex identification or status as an indicator or likelihood of being sexually abusive?	yes
115.342 (d)	**Placement of residents**	
	When deciding whether to assign a transgender or intersex resident to a facility for male or female residents, does the agency consider on a case-by-case basis whether a placement would ensure the resident's health and safety, and whether a placement would present management or security problems (NOTE: if an agency by policy or practice assigns residents to a male or female facility on the basis of anatomy alone, that agency is not in compliance with this standard)?	yes
	When making housing or other program assignments for transgender or intersex residents, does the agency consider on a case-by-case basis whether a placement would ensure the resident's health and safety, and whether a placement would present management or security problems?	yes
115.342 (e)	**Placement of residents**	
	Are placement and programming assignments for each transgender or intersex resident reassessed at least twice each year to review any threats to safety experienced by the resident?	yes
115.342 (f)	**Placement of residents**	
	Are each transgender or intersex resident's own views with respect to his or her own safety given serious consideration when	yes

	making facility and housing placement decisions and programming assignments?	
115.342 (g)	**Placement of residents**	
	Are transgender and intersex residents given the opportunity to shower separately from other residents?	yes
115.342 (h)	**Placement of residents**	
	If a resident is isolated pursuant to paragraph (b) of this section, does the facility clearly document: The basis for the facility's concern for the resident's safety? (N/A for h and i if facility doesn't use isolation?)	na
	If a resident is isolated pursuant to paragraph (b) of this section, does the facility clearly document: The reason why no alternative means of separation can be arranged? (N/A for h and i if facility doesn't use isolation?)	na
115.342 (i)	**Placement of residents**	
	In the case of each resident who is isolated as a last resort when less restrictive measures are inadequate to keep them and other residents safe, does the facility afford a review to determine whether there is a continuing need for separation from the general population EVERY 30 DAYS?	yes
115.351 (a)	**Resident reporting**	
	Does the agency provide multiple internal ways for residents to privately report: Sexual abuse and sexual harassment?	yes
	Does the agency provide multiple internal ways for residents to privately report: 2. Retaliation by other residents or staff for reporting sexual abuse and sexual harassment?	yes
	Does the agency provide multiple internal ways for residents to privately report: Staff neglect or violation of responsibilities that may have contributed to such incidents?	yes
115.351 (b)	**Resident reporting**	
	Does the agency also provide at least one way for residents to report sexual abuse or sexual harassment to a public or private	yes

	entity or office that is not part of the agency?	
	Is that private entity or office able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials?	yes
	Does that private entity or office allow the resident to remain anonymous upon request?	yes
	Are residents detained solely for civil immigration purposes provided information on how to contact relevant consular officials and relevant officials at the Department of Homeland Security to report sexual abuse or harassment?	no
115.351 (c)	**Resident reporting**	
	Do staff members accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously, and from third parties?	yes
	Do staff members promptly document any verbal reports of sexual abuse and sexual harassment?	yes
115.351 (d)	**Resident reporting**	
	Does the facility provide residents with access to tools necessary to make a written report?	yes
115.351 (e)	**Resident reporting**	
	Does the agency provide a method for staff to privately report sexual abuse and sexual harassment of residents?	yes
115.352 (a)	**Exhaustion of administrative remedies**	
	Is the agency exempt from this standard? NOTE: The agency is exempt ONLY if it does not have administrative procedures to address resident grievances regarding sexual abuse. This does not mean the agency is exempt simply because a resident does not have to or is not ordinarily expected to submit a grievance to report sexual abuse. This means that as a matter of explicit policy, the agency does not have an administrative remedies process to address sexual abuse.	yes
115.352 (b)	**Exhaustion of administrative remedies**	

	Does the agency permit residents to submit a grievance regarding an allegation of sexual abuse without any type of time limits? (The agency may apply otherwise-applicable time limits to any portion of a grievance that does not allege an incident of sexual abuse.) (N/A if agency is exempt from this standard.)	na
	Does the agency always refrain from requiring an resident to use any informal grievance process, or to otherwise attempt to resolve with staff, an alleged incident of sexual abuse? (N/A if agency is exempt from this standard.)	na
115.352 (c)	**Exhaustion of administrative remedies**	
	Does the agency ensure that: A resident who alleges sexual abuse may submit a grievance without submitting it to a staff member who is the subject of the complaint? (N/A if agency is exempt from this standard.)	na
	Does the agency ensure that: Such grievance is not referred to a staff member who is the subject of the complaint? (N/A if agency is exempt from this standard.)	na
115.352 (d)	**Exhaustion of administrative remedies**	
	Does the agency issue a final agency decision on the merits of any portion of a grievance alleging sexual abuse within 90 days of the initial filing of the grievance? (Computation of the 90-day time period does not include time consumed by residents in preparing any administrative appeal.) (N/A if agency is exempt from this standard.)	na
	If the agency determines that the 90 day timeframe is insufficient to make an appropriate decision and claims an extension of time (the maximum allowable extension of time to respond is 70 days per 115.352(d)(3)) , does the agency notify the resident in writing of any such extension and provide a date by which a decision will be made? (N/A if agency is exempt from this standard.)	na
	At any level of the administrative process, including the final level, if the resident does not receive a response within the time allotted for reply, including any properly noticed extension, may a resident consider the absence of a response to be a denial at that level? (N/A if agency is exempt from this standard.)	na
115.352 (e)	**Exhaustion of administrative remedies**	

	Are third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, permitted to assist residents in filing requests for administrative remedies relating to allegations of sexual abuse? (N/A if agency is exempt from this standard.)	na
	Are those third parties also permitted to file such requests on behalf of residents? (If a third party, other than a parent or legal guardian, files such a request on behalf of a resident, the facility may require as a condition of processing the request that the alleged victim agree to have the request filed on his or her behalf, and may also require the alleged victim to personally pursue any subsequent steps in the administrative remedy process.) (N/A if agency is exempt from this standard.)	na
	If the resident declines to have the request processed on his or her behalf, does the agency document the resident's decision? (N/A if agency is exempt from this standard.)	na
	Is a parent or legal guardian of a juvenile allowed to file a grievance regarding allegations of sexual abuse, including appeals, on behalf of such juvenile? (N/A if agency is exempt from this standard.)	na
	If a parent or legal guardian of a juvenile files a grievance (or an appeal) on behalf of a juvenile regarding allegations of sexual abuse, is it the case that those grievances are not conditioned upon the juvenile agreeing to have the request filed on his or her behalf? (N/A if agency is exempt from this standard.)	na
115.352 (f)	**Exhaustion of administrative remedies**	
	Has the agency established procedures for the filing of an emergency grievance alleging that a resident is subject to a substantial risk of imminent sexual abuse? (N/A if agency is exempt from this standard.)	na
	After receiving an emergency grievance alleging a resident is subject to a substantial risk of imminent sexual abuse, does the agency immediately forward the grievance (or any portion thereof that alleges the substantial risk of imminent sexual abuse) to a level of review at which immediate corrective action may be taken? (N/A if agency is exempt from this standard.)	na
	After receiving an emergency grievance described above, does the agency provide an initial response within 48 hours? (N/A if agency is exempt from this standard.)	na

	After receiving an emergency grievance described above, does the agency issue a final agency decision within 5 calendar days? (N/A if agency is exempt from this standard.)	na
	Does the initial response and final agency decision document the agency's determination whether the resident is in substantial risk of imminent sexual abuse? (N/A if agency is exempt from this standard.)	na
	Does the initial response document the agency's action(s) taken in response to the emergency grievance? (N/A if agency is exempt from this standard.)	na
	Does the agency's final decision document the agency's action(s) taken in response to the emergency grievance? (N/A if agency is exempt from this standard.)	na
115.352 (g)	**Exhaustion of administrative remedies**	
	If the agency disciplines a resident for filing a grievance related to alleged sexual abuse, does it do so ONLY where the agency demonstrates that the resident filed the grievance in bad faith? (N/A if agency is exempt from this standard.)	na
115.353 (a)	**Resident access to outside confidential support services and legal representation**	
	Does the facility provide residents with access to outside victim advocates for emotional support services related to sexual abuse by providing, posting, or otherwise making accessible mailing addresses and telephone numbers, including toll-free hotline numbers where available, of local, State, or national victim advocacy or rape crisis organizations?	yes
	Does the facility provide persons detained solely for civil immigration purposes mailing addresses and telephone numbers, including toll-free hotline numbers where available of local, State, or national immigrant services agencies?	no
	Does the facility enable reasonable communication between residents and these organizations and agencies, in as confidential a manner as possible?	yes
115.353 (b)	**Resident access to outside confidential support services and legal representation**	
	Does the facility inform residents, prior to giving them access, of the extent to which such communications will be monitored and	yes

	the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws?	
115.353 (c)	**Resident access to outside confidential support services and legal representation**	
	Does the agency maintain or attempt to enter into memoranda of understanding or other agreements with community service providers that are able to provide residents with confidential emotional support services related to sexual abuse?	yes
	Does the agency maintain copies of agreements or documentation showing attempts to enter into such agreements?	yes
115.353 (d)	**Resident access to outside confidential support services and legal representation**	
	Does the facility provide residents with reasonable and confidential access to their attorneys or other legal representation?	yes
	Does the facility provide residents with reasonable access to parents or legal guardians?	yes
115.354 (a)	**Third-party reporting**	
	Has the agency established a method to receive third-party reports of sexual abuse and sexual harassment?	yes
	Has the agency distributed publicly information on how to report sexual abuse and sexual harassment on behalf of a resident?	yes
115.361 (a)	**Staff and agency reporting duties**	
	Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information they receive regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency?	yes
	Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information they receive regarding retaliation against residents or staff who reported an incident of sexual abuse or sexual harassment?	yes
	Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or	yes

	information they receive regarding any staff neglect or violation of responsibilities that may have contributed to an incident of sexual abuse or sexual harassment or retaliation?	
115.361 (b)	**Staff and agency reporting duties**	
	Does the agency require all staff to comply with any applicable mandatory child abuse reporting laws?	yes
115.361 (c)	**Staff and agency reporting duties**	
	Apart from reporting to designated supervisors or officials and designated State or local services agencies, are staff prohibited from revealing any information related to a sexual abuse report to anyone other than to the extent necessary, as specified in agency policy, to make treatment, investigation, and other security and management decisions?	yes
115.361 (d)	**Staff and agency reporting duties**	
	Are medical and mental health practitioners required to report sexual abuse to designated supervisors and officials pursuant to paragraph (a) of this section as well as to the designated State or local services agency where required by mandatory reporting laws?	yes
	Are medical and mental health practitioners required to inform residents of their duty to report, and the limitations of confidentiality, at the initiation of services?	yes
115.361 (e)	**Staff and agency reporting duties**	
	Upon receiving any allegation of sexual abuse, does the facility head or his or her designee promptly report the allegation to the appropriate office?	yes
	Upon receiving any allegation of sexual abuse, does the facility head or his or her designee promptly report the allegation to the alleged victim's parents or legal guardians unless the facility has official documentation showing the parents or legal guardians should not be notified?	yes
	If the alleged victim is under the guardianship of the child welfare system, does the facility head or his or her designee promptly report the allegation to the alleged victim's caseworker instead of	yes

	the parents or legal guardians? (N/A if the alleged victim is not under the guardianship of the child welfare system.)	
	If a juvenile court retains jurisdiction over the alleged victim, does the facility head or designee also report the allegation to the juvenile's attorney or other legal representative of record within 14 days of receiving the allegation?	yes
115.361 (f)	**Staff and agency reporting duties**	
	Does the facility report all allegations of sexual abuse and sexual harassment, including third-party and anonymous reports, to the facility's designated investigators?	yes
115.362 (a)	**Agency protection duties**	
	When the agency learns that a resident is subject to a substantial risk of imminent sexual abuse, does it take immediate action to protect the resident?	yes
115.363 (a)	**Reporting to other confinement facilities**	
	Upon receiving an allegation that a resident was sexually abused while confined at another facility, does the head of the facility that received the allegation notify the head of the facility or appropriate office of the agency where the alleged abuse occurred?	yes
	Does the head of the facility that received the allegation also notify the appropriate investigative agency?	yes
115.363 (b)	**Reporting to other confinement facilities**	
	Is such notification provided as soon as possible, but no later than 72 hours after receiving the allegation?	yes
115.363 (c)	**Reporting to other confinement facilities**	
	Does the agency document that it has provided such notification?	yes
115.363 (d)	**Reporting to other confinement facilities**	
	Does the facility head or agency office that receives such notification ensure that the allegation is investigated in	yes

	accordance with these standards?	
115.364 (a)	**Staff first responder duties**	
	Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Separate the alleged victim and abuser?	yes
	Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Preserve and protect any crime scene until appropriate steps can be taken to collect any evidence?	yes
	Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Request that the alleged victim not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating, if the abuse occurred within a time period that still allows for the collection of physical evidence?	yes
	Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Ensure that the alleged abuser does not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating, if the abuse occurred within a time period that still allows for the collection of physical evidence?	yes
115.364 (b)	**Staff first responder duties**	
	If the first staff responder is not a security staff member, is the responder required to request that the alleged victim not take any actions that could destroy physical evidence, and then notify security staff?	yes
115.365 (a)	**Coordinated response**	
	Has the facility developed a written institutional plan to coordinate actions among staff first responders, medical and mental health practitioners, investigators, and facility leadership taken in response to an incident of sexual abuse?	yes
115.366 (a)	**Preservation of ability to protect residents from contact with abusers**	

	Are both the agency and any other governmental entities responsible for collective bargaining on the agency's behalf prohibited from entering into or renewing any collective bargaining agreement or other agreement that limits the agency's ability to remove alleged staff sexual abusers from contact with any residents pending the outcome of an investigation or of a determination of whether and to what extent discipline is warranted?	yes
115.367 (a)	**Agency protection against retaliation**	
	Has the agency established a policy to protect all residents and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other residents or staff?	yes
	Has the agency designated which staff members or departments are charged with monitoring retaliation?	yes
115.367 (b)	**Agency protection against retaliation**	
	Does the agency employ multiple protection measures for residents or staff who fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations, such as housing changes or transfers for resident victims or abusers, removal of alleged staff or resident abusers from contact with victims, and emotional support services?	yes
115.367 (c)	**Agency protection against retaliation**	
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor the conduct and treatment of residents or staff who reported the sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff?	yes
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor the conduct and treatment of residents who were reported to have suffered sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff?	yes
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report	yes

	of sexual abuse, does the agency: Act promptly to remedy any such retaliation?	
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor: Any resident disciplinary reports?	yes
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor: Resident housing changes?	yes
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor: Resident program changes?	yes
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor: Negative performance reviews of staff?	yes
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor: Reassignments of staff?	yes
	Does the agency continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need?	yes
115.367 (d)	**Agency protection against retaliation**	
	In the case of residents, does such monitoring also include periodic status checks?	yes
115.367 (e)	**Agency protection against retaliation**	
	If any other individual who cooperates with an investigation expresses a fear of retaliation, does the agency take appropriate measures to protect that individual against retaliation?	yes
115.368 (a)	**Post-allegation protective custody**	
	Is any and all use of segregated housing to protect a resident who is alleged to have suffered sexual abuse subject to the requirements of § 115.342?	yes

115.371 (a)	Criminal and administrative agency investigations	
	When the agency conducts its own investigations into allegations of sexual abuse and sexual harassment, does it do so promptly, thoroughly, and objectively? (N/A if the agency does not conduct any form of administrative or criminal investigations of sexual abuse or harassment. See 115.321(a).)	yes
	Does the agency conduct such investigations for all allegations, including third party and anonymous reports? (N/A if the agency does not conduct any form of administrative or criminal investigations of sexual abuse or harassment. See 115.321(a).)	yes
115.371 (b)	**Criminal and administrative agency investigations**	
	Where sexual abuse is alleged, does the agency use investigators who have received specialized training in sexual abuse investigations involving juvenile victims as required by 115.334?	yes
115.371 (c)	**Criminal and administrative agency investigations**	
	Do investigators gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data?	yes
	Do investigators interview alleged victims, suspected perpetrators, and witnesses?	yes
	Do investigators review prior reports and complaints of sexual abuse involving the suspected perpetrator?	yes
115.371 (d)	**Criminal and administrative agency investigations**	
	Does the agency always refrain from terminating an investigation solely because the source of the allegation recants the allegation?	yes
115.371 (e)	**Criminal and administrative agency investigations**	
	When the quality of evidence appears to support criminal prosecution, does the agency conduct compelled interviews only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution?	yes
115.371	**Criminal and administrative agency investigations**	

(f)		
	Do agency investigators assess the credibility of an alleged victim, suspect, or witness on an individual basis and not on the basis of that individual's status as resident or staff?	yes
	Does the agency investigate allegations of sexual abuse without requiring a resident who alleges sexual abuse to submit to a polygraph examination or other truth-telling device as a condition for proceeding?	yes
115.371 (g)	**Criminal and administrative agency investigations**	
	Do administrative investigations include an effort to determine whether staff actions or failures to act contributed to the abuse?	yes
	Are administrative investigations documented in written reports that include a description of the physical evidence and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings?	yes
115.371 (h)	**Criminal and administrative agency investigations**	
	Are criminal investigations documented in a written report that contains a thorough description of the physical, testimonial, and documentary evidence and attaches copies of all documentary evidence where feasible?	yes
115.371 (i)	**Criminal and administrative agency investigations**	
	Are all substantiated allegations of conduct that appears to be criminal referred for prosecution?	yes
115.371 (j)	**Criminal and administrative agency investigations**	
	Does the agency retain all written reports referenced in 115.371(g) and (h) for as long as the alleged abuser is incarcerated or employed by the agency, plus five years unless the abuse was committed by a juvenile resident and applicable law requires a shorter period of retention?	yes
115.371 (k)	**Criminal and administrative agency investigations**	
	Does the agency ensure that the departure of an alleged abuser or victim from the employment or control of the facility or agency	yes

	does not provide a basis for terminating an investigation?	
115.371 (m)	**Criminal and administrative agency investigations**	
	When an outside entity investigates sexual abuse, does the facility cooperate with outside investigators and endeavor to remain informed about the progress of the investigation? (N/A if an outside agency does not conduct administrative or criminal sexual abuse investigations. See 115.321(a).)	yes
115.372 (a)	**Evidentiary standard for administrative investigations**	
	Is it true that the agency does not impose a standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated?	yes
115.373 (a)	**Reporting to residents**	
	Following an investigation into a resident's allegation of sexual abuse suffered in the facility, does the agency inform the resident as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded?	yes
115.373 (b)	**Reporting to residents**	
	If the agency did not conduct the investigation into a resident's allegation of sexual abuse in an agency facility, does the agency request the relevant information from the investigative agency in order to inform the resident? (N/A if the agency/facility is responsible for conducting administrative and criminal investigations.)	no
115.373 (c)	**Reporting to residents**	
	Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The staff member is no longer posted within the resident's unit?	yes
	Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency	yes

	has determined that the allegation is unfounded or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The staff member is no longer employed at the facility?	
	Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The agency learns that the staff member has been indicted on a charge related to sexual abuse in the facility?	yes
	Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility?	yes
115.373 (d)	**Reporting to residents**	
	Following a resident's allegation that he or she has been sexually abused by another resident, does the agency subsequently inform the alleged victim whenever: The agency learns that the alleged abuser has been indicted on a charge related to sexual abuse within the facility?	yes
	Following a resident's allegation that he or she has been sexually abused by another resident, does the agency subsequently inform the alleged victim whenever: The agency learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility?	yes
115.373 (e)	**Reporting to residents**	
	Does the agency document all such notifications or attempted notifications?	yes
115.376 (a)	**Disciplinary sanctions for staff**	
	Are staff subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies?	yes

115.376 (b)	**Disciplinary sanctions for staff**	
	Is termination the presumptive disciplinary sanction for staff who have engaged in sexual abuse?	yes
115.376 (c)	**Disciplinary sanctions for staff**	
	Are disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) commensurate with the nature and circumstances of the acts committed, the staff member's disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories?	yes
115.376 (d)	**Disciplinary sanctions for staff**	
	Are all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, reported to: Law enforcement agencies, unless the activity was clearly not criminal?	yes
	Are all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, reported to: Relevant licensing bodies?	yes
115.377 (a)	**Corrective action for contractors and volunteers**	
	Is any contractor or volunteer who engages in sexual abuse prohibited from contact with residents?	yes
	Is any contractor or volunteer who engages in sexual abuse reported to: Law enforcement agencies (unless the activity was clearly not criminal)?	yes
	Is any contractor or volunteer who engages in sexual abuse reported to: Relevant licensing bodies?	yes
115.377 (b)	**Corrective action for contractors and volunteers**	
	In the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer, does the facility take appropriate remedial measures, and consider whether to prohibit further contact with residents?	yes

115.378 (a)	Interventions and disciplinary sanctions for residents	
	Following an administrative finding that a resident engaged in resident-on-resident sexual abuse, or following a criminal finding of guilt for resident-on-resident sexual abuse, may residents be subject to disciplinary sanctions only pursuant to a formal disciplinary process?	yes
115.378 (b)	**Interventions and disciplinary sanctions for residents**	
	Are disciplinary sanctions commensurate with the nature and circumstances of the abuse committed, the resident's disciplinary history, and the sanctions imposed for comparable offenses by other residents with similar histories?	yes
	In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident is not denied daily large-muscle exercise?	yes
	In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident is not denied access to any legally required educational programming or special education services?	yes
	In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident receives daily visits from a medical or mental health care clinician?	yes
	In the event a disciplinary sanction results in the isolation of a resident, does the resident also have access to other programs and work opportunities to the extent possible?	yes
115.378 (c)	**Interventions and disciplinary sanctions for residents**	
	When determining what types of sanction, if any, should be imposed, does the disciplinary process consider whether a resident's mental disabilities or mental illness contributed to his or her behavior?	yes
115.378 (d)	**Interventions and disciplinary sanctions for residents**	
	If the facility offers therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse, does the facility consider whether to offer the offending resident participation in such interventions?	yes

	If the agency requires participation in such interventions as a condition of access to any rewards-based behavior management system or other behavior-based incentives, does it always refrain from requiring such participation as a condition to accessing general programming or education?	yes
115.378 (e)	**Interventions and disciplinary sanctions for residents**	
	Does the agency discipline a resident for sexual contact with staff only upon a finding that the staff member did not consent to such contact?	yes
115.378 (f)	**Interventions and disciplinary sanctions for residents**	
	For the purpose of disciplinary action, does a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred NOT constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation?	yes
115.378 (g)	**Interventions and disciplinary sanctions for residents**	
	Does the agency always refrain from considering non-coercive sexual activity between residents to be sexual abuse? (N/A if the agency does not prohibit all sexual activity between residents.)	yes
115.381 (a)	**Medical and mental health screenings; history of sexual abuse**	
	If the screening pursuant to § 115.341 indicates that a resident has experienced prior sexual victimization, whether it occurred in an institutional setting or in the community, do staff ensure that the resident is offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening?	yes
115.381 (b)	**Medical and mental health screenings; history of sexual abuse**	
	If the screening pursuant to § 115.341 indicates that a resident has previously perpetrated sexual abuse, whether it occurred in an institutional setting or in the community, do staff ensure that the resident is offered a follow-up meeting with a mental health practitioner within 14 days of the intake screening?	yes
115.381 (c)	**Medical and mental health screenings; history of sexual abuse**	

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

	cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident?	
115.383 (a)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	Does the facility offer medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility?	yes
115.383 (b)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	Does the evaluation and treatment of such victims include, as appropriate, follow-up services, treatment plans, and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody?	yes
115.383 (c)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	Does the facility provide such victims with medical and mental health services consistent with the community level of care?	yes
115.383 (d)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	Are resident victims of sexually abusive vaginal penetration while incarcerated offered pregnancy tests? (N/A if all-male facility.)	yes
115.383 (e)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	If pregnancy results from the conduct described in paragraph § 115.383(d), do such victims receive timely and comprehensive information about and timely access to all lawful pregnancy-related medical services? (N/A if all-male facility.)	yes
115.383 (f)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	Are resident victims of sexual abuse while incarcerated offered tests for sexually transmitted infections as medically appropriate?	yes
115.383 (g)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	Are treatment services provided to the victim without financial cost and regardless of whether the victim names the abuser or	yes

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

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

	the confinement of its residents.)	
115.387 (f)	**Data collection**	
	Does the agency, upon request, provide all such data from the previous calendar year to the Department of Justice no later than June 30? (N/A if DOJ has not requested agency data.)	yes
115.388 (a)	**Data review for corrective action**	
	Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Identifying problem areas?	yes
	Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Taking corrective action on an ongoing basis?	yes
	Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Preparing an annual report of its findings and corrective actions for each facility, as well as the agency as a whole?	yes
115.388 (b)	**Data review for corrective action**	
	Does the agency's annual report include a comparison of the current year's data and corrective actions with those from prior years and provide an assessment of the agency's progress in addressing sexual abuse?	yes
115.388 (c)	**Data review for corrective action**	
	Is the agency's annual report approved by the agency head and made readily available to the public through its website or, if it does not have one, through other means?	yes
115.388 (d)	**Data review for corrective action**	
	Does the agency indicate the nature of the material redacted where it redacts specific material from the reports when	yes

	publication would present a clear and specific threat to the safety and security of a facility?	
115.389 (a)	**Data storage, publication, and destruction**	
	Does the agency ensure that data collected pursuant to § 115.387 are securely retained?	yes
115.389 (b)	**Data storage, publication, and destruction**	
	Does the agency make all aggregated sexual abuse data, from facilities under its direct control and private facilities with which it contracts, readily available to the public at least annually through its website or, if it does not have one, through other means?	yes
115.389 (c)	**Data storage, publication, and destruction**	
	Does the agency remove all personal identifiers before making aggregated sexual abuse data publicly available?	yes
115.389 (d)	**Data storage, publication, and destruction**	
	Does the agency maintain sexual abuse data collected pursuant to § 115.387 for at least 10 years after the date of the initial collection, unless Federal, State, or local law requires otherwise?	yes
115.401 (a)	**Frequency and scope of audits**	
	During the prior three-year audit period, did the agency ensure that each facility operated by the agency, or by a private organization on behalf of the agency, was audited at least once? (Note: The response here is purely informational. A "no" response does not impact overall compliance with this standard.)	yes
115.401 (b)	**Frequency and scope of audits**	
	Is this the first year of the current audit cycle? (Note: a “no” response does not impact overall compliance with this standard.)	yes
	If this is the second year of the current audit cycle, did the agency ensure that at least one-third of each facility type operated by the agency, or by a private organization on behalf of the agency, was audited during the first year of the current audit cycle? (N/A if this is not the second year of the current audit cycle.)	na

	If this is the third year of the current audit cycle, did the agency ensure that at least two-thirds of each facility type operated by the agency, or by a private organization on behalf of the agency, were audited during the first two years of the current audit cycle? (N/A if this is not the third year of the current audit cycle.)	na
115.401 (h)	**Frequency and scope of audits**	
	Did the auditor have access to, and the ability to observe, all areas of the audited facility?	yes
115.401 (i)	**Frequency and scope of audits**	
	Was the auditor permitted to request and receive copies of any relevant documents (including electronically stored information)?	yes
115.401 (m)	**Frequency and scope of audits**	
	Was the auditor permitted to conduct private interviews with inmates, residents, and detainees?	yes
115.401 (n)	**Frequency and scope of audits**	
	Were inmates, residents, and detainees permitted to send confidential information or correspondence to the auditor in the same manner as if they were communicating with legal counsel?	yes
115.403 (f)	**Audit contents and findings**	
	The agency has published on its agency website, if it has one, or has otherwise made publicly available, all Final Audit Reports. The review period is for prior audits completed during the past three years PRECEDING THIS AUDIT. The pendency of any agency appeal pursuant to 28 C.F.R. § 115.405 does not excuse noncompliance with this provision. (N/A if there have been no Final Audit Reports issued in the past three years, or, in the case of single facility agencies, there has never been a Final Audit Report issued.)	yes